



Department
for International
Development



Health Partnership Scheme

Evaluation Synthesis Report



October 2016



Expanding Horizons. Enriching Lives.



Authors: Georgia Taylor (Team Leader and Myanmar Lead), Katharine May (Uganda and online surveys, volunteer interviews), Paula McMeekin (Sierra Leone, Myanmar, remote case studies),

Country Case study Authors: Irko Zuurmond (Lead for Uganda and VfM methodology), Adetoro Adegoke (Lead for Sierra Leone and Zambia)

Quality Assurance: Lydia Richardson

With contributions from: Paula Quigley (Health systems QA), Clare Callow (MNCH portfolio review), Margaret Mannah-MacCarthy (Sierra Leone), Dr Khin Tar Tar (Myanmar), Maureen Syanzila (Zambia), Abeja Apunyo (Uganda), Sophie Greenwood (Report formatting and copy-editing).

Acknowledgements: With thanks to the support and significant effort provided for the evaluation from:
THET: Andrew Jones, Dan Ritman, Victoria Tayler and all of the THET project managers who spent a huge amount of time sourcing information and answering questions, always with a kind and helpful manner.
HPS Partners and volunteers for helping to organise the visits for the country case studies and to all of the health workers, education faculty, service users and managers who were kind enough to allow us to interview them.
DFID Management Group: Mary-Ann Taylor, Iain Jones and Nicola Watt for excellent and efficient management of the technical and organisational elements of the evaluation, and holding the evaluation team closely to account.
The Evaluation Reference Group and the Wider Stakeholder group for participating in several workshops and providing comments and contributions.
Thanks to the illustrator for the visual representations of our workshop discussions throughout the evaluation period.

Front cover photo: Monywa Hospital, Myanmar, from left to right: Dr Khaing Mar Thant, Dr Myint Myint Thein, Dr. Thant Myat Win, Senior Consultant Paediatricians and volunteers from the Royal College of Paediatrics and Child Health (RCPCH) Michael Malley and Marie Monaghan. Photo taken by Georgia Taylor

Summary: Health Partnership Scheme Evaluation

HPS in figures:

- ❖ From 2011 to 2017
- ❖ £30.2m budget
- ❖ 176 grants
- ❖ In 32 countries
- ❖ 139 partnerships
- ❖ 97 UK partners



The Evaluation in figures:

- ❖ 350 interviews
- ❖ 4 country visits (11 projects)
- ❖ + 5 projects remotely
- ❖ 3 online surveys
- ❖ 37 MNCH projects reviewed
- ❖ 122 Health workers interviewed



SUMMARY OF TOP LEVEL FINDINGS

- ❖ HPS projects have contributed to health system strengthening by strengthening health worker capacity in terms of their skills, knowledge and confidence.
- ❖ Long-term volunteering and strategic short term volunteering are most effective.
- ❖ The volunteering and partnership approaches used by the HPS represent good value for money.

- ❖ HPS projects are highly relevant and aligned with local government commitments and priorities.
- ❖ The HPS and THET's guidance have contributed to strengthening partnerships. THET's input around networking and technical assistance has been well delivered.
- ❖ There are examples of women health worker empowerment but gender and social inclusion approaches and analysis are not strong enough.
- ❖ The HPS benefits both volunteers and the UK health systems.
- ❖ Monitoring, evaluation and learning have improved considerably, but more is needed.



What worked well:

- ❖ Strong partnerships deliver strong projects. Long-term partnerships are effective at designing and implementing approaches that contribute to health system strengthening. Sustainability of project outputs are supported by the strength and longevity of the partnership.
- ❖ Volunteers overwhelmingly reported that their skills and confidence had increased as a result of working in challenging developing country situations.

What didn't work so well:

- ❖ There was very little collaboration between partnerships or with other aid programming in host countries.
- ❖ Health system constraints may have limited the chances for improving health worker capacity and health services.

KEY LEARNING

Wider learning:

- ❖ Partnerships that are able to link up, establish synergies and be more strategic are particularly effective, as are those which provide expertise for specialist technical areas.
- ❖ The best monitoring, evaluation and learning systems have been designed with and by the southern institution.
- ❖ Partnerships should be supported to have a more strategic approach to UK health worker professional development and health system strengthening in the UK.



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Acronyms

ASEAN	Association of South East Asian Nations
CPD	Continued Professional Development
CSCF	Civil Society Challenge Fund
CSO	Civil Society Organisation
DAC	Development Assistance Committee
DFID	Department for International Development
DHF	Dengue Haemorrhagic Fever
DHO	District Health Office
DoH	Department of Health
DRC	Democratic Republic of the Congo
EU	European Union
FCO	Foreign Commonwealth Office
FP	Family planning
HCWs	Health care workers
HDI	Health Delivery Institution
HEE	Health Education England
HEI	Health Education Institution
HMIS	Health Management Information System
HPS	Health Partnership Scheme
HRH	Human Resources for Health
HSS	Health Systems Strengthening
ICT	Information Communication Technology
iDSI	International Decision Support Initiative
IPC	Infection prevention and control
LAMRN	Lugana Africa Midwives Research Network
LMICs	Low Middle Income Countries
LSHTM	London School of Hygiene and Tropical Medicine
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MEL	Monitoring Evaluation and Learning
MNCH	Maternal, Newborn and Child Health
MPCU	Makerere Palliative Care Unit
NGO	Non-Governmental Organisation
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NMFUK	Nigeria Muslim Forum UK
PA	Professional Associations
QA	Quality Assurance
RCPCH	Royal College of Paediatrics and Child Health
RCSEd	Royal College of Surgeons of Edinburgh
SAAF	Safe Abortion Action Fund
SDGs	Sustainable Development Goals
SRH	Sexual Reproductive Health
TA	Technical Assistance
THET	Tropical Health and Education Trust
ToC	Theory of Change
TOR	Terms of Reference
ToT	Training of trainers
UHC	Universal Health Coverage
UUKHA	Uganda UK Health Alliance
UNaMHE	Uganda National Association of Medical and Hospital Engineers
VfM	Value for Money
VSO	Voluntary Service Overseas
WHA	World Health Assembly
WHO	World Health Organisation

1. Executive Summary

This report covers the theory based evaluation carried out between April and September 2016, of the £30.2 million Health Partnership Scheme (HPS) which started in June 2011 and is due to end in June 2017. HPS supports partnerships between UK and developing country health organisations in 32 countries. After a one month inception phase, the following **evaluation questions** were agreed:

1. To what extent and under what circumstances is the HPS programme achieving its stated outcome: “more effective and efficient health systems, with an emphasis on the performance of the health workforce” and is there any evidence of impact? (DAC Criteria: Effectiveness, Impact and Equity)
2. Is the programme delivering value for money? (DAC Criteria: Effectiveness, Efficiency, Equity, plus VfM criteria of Economy)
3. What lessons can be learned in relation to: strengthening partnerships between UK and developing countries’ health institutions; the partnership use of volunteers from the UK to deliver projects; and the effect of this on project effectiveness (to deliver stronger health systems and build capacity of the workforce)? (DAC Criteria: Relevance, Efficiency and Effectiveness)
4. To what extent have the HPS projects been identified, designed and delivered in response to the host country context and in alignment with government plans and strategies? (DAC Criteria: Relevance and Sustainability)
5. How has HPS benefited the UK in terms of strengthening the health workforce, health systems and/or in terms of recruitment and retention of health workers? (DAC Criteria: Effectiveness, Sustainability and Equity)
6. How can the HPS (programme, projects and partnerships) be monitored and evaluated?

The evaluation findings are based on data from six different sources: four country case studies; five remote project case studies; portfolio desk review of 37 maternal new born and child health projects (to assess effectiveness and impact only); a review of recent health partnership and volunteering research literature; a survey of volunteers; and a survey of UK and southern partners. In total 350 in-depth interviews were conducted. The evaluation framework was based on the newly-developed HPS Theory of Change and its assumptions. Whilst the range of findings are diverse corresponding to the wide ranging nature of the programme (with many very different projects and partnerships), the evaluation team considers the evidence and conclusions to be robust. Data from all sources was triangulated and analysed (with the help of NVivo software).

1.1. Findings

The evaluation findings overwhelmingly demonstrated the effectiveness of the partnership and volunteering approach in supporting health worker capacity strengthening. The Health Partnership Scheme has been successful in strengthening partnerships and project approaches so that there are more chances of sustainability and wide-scale change. The evaluation has distilled some common findings from the very diverse HPS projects. It is also recognised that there are exceptions to many of the generalised findings and hence some specific cases are highlighted.

1.1.1. Effectiveness and impact

- HPS projects have improved the knowledge, skills and confidence of low and middle income country (LMIC) health workers and in many cases this has resulted in increased quality of care or new services.
- Training and education capacity, accreditation and curricula have been improved in several countries, and on occasion this has impacted on a whole health cadre. There is less evidence of wider outcomes such as strengthening human resources financing, recruitment, deployment and retention.
- Some projects have influenced wider change in hospital systems related to equipment, record keeping and infection prevention and control (IPC), and sometimes this extends to several hospitals.
- Rigorous evidence of impact is scarce, due to the short-term nature of projects and the limitations of established monitoring and evaluation (M&E) frameworks; but there are enough examples of improvements in service delivery and quality of care to assume that HPS projects are currently making some improvements to the delivery of quality health services and are building the foundations for long-term impact.

- Some projects have empowered women health workers because of leadership and other training and opportunities, and women volunteers have acted as role models, but further analysis of gender equality is required.

1.1.2. Value for Money

- Partners and volunteers have a high level of commitment to value for money. They have applied this by economising where possible and creating high quality project inputs that produce efficient outputs and effective outcomes.
- The value of technical assistance using a partnership and volunteering approach is high compared to other comparable approaches. Southern partners and health workers value the project inputs highly. In particular effectiveness of health workforce capacity improvements is significant. Most of the project activities would not have been possible without the HPS funding support.
- Overall effectiveness in terms of health system strengthening (HSS) may not be as scalable and sustainable as larger aid programmes that target several areas of the health system at once, but there are HPS projects that show considerable promise in this respect. Further development of the partnership and volunteering approach would be advisable to understand how HSS can be maximised.
- HPS projects are missing the opportunity to create added value from coordination and integration with the other HPS projects and other aid programmes.
- Some health workers in low and middle income countries have been empowered with improved knowledge and decision making power, but the HPS has limited in-depth assessments and understanding of gender equality and social inclusion.



1.1.3. Partnership and Relevance

- The majority of partnerships have been strengthened by the HPS projects, by THET's guidance and by their work together.
- All projects were found to be highly relevant: aligning with government commitments and supportive of southern partner priorities. Partners were mostly planning, monitoring and adapting projects together.
- Very limited knowledge of, coordination or synergies with donor programmes, DFID or other partnerships.
- Partnerships are providing only limited analysis of approaches to address gender inequality and social exclusion in project design.
- Some success factors of stronger partnerships were: longevity, experienced UK partners, long-term volunteers, empowering behaviour and supportive management structures.

1.1.4. Volunteering and UK health system impact

- The HPS has benefitted volunteers and the UK health system by providing volunteers with opportunities to learn and enhance important competencies that they can bring back to their work in the UK.
- Long-term volunteering and strategic short-term volunteering are most effective and both have enhanced southern health workers' learning and application of skills.
- Volunteering works best within a well-functioning partnership, with involvement of the host partner in decisions on recruitment and appraisal, and with full support of the UK sending organisation and the volunteer employer (where it is not the sending organisation).

1.1.5. Monitoring, evaluation and learning

- The type of data used for reporting and monitoring required by THET and data collection methods by partners have improved over the last 2 years; and in some cases is contributing to the health system strengthening by ensuring data is used routinely for management decision making.
- Some outcome and impact level data will be available by the end of the programme from projects that are closely monitoring service delivery and system changes.
- Data on coordination and synergies with HPS partnerships, other partnerships and with other aid programmes is not being collected.

- The current focus of outcome and impact indicators on numbers misses an opportunity to define and track more qualitative changes. However THET do have qualitative case studies on their website.
- Data analysing gender equality within the health system and service delivery is limited to counting the number of women, though there are a small number of projects with a more in-depth understanding of gender.

1.2. Conclusions

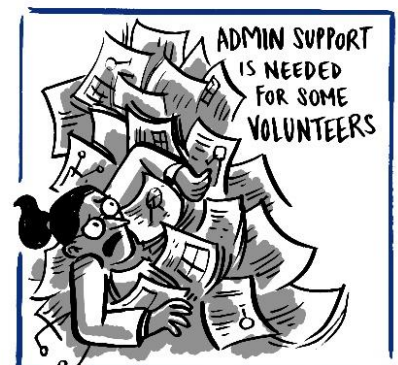
The evaluation shows that HPS projects have **contributed to health system strengthening by improving health worker capacity and by addressing certain other system constraints**, such as infection prevention and control (IPC) or medical equipment management. Critical factors in improving the likelihood of sustainability of project interventions include: those that work across the whole health projects that are aligned with and supported by government policies and strategies; have the commitment of health system leadership; contribute to the improvement and implementation of guidelines and protocols; and those that systematise and up-scales learning approaches by working on curricula, training of trainers and university faculty. Sustainability of the project approach is also **supported by the strength and longevity of the partnership**.

In a number of projects **health system constraints are inhibiting health workers' ability to improve service delivery** even if HPS partner work has been successful at increasing the skills and confidence of the workforce. There are also limitations to the changes in the wider health workforce, with only a small number of projects showing potential for an increase in skills across a whole cadre, and no evidence of an effect on recruitment, deployment and retention. These limitations are often being addressed by wider HSS programming (by government or aid programmes) and HPS projects that work in isolation are not necessarily collaborating with these to build synergies. Partnerships that have grouped together and developed projects (e.g. Uganda MNCH Hub – see Section 6) with synergies for addressing health system constraints appear to be more successful.

The **HPS is an effective way of enhancing partnerships and elements of health system strengthening through partnership approaches**. The small start-up grants have been useful for supporting partnerships in the early stages to develop their relationship and scope potential projects. The flexible funding across grant streams has been used effectively, though possibly not in the most strategic way to deliver the HPS outcome and impact indicator targets. Funding streams are mostly identified by grant size more than by what they want to achieve. Other THET input such as **networking and technical assistance** has been well delivered; and there is learning and technical guidance available which partners have found useful and which could be disseminated further.

Some projects have also enhanced women health workers' opportunities, skills, knowledge and confidence, with the potential to boost women's economic empowerment, though this is mostly coincidental and most projects have limited gender analysis.

HPS projects represent good value for money and the results show promise of lasting beyond the lifetime of the project. This is because project methodology enhances sustainability and projects are embedded within long-term partnerships. Partners and volunteers have a high level of awareness of value for money and the creation of high-quality and effective project approaches. HPS funds are managed efficiently and partners report satisfaction with the management and technical assistance. However, some systems could be tightened up, including managing adaption, and more support is needed to ensure project management and administration is not overloading the volunteer or the southern partner.



All projects were found to be highly relevant, and in line with government commitments and supportive of southern partner priorities. However, there was a lack of knowledge of other relevant aid programmes and only limited examples of partnerships that were working in synergy together, which is a lost opportunity. While there was the intention to build networks and strategic joint working at country level, the HPS has not been able to do this yet and this might be undermining the potential for a more strategic approach.

The HPS approach is successful because of the partnerships. Stronger partnerships support better quality projects and are more likely to be effective. Long-term partnerships or UK partners with more experience and expertise of developing international partnerships were more likely to implement effective projects.

The type of volunteering and the way it is managed from the UK partner(s) and the host partner(s) has an influence on how effective the project is, on the uptake of new learning and skills by health workers, and on the outcomes for the UK health system. Long-term volunteering shows a greater potential for enhancing the partnership relationships, strengthening the health workers' application of skills learned in training, enhancing attitude and behaviour change, and ability to act as role models and mentors to support change. Short term volunteering placements can work well as part of a wider project approach and in combination with long-term volunteering.



Volunteers gain a number of new skills, self-confidence, better cultural understanding and new levels of motivation and appreciation of the NHS. There is some evidence that they bring these back into the workplace in the UK and the health system benefits. There is some evidence that volunteers, their institutions and their southern hosts see the opportunity as a way of connecting with the wider global health community and building global excellence and networks.

THET's efforts to improve data collection and the quality and type of data have been appreciated by the partners and have resulted in the potential for some useful outcome level data by the end of the programme. However, there is still a lack of data on synergies and

coordination between HPS partnerships and other aid programmes, and a lack of data analysing gender equality within the health system and service delivery.

1.3. Recommendations

Below list is a summary of Section 8 of this report and concentrates on recommendations that can be put in action by DFID, THET and/or the partners in the current HPS. It will not be possible to implement all of these recommendations in the remaining time and budget of the HPS, but some could be prioritised or at least started. It is recommended that THET:

(i) Encourage existing projects to scope out and design how they might address some of the health system constraints to their projects by expanding to whole health facilities and communities, engaging more with leadership and making sure the approach is more institutionalised.

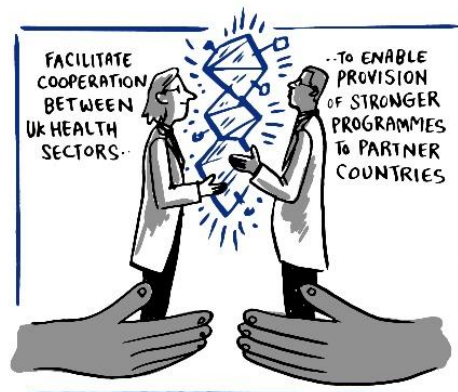
(ii) Continue to support the partnership work with funding (see section 9 for more details on this) and further strengthen technical assistance, networking and advocacy work.

(iii) Work with one or two partnerships to conduct a thorough gender analysis of the project, context and their organisation, while at the same time building skills and guidance to undertake this kind of work and to design appropriate ways of integrating gender equality approaches into project design, implementation and MEL.

(iv) Develop an understanding of how value for money could be enhanced through the development of synergies with other aid programmes in key countries and between partnerships. Develop a small number of case studies to promote learning from existing partnership networks (such as the MNCH Hub in Uganda) on efficiency and effectiveness.

(v) Ensure financial management and record keeping are enhanced in particular areas in order to better understand and manage how funds are spent. Make sure management costs are allocated to more specific reporting lines; and encourage partnerships to record their expenditure or in-kind contributions as project costs.

(vi) Develop country-level networking and learning opportunities for partnerships, starting with Uganda and Zambia and with a specific planned, strategic and target-driven work programme for the two THET offices.



For other countries, consider ways of supporting the network by setting up partnership associations and including health partnerships from other countries (European, Australia, and the USA in particular).

(vii) Continue to evolve the THET approach for strengthening partnerships in order to improve effectiveness by: strengthening international development expertise; simplifying and communicating the Principles of Partnership; develop guidance on institutional capacity strengthening approaches for partners.

(viii) Include in the work of the THET offices (mentioned in (vi) above) some effort to explore how networks and strategic funding could enhance the development of synergies between partnerships.

(ix) Continue to communicate the interesting role that UK volunteers, particularly long-term volunteers, are playing in HSS in LMICs; and build UK partner capacity for recruitment and management of volunteers.

(x) Start a dialogue with key UK stakeholders on how to strategically plan learning and benefit for the UK health system within partnership and volunteering programmes while, at the same time, maximising the benefit for the low- and middle-income countries.

(xi) Make sure that THET builds in time and funds to be able to collect and synthesise outcome and impact data coming from projects – and this should include qualitative outcome and impact data that is being collected by partners.

(xii) Only make minimal changes to the logframe to save data collection tasks where indicators are either difficult to measure or there is overlap.



1.4. Lessons and ideas for future programming

1.4.1. Enhancing partnership and project effectiveness.



One of the key strengths of the HPS is the way it has provided funding that has generated or supported a large number of nascent, experimental partnerships and growing partnerships, while at the same time encouraging a development-led approach. This has resulted in some larger, more established, and possibly enduring, partnerships being strengthened that have started to impact health systems and service delivery.

Partnerships that have linked up, established synergies and become more strategic have been particularly effective, as have partnerships providing expertise for highly specialist technical areas. The flexible form of funding has ensured a creative and entrepreneurial approach by UK and southern partners. Long-term volunteering and exchanges to the sending country have supported partnership development and are more likely to promote the attitude and behaviour change that are important for systems to change.

Future programming for health partnerships would do well to plan more strategically by country in line with national and international strategies and goals (SDGs and UHC) and provide longer term funding that can enhance a range of health system changes. Future partnerships would also do well to develop synergies with other aid programming and with other partnership projects in order to maximise effectiveness.



1.4.2. Ensuring efficiency in project management

Funding should be designed to use competition and other ways of allocating funds in order to enhance collaboration between partnerships and to ensure efficiency. Guidance on management structures, project management and volunteering could enhance project efficiency.

1.4.3. Volunteering and the UK health system

Long-term systemic change is more likely when volunteering placements are coupled with a systematic and long-term dedicated partnership and technical collaboration between the UK health system and LMICs at the systems level (Baxi, 2015). However, while partnership projects of this nature all need volunteers, not all organisations that provide volunteers necessarily need to develop the partnership or manage the project. There needs to be a specialism around developing partnership projects and it should be nurtured – but volunteers can be sourced from anywhere with any system – as long as there can be some system for building in learning and bringing back new skills to their employer.

The enthusiasm and commitment that volunteers bring to their overseas assignments is a significant factor in the success of the projects. Volunteers and their UK employers are more likely to benefit if they are part of a structured and strategic professional development approach within a long-term partnership. The volunteer learning is more likely to be applied back in the UK if sending organisations are closely involved in how this happens and have a strategic approach to learning. A more strategic approach to volunteering on the part of the NHS or other sending organisations might be required in order to maximise benefits and minimise cost.

1.4.4. Development of the monitoring, evaluation and learning system

Monitoring, evaluation and learning (MEL) has improved considerably during the lifetime of the HPS. However there is no simple solution to having a fit for purpose MEL system for a complex, diverse and dynamic system which is continually being adapted and improved. The best MEL approaches within the HPS have been designed with and by the southern institution. They are embedded within the system, focused on specific practical areas and concentrated on measuring and using data as a management approach rather than just for upward reporting.

Managing adaption is an important part of the MEL cycle. Partners who adapt by continuing to build on their technical expertise and strengths, rather than veering off into new territories, have been more successful.

2. Introduction/Background

This report records the findings, conclusions and recommendations for the Evaluation of the Health Partnership Scheme (HPS) managed by the Tropical Health and Education Trust (THET), contracted by DFID on 23rd February 2016 to IPE Triple Line (IPE Global Limited and its fully owned subsidiary Triple Line Consulting) and Health Partners International (HPI). This first section provides the background and context of the programme and a description of the theory of change.

2.1. Context of the development intervention

International health policy environment

Strong, resilient and responsive health systems are crucial to achieve both short and long-term health goals. The World Health Organisation's (WHO) overarching policy directions for strengthening health systems include, amongst others, a shift towards universal health coverage (WHO, 2011). The crucial building blocks required to attain universal health coverage include an efficient health system that meets population needs, provision of financial risk protection and access to essential medicines, and sufficient capacity of well-trained health workers. In May 2016 at the World Health Assembly (WHA) the member nations adopted a new framework for universal health coverage (UHC) that promotes "integrated people-centred health services". The new WHO strategy is "a call for a fundamental paradigm shift in the way health services are funded, managed and delivered."

As demonstrated by this framework and the 2030 Agenda for Sustainable Development, strengthening of the health workforce is a clear global health priority¹ (United Nations, 2015), and evidence suggests that adequate and smart investment in this can result in improved health workforce outputs, such as improved service delivery, as well as better health outcomes (WHO, 2011). However, the challenge of ensuring a sufficient, motivated and adequately-skilled health workforce remains paramount for many countries – key issues include a shortage of workers compounded by inappropriate skill mixes that are often poorly suited to the health needs of the populations they serve (WHO, 2006). This demonstrates the need for a demand-driven approach to any health workforce capacity-strengthening model, including one based on health partnerships. To address the health workforce crisis, the Global Health Workforce Alliance - a multi-sectoral partnership hosted by WHO – has produced a global strategy on human resources: "Global Strategy on Human Resources for Health - Workforce 2030", which was adopted unanimously, along with a resolution, by the World Health Assembly in May 2016. The resolution calls on countries to take steps to strengthen their health workforces, including actively forecasting gaps between need for and supply of health workers, collecting and reporting better data, and ensuring adequate funding for the health workforce.²

National context: DFID policy framework and DH/NHS strategies

Within the UK, strong support for health partnerships began in 2003 and was fuelled by Lord Nigel Crisp's Report on Global Health Partnerships (Crisp 2007), which outlined the importance and potential of UK health partnership schemes. At that time, the DFID policy framework was focused on how to deliver aid within the backdrop of a global recession – cooperation for mutual benefit was a core theme to the government's 2009 white paper – "Eliminating World Poverty: Building our Common Future" (DFID, 2009), which the HPS Scheme clearly aligns with.

The latest DFID aid strategy (November 2015) indicates an emphasis on building resilience of health systems, and strengthening their ability to respond to crisis, in which human resources for health play a key role. One of the government's 2015 manifesto commitments included the pledge to 'boost partnerships between UK institutions and their counterparts in the developing world'. DFID's health position paper: 'Delivering Health Results' (2013) underpins its approach to health systems strengthening, including the role

¹ As demonstrated by Target 3.c. Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States

² http://www.who.int/workforcealliance/media/news/2016/ghwa_wha16_global-momentum/en/

of the UK-based health community. The HPS was specifically cited as a programme that facilitates partnerships between UK-based health organisations and their counterparts in developing countries to enable skills transfer, exchange of ideas and building support for broader UK development outcomes.

The UK government (July 2016), focused on discussions to exit the EU, is even more interested in partnerships and connecting with the world beyond the EU. Health partnerships will continue to be on the political agenda. From an NHS and Department of Health perspective, health partnerships also appear to be gaining traction. Public Health England's recent Global Health Strategy (PHE, 2014) urges the use of the UK's skills and expertise to contribute towards addressing global health challenges. Strengthening UK partnerships for global health, and building capacity through a programme of staff secondments and global initiatives are cited as two of its five strategic priorities. NHS Health Education England, responsible for workforce development, recognises the role that volunteering abroad can play in building capacity within the NHS and ultimately improving the quality of care provided. In recent years, the Global Health All Party Parliamentary Group (APPG) has produced two reports in strong support of the HPS and similar schemes – describing how British health volunteers help to make improvements to health systems overseas while also benefiting the UK. The recent NHS Framework for Volunteering (NHS, 2014) also seems to set the stage for increased international volunteering of NHS staff in the future.

Relevant linkages to other programmes and donors

There are a number of other human resources for health, global health programmes and health partnership schemes of relevance to this evaluation. The WHO's African Partnership for Patient Safety programme, which was established in 2009 to strengthen patient safety and infection prevention control through hospital-to-hospital partnerships, supported by ministries of health and WHO regional and country offices. The programme is an example of WHO's 'twinning approach' to institutional partnerships. Another international partnership scheme of interest is the International Confederation of Midwives, which, with support from the Dutch Ministry of Foreign Affairs, has developed a twinning programme to strengthen midwifery associations in a number of countries across Africa and Asia. The European ESTHER Alliance, which consists of 12 country members, is a European network that works to implement capacity-building activities in global health through twinning hospitals in European countries and health institutions overseas in order to facilitate a two-way flow of expertise and ideas.

At the national level, programmes of interest include the £18m DFID funded 'Making it Happen' programme, which trained doctors, midwives and nurses to manage complications of pregnancy and childbirth. 'Making it Happen' phase 1 operated in five countries (Kenya, Sierra Leone, Zimbabwe, Bangladesh and India). Phase 2 of the programme operated in 11 countries across sub-Saharan Africa and South Asia (Kenya, Sierra Leone, Zimbabwe, Bangladesh, India, Pakistan, Nigeria, Malawi, South Africa, Ghana and Tanzania), and ran from 2012-2015. The approach included delivery of competency-based training packages by UK health worker volunteers (obstetricians, anaesthetists, paediatricians and midwives), strengthening data collection and quality improvement. The programme demonstrates similarities with the HPS, with its clear focus on health workforce strengthening, and its aim to be sustainable, for example by training in-country trainers and providing supportive supervisions. However, unlike the HPS programme, 'Making it Happen' did not involve direct partnerships between UK and developing country health institutions – instead, volunteers were sourced at an individual level and this process was managed directly by the Liverpool School of Tropical Medicine.

VSO is another relevant organisation that provides expert volunteers in a range of health and non-health areas in developing countries. Volunteers are sourced from anywhere in the world, not just the UK, and the work does not include a partnership with any relevant organisation. The VSO approach is, however, useful to look at as there are other interesting aspects that could be beneficial to HPS partners. For example VSO does provide a good support set up for volunteers in the country and often also provides administration assistance.

2.2. Theory of Change

2.2.1. Programme Description

The Health Partnership Scheme (HPS), July 2011 – June 2017, is a £30.2m DFID funded programme that supports partnerships between UK health organisations and their counterparts in 32 developing countries (mainly in Africa and Asia) to build capacity in the health workforce and health institutions in those countries and in the UK. The *Global Health Partnerships* report (Crisp Feb. 2007) recommendations led to the creation of the International Health Links Funding Scheme (IHLFS) and the International Health Links Centre. The HPS programme builds further on these recommendations.



The HPS, managed by THET, provided £20m over 4 years (July 2011-June 2015). In April 2014, the programme was granted two cost extensions: £10m to extend the programme until 2017 (HPS 1.5) and £200,000 to fund a 1 year pilot medical electives programme overseas. See a complete timeline, logframe and full description of the programme in Annex 1.

The Programme's expected outcome is "more effective and efficient health systems, with an emphasis on the performance of the health workforce in participating countries and the UK". This should contribute to the expected impact of the programme which is "more effective and efficient health service provision, with a special interest in Millennium Development Goals (MDGs) 4, 5, 6³, and rural and under-served populations". Impact and outcome have been the same since the programme began. Programme outputs are:

1. Improved and strengthened knowledge and capability in participating health institutions;
2. Improved and strengthened policies, protocols and curricula in participating health and health education institutions or across health systems;
3. Stronger and more institutional and country health partnerships that promote and enable mutual learning and skills and technology transfer; and
4. Effective and efficient grant funding and strategic management support to projects and health partnership community by the managing agent.

As well as capacity development of health institutions and health workers in developing countries, the programme seeks to benefit the UK public health sector by providing a valuable opportunity to UK public health professionals to improve their skills when volunteering in challenging environments.

HPS Grants for partnership projects are awarded to the UK partner. At the time of data collection for the evaluation, there have been 176 HPS projects (86 HPS and 90 HPS 1.5), 93 of which are still ongoing with 66 UK partner grant holders⁴. The projects were selected in calls for proposals for different grant streams. Nearly all partnerships that are funded by the HPS are pre-existing. Some are very early in their development and receive grants for developing partnership activities through visits between partners. Other partnerships are well developed and have on-going activities before they approach the HPS.

Grants have been used by partnerships in 32 countries the majority in sub-Saharan Africa. 1,700 volunteers (56% women and 44% men) have worked on these projects and have spent a total of 51,124 days⁵ overseas. Most of the UK partners and overseas partners have been health education institutions (39% of UK partners in ongoing projects), followed by professional associations (31% of UK partners in ongoing projects) and health delivery institutions (26% of UK partners in ongoing projects). There have been a limited number of research partners in the host countries, though some of the projects do include research. Health projects have mostly been targeted at general health, maternal and newborn health, child health, palliative health and mental health (see Annex 1 for charts on portfolio data).

³ MDG 4 – Reduce Child Mortality, MDG 5 – Improve Maternal Health, MDG6 – Combat HIV/AIDS, Malaria and Other Diseases

⁴ The data for projects and partners will be continually changing as HPS evolves. For the purpose of this evaluation, the analysis of data has been based on the dataset provided by THET in March 2016.

⁵ Number of volunteer days overseas includes / does not include weekends

Mean HPS grant size is £142,000 (without the very small start-up grants included). THET has managed the grants with an average overhead of 17%, which has decreased from 18% to 16% since the beginning of the programme in October 2011. “The overhead includes THET’s management costs and programmatic delivery in support of partnerships delivered by THET staff.” The HPS programme has been managed in line with Paris Declaration principles⁶ by ensuring partnerships build ownership and alignment in the host country, though there has been less attention given to coordination between partnerships.

2.2.2. Theory of change

The Theory of Change (see Figure 1 on page 16) was developed during the evaluation inception period⁷, with the help of the Reference and Stakeholder Groups workshop. It has again been adapted in light of the experience of the evaluation, in particular the country case studies, so that the views of host country stakeholders and findings about how change is happening could be taken into account. The Theory of Change presented here is an updated version that reflects these changes (the original version developed in the inception period can be seen in Annex 1.2). Section 3 describes the evaluation process and methodology which has fed into this Theory of Change. It has been an iterative process in order to better describe the programme in a way that reflects the implementers’ understanding. While the evaluation questions were agreed alongside the Theory of Change development, they do feed into each other and the relationship is explained in more detail in Section 3.

The HPS objective is to strengthen health systems, through a strengthened health workforce, in developing countries. Alongside funding the HPS provides a range of networking, technical assistance and communications services to the partnerships, aiming both to improve the effectiveness of the projects and to build and strengthen the partnerships.

The HPS is expected to make change along three interrelated change pathways, described below, and explored in Figure 2 (on page 18) with the Theory of Change assumptions listed in Table 1 below (and in a full narrative in Annex 1.2).

(i) The Partnership change pathway describes how partnerships evolve and develop through support from the HPS. The expectation is that partners with a longer term relationship, and with more experience of working together in the country will develop projects that will more strategically address health system constraints. While many partnerships have a particular technical focus area due to the core expertise of the partners involved, there is an expectation that partnerships will coordinate in order to create synergies in different technical areas and potentially address different elements of the health system, which is a complex adaptive system, responding best to multiple synergistic interventions.

(ii) The Volunteer and UK Health system change pathway describes how volunteering opportunities are expected to enhance UK health workers’ attitudes, skills and behaviour so that they bring new ways of working back to the UK and positively influence the UK health system and improve services. It is expected that the positive experience of the UK health workers will encourage more volunteering and a better supply of volunteers, and might help with recruitment and retention of health workers in the UK. The volunteer change pathway interacts with the partnership pathway through the HPS projects, recruitment and placement of volunteers.



⁶ Paris declaration principles: Ownership; Alignment; Harmonisation; Managing for results; Mutual accountability. <http://www.oecd.org/dac/effectiveness/45827300.pdf>

⁷ There was only a very high level theory of change in the original DFID Business Case and THET had done some further work to develop a theory of change by focusing on one project (Edwards 2016). This work was used to think through the development of this ToC.

(iii) **Host country health system change pathway** shows how the HPS projects, partnerships and volunteers enhance the knowledge, skills, attitudes and behaviour of host country health workers and this should result in a strengthened health workforce, delivering higher quality health services. Training curricula and certification, system inputs such as support for equipment management and infection prevention and control, leadership and HR management approaches are more likely to lead to sustainable changes in the partnering institution, rather than just the individuals. This will likely effect the health system and will reach more health workers over time. An *improvement of health workforce capability and status should lead to a strengthened health workforce* if the overall management and funding of human resources is improved. It could be argued that this will only happen if there are specific government strategies to address wider barriers to do with education, recruitment, deployment, retention (such as ensuring health workers will stay in remote areas) and that these are not currently addressed by the HPS projects. The host country health system is



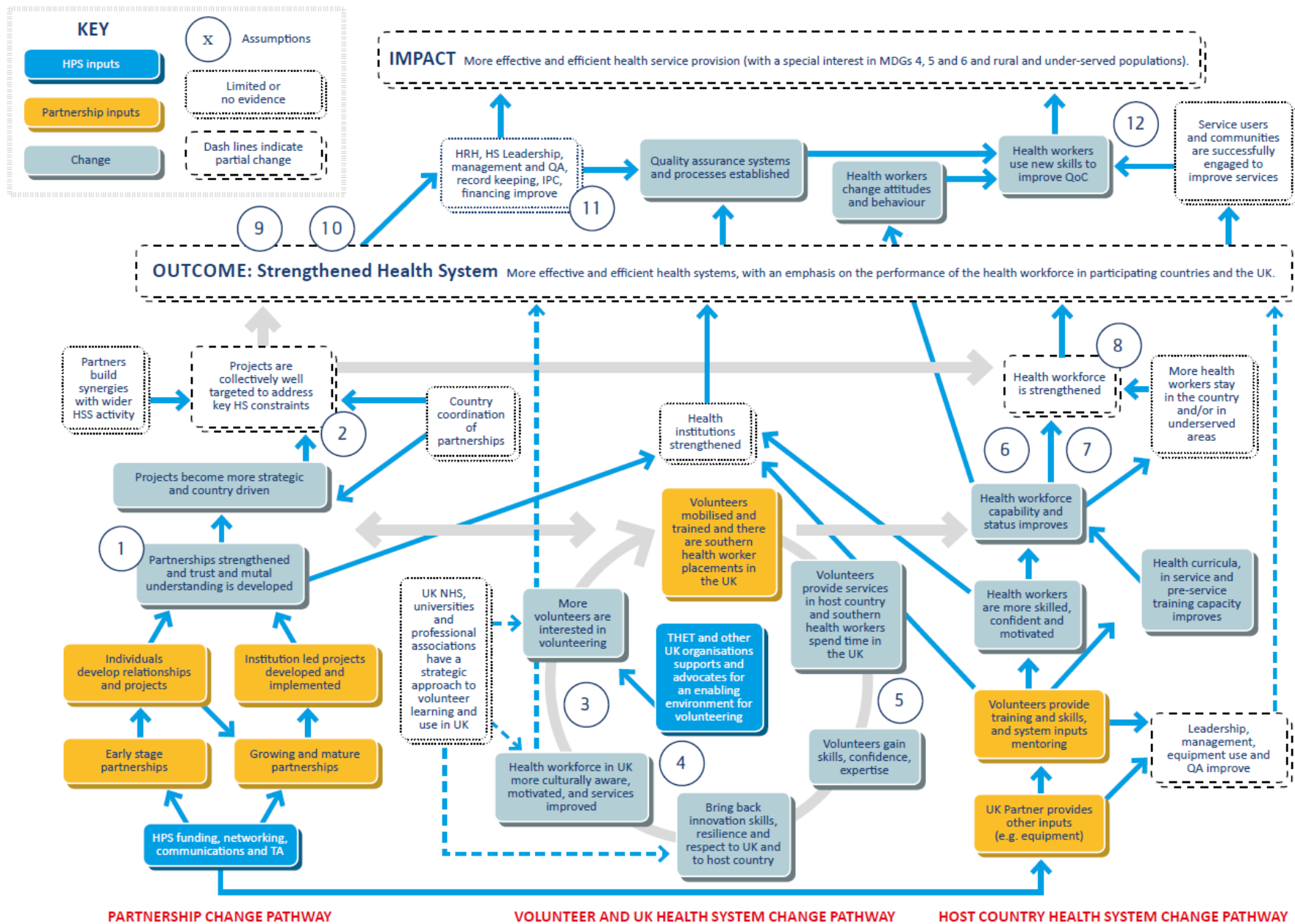
expected to change as a result of interaction with the partnerships and the volunteers.

This version of the Theory of Change shows some new areas of influence or change that would be expected, and also distinguishes between clear evidence of progress (solid colours) and more limited evidence (dotted or dashed lines).

Table 1: Theory of Change assumptions (for Figure 2)

Outcome and Impact assumptions		
11. Health workers and institutional partners are able to address a range of health system constraints in order to improve service delivery		
12. Health workers use new skills to improve the quality of care and inclusiveness of services they deliver to men, women and children.		
Overall Assumptions		
9. Activities are delivered in cost effective ways to maximise the outcomes for the investment		
10. Monitoring and evaluation are used at project and programme level to inform learning and improve effectiveness.		
Partnership change pathway	Volunteer and UK health system change pathway	Host country health system change pathway
1. More mature and better functioning partnerships have a better understanding of health systems needs in the host country and deliver better and more sustainable projects	3. Health workers can access information about volunteering opportunities	6. Partnership activities effect on human resources for health (HRH) is sustainable and saleable.
2. Gender equality and social inclusion improves through partnership interaction and exposure to equal opportunities policies of partners and different social norms of volunteers	4. Volunteers share their learning with their own institution and influence others and so service delivery improves.	7. There are specific government strategies to address wider barriers related to education, recruitment, deployment, and retention (such as ensuring health workers stay in remote areas).
	5.. Volunteers will have a positive and enriching experience whilst volunteering and this results in improved skills, resilience and capability	8. The HPS partnerships work leads to more equitable and gender equal human resource management systems and processes.

Figure 1: Health Partnership Scheme Theory of Change (Updated September 2016 as part of the evaluation)



2.3. Evaluation Questions

The evaluation questions were reviewed and agreed with DFID, the Evaluation Reference Group and the Wider Stakeholder group during the inception period. They are derived from the assumptions in the Theory of Change. All evaluation sub-questions can be seen in Annex 2.

HPS Evaluation Questions

All of the evaluation questions intersect with the DAC evaluation criteria and this is indicated below. All DAC criteria are covered in this evaluation:

1. To what extent and under what circumstances is the HPS programme achieving its stated outcome: “more effective and efficient health systems, with an emphasis on the performance of the health workforce” and is there any evidence of impact? DAC Criteria: Effectiveness, Impact and Equity: This question explores the effectiveness of HPS projects, and data has been collected on impact where it is available. It also provides a light touch exploration of equity in terms of gender and social inclusion.
2. Is the programme delivering value for money? DAC Criteria: Effectiveness, Efficiency, Equity, plus VfM criteria of Economy: This question covers the 4-Es as per the DFID definition of VfM.
3. What lessons can be learned in relation to strengthening partnerships between UK and developing countries’ health institutions, the partnership use of volunteers from the UK to deliver projects and the effect of this on project effectiveness (to deliver stronger health systems and build capacity of the workforce)? DAC Criteria: Relevance, Efficiency and Effectiveness: Relevance is explored in relation to partnerships; partnership and project related efficiency and effectiveness are explored.
4. To what extent have the HPS projects been identified, designed and delivered in response to the host country context and in alignment with government plans and strategies? DAC Criteria: Relevance and Sustainability: This question explores the relevance to the country and the partners and the sustainability of the project outcomes.
5. How has HPS benefited the UK in terms of strengthening the health workforce, health systems and/or in terms of recruitment and retention of health workers? DAC Criteria: Effectiveness, Sustainability and Equity: The volunteering and partnership effect on the UK health system is explored through this question.
6. How can the HPS (programme, projects and partnerships) be monitored and evaluated?

3. Purpose, scope and methods

3.1. Evaluation purpose and use

The **purpose of this evaluation** is to examine the health partnership model that has been implemented in the HPS programme. The focus is on the effectiveness of the programme as a whole, plus learning about what works and what does not work in the current programme’s approach. The evaluation will inform wider lesson learning about volunteering and building health worker capacity in developing countries, and reciprocal benefits of partnerships, and associated volunteering in the UK. It will also be used to strengthen the current HPS programme in its final year and to develop future programming. There is a growing interest by the new UK government in partnership programming.

Primary evaluation audiences: DFID, THET, other UK Government Departments (including NHS Improvement and Department of Health), the non-state sector (e.g. Global Health Group of the Academy of Medical Royal Colleges) and developing country government institutions and other HPS health partners in the south.

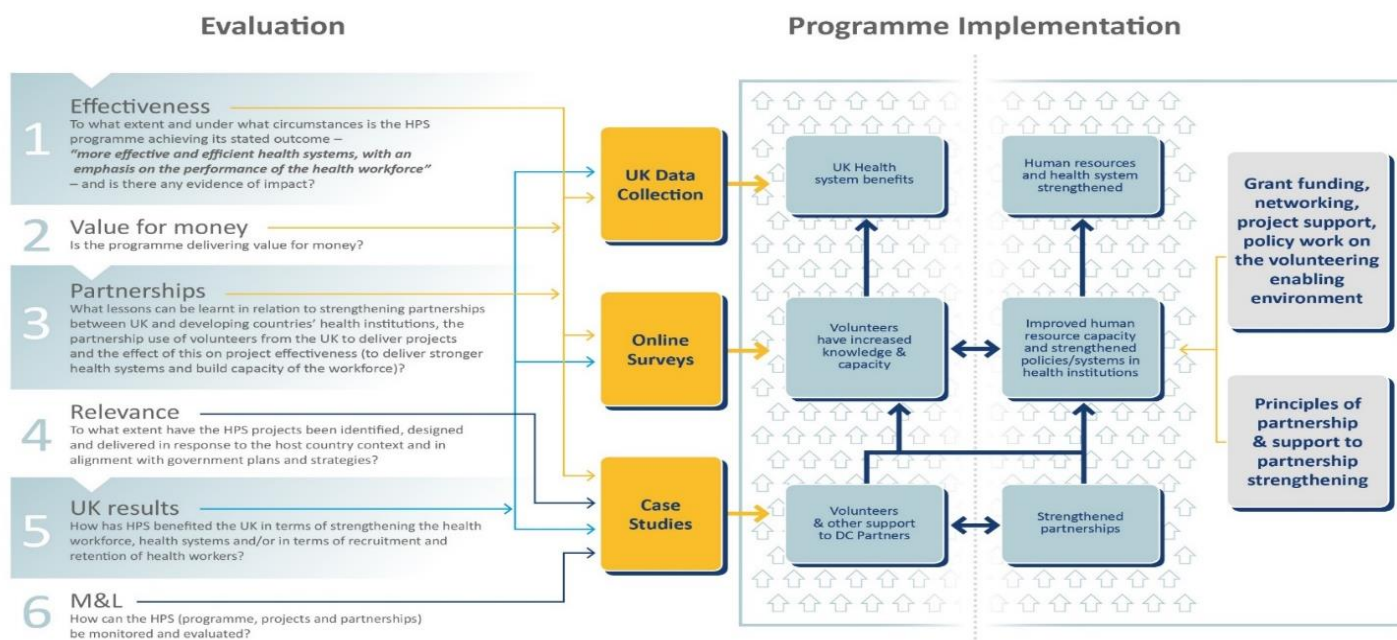
Secondary evaluation audiences: Organisations involved in health partnerships, other development partners (bi-laterals and the WHO), developing country governments, civil society, and practitioners who are working on the improvement of health systems.

3.2. Evaluation Framework

This is a theory-based and utilisation-focused evaluation with a heavy emphasis on delivering evidence for the requirements of the key stakeholder community. The Theory of Change assumptions form the basis of the evaluation questions (and these questions also cover the DAC evaluation criteria – see Section 2.3). The Theory of Change has been used to explore change prompted by the projects, and has also been used as the framework for analysis and reporting; it is presented in Figure 1. Evaluation sub-questions were developed

to form the basis of instruments for the data collection interviews and discussions. (See Annex 2 for full list of sub-questions and Annex 13, for the instruments). The evaluation framework Figure 2 below shows how the data collection interacts with a simplified version of the theory of change. On the left the evaluation questions are answered using three data collection methods to investigate the levels of change that the programme is proposed to have provoked. On the right the framework acknowledges inputs from the granting mechanisms and THET.

Figure 2: Evaluation Framework



3.3. Methodology

3.3.1. Methodology overview and scope

The **evaluation methodology has been designed to assess contribution of the programme to the changes observed and picked up through the data collection methods**. The team has used thematic analysis through exploring the theory of change and the assumptions, identifying themes and patterns across the data sets, and by understanding what other initiatives might have contributed to change. For the value for money analysis the evaluation considers the approach and relative effectiveness in comparison to other similar programmes or similar partnership and volunteering programmes (for example VSO). In addition, the evaluation refers to the WHO Universal Health Coverage and Health System Strengthening frameworks as appropriate and the THET Principles of Partnership.

The evaluation covered all the main areas of the programme, including the funding scheme, the management by THET, the projects, the partnerships and the volunteering, as required by the evaluation questions. All of the data collection planned in the inception period was implemented, with the exception of use of the final research paper from Salford University, which only became available at the end of the implementation period. Data collection reached saturation point and there was sufficient good quality data for analysis.

The **evaluation does not cover** an assessment of every project in the HPS portfolio, but does provide an in-depth assessment of 11 projects, a light touch assessment of a further five projects, and a review of project reporting on outcome and impact of the 37 MNCH projects funded under the HPS. Further, the evaluation has not provided a full assessment of the UK health partnering landscape – it has covered some of the key stakeholders in interviews and assesses the HPS in relation to the other programmes. The criteria and process for site selection was agreed with the Evaluation management group and was not based on the typology of partnership that had been developed by THET. The evaluation does not give definitive categories (typology), but indicates the way project effectiveness and volunteering is more or less successful depending on types of partners and strength of the partnerships.

All evaluation **team members are independent** of the HPS, THET, DFID and the partner organisations. Team members have no vested interest in any particular area of the evaluation or in the findings. They have used their technical skills and knowledge, and independent judgement, to undertake the data collection and analysis. During the country visits, interviews with stakeholders were undertaken independently without participation from the partner organisations. Political or organisational influence of responses in the countries and in the UK were avoided.

3.3.2. Overview of the evaluation phases

The evaluation inception phase has involved the following processes:

- Literature review of technical and programme literature (including recent programme documents on value for money and grant typology). (See inception report for full Literature Review and Bibliography).
- Analysis of HPS programme data in order to understand the portfolio, to develop sampling for country and project case studies, and undertake the evaluability assessment.
- Workshop with the Evaluation Reference and Stakeholder Group (see Annex 6 for the evaluation governance terms of reference). The workshop explored the context, the evaluation questions and the theory of change. Overseas governments and stakeholders were not involved in the evaluation workshops as the evaluation team planned to meet with government representatives and further discuss their understanding of the programme during the country visits. For projects of such a small size across a range of countries it would not have been appropriate to choose any one government to attend and there was also insufficient budget to do this.
- Coordination, regular updates and feedback with DFID Evaluation Management Group to agree the evaluation questions, theory of change, sampling and evaluation processes. THET was occasionally included in stakeholder meetings, but did not influence the findings.
- Presentation of evaluation approach and workplan at the cross government NHS International Health Group meeting where other key stakeholders and subjects for interview were identified.

The **implementation** phase has continued to be managed with a transparent and interactive process, with monthly written progress reports and meetings with DFID to discuss any challenges and data collection and timing issues along the way. Early on in the implementation phase, before interviews and visits began, the evaluation team shared a summary of the evaluation method and objectives with HPS partners and other stakeholders who were to be involved in the evaluation. The evaluation team has also maintained a close relationship with THET with an early checking of facts in the findings. Two Reference Group and Stakeholder Group meetings were held at the end of August and initial findings, conclusions, and recommendations were discussed in order to engage key users in the analysis and reporting. A further presentation was made to the NHS International Group in October and a presentation at the THET conference. The Health Minister of Uganda was present at the THET Annual Conference presentation.

3.3.3. Evaluation process

Data collection was conducted in four countries covering 11 HPS projects; by Skype or phone with a further five projects; through three online surveys with volunteers, southern partners and UK partners; Skype interviews with UK and international stakeholders; and a document review of key programme documents (including a sample portfolio analysis to aggregate effectiveness and impact findings from project documentation of 37 MNCH projects). The Country Case Study data collection included semi-structured in-depth interviews and participatory group discussions as well as facility observation.

The evaluation team selected the sample of countries and projects to cover a range of criteria.⁸ The sampling process used quantitative and qualitative analysis of ongoing projects, various discussions with DFID and THET at different points of the inception phase and discussions with the other key stakeholders during the inception workshop. A purposive sampling method was used to select a sub-group of projects for the country case studies and the remote project studies so that they would be as representative as possible of the different

⁸ A flexible and purposive sampling methodology that evolved during the process

types of project, partners and the geographical regions. The selected projects covered four regions: East, West, Southern Africa and Asia; and a variety of the projects' characteristics (partner type, project technical focus, funding stream, grant size). See Tables 3 and 4 for a list of the projects. A full description of the sampling method can be found at Annex 3.1.

Table 2 shows how data collection is related to the evaluation questions and to different levels of change by individual, organisation, programme and health system. (A full description of data collection and analysis can be found in the Annex 3)

Table 2: Data collection by participant and evaluation questions

Change level	Country & project case studies – Qualitative data collection	UK and international interviews – Qualitative data collection	Online surveys – Quantitative data collection	Document review – Qualitative and Quantitative secondary data collection
Individual	Serving volunteers Host country health workers Service users	Returned volunteers Colleagues of volunteers	Returned and serving volunteers All partner organisations	Service delivery in MNCH projects
Organisation / institution	Host country partner institutions Host country health workers and staff	UK partner institutions	All partner organisations	Reports on partnerships from MNCH projects
Health system	Ministry of health and other host country institutions Service users	UK partner organisations, DFID, UK health system institutions European and US partnering organisations	All partner organisations	Service and human resources for health (HRH) data from MNCH projects UK Health system impact from recent research
Programme (funding mechanism and other inputs)	Host country partner organisations	THET, UK partner organisations, DFID, UK institutions European and US organisations	All partner organisations	Funding guidance and formats
Evaluation question topics covered (see framework on p.8)	1. Effectiveness and any evidence of impact 2. Value for money 3. Partnership 4. Relevance 6. MEL (monitoring, evaluation and learning)	1. Effectiveness 2. Value for money 3. Partnership 5. UK Results 6. MEL	1. Effectiveness 3. Partnership 4. Relevance 5. UK Results 6. MEL	1. Effectiveness and any evidence of impact

Data was collected in an appropriate and respectful manner, taking into account cultural, ethical and legal concerns. Participants were asked to sign consent forms for the interview and for photographs and digital recordings of the interview. The team used sensitivity about hospital overcrowding and health worker time pressures to plan the evaluation visit – in Sierra Leone this meant not planning a workshop due to the severe shortage of health workers and other university faculty due to the Ebola epidemic; in Myanmar it meant limiting the number of parents of sick children interviewed because of the high level of hospital admissions due to Dengue Haemorrhagic Fever (DHF). Cultural context was taken into account by the evaluation team through the adaption of interview techniques and tools for each country. When disclosure was not fully forthcoming, (as in Myanmar) due to cultural issues, triangulation and verification would be strengthened. Data that was not well supported or trusted was discarded.

Testing and adaption of methods and tools was undertaken for the country case studies by reviewing during and after the first visit; and for the online surveys by testing with several appropriate participants and adaption. **Quality assurance** for data collection was the responsibility of the lead consultant for each country visit. Joint interviews and review of notes by the country evaluation lead was undertaken for every interview. Team analysis was used in country to review each set of findings by project. A country “write-up” was produced by each project and this was quality assured by the country lead and by the Evaluation team leader, as well peer QA within the team.

Coordination and collaboration were encouraged as part of the evaluation, in line with the Paris Declaration principles. All country visits included interviews with government and a sharing of information

and reflections with both government and host partners in the hope of building further ownership of the evaluation. The two country workshops generated a lot of inter-partnership interest and communications, which had not previously been in place. Where possible, volunteers and host partners were put in touch with relevant programme staff on donor and civil society programmes that had been included in evaluation interviews, with the hope that coordination would improve. The evaluation has been coordinated with WHO in order to inform global partnering and contribute to wider learning.

Analysis of data was undertaken with all data organised and coded into NVivo software and triangulated. Because each country case study covered a range of different qualitative data sources, analysis by country study was well triangulated. Findings from the country case studies noted in this synthesis report are extracted from the country analysis and is considered to be strong evidence. The general NVivo coding framework was based on the evaluation questions and included the following headings (full framework with sub-nodes can be seen in Annex 3.3): Activities and outputs, Barriers, Donor Landscape, Effectiveness, Innovation, M&E, Partnership, Project Background Information, Recommendations, Relevance, Sustainability, THET, Value for Money, Volunteering. The following projects were reviewed:

Table 3: Country Case Study Project Sample

	Code	Health focus	Size	length month	UK partner	Southern partner	Project title
Uganda	D43	Palliative health	£248,428	23	University of Edinburgh	Makerere University	Development of Nurse Leadership for Palliative Care in Uganda.
	D39	SRH	£72,355	23	Royal College of General Practitioners	Bwindi Community Hospital	Strengthen the capacity of the health system in South-West Uganda to promote sexual and reproductive health
	D2.40	General health	£197,120	19	University of Salford	Multiple	Scaling up medical equipment knowledge exchange in Ugandan hospitals
Sierra Leone	D2.53	Infectious disease	£134,507	19	Plymouth University Peninsula Schools of Medicine and Dentistry	Masanga Hospital	Building capacity and sustainability within Sierra Leonean Health Service to improve resilience to future outbreaks of Viral Haemorrhagic fever.
	VG 10	Child health	£834,928	59	Royal College of Paediatrics and Child Health	West Africa College of Physicians	Reduce infant and child mortality.
	LPIP.5 6	General health	£114,482	54	Kings Centre for Global Health	University of Sierra Leone	King's Sierra Leone Partnership health education strengthening project
Zambia	A2.18	MNH	£201,557	24	University of Manchester	Nurses and Midwifery Association	Supporting evidence-based midwifery practice through audit and feedback: a LAMRN project in Kenya, Uganda and Zambia.
	A35	Mental health	£99,970	28	NHS Highland	Chipata General Hospital	Mental health literacy and improved patient safety: empowering communities.
Myanmar	A18	A&E	£196,808	27	Cambridge University Hospitals	Yangon General Hospital	Enhancing Trauma Patient Outcomes through Hospital Training Partnership
	D35	Child Health	£236,656	23	Royal College of Paediatrics and Child Health	Myanmar Paediatrics Society	Emergency Paediatric Care

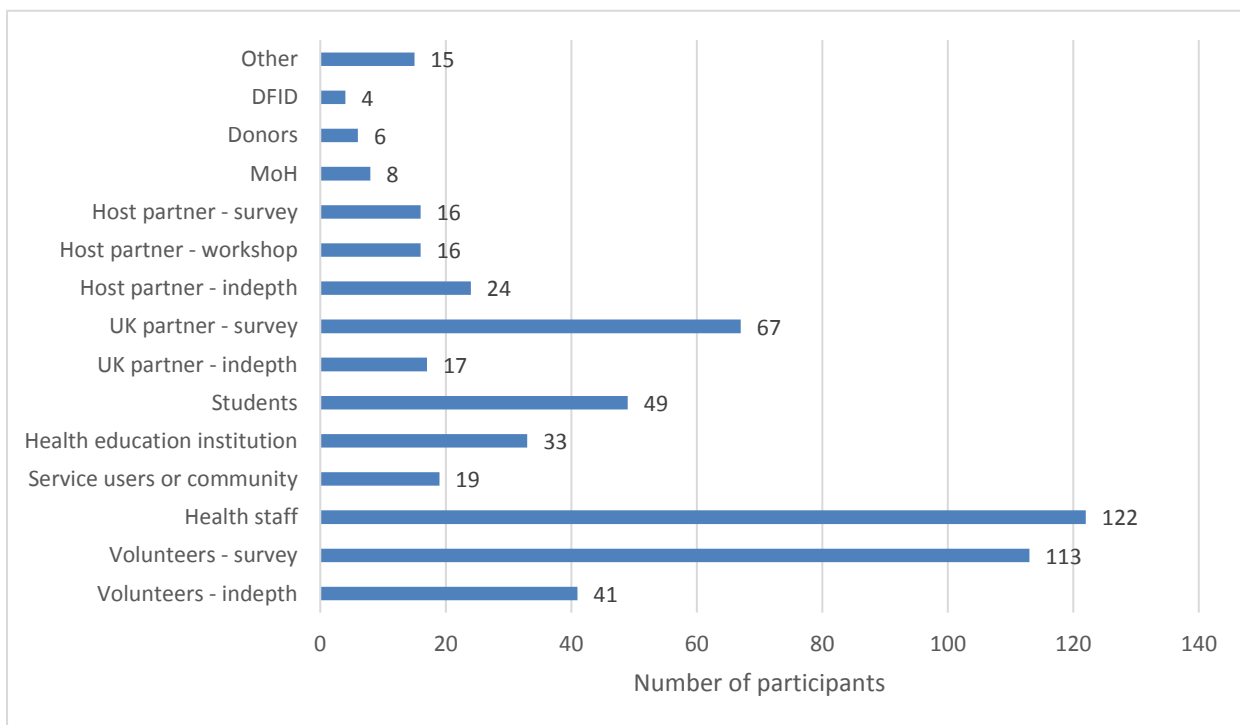
A2.05	Other	£83,461	23	Royal College of Surgeons Edinburgh	Yangon Hospital	Developing Surgical capacity in Myanmar through training
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Table 4: Remote Case Study Project Sample

Code	Health focus	Budget	Partners	Country	Title
P1	Policy	£954,370	NICE and China National Health Development Research	China / India	Improving the legitimacy and efficiency of healthcare resource allocation through the systematic use of clinical and economic evidence and social values in decision-making.
A37	MNH	£165,440	North Bristol NHS Trust & Catholic Bishops Conference	Zimbabwe	Replicating success: the dissemination of PROMPT - an effective maternity quality improvement package of in-hospital training, tools and performance monitoring
F11	Patient Safety	£57,000	University of Sheffield & Bayero University Kano and Aminu Kano Teaching Hospital	Nigeria	Strengthening systems necessary for improving patients' safety and quality of health care in tertiary hospitals in northern Nigeria
EA22	A&E	£7,000	Kings Centre & Bas Congo Ministry of Health	DRC	To strengthen capacity in the field of trauma training, trauma system development and trauma clinical care in the Bas Congo province of the Democratic Republic of the Congo.
EB3	Eye Health	£191,695	LSHTM	Multiple	Educator Development as a key to strengthening health partnerships

Sampling of evaluation participants for the country case studies was led by the host partners and supported by the volunteers and the institutions that they were working in or with (e.g. hospitals, universities, professional associations). The evaluation team found that saturation had likely been reached towards the end of the evaluation period as the same messages were coming up repeatedly, especially from volunteers and trained health workers in the host countries.

Figure 3: Evaluation Participants



Overall the evaluation covered 17% of all the 93 current projects (or 37% including the country workshops) and 23% of 66 current lead partner organisations. There were 350 interviews and out of 890 volunteers in current HPS projects, 41 in depth interviews were conducted with volunteers (5%), and 113 volunteers responded to the survey (13%)

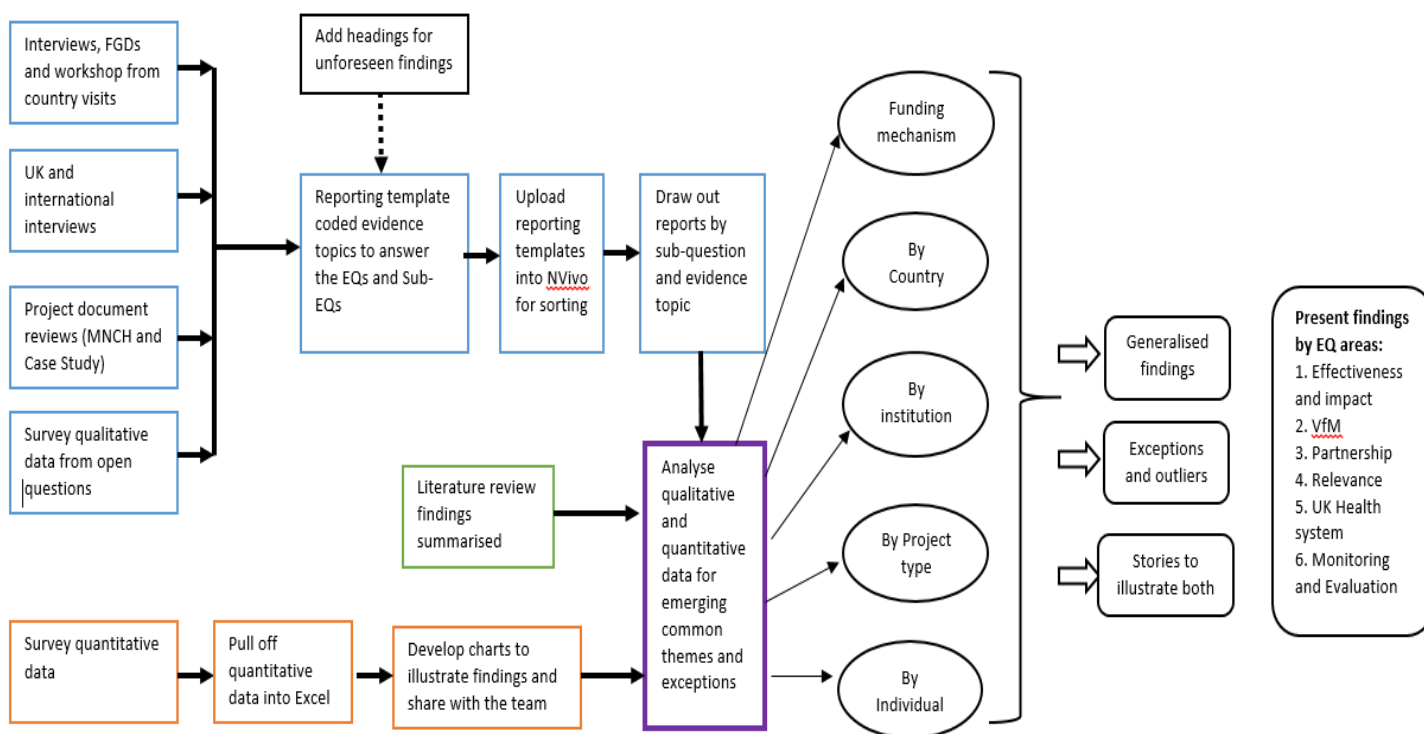
4. Evaluation Work Plan

4.1. Pathway from data collection to reporting

The Evaluation workplan is illustrated in the following flowchart, with dates of key activities recorded in the table in Annex 3. Also see Table 2 in the previous section for details of data collection participants by evaluation question. Quality assurance took place throughout the evaluation, during data collection by each country team leader, and for every product. The team leader and most of the team members were involved in quality assurance through peer review and by the team leader for final products.

As part of the analysis a workshop with the Evaluation Reference and Stakeholder group was held to discuss the initial findings and review the Theory of Change. As part of the workshop an illustrator captured key findings and conclusions which have been used to illustrate the points in this report.

Figure 4: Flowchart for Data Collection to Analysis and Reporting



4.2. Evaluation dissemination, communication and use.

Consultation on the evaluation draft report has been coordinated by DFID.

The final **evaluation report will primarily be disseminated** by DFID through the website and direct contacts with the Reference and Stakeholder Group. THET will disseminate to their partners and key stakeholders. It is expected that all UK partners will share the report with their country partners and the information can cascade from there in the appropriate format. It is the responsibility of partners to ensure key stakeholder groups such as health workers and services users are informed of the results and that the relevance is discussed where possible. The executive summary will be widely disseminated in this way.

There have been **two presentations by the evaluation team** to the UK cross Government NHS International Health Group (14th October 2016) and the THET stakeholders at their annual conference (20th and 21st Oct 2016).

Data will be shared with DFID and THET only. No interviewee information will be provided beyond DFID and this will be kept confidential. Key data to be shared: project write-ups, reports for all remote project case studies, country case study reports, online survey reports, MNCH raw data (in excel).

Table 5: Evaluation Audience Evaluation Use

Audience	Evaluation use
DFID UK, DoH, NHS International Health Group	* Learning for the design of future programmes * Accountability and reporting to ministers
THET and health partners	* Inform final year of programme and learning from processes and results to date
UK Ministers	* Clear understanding of and learning from results to date to inform future health partnership programmes or other forms of aid
Non-state sector and private sector in UK (e.g. Royal colleges, education institutions)	* Learning to improve enabling environment for volunteering
DFID Myanmar & Sierra Leone	* Engagement with partners and national government on the volunteer approach to technical assistance
Other DFID country offices	* Information about different forms of TA for health and about the HPS
Other donors including WHO	* Comparison with their own programmes * Contribution to design of future programmes and collaboration with other donor partnership programmes
Developing country governments	* Planning technical assistance for their HRH and health system
Participants in the evaluation – men and women, vulnerable and excluded groups	* Men, women and excluded groups are informed of the HPS work and findings in their communities
Wider development and HRH / HSS community and the public	* Learning for HSS/HRH programmes *Accountability

5. Limitations

The evaluation data quality may be affected by the following limitations:

(i) This is a six year programme and expectations about monitoring and evaluation have changed over time. Very few of the projects in the first round collected baseline data (though more projects are now collecting data). Therefore rigorous impact data was not available in many of the project reports. Among the 37 MNCH projects reviewed on paper there were only three independent evaluations and none of them reported impact, but indicated positive potential. Also the in-depth studies were of ongoing projects, most of which had been implemented for around 12 months of their 24 – 28 month length, so a short time period for sustainable change to be proven, especially for impact. Evidence of changes in service delivery and quality of care (HPS impact) was sourced from qualitative interviews among health workers, hospital management, volunteers and service users. However, very few service users and community members were interviewed in the end, due to the type of project (many were university based so were not directly impacting on communities) or the conditions for interviewing service users were difficult, and the evidence therefore is mostly self-reported and on a small scale.

(ii) The previous point also means it is difficult to measure cost effectiveness of this programme in quantitative terms, and so the value for money analysis is mostly qualitative. In addition, it was not possible to get cost comparators for the country case studies from the DFID offices. In one case they would not share data as it was “confidential”. In another case the team was referred to one of the implementation partners who did not end up sending the information.

(iii) It was not possible or useful to undertake workshops in all of the countries selected for the case studies. In Sierra Leone, the evaluation team was advised by THET that the severe human resource shortage, resulting from the Ebola epidemic, meant that it would not be ethical to take health workers away from their places of work for long periods. The lack of workshops meant that views from a wider number of host partners in Sierra Leone was not possible. For Myanmar, the three projects reviewed were the only three HPS projects in the country, so it would not have been a good use of time to conduct a workshop.

(iv) While the sampling method has ensured that there is representation from a range of project types, the high diversity of the HPS portfolio has meant that it is difficult to synthesise common findings across the whole portfolio in a way that shows health system strengthening in any one country. However, the evaluation provides specific examples of contribution to the HPS programme outcome. There were also some partnerships that had implemented previous HPS projects and received funding from elsewhere and it was not possible to attribute changes specifically or exclusively to the current HPS project.

(v) The evaluation was looking for evidence of contributions to a “more effective and efficient health system”. Whilst even the smallest contribution could be counted as contributing to the strengthening of the health system it is widely recognised that systems do not change unless a range of inter-related and complex changes take place at the same time. The health system is a complex adaptive system and with the new WHO conceptual framework for “people centred and integrated health services”, this system is recognised to interrelate with communities and families as well as other sectors and the enabling environment, going well beyond the original six pillars of the supply side. This evaluation is too small and limited to measure the kind of complex changes required for whole health system change. It recognises where the HPS has contributed change within the health system, though does not measure the extent of whole health system change. At the same time it acknowledges that there are other efforts also contributing that have not been assessed as part of the evaluation.

(vi) While the whole team had significant evaluation experience and expertise, the three country evaluation leads had different kinds of expertise beyond the basic evaluation skills (health system and human resource strengthening; volunteering and partnership; health policy and health system). This meant that each of the country case studies may differ slightly in its focus. However, the team has aimed to overcome this potential bias (in interview technique and analysis) through the use of a second international consultant per visit and through peer and team leader quality assurance. Team expertise did not stretch to highly technical medical skills so some of the quality of care issues could not be assessed directly (e.g. for urology surgery).

(vii) There might be some bias in the sample of volunteers as a small number of them responded to the online survey and offered to be interviewed. These were, therefore, self-selecting; and there were very few unsuccessful applicants for HPS funding responding to the survey. There may also have been some bias from the interviews in the country case studies because of the following issues: in the hospitals hosting volunteers, the volunteers and the senior staff recommended interviewees, but the interviews were not limited to these. Cultural aspects may also have influenced participant responses – for example, in Myanmar there is a reluctance to report poor performance or to fully disclose information. This has been taken into account during the analysis (e.g. some interviews that were thought to be biased were not given so much weight).

6. Findings

This section is based on a complete review of the data that was in NVivo, the MNCH report, literature review and the survey reports. It includes references and stories from a range of those sources of evidence. Evidence quality has been assessed in reference to the reliability of the data and the number of sources triangulating the key themes that have emerged. (See Section 7 Conclusions for more detail of data quality and triangulation by conclusion). All references to projects in this section have been made by using the code allocated to each HPS project. This has been done for brevity, but also to ensure there is more of an emphasis on the overall learning than on the specific issues related to individual projects. Where individual projects have been used as an example, this may be as a positive outlier or example of an exception to a general finding, or a learning example.

6.1. Effectiveness and impact

Evaluation question:

1. To what extent and under what circumstances is the HPS programme achieving its stated outcome: “more effective and efficient health systems, with an emphasis on the performance of the health workforce” and is there any evidence of impact? (DAC Criteria: Effectiveness, Impact and Equity)

Summary findings:

- HPS projects have improved the knowledge, skills and confidence of health workers and in many cases this has contributed to increased quality of care or new services.
- Training and education capacity; accreditation and curricula have been improved in several countries, and on occasion this has impacted on a whole health cadre, but wider human resources outcomes are not apparent.
- Some projects have influenced wider level change in hospital systems with equipment, record keeping and infection prevention and control (IPC), and sometimes this extends to several hospitals.
- Rigorous evidence of impact is scarce, but there are enough examples of improvements in service delivery and quality of care to assume that the HPS projects are impacting the delivery of quality health services, even if it is not being measured.
- Some projects have empowered women because of leadership and other training and opportunities, but in general the majority of projects do not have a specific approach to enhance gender equality and social inclusion.

The effectiveness of the HPS programme was assessed by looking for evidence of contribution to the expected outcome: “*More effective and efficient health systems, with an emphasis on the performance of the health workforce in participating countries and the UK*”. Because the health system is a complex adaptive system (see limitations section), it is recognised that the HPS projects do not have the budgets or mixture of expertise to cover the range of changes necessary across the whole health system. The Evaluation has therefore looked for evidence of contribution to the change in health workforce capacity and other areas of the health facility systems including infection prevention and control and medical equipment management.

Change and quality was assessed by triangulating qualitative information from health workers, service users, health facility management, government interviews and academic personnel and quantitative data from the online surveys and secondary sources. There are examples from some of the projects that illustrate how quality has been assessed (as it is specific to each technical area).

HPS outcome indicators:

- Number of developing country health workers demonstrating improved performance, at least 3 months after education or training
- Number of participating institutions demonstrating implementation of improved policies and curricula, 12 months after sign-off or approval
- Number of participating institutions using and maintaining improved equipment, ICT or health information management systems, 12 months after delivery
- Number of UK volunteers self-reporting or demonstrating improved clinical and leadership skills

The programme achieved consistently high scores in the DFID Annual Reviews from 2012 to 2016, ranging from A to A++, reflecting achievement of output targets and good progress towards achievement of outcome targets. However, despite the availability of multiple reports on individual projects, there have been very few independent project evaluations and there is limited quantitative data from projects demonstrating meaningful and sustainable outcomes. Nevertheless, the evaluation found evidence of many positive changes in the following areas⁹:

⁹ Evidence supporting the 4th outcome indicator on UK volunteers is presented later in the report

6.1.1. Human resources (HR) outcomes

Given that several sources of evaluation data demonstrate significant human resource outcomes, the findings in this section can be considered robust. The findings from the country case studies were particularly compelling as virtually all respondents across the four countries had similar and very positive comments. (See table 7 in Annex 3.3 for more detail on triangulation and quality of evidence).

A significant number of projects reviewed as part of the MNCH portfolio review have reported improvements in skills and confidence of staff and many have given examples of how the skills are being used to deliver improved services. However not all projects were reporting all of the areas of change. (For a full analysis of triangulation and quality of the evidence by conclusion see Table 7 in Annex Section 3.3).

The country case studies provided examples of the delivery of **high quality, relevant, practical and well appreciated training and education approaches.** These approaches include training in clinical skills, mentoring, university level education and teaching, training of trainers and leadership and management skills. Most projects were performing well in terms of meeting their targets. Training had resulted in improved technical and leadership skills as well as increased self-confidence and motivation. Most of the projects reviewed were building training, education or research capacity within the country, ensuring approaches were sustainable. Three projects from the country case studies had developed community awareness and linkages with the hospital (D39, D2.53 and A35 – See Table 3 with details of the project codes by country).

Positive human resources outcomes from the country visits are illustrated by the following:

- In Uganda, the three projects reviewed in depth showed a significant contribution to strengthening the capacity of the workforce; all were meeting (or exceeding) their project targets in terms of the number of people trained; training courses provided through the projects were highly relevant and significantly more practical; training provided had resulted in improved technical/clinical skills, as well as increased self-confidence and motivation, and efforts were underway to develop and strengthen the training capacity in country.
- In Myanmar, HCWs and university staff consistently report on the high quality of the training and technical expertise of trainers and volunteers and reported increased knowledge and skills; teaching and training capacity has been built among 75 senior paediatricians, nurses and university professors, which increases the chances of sustained activity and change; and the whole of the Urology surgeon cadre is being impacted by the HPS project due to the involvement of all of the medical universities and establishment of new curriculum.
- In Sierra Leone, all three HPS projects reviewed in-depth have made significant contributions to improved quality of care, strengthening the capacity of the health workers and lecturers and raising practice standards; all the lecturers and HCWs trained have lauded the high quality and relevance of the training; on the job mentoring, coaching and support provided by the UK volunteers have been linked to changes in attitude and increased motivation of HCWs and lecturers.



In the 37 MNCH project reports reviewed outcome and impact data (see footnote):

- 32% of projects reported an increase in the skills of health care workers (HCWs)
- 22% reported an increase in the knowledge of HCWs working with the project post intervention
- 19% reported an increase in the confidence of the HCWs
- 16% of projects are involved with the expansion of their training courses
- 43% of projects demonstrated improvements in clinical practice as a result of the project intervention.

*This box shows only those projects that have reported these changes in their narrative report or results framework. It is highly probable that there are more changes happening that are not measured or reported.

- In Zambia, national capacity has been developed for midwifery research leadership, and the knowledge, confidence and skills of midwives has reportedly improved through the Lugina Africa Midwives Research Network (LAMRN) project (A2.18)¹⁰; mental health literacy and awareness has improved in the communities surrounding Chipata hospital; patient care has reportedly improved and active community engagement has contributed to community empowerment and reduced stigma concerning mental illness.

The country case studies, remote case studies and the MNCH reviews and surveys all provided evidence of **improvements in ability to deliver care, and many examples of improved knowledge attitudes, confidence and behaviour, better communications and team work and a sense of empowerment of health care workers**. Some provided leadership and networking skills.

Results from multi-country partnerships also support effective human resources outcomes. For example, the final internal report from the 'Multi-level training in Trauma and Musculoskeletal Impairment in East, Central and Southern Africa' (COOL project MCP26)¹¹ states that their six-month+ follow-up assessment of trainees indicates that the training has resulted in '*significant improvement in health workers' confidence and ability to deliver appropriate care*' for trauma and musculoskeletal impairment (TMSI) in the included countries.

An independent evaluation of MCP2.2¹³, a research focussed project to improve and increase midwifery research generated in the region¹², reported success in developing a group of midwives who share a passion for research and evidence based practice, and increases in transferable skills of those who took part, such as Information Technology and presentation skills. In addition, there are numerous examples of improved knowledge, attitudes, confidence and behaviour; better communications and team work; and a sense of empowerment of HCWs.

An interesting and rather unusual example of linking partnerships and facilitating wider change is the LSHTM project, 'Educator Development as a key to strengthening health partnerships and improving health outcomes' (EB3 remote case study). This project contributes, through its focus on leadership and communications skills, to the effectiveness of 12 existing partnerships, hoping to unfold some of the potential benefits of the broader programme they belong to: Vision 2020 links.

The surveys conducted with UK and overseas partners and with volunteers support the findings above. When asked about the effectiveness of their HPS project in **strengthening the capacity of the health workforce**, 75% of overseas partners and 70% of UK partners rated the effectiveness as 8-10 on a scale of 1-10. Evidence provided to back up their scoring included improvements in pre- and post- training questionnaires, baseline and endline assessments, qualitative assessments and observations of health workers. In the volunteer survey, when asked what were the main changes observed among overseas colleagues as a result of training or coaching, common responses included improved technical/hard skills in their field of work, improved leadership and facilitation skills, increased confidence in management decisions and personal abilities, and better multi-disciplinary working. Sixty percent of respondents rated the improvement in skills and capacity of colleagues between 7 and 10 on a scale of 1-10 with evidence including their own observations (88%), pre and post training tests (43%) and feedback from supervisors (43%) among others.

6.1.2. Other health system outcomes

There were fewer stories and findings from the different sources of data on other health system outcomes, but the small number of positive findings are nevertheless robust if they have come from the country case studies and are presented here. Other sources presented here (e.g. MNCH portfolio review) of individual stories are less robust.

Equipment management

Many partnerships include at least an element of improving equipment availability and use, and this is often linked to the skills development of health care workers. However, the scale of such investments is generally quite limited and there is little evidence of this having significantly strengthened health systems or resulted in

¹⁰ Lugina Africa Midwives Research Network project in Kenya, Uganda, Zambia and Zimbabwe

¹¹ Operates in Ethiopia, Kenya, Uganda, Tanzania, Rwanda, Malawi, Zambia, Zimbabwe, Mozambique

¹² Operates in Kenya, Malawi, Tanzania, Uganda, Zambia and Zimbabwe

larger scale improvements. An exception is the project D2.40 ‘*Scaling up medical equipment management*’ in Uganda which influences a large number of partnerships through the Ugandan MNCH Hub and indeed, was developed in response to an acknowledged gap regarding equipment in the maternal and newborn health projects. The Hub aims to interlink existing healthcare partnerships in the country, adding value to the collective outcomes and supporting effective lobbying and proactive engagement with strategic policy making at the Ugandan Ministry of Health. The investment in the management of medical equipment has **resulted in increased access to functioning medical equipment as well as cost-savings at hospital level**. The effectiveness of this project is enhanced by the links with other projects and ability through these links to have a greater reach.

HMIS or other record keeping outcomes

Many projects report improved data management and use, and provide examples of how this has resulted in more systemic changes at the facility level and sometimes on a larger scale. For example, in Zambia, there were improved databases with the Zambia national blood transfusion services and in Uganda the Community Health Worker project reports extensive improved reporting to health facilities. Some projects also reported plans to scale up improvements, as with the small hospital project in DRC (EA22 remote case study) on expanding the trauma registry database. In Myanmar, there is evidence of new systems of record keeping, equipment assessment and health worker expertise inventory in three of the hospitals visited, though the change is mostly limited to one or two departments (A18 and D35 project in the Country Case Studies).

Other systems

In the MNCH portfolio review, 8% of projects reported that they had **developed and implemented various protocols and guidelines**, for example the project to reduce neonatal mortality in Rwanda was instrumental in developing national guidelines for initial care of preterm babies which are available and in use in all of the four units where the project was operational. There are five Emergency Triage Assessment and Treatment (ETAT+) projects with RCPCH as UK lead partner – MCP1¹³ in Kenya, Uganda and Rwanda, D35 in Myanmar, A2.24 in Uganda (follow on to MCP1), A2.25 in Rwanda (follow on project to MCP1) and D2.32 in Sierra Leone. From MCP1 there is evidence of health systems strengthening with the three countries now having ETAT+ instructors who are being utilised by the Ministries of Health, and Rwanda and Uganda forming central leadership teams to guide ETAT+ implementation and sustainability locally. The follow-on projects in Uganda and Rwanda are thus now benefitting from this investment.

Some projects reported that they had **implemented a ‘whole institution’ approach and that this was a significant factor in their effectiveness**. This was clearly demonstrated in two projects assessed as part of the country case studies: 1) the Uganda Sexual Health and Pastoral Education – USHAPE project (D39), where Bwindi Community Hospital (BCH) in partnership with the Royal College of General Practitioners (RCGP) aims to strengthen sexual and reproductive health services in South-West Uganda to address unmet need for family planning. It has resulted in all patients being screened for unmet needs in family planning, and family planning service statistics being routinely collected and fed into management reporting. The **‘whole institution approach’ is now firmly embedded and likely to be sustained beyond the duration of the project**, and 2) in Sierra Leone, the VG10 project on reducing infant and child mortality has strong partnerships and **a high degree of in-country ownership by the partners**. It is institution focused, with a clear emphasis on continuation of effort and ensuring institutional memory. This example contrasts with the RCPCH project reviewed in Myanmar¹⁴ which was focused on the paediatric departments. In one of the hospitals, where long-term volunteers were placed, there was difficulty introducing emergency paediatric care in the obstetrics department (due to lack of leadership commitment). The lack of a whole hospital approach was limiting the scalability and sustainability of the project.

¹³ These projects are not case study projects, but are from data collected in the online survey of the MNCH document review. Not all of them can be identified by number as the online survey was anonymous.

¹⁴ D35, Emergency Paediatric Care: Working in partnership to improve the quality of hospital care for seriously sick /injured children and newborns in Myanmar through an ETAT+ package of training with ongoing support and mentorship, leading to sustained changes in clinical practice.

Additional evidence from the surveys with UK and overseas partners and with volunteers confirms positive perceptions. When asked about strengthening the **institutional capacity of their organisation**, 78% of overseas partners, 43% of UK partners and 36% of volunteers rated the effectiveness as 8-10. The overseas and UK partners cited qualitative case studies or stories and external testimonials of improvements as evidence.

Community based systems and links with health facilities

There are very limited examples of community mobilisation, demand stimulation or social accountability approaches with the HPS projects. In particular demand side barriers are rarely analysed and addressed. Three of the country case study projects had developed community level approaches to varying degrees of success. A35 in Zambia and Ghana was mostly focussed on changing attitudes and practice around mental health at the community level and building linkages between the community and the hospital. It had innovatively used community volunteering, art and theatre to raise awareness on mental health and as a result had removed the silence and stigma attached with mental illness (common in remote rural areas). This was also encouraging community members to demand better services for family members. D35 in Myanmar had attempted to engage with community health workers to expand the hospital based emergency paediatric care package. Some training and awareness raising had been successful, but the approach needs better coordination with other community based programmes and planned follow up in order to be sustainable. Community engagement with pastoral lead teachers to delivery sexuality education in schools in the D39 project in Uganda was still in its infancy, with the potential for the project to make stronger linkages with the core elements of the project that are working more specifically within the health structure.

6.1.3. Sustainability

Nearly all of the findings in this section have come from the country case studies and much is confirmed by the MNCH portfolio review and the remote case studies, so the findings in this section are robust.

The evaluation assessed sustainability based on the likelihood of the partnership activities, outputs and outcomes lasting beyond the life time of the project. **Sustainability of projects was seen to be more likely if the projects are embedded in long-term partnerships (D2.40), or if the UK partner has previous good quality experienced with international work (D35)**, because the relationship between the UK partner(s) and the host country partner(s) had existed and continued to exist beyond the project cycle. There was also more chance of sustainability resulting from projects that demonstrate one or more of the following characteristics:

- Training of local trainers (nearly all case study projects) who can continue the expansion of training and mentoring of health workers at local and national levels;
- Project activities and approach that extend to several hospitals around the country (D2.40, D35 and A2.05);
- Demonstrated commitments from leaders in the hospital or health system (several of the projects);
- Interest and commitment from government (nearly all projects);
- Accreditation of training or curriculum uptake (many of the case study projects).
- Continued funding from donors or government. One of the projects (D35) has funding from UNICEF for expanding and continuing the project activities as part of a national programme.

Uganda MNCH Hub collaborates on effective project: D2.40 'Scaling up medical equipment management' in Uganda

Eight partnerships collaborate through the Ugandan MNCH Hub and they developed the D2.40 project, which was developed in response to an acknowledged gap regarding equipment in the maternal and newborn health projects. The Hub aims to interlink existing healthcare partnerships in the country, adding value to the collective outcomes and supporting effective lobbying and proactive engagement with strategic policy making at the Ugandan Ministry of Health. The investment in the management of medical equipment appears to be **resulting in increased access to functioning medical equipment as well as cost-savings at hospital level**. The effectiveness of this project is enhanced by the links with other projects and ability through these links to have a greater reach.

However, health system constraints were reported (by a number of country case study interviewees) to be limiting chances of sustainability and scalability (in nearly all of the projects) and these included: supply chain challenges (one Uganda project); insufficient numbers and frequent movement of health personnel; poor

management; and limited whole-system approaches to infection prevention and control and improvements in record keeping (Myanmar).

6.1.4. Health services and quality of care: Impact

HPS Impact indicators:

- i. Number of participating institutions demonstrating delivery of higher quality specified health services
- ii. Number of patients using a new or improved specified health service at participating institutions
- iii. Number of participating institutions demonstrating improved health outcomes for patients

THET reports aggregated numbers for these indicators with indicator i. achieving 379 in 2015 with a final 2017 target of 420. Indicator iii. Achieved 20 in 2016 with a final target of 60. This third indicator is challenging to report on as most health facilities do not monitor health outcomes.

The MNCH portfolio review showed that 3 of the 37 projects had conducted independent evaluations – and there was not enough data to show impact, and overall only 8% of the projects reported any impact (this is not to say that there was no impact, but that it has not been measured and reported). However 43% of projects in the MNCH review reported improvements in clinical practice as a result of the project intervention. These ranged from improved infection control measures such as better hand hygiene, to more consistent observations recorded at triage. A project to reduce neonatal mortality and maternal and paediatric infection in Rwanda (A2.25¹⁵) showed improvements in mortality rates. Another project in Nepal (MPIP.51¹⁵), reported a 48% increase in the number of children weighed in the health centres, and therefore an increase in the diagnosis of malnutrition. It also claimed a 72% increase in the number of children vaccinated due to an intensive awareness raising programme.

The patient safety project in Nigeria (F11 remote case study) provides an example of health services reaching vulnerable populations, where volunteers reported that the hospitals supported the poorest to receive services through a special fund, a camp for relatives and waiver of fees in dire cases (though this was not as a result of the project). This indicates that the project active in the two hospitals was reaching low income groups.

In Zimbabwe, a project to improve maternal and perinatal outcomes reported a Maternal Mortality Ratio (MMR) of 520 per 100,000 live births at the start of the project in 2008, and by the end of the project in 2013 this had reduced to 475 per 100,000 at Mpilo and United Bulawayo Hospital and the surrounding Matabeleland Region. However, measuring MMR on a small scale is notoriously unreliable because there is usually not enough data (meaning large confidence intervals) and should therefore be interpreted with caution. The LabSkills Africa project supported the development of Standard Operating Procedures (SOPs) and trained 100 pathologists, biomedical scientists and technologists on leadership and quality management resulting in an improvement in diagnostic testing and increased accuracy of test results. Turnaround times were reduced across all laboratories by an average of 20% and the number of laboratories conducting and acting on clinician/ user satisfaction surveys increased from 35% to 95%.

Country case studies carried out by the evaluation team showed an increase in new patients for palliative care services in Uganda; reduction in waiting times for sick children, and verbally reported reduction in mortality in Sierra Leone; and improved service provision, quality of care and reduction of child mortality and reduction in pathology sample turnaround time in Myanmar. Three projects were seen to use audit (A2.18 in Zambia, and D2.05 and D35 in Myanmar) as a tool for improving quality of care.

Emergency Paediatric Care Project in Sierra Leone measures and demonstrates impact

In Sierra Leone, only VG10 had objectives set at the level of improved health outcomes and there was evidence that the triage system introduced has dramatically reduced the waiting time of patients which is likely to contribute to a reduction in mortality figures. For example, comparison of waiting time pre and post triage system implementation, shows a significant drop in the mean waiting time from 2h 55 min to 45 min. Data also show a significant increase in the emergency signs correctly identified by triage nurses from 28% to 83% pre and post intervention respectively. All respondents claimed a reduction in mortality figures in the hospital but this could not be verified as there were no official 'before' and 'after' data from the hospital records.

¹⁵ These projects are not case study projects, but are from data collected in the online survey of the MNCH document review. Not all of them can be identified by number as the online survey was anonymous

The surveys with UK and overseas partners and with volunteers provide additional qualitative evidence of potential impact. When asked to rate the change in delivery of services and quality of care resulting from their HPS project, 77% of overseas partners and 54% of UK partners rated this as 8-10 on a scale of 1-10. Evidence to back up these scores mainly included feedback from trained health workers and health facility observations. However, 31% of overseas respondents and 19% of UK partners had conducted baseline and endline surveys with health service users to assess quality of care but very few referred to HMIS or service use statistics.

6.1.5. HPS Funding Mechanism

Findings in this section are strong and robust as they come from the surveys and are strongly backed up by evidence from the literature review, phone interviews and the country case studies.

The survey and all partner interviews indicate a **high level of satisfaction with THET's management of the granting, networking, technical support and monitoring**, though less satisfaction with the proposal and decision-making process among unsuccessful applicants. UK interviews indicate that THET's relationships with and understanding of the UK health sector is clearly a huge benefit to the work they are doing with the HPS.

Clear expectations and accountability by THET on partnership development.

"THET helps to strengthen the partnership. We feel that we are not only accountable to the partnership for our performance with them but also to THET as the funding body."
(UK partner survey).

THET provides a range of inputs besides grant giving, including support for project planning, MEL and reporting; support in resolving project management challenges, sharing, learning events, publications and online resources, policy and advocacy work in the UK for volunteering. Survey respondents and case study participants reported that the **Principles of Partnership and THET's direct support and oversight had helped strengthen partnerships**. The mix of grant sizes and flexible levels of funding have been seen to effectively support innovation and start-up partnerships as well as growing, maturing and coordinating groups of partnerships.

THET has developed the reporting templates and systems significantly since the beginning of the programme and there are now guidance and case studies for learning that partners are using. There were some indications of inefficiency. For example some of the HPS documentation provided to the Evaluation team was disorganised and out of date. Some documents don't have dates or information about the key personnel, there were several versions of the project plan in one case and no indication of the current one in use.

However, the evaluation team assessed that the **granting streams were not particularly strategic in terms of the desired outcome and impact for the HPS**, as they are defined more by the grant size than strategic objective. There have also been a couple of occasions when the HPS has been required by DFID to fund initiatives that may not fit well into the overall strategy and approach of the fund. More recent funding streams focusing on key health system constraints (such as IPC and equipment) have interesting potential, but have suffered from insufficient time to develop fully.

Small start-up grants have been an excellent vehicle for the building of relationships, understanding context and joint planning. Project EA22 has innovatively used £7,000 to develop a new relationship at the same time as piloting and testing trauma training approaches for the context in DRC. It also has used the grant to build up relationship with government, who are fully committed to project. Both start-up grants in Myanmar have grown to larger projects now implementing under HPS and one of these (D35) has follow on funding from UNICEF.

Even though webinars, conferences and workshops have been successful and well attended, THET has **not yet been able to effectively coordinate and build synergies between partnerships within countries**. Granting to promote networking and coordination has not worked so well (e.g. Uganda- UK Health Alliance (UUKHA)), though there are two, and maybe more, interesting self-led examples that can be learned from (e.g. Uganda MNCH Hub).

There were also some limitations in the application (proposal) form, which made it difficult to assess competency of the partners. For example there is no requirement to present the organisational capacity of the partner organisations (e.g. ability to manage and technical skills), or personnel CVs in the proposal development and assessment stage. So it is hard to see whether there are sufficient levels of expertise for the implementation and a potential project adaptation. If a project veers away from its original purpose and

activities, which might include the need to implement in a technical area that is not part of the UK partner's key strength, there does not appear to be a process for re-assessment of the project.

Evaluation online survey and interview comments about HPS management

- *Useful materials and helpful staff:* The majority (76%) of UK partners who answered the survey felt that the information on the website and in HPS materials was easy to use and understand, and 86% found HPS staff to be helpful and knowledgeable. (50% and 58% respectively among unsuccessful applicants).
- *Uncomplicated application process and helpful application webinars:* 78% of respondents of the UK partner survey found the grant application form self-explanatory and 61% felt they received the necessary technical support during the grant application. (58% and 17% respectively among unsuccessful applicants).
- *Issues with transparency in the grant decision making:* 49.2% of successful HPS applicants felt that the grant decision making was transparent, with 13.6% thinking it was not. These numbers look unsurprisingly worse when we look at the responses from unsuccessful applicants (16.7% and 25% respectively). During the evaluation interviews, two UK partners mentioned the lack of transparency in this process referring to issues like "insufficient feedback", "no feedback on the specific appraisal criteria", or "long delays to schedule a meeting to discuss an unsuccessful application".
- *Flexibility:* both during the interviews and in the online survey, UK partners seem to highly appreciate THET's flexible approach to programme management, allowing and supporting changes in the implementation of projects and in project design to make the interventions more effective and to better respond to contextual or unexpected factors (e.g. Ebola). In the survey for UK partners, 76.6% of respondents agreed with the statement "THET has enabled the partners to adapt to changing project circumstances efficiently", with only 2.1% disagreeing.
- *Efficient funds management:* almost all (91.5%) of the UK partners who responded the evaluation survey feel that the fund disbursement was managed timely and efficiently by THET.
- *Financial template is useful for grantees,* but it is not easily used for re-budgeting or cumulative budget tracking, so needs a bit of adaption.

Capacity building and other types of THET's support

- *Networking support:* THET conducts a number of webinars, conferences and workshops aiming at both building capacity and networking amongst partners. According to the UK partners' survey conducted by this evaluation, these networking opportunities are generally valued, with 64.8% of respondents agreeing and 18.5% disagreeing with the statement: "THET networking and communications support has been crucial to the building and development of our partnership".
- *Monitoring, Evaluation and Learning:* THET supports UK partners through the design of their project plans contributing with their experience of designing and managing MEL systems. This support is more visible in HPS 1.5 and some, but not all, of the UK partners seem to generally appreciate it. 32% of survey respondents found the "monitoring data and reporting required by THET too time consuming", with the majority (55%) disagreeing with this statement.
- *The principles of partnerships* developed by THET are a useful source of information about good practice to make successful partnerships. In some cases, UK partners have used them to discuss their partnership with their overseas partner (eg. A18) potentially strengthening the relationship. According to this evaluation's UK partners' survey, 81.5% of the respondents thought that "The HPS Principles of Partnership have guided us on better partnership working and more effective projects"

6.1.6. Gender, social inclusion and equity

This section covers issues of gender and social inclusion across the project cycle, (including proposal assessment and monitoring and evaluation) and the value for money assessment (in terms of equity). Because there was not much depth in partners analysis, the information from this section is less robust than other sections. The small number of examples that are presented were well supported by different interviewees in the country case studies.

Very few of the context assessments in project proposals had adequate analysis of the context in relation to gender inequality and social exclusion. Projects reviewed for the country case studies tended to have **limited understanding or analysis of how gender inequality and social exclusion can affect efforts to enhance human resource capacity and skills or improve people's access to and use of services**. Many of the

Equity conclusions for SRH project (D39) in Uganda

- Some of the trained nursing students are from remote and rural parts of the country and likely to return there to deliver services – thereby reaching a wider range of underserved population.
- The project's integrated approach has meant that young people are (anecdotally) more comfortable coming for FP services as don't have to come to a "FP unit" where they may feel stigmatised – instead can access FP from other general wards too.
- Wider inclusion: the hospital serves a range of clients, including the marginalised Batwa community. Outreach programme visits remote and underserved communities.
- Some challenges in terms of service delivery e.g. men still the key decision makers so some women have to return home after FP counselling to obtain their permission, and in general, ensuring male involvement remains a challenge for staff.
- Gender is considered in the training materials (how to talk to men vs women, couples' counselling, etc.) and role plays etc. focus on differentiating between counselling men vs women.

Source: interviews and project materials

projects were being implemented in tertiary facilities or in secondary facilities in urban areas, but claimed to provide services to low income populations and to receive referrals from rural areas. For most specialisms the health workers stated that referrals were coming from rural areas, but it is likely that some rural areas were too remote to enable access to the facilities and it is generally known that urban facilities mostly serve the surrounding population. It was also clear, from observation and testimonies, that the health facilities were over-crowded and there was a shortage of health workers. So if additional harder to reach populations were to access services there would need to be an increase in the service delivery capacity (health care workers as well as systems and supplies improvements). Gender was explored in relation to specific service delivery in only one project among the country case studies. D39 in Uganda considers gender norms in the training materials, by exploring traditional gender roles and the implications for family planning and counselling and had information about equity and inclusion in terms of the service users and the nurses.

There was no analysis of health worker ethnic group, social status or income level, or of how exclusion or discrimination might work within the human resources system, nor was it required by THET (e.g. certain health cadres and management jobs being limited to certain ethnic or social groups as in Nepal¹⁶), and this was not required by DFID.

However, some projects now have disaggregated data and are reporting on some aspects in relation to improvements in gender equality. These appear to be limited to assessing number of women and men and inclusion of women in activities.

The volunteer effects on improving equality and encouraging attitudes to support women's rights were more coincidental than planned (see Section 6.4 volunteering). A **small number of projects have offered opportunities for women to challenge gender roles**, for example in D2.40 medical equipment project, fourteen of the 42 technicians and students trained are female, in a traditionally male role. The project provides a platform for female students in particular to defy traditional gender roles. Increasingly, the role of women in biomedical engineering is recognised by management in participating hospitals.

Discussion about gender often brought up issues of the number of health workers of each sex and some assumptions around roles or about service users access to services. For example for project A2.05 in Myanmar the majority of urology surgeons and students are men, even though nearly half of medical students are now women, and it was thought to be more acceptable for surgeons in general to be men. The small number of female Urology students (including one doctorate student) found that it was very challenging, but did not recognise any discrimination.

Some **training approaches (e.g. the RCPCH Emergency Paediatric Care training) include methods to empower health workers, encourage multi-disciplinary teams and challenge unhelpful hierarchical barriers to good service provision**. Negative hierarchy and power differentials between health cadres was thought to be a barrier to good team working and may influence how services are provided. Lower status health workers in Myanmar tend to defer to the higher status professional even if they think they are doing something wrong. In project D35 in Myanmar it was seen that all of the paediatricians were women and the nurses were women, while the junior doctors were mostly men. The status issue and power differentials had made it difficult for the project to make progress to change attitudes and behaviour and to improve team work. The RCPCH/MS EPCP training and the work of volunteers includes communications techniques team working and inclusion, and the volunteers reported that they encourage nurses to subtly discuss issues with doctors and to feel empowered to do so (*"if you know the consultant is not ventilating the baby well, you can step in and demonstrate how to do it properly"*). This appeared to be working for some nurses who reported that they

Examples of empowerment

"When I go to hospital I can see that people question my competence. They don't say it, but you can see it. To me that gives me a chance to show that I can do as well [as men] in the field of technology". (Graduate woman in biomedical engineering, Uganda)

"When you have knowledge, nobody can undermine you." (Female link nurse at Kibuli hospital, Uganda)

Quote from female doctorate student

"Being a general surgeon is more difficult for a lady – and being an Urologist is even more difficult. It is not because of sex discrimination, but because of the culture. People in general trust men more." (A2.05)

¹⁶ [http://www.nhssp.org.np/human_resources/HRH%20profile%20\(QA\).pdf](http://www.nhssp.org.np/human_resources/HRH%20profile%20(QA).pdf)

felt more confident and more empowerment to make decisions after the training and mentoring. However there were still some nurses who were not confident enough to challenge someone senior to them.

The work of the volunteers has also possibly made some difference to gender relations and a small number of volunteers recognised this. 66% of volunteer survey respondents (female) saw themselves as role models for women health workers (one female volunteer interviewed told a story of giving a presentation at a conference in Northern Nigeria – the only woman to do so - and having other female health workers tell her afterwards that they now felt they could also do the same), 21% respondents stated that they had challenged discrimination during their placement, and 10% stated that they had encouraged institutional changes through adoption of equal opportunities policies. 10% also felt that they had changed attitudes amongst health workers towards gender equality for the better. However, 25% of respondents also stated that existing attitudes towards gender equality were positive and had not changed as a result of their visit and 35% stated that they either didn't know or had nothing to add about gender equality.

There were other projects that were specifically **empowering nurses and midwives, building leadership or research skills**, who are mostly women, for example in D43 in Uganda (see box) and A2.18 in Zambia. However they do not necessarily take a wider view of women's roles and the gender related barriers within the health system and in their communities. Nor is there a good understanding of how gender and power differentials might be addressed in order to improve project effectiveness and women's rights more generally.

Consequently, projects did not have specific activities to support gender equality and social inclusion nor were they measuring the potential changes, for example, in social norms, management techniques,

women as leaders, women's rights within the workplace, issues of unpaid care and work-life balance. (See M&E Section 6.5 for one exception on social norms). As can be seen in a recent WHO survey (WHO 2016)¹⁷ there are persistent and damaging social barriers to midwifery personnel in the health system (see box below).

Development of Nurse Leadership for Palliative Care – D43 Uganda

A previous project had identified nurses' leadership skills as a key gap in improving quality palliative care and so had designed a project to specifically address this. Interviews by the evaluation team with leadership nurses highlight the effectiveness of the training, with all trainees interviewed showing high levels of self-confidence and being able to give concrete examples of how the training has helped them to take on a leadership role in the provision of palliative care on the ward. The clinical and leadership skills are increasingly recognised by their nurse colleagues, as well as the clinical officers and doctors they work with. The continuous mentorship following training by MPCU in particular has played an important role, with the MPCU staff playing a critical part as role models.

Social barriers experienced by midwives

37% of all the (2,470) midwives in the survey have experienced harassment at work, with many describing a lack of security and fear of violence. A significant number of respondents, particularly in Africa, say that disrespect in the workplace "extends to harassment – verbal bullying and, at times, physical and sexual abuse". This affects their "feelings of self-worth and their ability to provide quality care". Other barriers to providing quality care include living in inadequate and unsafe accommodation leading to isolation from family support, and difficulties in managing paid employment with domestic and childbearing responsibilities.

6.2. Value for money

This section responds to evaluation question two about value for money. The majority of the data is from the in-depth country case studies, though some data on value created by the projects is from the surveys and wider interviews. In the absence of standardised and centralised information this evaluation has applied a more discrete and differential approach to VfM focusing on: (i) VfM focus in the project cycle for the country case studies (ii) overhead and training output costs and budget utilisation (iii) value of volunteering time and technical assistance (TA) compared to other forms of TA and the "do nothing" scenario (including value to the southern partners) and (iv) value to the volunteers.

This section should be read with an understanding of the value created through partnerships and volunteering that are explained in sections 6.3 and 6.4. It is presented before those two sections in order to be consistent with the priorities given during the inception period and the overall evaluation framework structure. The

¹⁷ http://www.who.int/maternal_child_adolescent/documents/midwives-voices-realities/en/ .

qualitative data in this section is strong and confirmed across the country case studies in particular. However there is scant quantitative or comparative quantitative data.

Evaluation questions:

2. Is the programme delivering value for money? (DAC Criteria: Effectiveness, Efficiency, Equity, plus VfM criteria of Economy)

Summary findings:

- Partners and volunteers have a high level of awareness of value for money and the creation of high quality and effective project inputs.
- The cost of technical assistance using a partnership and volunteering approach is low, though this is because of low “pay” and may limit the number of “volunteers” interested in this kind of work, even though the volunteer accrues value in terms of learning.
- Overall effectiveness in terms of health system strengthening may not be as scalable and sustainable as other larger aid programmes that target several areas of the health system at once, but there are HPS projects that show considerable promise in this respect. Further development of the approach would be advisable to understand how HSS can be maximised.
- HPS projects are missing the opportunity to create added value from coordination and integration with other forms of aid.
- Partners and health workers in the LMICs value HPS partnerships and projects highly.

6.2.1. HPS partner concern and implementation of VfM principles through project cycle

All of the projects reviewed for the country case studies and the interviews for the remote case studies demonstrated a **high level of awareness of and commitment to the importance of economy (in particular), efficiency and effectiveness as well as sustainability, and this is driving behaviour**. There is a strong culture and practice of cost minimisation across all projects, using low cost transport, conducting training in health facilities, and combining different cohorts of trainees to avoid extra costs. This is partly because of the nature of partnerships (“*you hit the ground running*”) and most of those implementing the HPS projects from the UK are volunteers and only have basic living costs covered by the project, so are wary of expenditure.

There is also a high level of awareness and responsibility of ensuring project effectiveness.

Volunteers demonstrated a particularly keen commitment to and responsibility for high quality work, innovation and tenacity in the face of challenges. Volunteers were also

willing to continue giving support for no remuneration either to continue working in the country they have been volunteering in with their own or raised funds (EA22 in DRC and F11 in Nigeria), or from their home base. The volunteer survey showed that nearly three quarters of respondents (71%) had continued to provide remote support after they had returned from their volunteering assignment overseas. For most, this took the form of email support, or WhatsApp/skype or other forms of social media. The remote support included ongoing mentoring to health workers, as well as support and advice to new volunteers or project management staff overseas.

Commitment of volunteer – Infection prevention and control project (F11), female long-term volunteer, Nigeria

“There is a high chance of change if they (the hospital staff) continue with this trajectory and do not lose momentum. I will come back again at the end of November to continue the training by myself. It feels a bit premature to leave the project – we have just started putting the structure in place and there are parts of the WHO patient safety curriculum that would strengthen their clinics’ risk management structure and quality improvement. And I would like to see whether the small changes are making them advance forward. They need that. We did apply for further funding to come back in November but we were unsuccessful. So I have taken it upon myself. I have been meticulous in spending the money for these expenses and I have some money that I can use.”

A high number of projects providing training were developing capacity in the country to continue the training with even lower costs, or as part of the government funded system. This training of trainers approach will result in average training costs dropping as economies of scale kick in. The A37 PROMPT project in Zimbabwe has very modest spend and the methodology that has resulted in phasing out of the UK trainers and delivering the training within the hospital rather than pay for an external venue. There was also evidence that southern partners contributed to inputs when possible (e.g. A2.05 in Myanmar), particularly in supporting volunteer housing and supporting short term volunteers.

Efficiency of project implementation was reported to be high by many country case study participants. As reported in the previous section, training and development of curricula and education systems were reported to be particularly efficient and effective by health workers and university staff interviewed as part of the country case studies (see Section 6.1 for examples). UK and southern partners were able to mobilise and organise the training and engage sufficient participants in the majority of projects. The high quality, relevant,

appropriate and enjoyable nature of the training was cited by interviewees across all countries. However this was undermined to a certain extent in a small number of projects by (i) the in-country project management system in some projects where a coordinator or an NGO had been hired to manage project funds (see partnership Section 6.3 for more details) and (ii) the lack of transparency between UK and southern partners in relation to budgets and project plans (some of the southern partners had not seen the plans – section 6.3).

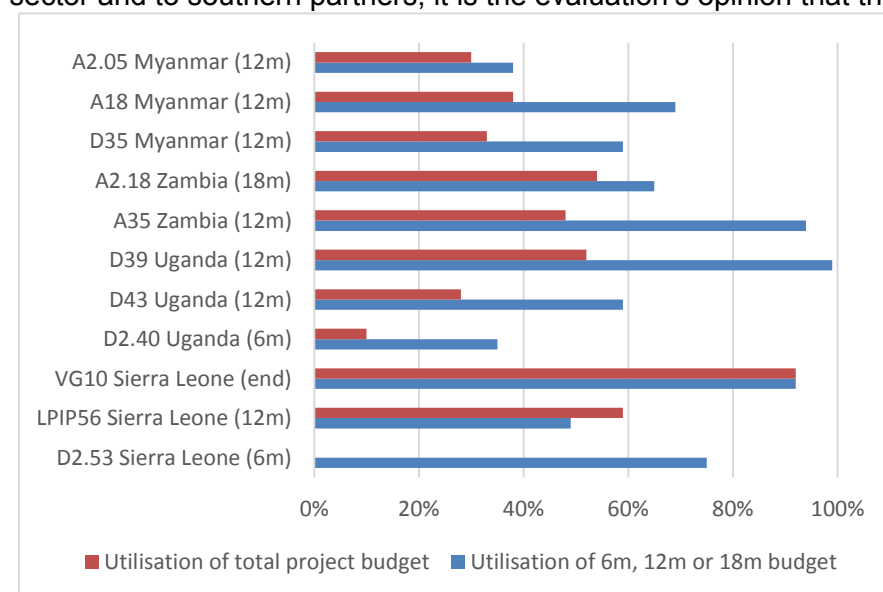
6.2.2. Costs and management efficiency

Table 6: Whole HPS Fund expenditure by category

Costs	2014/15 Spend		2015/16 Spend		2016/17 Forecast	
Grants	£4,905,701	82.7%	£4,306,374	83.1%	£2,345,355	70.0%
Staff/Consultants	£740,178	12.5%	£613,064	11.8%	£702,805	21.0%
Communication & Engagement	£83,028	1.4%	£61,348	1.2%	£81,085	2.4%
Monitoring & Evaluation	£36,711	0.6%	£45,904	0.9%	£15,000	0.4%
Travel subsistence	£37,601	0.6%	£26,021	0.5%	£40,993	1.2%
Other costs	£127,783	2.2%	£127,244	2.5%	£167,157	5.0%
Total	£5,931,002		£5,179,955		£3,352,395	

Overall **HPS Fund utilisation (86% spent by June 2016) and the non-grant funding (17%¹⁸ of overall expenditure see Table 6)¹⁹ is good value** given the range of UK partner types (grant holders) and the extra input provided by the HPS team at THET. Many of the UK partners do not have in house development experience or expertise and are not familiar with logframes or the HPS project plan format that are used for this kind of funding and so have to be given guidance by the THET team. The Principles of Partnership also need to be well explored with the UK partner and plans for partnership development are supported. This kind of technical assistance is extensively provided by THET staff, but it is not possible to extract the amount of time spent on technical assistance in relation to other programme tasks or wider advocacy and M&E because staff time is not allocated in the budget. So in the table above the cost of staff and consultants is allocated to overhead, when it is probably a more complex picture.

Given that one of the key added value areas of the HPS is the value of partnerships, both to the UK health sector and to southern partners, it is the evaluation's opinion that this **money is well spent on generating effective approaches and partnerships.**



Project level budget expenditure efficiency and allocations are variable. A large number of project have had slow start up and some projects have only spent between 40% and 60% of their budget in the first 12 months. As this is a pattern across several projects (but not all – see Figure 5) it indicates that better advice about budgeting and inception period preparation may be required. If

**For figure 5 the length refers to how long the project has been going for and when the utilisation was measured*

¹⁸ This is projected to increase to 30% of all funds in 2017, probably because of the reduction in grant funding as proportion of the overall fund.

¹⁹ Figures also reported in the HPS Annual Review by DFID July 2016.

projects are rushing to implement the rest of their budget over the final period, this can increase risk of mismanagement and inefficiency. Project P1 in India and China had a particularly poor budget utilisation and an allocation to training that was too low.

Cost drivers across the projects are overwhelmingly travel and training and capacity building. For projects with majority short term volunteers the travel is the bulk of the budget (highest 76%), with lower training costs (see Table 9 in Annex 4).

On average country case study project management costs account for 17% of total budget ranging from 7% to 24% (VG10). The lower rates tended to relate to those projects with a lower number of volunteers and short term volunteering, but there were also exceptions – such as the Kings partnership in Sierra Leone, which has a management cost of 9.5% and this may reflect some economies of scale given they manage several projects in Sierra Leone and have an office in the Connaught Hospital.

In some cases, where the southern partner does not have the organisational capacity to manage the project, the administration appears to be less efficient (e.g. D35 in Myanmar) or they are using high value individuals to do admin (e.g. a senior surgeon A2.05 Myanmar), and even though this is a cost to the southern organisation, is not a very efficient approach overall. (See section 6.3 for more analysis of this relationship).

The THET value for money methodology has included an assessment of training costs per health worker trained by project (these can be seen in Table 10, Annex 4 (sect 4.3.3)). While these costs are interesting to assess (and the evaluation also presents the costs of training in the box), they are not comparable or accurate. While the project reporting formats are useful for financial oversight, they do not allow for an accurate breakdown of all costs associated per training (e.g. international travel is often missed out) or by other activities and outputs. The diverse types of training and levels of expertise needed by project makes it challenging to compare costs per training across the projects. Similar projects could potentially compare cost more usefully and use the information to reduce costs where feasible.

The costs per training day and per trainee relate more to efficiency than cost-effectiveness. It would be more interesting to measure the cost per healthcare worker who has improved clinical practice and applies new knowledge. This would need to include costs of mentoring and ongoing support – and may even have to include access to equipment and supplies as relevant.

6.2.3. Value created for southern health workers and health systems

The time leveraged by volunteers and the training provided has a huge value to partners, host organisations and health workers. **The 11 country case study projects reviewed have provided (leveraged) over 4,000 volunteer days overseas, working with 97 volunteers so far in their first 12 months and have trained 2,358 people in Uganda, Zambia, Sierra Leone and Myanmar.** (See Table 9 in Annex 4 for details by project. Data comes from the latest project reports,

Example training and placement costs

Training costs: most were very low cost around the £30 to £200 per person per day range. One partner specified that if they had conducted the same training with professionals that were paid the whole training would have cost them £202,404 (A18 Myanmar).

Volunteer cost: volunteer paediatrician placement (RCPCH) is around £15,000 per year in country, including all preparation. This compares to the salary of a paediatric registrar, which is between £30,302 and £47,647 or a consultant paediatrician salary, which is £76k – 102k.

Value created by HPS volunteers - Southern Partner survey

- Skills and expertise, mentoring and support, increased motivation and focus, reinforcing good practice,
- Ensured the right prioritisation in use of resources (human and financial) to achieve goals.
- Significant improvement in patient safety
- Better management of childhood illnesses
- Different way of looking at things
- Behaviour change theory training among beneficiaries of the project.
- Improved communication skills and planning, in the organisation.
- Improved learning environment in pilot sites,
- Standards and module development enhanced for nursing and midwifery mentorship
- Technical support for the establishment of a Birthing Centre
- Strengthen health worker association

“The training of Peer Support Workers (in Uganda) has provided a new resource of health works within the hospital. We hope to be able to provide evidence of PSW as a cost-effective intervention that benefits not only those who receive peer support but also those offering peer support as well. This is a new initiative at 7 of the 8 hospitals that Brain Gain2 is working with”. (Survey respondent - This project is undergoing a rigorous evaluation).

“It is not just about trainers, but about building a lasting relationship and the training is different- giving more continuity and focus on follow up. All inputs are important but financial input is the most important. Without it nothing would happen.” (Uganda partner workshop)

dated Feb – Mar 2016). This funding and the partnerships have resulted in changes in human resource knowledge, skills, attitudes and behaviour; education and training systems and capability; management of equipment and supplies; better links with some communities and referral; leadership skills and better management in health system; record keeping and registry systems.

When given the hypothetical choice between the projects versus a cash amount equal to the project budget²⁰, the overwhelming response was to select the project rather than the cash amount. The reason given was the **importance of the long-term partnership and the lasting effect generated by the HPS-funded projects, in particular in terms of staff capacity**. There were numerous examples of change that would not have happened without the project and the partnership.

For Bayero University in Nigeria (F11): *“If we hadn’t got this grant, we would just have continued as normal. Patient safety would have just remained in the background. There would still have been the closed infection prevention committee that existed before, but it would have remained underdeveloped and not useful.*

For project A2.53, part of the Sierra Leone case study.: *“Tonkolili District and the whole of Sierra Leone would have continued with traditional method of IPC training which has been attributed to boredom amongst participants. The traditional IPC also lacks a system for evaluating changes in skills and knowledge.”*

Changes that would not have happened without the HPS project – the opinion of partners, trainees and students based on their experience of the project training compared to other training. Medical Equipment project D2.40 Uganda

- The standard of teaching in biomedical engineering at Makerere University would have been much lower. Teaching would have been much less practical and applied
- The decision to establish a dedicated department for biomedical engineering as part of the renovation of Mulago hospital would not have been made without the project.
- Management would not have an overview of the status of medical equipment in the hospital for which they are responsible.
- Money would continue to be spent on replacing equipment that can still be repaired (see example of microscope at Kabubbu hospital).
- Hospitals would continue to be dependent from technical services provided from Kampala/Entebbe, or even international technicians.
- Down-time of medical equipment would be longer as a result, as well as the costs of repairing them.
- The quality of care provided by participating hospitals would have continued to be compromised by inadequate and/or malfunctioning equipment.
- Technicians trained through the project would not have been empowered. Their potential would have remained untapped, as result of which much hospital equipment would remain broken a/o unutilised.

6.2.4. Value of volunteering to UK health workers

All volunteers interviewed for the country case studies, for the remote reviews and the returned volunteers stated that they had learned technical and personal skills they plan to use in their work in the UK. Respondents in the volunteer survey had much the same story and the large majority of respondents (93%) felt they had benefited from their volunteering experience with HPS. Volunteers claimed they had strengthened technical/hard/clinical skills, increased soft skills (confidence, motivation, leadership etc.), and international exposure and improved cultural awareness. On return to the UK more than two-thirds (67%) of respondents stated that they had taught others in their organisation about the challenges that health workers face overseas, and that they had better cross-cultural understanding. 63% stated that they respected the NHS more and 54% felt more confident and capable in their jobs as a result. 24% felt that they had brought back innovations which they were now using in their work in the UK. Only 8% (6 respondents) felt that their work in the UK had not changed as a result of their volunteering experience.

There are clearly some costs also associated to volunteering for both the volunteer and the UK health service. For example the loss of volunteer working time - it is impossible to estimate whether the value of the returned volunteer with new skills is equal or more than the cost to the UK health system. Further research is being undertaken by Salford University to understand this relationship.

²⁰ This type of social research method – asking choice questions – reveals reasons behind preferences that are illuminating in terms of the value given to a particular approach. It is more likely to result in an honest response than a straight question.

Table 7: Costs and benefits to different stakeholders in the partnerships

	Benefit (value) to host country	Cost to host country
Benefit (value) to UK health system	Development of international networks and global excellence through connections between health systems and health experts. Short term (ST) senior and technically experienced volunteers and leaders gain important international experience and connections.	Less experienced volunteers, possibly learning more than contributing, but bringing back learning to the UK if strategically planned and enabled by the UK health system.
Cost to UK health system	Senior and technically experienced volunteers and leaders (Long Term- LT) are not available in the UK, colleagues have to cover their roles.	One off volunteering that is not part of a project in the LMIC or part of a strategic approach in the UK, and where learning does not come back to the UK, or the volunteer leaves the NHS.
Benefit (value) to volunteer	ST or LT where there is a high level of learning, Satisfaction of giving and contributing to world health by developing international networks	Less experienced volunteers, possibly learning more than contributing.
Cost to volunteer	ST assignments in their leave time or taking career break for LT assignments so that it jeopardises career progression.	Unstructured placement with limited support for less experienced volunteer

Value that volunteers have gained – volunteer survey

"I have an increased understanding of low resource countries and their problems and the difficulties faced. My political and personal views have become more focussed. I am more aware of human and particularly women's rights. I have an increased interest to learn more and become active in my beliefs. I am more self-aware of how I speak to and treat others. I have gained confidence to speak out and discuss political and human aspects of healthcare in this country and abroad. It has ultimately given me the confidence to take time out from my full time job to go to university to study peace and development."

"Invaluable experience to develop leadership skills, learn about my own competencies and self-development to realise areas of difficulty and why they occurred. I learnt a lot about the NHS and why our systems may have developed as they have and also I learned how similar human behaviour is across cultures/borders, which I believe is a strong realisation to help me in any future roles of leadership and how to influence for positive change."

"Skills - teaching training mentoring clinical work and running projects, managing people and funding. Experience - different ways of working and dealing with people, appreciation of different culture. Knowledge - vast increase in clinical skills as honed these whilst less technology available."

There are also examples of where the volunteers have not started their placement with sufficient experience for the task, but through the long-term placement have learned how best to work in the context (see box below).

Lack of exposure to or understanding of the context:

"A couple of volunteers were not well qualified to train Nepali health workers in the rural context," (Online survey respondent Nepal project)

"In the first years of the partnership the volunteers had less insight into the challenges of working in a rural hard-to-reach location with very poor communities and limited resources but as the partnership developed and matured they now understand much more the issues Kisiizi faces. Initially there was frustration if progress seemed slow but now there is a more realistic recognition of the big picture and how the project fits into a wider agenda of work by Kisiizi and how by persistence and determination good outcomes are achieved." (Online survey respondent Uganda project)

6.2.5. Comparisons of efficiency and effectiveness with other programmes

In comparison to wider aid programming, the HPS has a clear VfM advantage due to the use of expert volunteers who provide specialist expertise while at the same time learning and building potential for enhancing the health system in the UK. The value accrues to the volunteer, the host country health system and the UK health system in non-monetary terms. Most other types of aid programming accrue value to the health expert in monetary terms through payment, and to the host country, but not necessarily to the UK health system. It is also true that most UK volunteers through the HPS (but not all) are paid only expenses and very low subsistence, so they cost little in terms of technical assistance. This could be seen as a bit exploitative, but the non-monetary relationship has clear intangible advantages for both the volunteer and the host country,

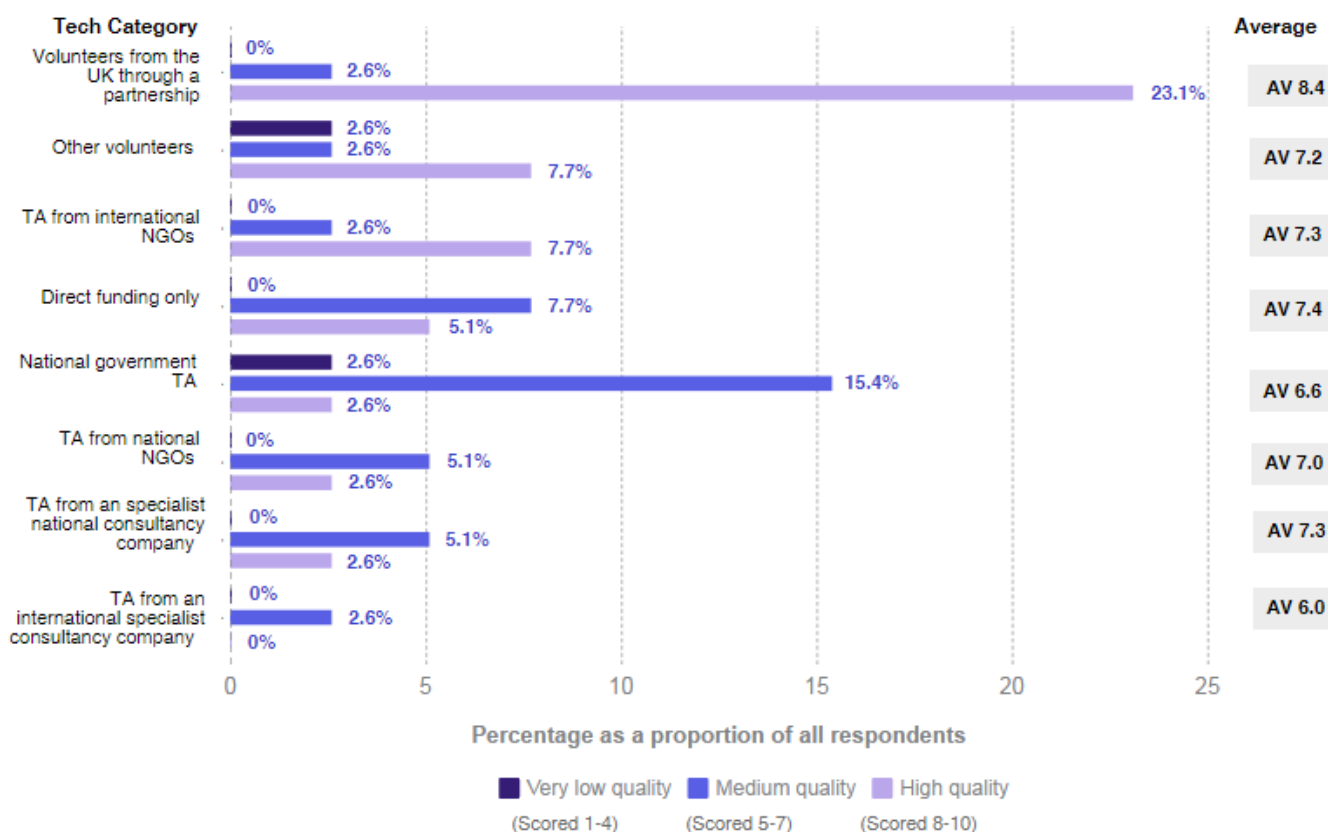
where commitment and relationship goes well beyond a simple economic transaction. However the low “pay” to volunteers may limit the number of volunteers who can be mobilised (in comparison to the Norwegian volunteering programme or VSO where they are paid a salary). See table 8 below.

In comparison to other larger DFID health programmes, the HPS is quite targeted and is limited to training and education of the health workforce (see section 6.1) and does not appear to effect recruitment, deployment and retention, or some of the gender related barriers to health workforce development, and only limited effect on other health system aspects. Larger programmes that work on a range of human resources issues (for example see box below on Women4Health below) demonstrate that targeted partnership can be combined with work on infrastructure, governance and community engagement to effect change.

Not all HPS volunteering brings the same level of benefit to the UK health system (See sections 6.4 and 7 for more exploration of this issue). When volunteering is strategically organised for learning and career planning there are likely to be more benefits in the UK. (e.g RCPCH Fellowship and IGH Leadership Development programmes)

However, evaluation participants in southern institutions have reported a high level of appreciation of the HPS technical assistance provided. The **quality of HPS volunteer technical assistance is rated higher by southern partners** than other forms of technical assistance (see Figure 6 below).

Figure 6: Quality of different types of Technical Assistance received over the last three years



DFID programme in Nigeria using partnering with the Royal College of Midwives (RCM) – [Women4Health](#)

This non-HPS programme mixes partnership with mainstream aid delivery. It aims to increase the number of women midwives practicing in Northern Nigeria and improve the quality of care. It has a whole cadre approach and looks at barriers throughout the human resources cycle of education, recruitment, deployment and retention and addresses a range of practical and social barriers that are limiting the number of women health workers in Northern Nigeria. The following areas of work are highlighted: (i) Work in communities to address barriers to women’s education and employment and identification of young women who can continue education. (ii) Foundation year for young women who do not have sufficient science skills to enter the health training institution because of poor high school education. (iii) Work with health training institutions to improve attitudes to young women from rural areas, to gain accreditation, to improve teaching practice and increase the number of women leaders and faculty (this is done with the help of the RCM), improve conditions for married women with children (including introducing a crèche), and building rehabilitation. (iv) Recruitment through bonding young women from rural communities to return and practice in their communities post training, guarantee of a job through local government.

The HPS partnerships have a range of different approaches to project management, volunteer management and working with human resource capacity building in LMICs.

Table 8: Comparison of HRH and partnership approaches

Examples	Project management	LMIC HRH and HSS work	Volunteer management and UK impact
HPS	A range of different management structures, that does not often build the capacity of the LMIC partner. Volunteers do not tend to have good project management and administration support.	<p>The HRH work is limited to education, training, mentoring and support. There are virtually no examples of human resource strengthening from a system point of view – tackling recruitment, deployment, retention and financing to increase numbers of health workers. Some HSS work is included.</p> <p>Partnership approach means that relationships are more sustainable and that volunteering is managed within this long term relationship.</p> <p>Specialist clinical expertise used to design, implement and monitor the projects – relevant to the specific technical clinical areas.</p>	<p>Some volunteering is well managed, but payment is usually just subsistence. Volunteers suffer financially from the placement, and sometimes contractually also.</p> <p>Benefit to the UK health system is more likely than in other partnership programmes.</p>
VSO	Supports management of volunteering with professional project management and offices in the LMICs and dedication of junior local volunteers to support volunteer administration capacity.	<p>VSO has some examples of institutional and health system strengthening in coordination with large aid programmes.</p> <p>They only support project specific volunteering placements which are not necessarily sustainable or linked to an institution that can provide a follow-on relationship. And while VSO might have good development programme management expertise, they lack the clinical specialist expertise for oversight of a targeted specialist health initiative (e.g. emergency paediatric care or urology surgery).</p>	<p>Volunteers are paid salaries and have uniform terms and conditions.</p> <p>Volunteers come from a range of different countries and organisations. So there is only likely to be coincidental benefit to the UK health system.</p>
DFID Human resources programme – e.g. Women4Health (see box on page 41)	<p>Programme management takes place within a national team in Nigeria. All support for experts is managed by that team, with further administration support from the UK programme office.</p> <p>Good qualitative and quantitative data collection and measurement of changes.</p>	The programme covers education and training through midwifery and nursing education institutions – supporting infrastructure, teaching capacity, certification and curriculum (including IT access to high quality teaching materials). It also covers recruitment and deployment through community based approaches and links with government recruitment programmes.	<p>There is only benefit to the UK health system through the Royal College of Midwives. Some midwives may have benefited through learning and bringing that back to the UK, but it is not strategically planned or part of the project.</p> <p>Technical experts receive market remuneration.</p>
Making it Happen (MiH)	<p>Management by the Liverpool School of Tropical Medicine in partnership with ministries of health. Some institutional capacity strengthening.</p> <p>Good quantitative data collection and measurement in changes in service delivery.</p>	<p>Focus on training and education capability specifically on emergency obstetric and newborn care (EmONC). Not addressing other aspects of HRH, but did result in improved service delivery for MNH.</p> <p>MiH suffered from the same health system constraints as HPS projects such as lack of equipment and supplies, shortages of staff, demand side barriers.</p>	Reported benefits to the UK volunteers and their work in the UK, but it does not appear to be planned to input into the UK health system.

<p>Norwegian volunteering programmes</p>	<p>Just fund the projects and provide advice, do not operate them. Projects are very free to shape their own purpose as long as it is focused on health. Currently there are 40 projects with minimum 2 partners involved. They organise frequent Partnership Forums in different countries, which increases communication amongst all stakeholders.</p> <p>They have both North-South and South-South partnerships. It is entirely up to the partners to decide who is in charge of the funds and reporting (except a few cases for practical reasons e.g. Bangladesh).</p> <p>Very strong relationship with THET and mutual learning.</p>	<p>They work within the ESTHER umbrella, although each country uses different approaches. Working within ESTHER allows for exchange and learning from other European countries and their partners in developing countries.</p> <p>In June 2016 a database was launched with the aim to collate all available information among members and avoid duplication of work within the different developing countries.</p> <p>The Norwegian Ministry of Foreign Affairs has limited the intervention of the project to 25 countries (mainly Africa).</p>	<p>Age limit for participants: 35 years old.</p> <p>In the main programme, volunteers are health professionals who get maximum allowance from the ESTHER programme and a complement (generally) from their health institution to increase allowances to the normal salary level they would get in Norway. The programme also covers all living expenses. In the youth programme, volunteers don't receive salaries but all living expenses are covered.</p> <p>Norway institutions are starting to see the benefits in terms of: cultural awareness, learning from southern participants, learning from volume training (e.g. midwives) and learning on tropical diseases.</p>
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6.3. Partnership and relevance

This section responds to Evaluation Questions 3 and 4 about partnership and relevance of the projects. The project relevance is highly related to the way the partnership works, to the role that the southern partner plays within the partnership and their capacity to engage with government and the wider work on health system strengthening in their country, so it has made sense to report them together. Evidence presented in this section is well supported across all of the data sets and can be considered strong and robust.

Evaluation questions:

3. What lessons can be learned in relation to strengthening partnerships between UK and developing countries' health institutions, the partnership use of volunteers from the UK to deliver projects and the effect of this on project effectiveness (to deliver stronger health systems and build capacity of the workforce)? (DAC Criteria: Relevance, Efficiency and Effectiveness)
4. To what extent have the HPS projects been identified, designed and delivered in response to the host country context and in alignment with government plans and strategies? (DAC Criteria: Relevance and Sustainability)

Summary findings:

- The majority of partnerships have been strengthened by the HPS projects, by THET's guidance and by their work together.
- All projects were found to be highly relevant, and in line with government commitments and supportive of southern partner priorities, with joint planning and ongoing adaption.
- Very limited knowledge of, coordination or synergies with donor programmes, DFID or other partnerships.
- Very limited analysis of or approaches to address gender inequality and social exclusion in project design.
- Partnerships were strengthened by longevity, experienced UK partners, long-term volunteers and empowering behaviour and management structures.

6.3.1. Relevance, ownership and alignment

The vast majority of evidence from all sources revealed **a high level of knowledge of the health context**, rationale for needs for their project and an **awareness of and alignment with government policies and strategies** within which it operates. Grant applications include a contextual analysis section, which has an interesting level of detail of the facility and health system context. Interviews with the UK partners demonstrated a high level of engagement in the context through discussion with the southern partner(s), visits and feedback.

Virtually all projects had some contact or involvement with national or local government in the host country. Seven²¹ of the 41 MNCH projects are led by partnerships between an NHS Trust and a local health authority (district or sub-county health office, directorate or health management team in the host country), so have partnerships that are government to government. All projects reviewed for the country case studies are working within the public health system with the existing cadres of health workers and within existing structures.

Many of the project partners either undertook joint assessments and project planning (D35 and A2.05 in Myanmar and A35 in Zambia) or delegated project scoping to the national partner (F11 in Nigeria). This was sometimes made possible by HPS start up grants (EA22, D35 and A18), and where this has happened there are high levels of ownership by the country partner. However, very few of all the assessments had adequate analysis of the context in relation to gender inequality and social exclusion.

Some of the projects had evolved from previous partnership work – for example, the D2.40 project on medical equipment had evolved from the work of the MNCH Hub (a consortium of 8 partnerships working in MNH in Uganda), and their identification of medical equipment as a key barrier for health system strengthening (HSS) and the objectives of their partnerships. This project and partnership is thought to be one of the strongest and most effective. Ownership and information sharing is not happening in all projects and there are a small number of southern partners who have not seen the project plan or the budget (e.g. D2.53 and LPIP56 in Sierra Leone).

Relevance of project focus: Scaling up Medical Equipment Management (D2.40), Uganda

“I am a surgeon. From my own experience, I know that the lack of functioning equipment is a very significant stumbling block in the functioning of the hospital. The equipment may be there, but it is often broken, or simply locked away. It affects all disciplines”. Hospital leadership, Uganda.

“The project is extremely relevant. It responds to a reality that much of the medical equipment across the MOH is not functioning, very often for very simple reasons. We don’t seem to have the skills nor the attitude to trouble-shoot. For training we were dependent on training abroad, e.g. in Kenya, South Africa, China and Hong Kong. That is not cost-effective or sustainable. Traditionally, when equipment was broken, my team would be called out to fix it, often across the country. This project is addressing this gap by building a network of technician and BM engineers across the country.” Medical and Hospital Engineers professional association, Uganda.

Ongoing context assessments, partner interaction, use of pilots approaches and consequent project adaption was effectively taking place across a number of projects (EA22 in DRC, F11 in Nigeria and all three projects in Myanmar). In Myanmar and Uganda training has been adapted to be less academic and more useful on the job. However on occasions, adaption to the context has meant that the project veers away from the core expertise area of the UK partner organisation (e.g. P1 NICE project in India started to work on *implementation* of the quality standards after a request from their Kerala partners, even though this is not their core competency) and quick adaption sometimes means insufficient planning and preparation (noted in the P1 evaluation).

6.3.2. Types of partnership, strengthening and relevance for effectiveness

Nearly all of the partnerships have built up as a result of ***personal contacts and the development of trust over time*** (e.g. P1 in India, D35 and A2.05 in Myanmar projects, D43 and D39 in Uganda and A35 in Zambia). The involvement of diaspora personnel and volunteers (e.g. Zimbabwe, Uganda, Myanmar, Nigeria, DRC) has facilitated the relationship and development of projects in several cases.

Kenya trauma project illustrates how the ***maturing of the partnership led to a scalable HSS project***. (From the survey. Project info in MNCH review)

“The partnership did develop and mature and then after just working with the hospital to set up an A&E department, it then extended to the communities and provided training; and finally expanded to develop leadership and management skills in order to ensure sustainability. More recently the work has extended to other hospitals.” (Partner survey)

²¹ VG.5 and LPIP.54 in Sierra Leone, LPIP.6 in Uganda, LPIP.17 in Liberia, MPIP.51 in Nepal, SPIP.28 in Ethiopia and D2.24 in Kenya.

The theory of change supposes that the partnerships will strengthen through engagement with the HPS and when they strengthen and have more experience their projects will become more strategic and have a greater impact on the health system. In general, the evaluation has found that **longer lasting partnerships have higher resilience** (especially in the face of disagreements and challenges) **and more effective projects** (D43 and D2.40 in Uganda, D2.53 in Sierra Leone) strengthen partnerships (*“joint working, with tangible and concrete results, is the most important aspect of long-term partnership development,”* P1 Evaluation). They have also enabled the partner organisations to build a **longer-term agenda for change that is flexible and evolves** over time in response to learning and changes in the context, and over a series of projects. This is particularly apparent in the two Uganda projects.

There are three exceptions to learn from: (i) relatively new partnerships which are managing to develop effective approaches due to the existing international experience of the UK partner (RCPC in Myanmar); (ii) UK partners that have been working successfully for a long time with a particular partner in a country, and then have a less productive partnership with a new partner in the same country (e.g. LPIP56 and A37); and (iii) not all long-term partnerships build sufficient ownership and this can affect the project design and sustainability (for example D39).

Some UK partners demonstrate **empowering attitudes and behaviours, which strengthen the partnership and build ownership** more effectively. This has worked successfully with the RCSEd, who appreciate the attitudes of their Myanmar partner, while at the same time they use communication to build ownership.

Projects and partnerships are interdependent - NICE Kerala project (P1)

This partnership appears to have developed and matured through the implementation of the project and is now well known nationally as an example of good practice of institutions from different countries collaborating in a complementary way towards a shared objective. It could be argued that, beyond trust, *joint working, with tangible and concrete results*, is the most important aspect of long-term partnership development. Effectiveness of the project would appear to be an important ingredient for the quality of the partnership relationship. (Evidence from Evaluation Itad 2015)

Partner attitudes that builds ownership: Developing Surgical Capacity (A2.05), Myanmar RCSEd

“Models from the UK can be adapted to the local context. Our strategy has been not to impose anything from this country – but to work with them to develop solutions that work for them in their context. This is what we do, and that reflects on how we can learn from it. To take those principles and strategy and see it in action. Present these approaches to another culture. To see how we can work. We have been constantly adapting our project to see what they need.”

“It is their can-do attitude that has made this work in Myanmar. It is a close partnership and a partnership of equals. We have asked team what they want to do about their curriculum change and targets, what they think they can achieve and we have supported it.”

Reflection and lesson sharing between southern partners is also an important way of facilitating ownership and sustainability. LARMN (A2.18) in four countries builds this at learning and sharing events. This was mentioned several times during field visit in Zambia. Regional learning and sharing events helps to communicate successes and lessons to midwives in all LAMRN countries, including the remaining two countries not involved in this audit project (Tanzania and Malawi). A national event is also planned, to disseminate the lessons learnt more widely, to key stakeholders in country.

Placement of long-term volunteers appears to strengthen the partnership further. Short-term volunteering can be a challenging way of developing the relationship needed with partnerships, especially if a range of different short-term volunteers visit each time (e.g. D39 in Uganda and A37 in Zimbabwe). *“It is difficult when the partner is outside of the country. It is difficult to communicate with the partner.”* However some short term volunteering was effective if functioning within a strategic project. Short term volunteering is particularly effective with experts who have highly technical or specialist skills (e.g. A2.05 or D43) or who combine efforts with the long-term volunteers (e.g. D35).

THET and the HPS role in strengthening partnerships has been crucial. The funding has enabled partners to implement projects together and to build their relationships. THET’s Principles of Partnership have guided partners on good practice and laid out ground rules that are also empowering for the partners. Nearly all partnerships were following the Principles fairly well and several mentioned the important role that THET plays in the development of the partnership. From the UK partner survey 76% (n=41) felt that THET had provided inspirational leadership to encourage good partnership working, and 82% (n=44) felt that the HPS Principles of Partnership had been a useful guide to partnership working and effectiveness.

6.3.3. Leadership, management and administration and the use of volunteers

Project management and the governance structure for financial management varies by project, with varying levels of sharing and joint management among partnerships. In five out of the 11 **country case studies the locally implemented project funds are not managed by the southern partner** and this can sometimes lead to difficulties with projects, but also reveals power differentials between partners. The different approaches are usually designed to ensure efficient transfer of funds and to ensure financial accountability, but may result in inefficient management (See Section 6.2 on VfM). The approaches include:

(i) The employment of an individual project coordinator locally. For example the RCPCH (D35) in Myanmar employs a local coordinator. He has to manage all local funds and is expected to undertake facilitation and mobilisation activities. Because of his lack of institutional home (even though he is associated with the Myanmar Paediatric Society (MPS)) this has meant he has little power and limited accountability for his activities. The MPS has no secretariat or administrative base and so cannot project manage at present, and the RCPCH has not yet included any institutional development activities for the MPS in their project plan, which would possibly be a more long-term aim.

(ii) Partnering with a national or UK NGO to manage the funds. This has been done, e.g. by D2.40 and D43 in Uganda (through a UK based charity) and VG10 in Sierra Leone (through a national NGO). This has sometimes led to difficulties with fund transfer and also mismatch of expectations of the role of the NGO.

(iii) The UK partner having their own office in the country. For example the Kings partnership has an office in the Connaught Hospital from where they manage all of their project activities. It is staffed by international personnel and does not appear to transfer administrative responsibility to the COMAHS University.

(iv) Some long-term volunteers are also the project managers and have to manage all administration and funds in the country. The diaspora volunteer in A18 Myanmar project is responsible for administration tasks as well for mentoring four of the Health Education England leadership fellows, providing technical assistance for the HPS project and oversight of her own NGO, which could be overwhelming.

Partnerships and diaspora volunteers – F11 Infection prevention and control (IPC) project Nigeria

(Led by Sheffield University and in partnership with Bayero University in Kano and the Nigeria Muslim Forum UK (NMFUK).)

Bayero and Sheffield universities have had to build relationships with the two project hospitals in Kano and Gombe to develop a whole hospital approach to IPC. The relationship development has not always been straightforward, especially when the volunteers were only visiting occasionally. In particular, it was thought that Bayero was initially not providing the in-country support to the project that was required. The key individual leading the work is a British Nigerian academic from Sheffield University and the three short-term volunteers come from three different NHS Trusts and were recruited through the NMFUK. They are Hausa speakers and know Northern Nigeria. When one of the volunteers was awarded further funding by THET to stay in the country, the project made a lot more progress with systems, processes and structural changes that could support IPC in the two hospitals, and this also improved the engagement with Bayero University.

“To be fair to the Bayero staff, the second time we went they were a bit more prepared and a bit more receptive, so the professor of community medicine was the one who enabled my connection with senior staff of the departments. And all of the heads of departments. The dedication of the clinical risk manager who is also on the infection control team. He was instrumental in liaising with the nursing department. We got more numbers of delegates to the training the second time around. They really did help me.” (Female, long-term volunteer)

According to Bayero, the partnership is of great value to them. “We are now viewed as the champions of patient safety and for public health and I am proud of that. It also improves the image of the department and the hospital. The partnership with Sheffield also gives the whole university a better image and reputation.” (Bayero partner interview)

There is an expectation that Bayero University will continue to build IPC expertise within their faculty and research activities, even though there is currently no specific IPC centre of expertise and organisational capacity strengthening may be required.

Institutional, organisational or project management capacity building of southern partners is only apparent in a small number of case study projects reviewed. One such is the LAMRN project (A2.18, working in Zambia, Kenya and Uganda) that provides support and mentoring in order to specifically hand over the project management. The southern partner survey showed that a third of the 16 respondents stated that they were receiving financial management support and around 80% thought that the project was effective in strengthening their institution. Over half of the respondents said there was no improvement to gender equality and social inclusion as a result of the project, and there were no specific examples given. From the in-depth case studies there have been ***no specific activities designed to increase organisational learning around gender equality*** as part of the partnership, nor awareness of the issues that might be addressed.

Value of long-term volunteering, visits to the UK and the development of the partnership - returned volunteer interview

Nanyuki (the Kenyan partner) has valued the visits to the UK. The MOH has said “everyone that comes back from the UK is different, they are changed and they have new aspirations”.

“Everything works best if you have good communications and relationships. We have learnt so much about practicing in Kenya – and the ongoing partnership with Nanyuki has helped us get under the surface of Kenyan expectations, to be in line with relevant policies, to have time to develop trust and good relationships”. Role of long term volunteers is crucial in this. The volunteer knows the MOH so well now – she wants to know what is most useful and how best to spend their time – and she now feels that she can ask what the real value will be to the MOH. The partnership enables this and helps shapes things.

6.3.4. In-country coordination and synergies with wider HSS programmes

UK and DFID priorities are represented well in the choice of HPS countries and health areas, and the emphasis on building long-term partnerships and international health networking. (See Annex 1.1 for full portfolio information). HPS projects could be seen to be complementary to other donor approaches due to their partnership with secondary and tertiary hospitals, health training institutions and health authorities, when many aid programmes focus on primary health care and communities. For example, much of the MNCH work in Myanmar is primary health facility and community level, so referral and the hospital work is a gap that needs to be filled and the focus of all three HPS projects in Myanmar.

In general, only a small number of **projects are building synergies with other relevant aid programmes** in the country. There was limited knowledge of other aid programmes and projects in the country and this is partly because the projects are relatively small, with limited resources for coordination, and the UK partner is not present in the country, so the usual aid coordination meetings and engagement with government is more limited. For many projects the long-term volunteers are the only project personnel in the country and they have not been mandated to or prepared for coordination with other aid projects. However there are some projects that work with the wider aid community. For example project D2.53 at Masanga Hospital in Sierra Leone project engages on IPC with a range of actors in the district including Concern Worldwide and WHO and ensures that the new training modules are aligned with the newly developed national IPC guideline (developed by WHO). The D35 Emergency Paediatric Care project in Myanmar has adapted the technical approach and guidelines (originally ETAT+) to take into account the national and donor approaches, particularly coordinating with UNICEF and WHO and using the IMNCI with FIMNCI approaches, to develop a nationally owned Emergency Paediatric Care Programme (EPCP) approach with guidelines.

There is also very little evidence of connections between HPS projects or with volunteering and partnership programmes from other countries or through VSO. (e.g. A18 overlap of original project plan with orthopaedic project run by an Australian organisation with volunteers in the same hospital – this was resolved by changing the project design). The HPS partner workshops in Uganda and Zambia revealed the **lack of interaction between the southern HPS partners, limiting the potential for joint learning and synergies.**

Connections with the FCO, DFID offices and DFID programming are almost non-existent, and this is not surprising given the need for DFID staff to prioritise larger programmes. The potential for linking between partners, with government and with the wider aid community might have been an important role for the UUKHA, funded by the HPS and managed by Global Health Exchange. However the evaluation workshop in Uganda revealed that there has been very little coordination among HPS partners in Uganda. A telephone interview with a UUKHA representative revealed no understanding of the coordinating role of the UUKHA, and that the Alliance is more concerned with online teaching resources and communities. Further interviews indicated that there appears to be mixed understanding about the role of the Alliance. The potential for linking between partners, with government and with the wider aid community will be an important role for the UUKHA, funded by the HPS and managed by Global Health Exchange. As yet this phase of the project has not started. The evaluation workshop in Uganda revealed that there has been very little networking or coordination among HPS partners in Uganda and a great demand for this kind of support for further development of the partnership work between the UK and Uganda health communities

6.4. Volunteering and UK health system impact

Evaluation questions:

5. How has HPS benefited the UK in terms of strengthening the health workforce, health systems and/or in terms of recruitment and retention of health workers? (DAC Criteria: Effectiveness, Sustainability and Equity)

Summary findings:

- The HPS has benefited volunteers and the UK health system by providing volunteers with opportunities to learn and enhance important competencies that they can bring back to their work in the UK.
- Long-term volunteering and strategic short-term volunteering are most effective and both have enhanced southern health workers' learning and application of skills.
- Volunteering works best within a well-functioning partnership with decision making involvement of the host partner in recruitment and appraisal and with full support of the UK sending organisation and the volunteer employer.

6.4.1. Volunteer attributes and type of posting that enhance effectiveness

Across all data collected, the personal and professional attributes recognised and valued in a volunteer included: relevant **technical skills and experience; leadership, mentorship and teaching skills; enthusiasm and respect; strong volunteering ethos and motivation; creativity and innovation; interpersonal skills; cultural awareness; flexibility; willingness to learn** and adapt to local culture and previous overseas experience in a similarly under-resourced setting. Volunteers are frequently seen as role models or leaders in their professional fields. Although context specific, the added value of diaspora volunteers included their ability to understand the health system, the language and customs, to act as role models and to build up relationships from an early stage of their placement (or sometimes pre-placement). In the online volunteer survey, the profile of respondents were 77% female, 43% were doctors, and 26% were midwives, and 53% were aged between 31-50 years at the time of volunteering.

The overwhelming **majority of volunteers are engaged in capacity building or quality improvement efforts**; some also engage in direct service delivery – although the extent of this varies by partnership. The particular approach used by UK volunteers is what differentiates the training provided through the HPS – the use of practical teaching methods and interactive demonstrations was often considered more dynamic than the more traditional 'rote learning' approach that health workers in-country may have been exposed to. The use of ongoing/in-service mentoring, co-working and support, as opposed to simply one-off teaching, is considered a critical supporting factor; training without follow up is considered less effective. Where volunteers are providing training of trainers and follow up mentoring, sustainability is already built into the approach, also contributing to longer term effectiveness.

The largest proportion (17%) of volunteer survey respondents spent 14 days volunteering overseas, 11% spent 7 days and 10% spent 180 days. **Across all data collected, there was an overwhelming preference for long-term volunteering from the perspective of the host partner and project.** Benefits over short term placements included: allowing volunteers to understand the contextual realities and sufficient time to develop relationships with key stakeholders; enabling flexibility and for partnerships to develop common knowledge and trust; enabling partnerships to make longer-term and more systemic and sustainable changes (e.g. D2.40 in Uganda); enabling partnerships to be more strategic in their nature and focus; helping with data collection – including for baselines and monitoring, especially in contexts where the data is not available (e.g. emergency Paediatric care project in Myanmar) and for long-term volunteering that involved training; and allowing for on the job supervision and ongoing mentoring. The value of longer-term placements is illustrated by the following comment: *"To generate changes in attitudes and behaviours, an ongoing presence, hand-in-hand work and on-the-job mentoring are required"* (Project Coordinator, remote case study, DRC). Although there are exceptions, the length of the existing partnership often correlates with success of placements – volunteers can 'hit the ground running' and partners can manage expectations and adjust.

Short term visits without clear objectives, follow up and strong management and support in-country were found to be less effective, with more limited potential for change. Barriers linked to short-term volunteering include lack of deep knowledge of the local context and its challenges and lack of trust with

partners. In addition, sending a series of different short-term volunteers often means there is insufficient continuity, making it difficult to build relationships in the longer term. **Where short-term placements were considered effective, key factors included clear and specific TORs, targeted objectives, and highly specialised technical skills of the volunteers, high-quality pre-visit support, successive visits building on one another and strong coordination and management arrangements.**

Long-term or short term volunteering?

“A mixed approach of short term and long-term support is the most effective one. Short term intensive visits provide specific training and are very good to upgrade existing knowledge and skills, but the long-term approach is crucial if you want to change culture and to initiate systems”. (A18, Myanmar)

There is evidence to suggest there are particular **advantages and limitations for each type of volunteering sending institution**. For example, universities that are not teaching hospitals and professional associations sourced their volunteers from elsewhere – either through an NHS Trust or through NGOs (for example, the F11 Nigeria project, Sheffield University recruited the volunteers through the Nigeria Muslim Forum UK, a UK based NGO that sends UK health volunteers to Nigeria). As a result, there is no institutional base for the returning volunteers, so they tend to have a more random or unsystematic impact on the organisations from which they originate. In the case of professional associations (PA), volunteers are members of the associations, meaning that the PA can be more strategic across their cadre about learning that comes back to the UK (e.g. the RCPCH’s 3-year fellowship programme). There is an argument for linking PAs with each other or with other health partners, thereby tackling one of the big drawbacks of working with them – that they can only work in their expertise area, so are not necessarily best placed to address challenges that fall outside of this specific area.

In comparison, university hospitals, other hospitals or NHS Trusts sent volunteers from their own institutions and were thus able to cover a range of specialist areas, including management and systems (e.g. A18 and A37). In this way they may have wider potential than other types of volunteering institutions. However, the negative impact on the hospital could be substantial if several staff are away volunteering at the same time, so the approach needs to be carefully planned to be strategic. The approach of NHS Trusts partnering with District Health Authorities is interesting and would merit further research and exploration with regards to the potential impact of this type of partnership with respect to governance, human resource systems and the health system overall.

6.4.2. Volunteers bringing skills back to the UK

There is strong evidence of volunteers’ returning from overseas placements to the UK with:

- **Improved soft skills and attitudes:** leadership and management; confidence, assertiveness and resilience; greater cross-cultural awareness; international exposure; and increased understanding of global health and personal satisfaction.
- **Improved technical skills** in specific clinical areas, experience of multi-disciplinary working, and project management, financial management and M&E skills.

Volunteers bringing skills back

“A huge thank you for DFID and THET – it is a dream to me. I have been thinking for a long time about how I could contribute something to the Nigerian health sector. This project and the support we got from the donors to make this dream a reality.” (Long-term volunteer, F11 project, Nigeria).

“I have an increased understanding of low resource countries and their problems and the difficulties faced. My political and personal views have become more focussed. I am more aware of human and particularly women’s rights. I have an increased interest to learn more and become active in my beliefs. I am more self-aware of how I speak to and treat others. I have gained confidence to speak out and discuss political and human aspects of healthcare in this country and abroad. It has ultimately given me the confidence to take time out from my full time job to go to university to study peace and development.” (Volunteer survey).

“I think I may have learned more than I have taught” (Volunteer survey).

Almost all the above skill areas are transferable, and a number of interviews, case studies and surveys demonstrated that these skills are brought back to the UK institution. More than two-thirds (67%) of survey respondents stated that they had taught others in their organisation about the challenges that health workers face overseas, and that they had better cross-cultural understanding. 63% stated that they respected the NHS more and 54% felt more confident and capable in their jobs as a result. Only 8% (n=6) felt that their work in the UK had not changed as a result of their volunteering experience.

In a large number of projects, the UK partner cited increased visibility of their organisation in the international arena as a key institutional benefit. This is a clear UK health system benefit and also demonstrates the promotion of the NHS abroad. Placing staff overseas was seen as a way to raise the profile and reputation of the UK organisation as a potential provider of global health programmes, and their involvement in the HPS had facilitated wider networking opportunities and relationship building with other health institutions or donors. Participation in HPS was seen to benefit the development of new academic, clinical or research links with other institutions in the global health community.

A significant number of volunteers were increasingly motivated and 're-energised' through their volunteering placement. In some instances, the experience with HPS generated renewed respect for the NHS amongst UK volunteers and staff. Volunteering through the HPS provided staff development opportunities – and this may potentially impact NHS staff retention.



Returned volunteer reports: "I now have increased confidence, renewed enthusiasm for healthcare and the NHS. I would have left the NHS had it not been for this placement but instead returned renewed and full of enthusiasm and passion and with new ideas" (Volunteer survey respondent).

6.4.3. How HPS has facilitated good quality volunteering

At the partnership level, volunteer placement attributes which facilitated a successful posting included: active involvement of overseas partner in volunteer selection, good preparation and pre-visit support to the volunteer (particularly for short-term visits); structured and well-managed induction, with ongoing support provided; clearly defined volunteer roles and responsibilities, and facilitating arrangements (e.g. administrative support).

From the UK partner perspective, several attributes contribute towards more effective volunteering. Firstly, that the employer facilitates the volunteering placement, e.g. is supportive institutionally, provides flexible study leave, or continues to make pension contributions whilst the volunteer is overseas. Secondly, that the placement is conducted within a continued professional development (CPD) framework – where there is formal recognition of the placement in the UK, this tends to facilitate volunteering. Some UK organisations appear to do CPD better than others, for example, the Royal Colleges have a requirement for accreditation of international project work for CPD and revalidation. Ensuring a systematic feedback mechanism is in place upon completion of the volunteer assignment is important – both to inform future placements, but also to feed into the performance appraisal of the volunteer. Remuneration to volunteers seems to vary across HPS partnerships – determined or set by the partnership itself. In some cases, volunteers report needing to invest some of their own money e.g. to pay for medical council registration. Remuneration of volunteers under the HPS also differs to how volunteers are remunerated on other partnership programmes; for example, VSO and the Norwegian ESTHER programme, which both pay their volunteers a salary.

THET has supported the access of UK health workers to volunteering opportunities and therefore the supply of volunteers through the HPS. For example through the HPS THET pays the pension of volunteers on a placement of six months or more. They also input into NHS discussions on terms and conditions that facilitate volunteering²². Nevertheless there are still contractual issues for UK doctors and nurses that make it difficult to fit a 6-18 month volunteering placement into their career development without jeopardising their chances of promotion and advancement in the UK health service²³.

Challenges experienced by volunteers in-country included language issues, lack of knowledge of the local systems which created barriers, and an expectation from their counterparts to work in direct clinical service delivery i.e. labour substitution – which can undermine systems level strengthening efforts. Other risks that

²² Information from THET

²³ Information from a senior paediatrician consultant in a London hospital

needed to be managed included potential ‘volunteer fatigue’ within the partner institution, and ensuring that volunteers are sufficiently well qualified or supported to deal with specific cases presented. Challenges for the UK system to manage include: managing workload during staff absence, reintegration of staff post-placement, contributing towards pension costs (currently £1,397 per volunteer per year), and “hidden” costs for UK partners – including administration or management that goes beyond what is covered in the project budget. Given that many UK partners are often unfamiliar with managing overseas projects and volunteers, there is also a learning curve to take into account, which may translate to a tangible cost to the UK partner, or THET as the fund manager.

6.5. Monitoring, evaluation and learning

Evaluation questions:

6. How can the HPS (programme, projects and partnerships) be monitored and evaluated?

Summary findings:

- Type of data used for monitoring and data collection methods have improved over the last 2 years and in some cases is contributing to the health system strengthening.
- Some outcome and impact level data will be available by the end of the programme from projects that are closely monitoring service delivery and system changes.
- Data on coordination and synergies between partnerships and with other programmes is not being collected.
- The current focus of outcome and impact indicators on numbers misses an opportunity to define and track more qualitative changes.
- Data analysing gender equality within the health system and service delivery is limited to counting the number of women, though there are a small number of projects with a more in-depth understanding of gender.

The **quality of M&E has improved over the last two years** as the HPS has required more rigorous project plans, data collection and reporting. This has meant that some projects will have some useful rigorous data by the end of the programme mid-2017 and some will have built partner research and monitoring capacity. For example D43 has good qualitative and quantitative data collection ongoing and they are even collecting and reporting service data on palliative care (see Impact Section in 6.1). They are also emphasising the development of M&E and research capacity of the Makerere Palliative Care Unit at the University, which means their approach to M&E has more chance of being institutionalised and becoming sustainable.

However there is still **significant variation in the quality of monitoring and evaluation of HPS projects**, with some projects providing good quality baselines and measures of progress and others facing challenges with measurement. At least two projects in the case studies had to re-do their baselines with the help of volunteers after the UK partner had delegated data collection to the host partner organisation without sufficient support. Small start-up projects (EA of which there are 17 and SPIP of which there are 25 completed projects) are only required to write a project completion report, so there is very little data available for them.

Evidence used by partners to verify findings for improvements in health workforce capacity and service delivery outcomes were limited to pre- and post-training questionnaires and observation, followed closely by qualitative assessments. Very few partners are using baseline and endline surveys (about a third of survey respondents, but fewer case study participants) and even fewer are using HMIS systems (between 9 – 15% of survey respondents). Efficiency and effectiveness of on-the-job training and mentoring are particularly hard to measure as they are happening continuously – though it is this aspect of long-term volunteering that appears to make it most effective (evidenced from health worker interviews in the four countries).

Some of the more rigorous data collection approaches are used to measure outcome and impact level changes, but they are very specific to the particular health area that they are covering, so difficult to generalise across the whole HPS programme. The seven RCPCH HPS projects, all implementing a form of emergency paediatric care, collect a range of data on service delivery and quality of care that is comparable across their projects (e.g. triage time, or health worker effective use of resuscitation skills, systems for newborn checks). The RCPCH is also trying out a system of rating trainees and mentees over time and

Example of behaviour change measurement – UK Partner Survey response

“Our project seeks to strengthen existing health partnerships by promoting understanding of behaviour, driving behaviour change and evaluating project outcomes using behavioural frameworks. A good understanding of what drives behaviour helps health partnerships focus on the barriers and facilitators to strengthening capacity in a way that no other focus offers.”

using scenario testing of health workers, where they are tested on key skills they should have learned and practiced. While these are important and useful for the health facilities and host paediatricians, they would not be comparable with other HPS projects, (for example PROMPT A37 project in Zimbabwe collecting data before and 9 months after training for maternity care).

Some projects are collecting interesting data about governance in the health system, such as connections between local government and health workers in MPIP.51 in Nepal, “increased contact between frontline health workers and DHO: number of phone calls and personal meetings” and changes in management and systems in hospitals. There is also evidence that some partners are considering how to collect behaviour change data, which is crucial to understand how systems change and how health workers apply new knowledge and skills (see box below). Again this is not necessarily useful for aggregation of data at the HPS programme level.

Furthermore, there does not appear to be any required data collection of how health facilities engage with communities or of coordination with other partnerships or with the wider aid community and related programmes. If this is reported, it is because of the partners’ understanding of the importance of this data.

From the draft theory of change in Section 2, the change from individual projects to wider health system strengthening approaches that will produce change at outcome level is now drawn to show engagement by THET and the partners in coordination with each other and with the wider health system. Project D2.40 has shown how the MNCH Hub in Uganda (see section 6.1) has used coordination between partnerships and the identification of barriers to wider health system strengthening to design a joint project to address the barriers.

The expenditure on M&E varies from 9% to 20% of total expenditure for the case study projects, which demonstrates how differently the projects approach and spend on M&E. For the overall HPS programme M&E expenditure was 0.6% of total expenditure in 2014/15 and 0.9% in 2015/16, which is low, though some THET staff costs also should be allocated to M&E. While some partners found the reporting and the THET templates easy, others found it too time consuming or inappropriate for their project or partnership. A small number of partnerships had developed their own record keeping and monitoring systems that has now been integrated into hospital systems, with data used for management decision making, which is more sustainable in the long run. (See example from D2.40 below in the box).

Challenges and resolutions for M&E: a solution that strengthens systems as well as reporting – D2.40 Uganda

Previous projects implemented by the partnership/HUB struggled to identify a meaningful way of capturing and communicating progress in a way that met THET’s requirements. Under the current project, however, many of the issues seem to have been resolved with the introduction of a simple and well-designed inventory logbook for technicians, in which they can track the status of the equipment in the hospital and the repairs they carry out. This information is directly relevant for the technicians and enables them to provide management information to their supervisors and hospital management.

At the end of the month, the technicians use the logbook to generate a report which collates the work they have done over the month and records challenges, achievements and plans for the following month. The monthly report is sent to the project lead and his team, who use it to evaluate the gaps in service delivery that are encountered by the technicians and in turn use that information to plan for training and mentoring support.

This integrated approach to M&E that builds on the information needs and relevance of the information at local/implementation level is a significant step forward resulting in M&E that is meaningful and reflective of the reality on the ground. The information gathered serves multiple purposes at multiple levels at the same time, thereby reducing the transaction cost of M&E.

In addition to the logbooks, the project applies pre- and post-training assessment as an integral part of its training events. All of the information now also provides the requirements for project reporting to THET.

7. Conclusions

7.1. Effectiveness and HPS fund management

(i) HPS projects and partnerships have successfully contributed to health system strengthening, in particular to the performance of the health workforce (Outcome), and are possibly also contributing to improvements in health services (Impact). While the findings are all encouraging, there is limited objective evidence of a sustainable improvement in health workforce recruitment, deployment and retention, or indeed that the increased skills have resulted in longer term improvements to clinical practice and performance. However, it is plausible that this is the case as there have been many investments in improvement to training courses and

the ongoing support particularly from longer term volunteers was widely reported as helping to embed new learning in the workplace. It is also likely that the widespread evidence of changes in health workers' attitudes, knowledge, skills and behaviour is translating into better service delivery, at least within the limitations of their working environment.

- A higher chance of sustainable and systemic change has been possible for HPS projects that:
 - Work with a whole hospital, across a whole health cadre or with local health authorities
 - Systematise and upscale learning approaches by working on curricula and training of trainers and university faculty, including ongoing mentoring and support
 - Align with government systems and policies, actively engage with government to replicate and upscale effective approaches

Example of project that has a high chance of sustainability and systemic change. D2.40 Medical Equipment, Uganda.

- The MNCH Hub in Uganda is made up of 8 partnerships, that are brought together around common implementation issues that need a solution, but not all managed together (they maintain their independence).
- The initiative evolved over time to take a whole-hospital approach and address a major HSS constraint identified by the previous HPS projects,
- The project is led in country by two long-term diaspora volunteers (one year and 3 years),
- Working through the National Association for Medical and Hospital Engineering (UNAMHE),
- Establishment of new Department of Biomedical Engineering at the University,
- Short-term volunteers carefully managed by the long-term volunteers; and the short-term volunteers providing continuity in the UK for Ugandan visitors.

- Focused technical approaches (such as emergency paediatric care) can also be effective, but are limited by wider system constraints. Often the implementing partners do not have the expertise to address the wider system constraints and would benefit from working with others.
- The combination of training and mentoring with curriculum development and the development and implementation of protocols and guidelines show a good potential for sustainability and scale-up.
- Health workers benefitting from training, mentoring and on-the-job learning with volunteers have shown a high level of attitude and behaviour change and increased confidence and motivation; and this has also, in some cases, resulted in delivery of new or improved services.
- Health worker ability to improve service delivery is limited by several health system constraints such as inadequate number of health workers, problems with management and leadership, inadequate or non-functioning equipment, record keeping and HMIS deficiencies, which indicates the need to engage with higher level health system issues to improve the potential for outcome to impact change (as seen in the HPS theory of change in section 2, figure 1). For example, there is limited objective evidence of sustainable improvement in health workforce recruitment, deployment and retention – areas that the HPS projects do not tend to directly engage in. However, over the medium to long-term, the improvement in health worker motivation and satisfaction may influence others to become health workers and more possibly help with retention. This would only help with recruitment if the education and financing for the posts were available.
- The theory of change shows that change required around coordination and building synergy with wider health system strengthening activities is not currently happening – particularly in relation to leadership, management, community engagement and health financing.

(ii) The HPS is an effective way of enhancing partnerships and elements of health system strengthening through partnership approaches.

- Funding to support the development of new partnerships, to scope project activities and develop the relationship has been successful and several larger projects have grown out of this funding.
- Networking, advocacy and technical assistance support by THET has also enhanced partnership and volunteering activity, and has enhanced learning between partnerships.
- The funding mechanism is flexible enough to encourage adaption and innovation, while being rigorous enough to ensure accountability and effectiveness. However, there are a small number of projects that could have benefited from more stringent requirements and management, and they tended to be the more politically-motivated projects (and possibly were not required to pass through all of the HPS management hoops to get funded – e.g. Project P1). There also appears to be no requirement in the proposal stage for partners to present the credentials of key project personnel, nor the recruitment and management procedures for the volunteers. Possibly this would be expected for some of the higher value projects.

- The HPS does not appear to have a standardised approval process for project adaptation – which means that when projects undergo a substantial change they may no longer have the right team or partnership to deliver an effective project.
- THET have worked hard to manage a very high volume of grants, from many different grant streams in many different countries and they have learned a lot over the last five years. The complexity of their fund management role is high and THET have managed to conduct it with high professionalism and a focus on learning and adapting. This learning has and still is reflected in evolving changing procedures and a very interesting database of resources in their website that is used by partners (e.g. Principles of Partnership and various guidance documents). In comparison to other vehicles for funding health partnerships and volunteering, THET’s approach is more focused on effectiveness in some aspects of health system strengthening and building long-term partnerships.
- THET, as fund manager, enjoy a high level of autonomy with decision making through all the stages of the granting cycle, which has meant they have had the responsibility to define country and strategic granting stream objectives and funding. The strategic focus of the countries and the granting streams do not necessarily align with the key objectives of the HPS and the theory of change, and more time could have been spent thinking this through with key stakeholders. For example, there are clearly some advantages to UK partners having multi-country projects as it enables them to minimise the transaction costs of managing several grants, and there is potential for inter-country learning. However, it is not clear whether this kind of funding is the best for enhancing efficiency and effectiveness in the countries.

(iii) Some projects have also enhanced women’s opportunities, skills, knowledge and confidence which has the potential for wider economic empowerment for women, though most projects are gender blind.

- A small number of projects have enhanced research and leadership skills, mostly among women in the nursing and midwifery cadres.
- Other projects have provided opportunities for women in non-traditional roles, such as engineering and surgery, though this tends to be circumstantial rather than planned.
- However, the projects in general tend to have limited or no in-depth analysis of gender inequality and social exclusion in relation to the health workforce, health system and service delivery in project proposals and reporting. While the case studies did find some projects are aware of power differentials between different health cadres and levels within the health system, this has not translated into an analysis of the intersection of gender, race, ethnic and social groups. This means that it is difficult for projects to integrate approaches to enhance gender equality and social inclusion effectively.

7.2. Value for money

(iv) Partners and volunteers have a high level of awareness of value for money and the creation of high-quality and effective project approaches. The projects represent good value for money and the results are often likely to be lasting as project methodologies enhance sustainability and are embedded within long-term partnerships.

- Partners and volunteers minimise costs where they can and present high levels of responsibility and motivation. Saved money is used in different ways in the project.
- The benefits from partnership and volunteering based technical assistance accrues to both the southern partner, the volunteers and the UK health system, and there is a high value created and perceived from the projects.
- Effectiveness: Given the complex nature of health systems and the need to strengthen several elements of the system at once, many HSS aid programmes have much larger budgets and a more comprehensive approach than the smaller HPS projects. However, there are HPS projects that show considerable promise contributing to HSS, even if it is often limited to specific elements of the system.
- The HPS has limited in-depth assessments and understanding of “Equity” in terms of gender equality and social inclusion, but some volunteers have added value in this respect.
- The lack of synergies with other aid programmes or with other HPS projects most likely limits the effectiveness and efficiency.

(v) Efficiency of fund management is good, with sufficient utilisation of funds and reports by partners of good quality fund management and technical assistance inputs. However some systems could be tightened up.

- The THET approach to monitoring and maximising value for money approach is relevant for this kind of partnership and volunteering programme, though data collection remains an issue.
- A number of projects have had slow expenditure in the first 12 months, with low utilisation rates, which indicates poor budgeting, or inexperience of the challenges of the task, and can result in inefficiencies as the project goes on. The financial reporting template does not enable easy monitoring of this and there is no requirement for re-budgeting on a regular basis.
- Management fees for projects are very wide-ranging and could be standardised in order to ensure there is no unnecessary expenses creeping in or that individuals (volunteers or partner representatives) are left to cover expenditure with their own funds.
- Partners are not recording their own financial or “in-kind” contributions, and this would be useful to understand the cost to their own institutions (the NHS in some cases) and the actual cost of the projects.
- The management allocation is currently 17% of the overall expenditure. It is not possible to differentiate between actual grant management costs and the substantial “programme” activities that THET undertakes, such as advocacy and wider partnership building and networking.

7.3. Partnership, relevance and ownership

(vi) All projects were found to be highly relevant, and in line with government commitments and supportive of southern partner priorities. However, there was a lack of knowledge of other relevant aid programmes and only limited examples of partnerships that were working in synergy together, which is a lost opportunity.

- Partnerships that had implemented previous projects had a higher level of understanding of how their approach works within the health system. The more significant the role of the national partner the higher the relevance of the project – due to their contextual and background knowledge, cultural awareness and local networks.
- There is very limited analysis of or approaches to address gender inequality and social exclusion in project design.
- Project proposals do not appear to require an assessment of other relevant aid programmes, to interact with other partners in the country or to provide analysis of gender inequality and social exclusion in the health system.

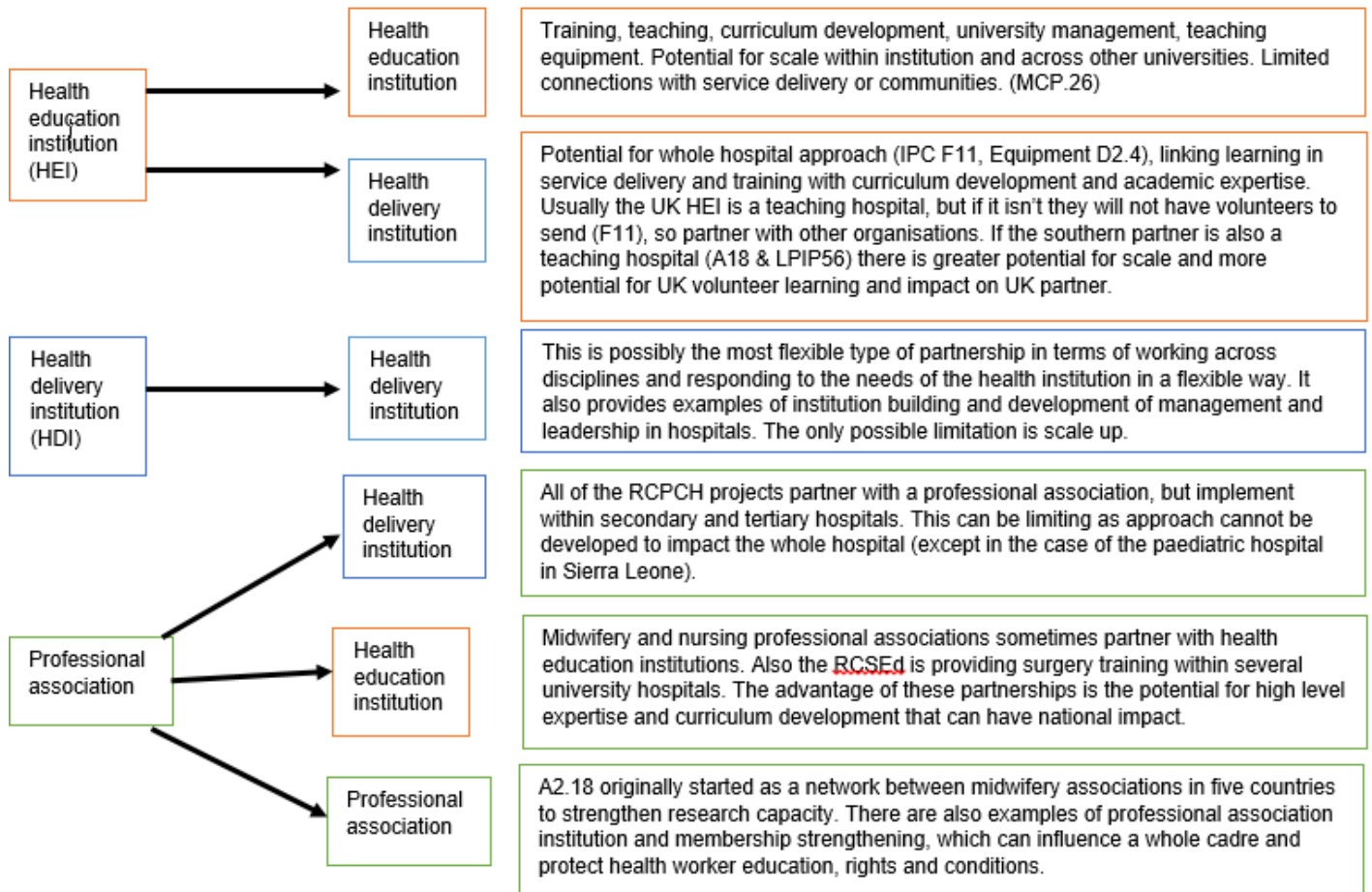
(vii) Good quality HPS partnerships are crucial to the HPS approach and the quality of the partnership is related to the quality of the projects and their effectiveness.

- A decent number of partnerships are built on trust, mutual respect, a shared agenda for change, transparency and accountability and partnerships had been strengthened by the HPS projects, by THET’s guidance and by the partners’ joint working.
- Projects have been more successful when implemented by more mature and longer-lasting partnerships or when partners have a good level of experience and expertise with international work.
- The use of long-term volunteers and empowering behaviour and management structures also helps to strengthen partnerships.
- UK partners have occasionally supported southern partners to strengthen their organisation, and these partners recognise the importance of a capable, empowered partner as key to effectiveness. However a larger number are not providing this support, and this is not necessarily a requirement or a method for the HPS.
- The allocation of project and financial management roles and responsibilities between partners is sometimes not as beneficial or as efficient as it could be and this is linked with the previous point on partner capacity and institutional strength.
- Coalitions or networks of partnerships (such as the MNCH Hub across 8 partnerships in Uganda, and the LHSTM project across 12 partnerships), that have designed their projects as a result of identifying key health system constraints in previous projects, appear to be particularly strategic and effective.
- The type of institutions that are partnering (e.g. professional associations, health education institutions or health delivery institutions) makes a difference to the way scale up and overall system strengthening can be promoted. It also effects the extent to which the UK health system will benefit from volunteer learning. There are many combinations of partnerships sometimes with multiple diverse partners (such as the Kings Partnership) that spans health education institutions and health delivery institutions. (see Figure 7 below).

(viii) While there has been a more recent intention to build networks and strategic joint working in a couple of countries the HPS has only achieved this to a limited extent and this might be undermining the potential for a more strategic approach.

- There is clear demand for more networking and learning at country level and this may need to be the role of THET rather than a particular grant holder (learning from the limited progress of the UUKHA grant).
- The role of the two small THET country offices (one in Zambia and one only just opened up in Uganda) in supporting networking locally is not yet fully defined and needs further work
- The funding streams do not have vehicles for encouraging country level strategic funding.

Figure 7: Advantages of different partnerships



7.4. Volunteering and UK health system

(ix) The type of volunteering and the way it is managed from the UK partner(s) and the host partner(s) has an influence on how effective the project is, on the uptake of new learning and skills by health workers and on the outcomes for the UK health system.

- Long-term volunteering shows a greater potential for enhancing the partnership relationships, strengthening health workers' application of skills learned in training, enhancing attitude and behaviour change and acting as role models and mentors to support long-term change.
- Short-term volunteering works best when it is strategically planned and involves return visits by the same people in a structured programme of support, within a clearly defined long-term plan. It can work well combined with long-term volunteering and when short-term volunteers have a particular type of highly-specialised expertise.
- Diaspora volunteers can be more effective in situations where language, cultural barriers or security issues are significant.
- Volunteers were particularly effective in bringing new ways of training and providing on the job learning through a range of methods, that health workers found inspiring and motivating.

- There are risks of volunteering related to insufficient expertise or seniority of volunteers; labour substitution that undermines health system strengthening efforts; host partners experiencing volunteer fatigue; costs to the UK health system.

The enthusiasm and commitment that volunteers bring to their overseas assignments is a significant factor in the success of the projects. This volunteer energy is an important aspect of capacity strengthening for health workers that takes place in the host country, and also important to the volunteers' own learning. The way the learning is used on return to the UK depends to a certain extent on the type of volunteering-sending institution. (see Figure 7 above).

- **Universities** that are not teaching hospitals have sourced their volunteers from elsewhere – either through an NHS programme or through NGOs. This means there is no institutional base for the returning volunteers and, unless they are part of a special programme, so they tend to have a more random or unsystematic impact on the organisations from which they originate.
- **Professional association (PA)** volunteers do not work directly for the PA, but for health delivery institutions in NHS trusts; instead, the volunteers are members of the associations and gain professional learning and status from the organisation. This means that the PA can be more strategic about learning that comes back to the UK. For example, the RCPCH is now developing a 3-year fellowship programme that will include a year overseas or a year working with refugee communities in the UK. However, there is not necessarily a managed impact on the institution where the volunteer is employed. One of the drawbacks for PAs is that they can only work in their expertise area, so when they come across other challenges they are not necessarily the best people to address them (even though they are usually mid-high level experts in their particular area). In this way, they may not be best placed to generate whole-hospital system change. These findings suggest that PAs should either partner with others to develop their approach or link with existing programmes for synergies.
- In comparison, **university hospitals, other hospitals or NHS Trusts** sent volunteers from their own institutions and were thus able to cover a range of specialist areas, including management and systems. In this way, they may have wider potential than other types of volunteering institutions. However, the negative impact on the hospital could be substantial if several staff are away volunteering at the same time, so the approach needs to be carefully planned to be strategic. The approach of NHS Trusts partnering with District Health Authorities is interesting and would merit further research and exploration with regards to the potential impact of this type of partnership with respect to governance, human resource systems and the health system overall.

(x) Volunteers gain a number of new skills, self-confidence and new levels of motivation and appreciation of the NHS. There is some evidence that they bring these back into the workplace in the UK and the health system benefits.

- The type of UK partner sending the volunteer (health education institution, health delivery institution or professional association) has an influence on how their UK employer or sending institution benefits from the volunteering on their return.
- There are examples of strategic learning approaches to volunteering (e.g. the IGH Leadership Development Programme and the new RCPCH 3 year Fellowship programme), but the majority of volunteering is more opportunistic and the advantage to the UK health system is not planned strategically.
- There is some evidence that volunteers, their institutions and their southern hosts see the opportunity as a way of connecting with the wider global health community, and building global excellence and networks to bring health benefits well beyond their country boundaries.

7.5. Monitoring and evaluation

(xi) THET's efforts to improve data collection and the quality and type of data (e.g. to measure improved performance and not just skills of health care workers) have been appreciated by the partners and have resulted in the potential for some useful outcome level data by the end of the programme. However, there is still a lack of data on synergies and coordination between partnerships and other programmes, and data analysing gender equality with the health system and service delivery.

- The evaluation confirmed that there is limited objective (independently verified) evidence of impact of the partnerships as most of them have not had externally conducted evaluations and sometimes because projects are in a relatively early stage of implementation or because they are implemented on a relatively small scale.
- It is also important to acknowledge that achieving improved performance of healthcare workers is a long-term and complex issue and not just related to improved skills, but to the entire operating environment and, therefore, there has to be coordinated change across a range of areas in the system such as those covered in the Finding Section 6.

- Several southern partners did not have any ownership of the M&E project plan and this meant that there was little understanding of the data collection that the UK partner wanted to achieve.
- The better quality M&E systems seen in the evaluation were those that had been grown from the bottom up in close alignment with southern institutions and in line with the management needs of the institutions. These systems had then become part of the health system rather than an add-on that would die with the project.
- There is some evidence that data collection techniques by southern partners needed further support from UK partners and that this was often not yet happening.
- The indicators showing progress on partnership development were sufficient and need further development so that partners can report on the range of different aspects that indicate success in partnership development.

(xii) While impact data has been difficult to collect it is arguable that some of the indicators in the HPS logframe are either not very meaningful without specific quality definitions, or are too demanding (e.g. health outcomes) – also there is a need for more specific and measurable indicators at outcome and impact level that are using facility or national data collection systems. However only minimal changes to the logframe can be made in the remaining programme timeline.

8. Recommendations

This section focuses on recommendations that can be acted upon in the current HPS period. These recommendations obviously rely on funding available to undertake them and the limited time left for the HPS, so they will have to be prioritised by DFID and THET. **Each recommendation relates directly to the numbered conclusion in the previous section.** Higher priority recommendations are marked with a star *.

Recommendations for future programming are presented in the Learning Section 9. All recommendations in this section can also be considered for other or new partnership programmes – they are not repeated in the learning section.

8.1. Effectiveness and HPS fund management

(i)* THET to encourage partners who are implementing existing projects to scope out how they might address some of the health system constraints to their projects by linking with and enhancing existing government or donor programmes. (This does not mean that the partners are required to change their current projects in any way, but that they will do this scoping within the current resources of their projects to plan ahead). Ensure that the technically-focused nature of their approach is maintained, and that partners are able to continue to draw from the key competency areas, whilst at the same time working with others with complementary skills.

- Partners might look at ways to expand to whole hospitals or to strengthen work in the community by linking with other organisations and agreeing common approaches to issues such as infection prevention and control, human resource management, and equipment and supplies.
- Partners could begin to engage with leaders within the health system (if they have not already) so that they are informed of and possibly participate directly in learning and change processes.
- More training and mentoring approaches could be institutionalised through accreditation systems and curricula, and in some cases these could be expanded in regions that are aiming to standardise health education (e.g. ASEAN). The use of protocols and guidelines that are accredited by government systems should also be encouraged.

(ii) THET should continue to support the partnership work with funding (see Learning Section 9 for more details on this) and should strengthen further the technical assistance, networking and advocacy work.

- THET to develop good practice guidance on project and partnership management that draws on some of the partnerships that have managed their projects well and have interesting effective governance and financial management approaches. Make sure to include information and stories on empowering behaviours and inclusive leadership between partners.
- As well as the networking webinars, THET should strengthen country coordination by possibly holding a series of events in key countries to explore where synergies might be possible in order to expand the impact on the health system.

- Develop a clear risk management strategy and procedures for projects that diverge from original purpose.
- Ensure wider dissemination of key THET learning and guidance documents.

(iii) THET to work with one or two partnerships to conduct a thorough gender analysis of their context, while at the same time building skills to undertake this kind of work and to design appropriate ways of integrating gender equality approaches into project design, implementation and MEL.

- Develop guidance on what partnerships could be counting as improvements in gender equality and social inclusion (e.g. empowerment, communication and leadership skills). Develop a seminar for learning to support partners to undertake this task.

8.2. Value for money

(iv) THET to develop an understanding of how value for money could be enhanced through the development of synergies with other aid programmes in key countries and between partnerships. Develop a small number of case studies to promote learning from existing partnership networks (such as the MNCH Hub in Uganda) on efficiency and effectiveness.

(v) THET to ensure financial management and record keeping are enhanced in particular areas in order to better understand and manage how funds are spent.

- * THET could look carefully at the THET HPS management costs and begin recording the allocation of costs more carefully between technical assistance, and programme activities in order to differentiate grant management from other strategic activities that THET is involved in. This can be done by using timesheets for staff in order to better allocate their time to specific expenditure lines.
- Develop methodology with a small number of partnerships (with the UK and the southern partner) in order to support them to record their own contributions to the project and partnership in terms of expenditure and their in-kind support.

8.3. Partnership, relevance and ownership

(vi) THET to develop country-level networking and learning opportunities for partnerships, starting with Uganda and Zambia and with a specific planned, strategic and target-driven work programme for the two THET offices. For other countries, consider ways of supporting the network by setting up partnership associations and including health partnerships from other countries (European, Australia, and the USA in particular).

(vii) THET to continue to evolve their approach for strengthening partnerships in order to improve effectiveness.

- Encourage UK partners to consider the amount of development and overseas expertise they have in the organisation and to plan how to recruit staff with the right skills and experience if they are to expand their international work. Alternatively, they could work together with other organisations to provide the development experience and complement each other.
- Consider re-designing the Principles of Partnership to make it more user friendly, easier to understand and easier to communicate widely. This might involve separating out what is (i) good development practice from (ii) the partnership elements and shorten to 3 or 4 key points each so that it is easier to describe healthy partnership and good development practice.
- Encourage UK partners to include in their projects institutional and capacity strengthening of their southern partner(s) where necessary. This could include helping to set up a secretariat and/or institutional base (e.g. for the Myanmar Paediatrics Society); supporting the development of research skills for data collection (e.g. Bayero University in IPC baseline); financial and project management skills.

(viii) Include in the work with the THET offices (mentioned in (vi) above) some work to explore how networks and strategic funding could enhance the development of synergies between partnerships.

8.4. Volunteering and the UK health system

(ix) THET and partners to continue to communicate the interesting role that UK volunteers are playing in HSS in LMICs.

- Any volunteering placement requires clear objectives and clear/bespoke pre-induction programmes (e.g. focusing on leadership development/ project planning/ teaching/learning/ QI methods etc., dependent on nature of placement). Project partners need to ensure clarity about the role and responsibility of the volunteer in country.
- Strong due diligence on both the UK and overseas partner side is required to ensure the right volunteers are selected, that there is good induction, support in country etc., and to ensure that the placements are demand driven.

(x) Strengthen dialogue with key UK stakeholders on how to strategically plan learning and benefit for the UK health system within partnership and volunteering programmes, while at the same time maximising the benefit for the low and middle income countries.

- Include in discussions an exploration of the benefits of the UK contribution to a global health excellence and learning network, and the role of volunteering and partnership in this.
- Ensure that the risks and negative outcomes of volunteering are transparently shared and learned from.

8.5. Monitoring, evaluation and learning

(xi) * THET to build in time and funds to be able to collect and synthesise outcome and impact data coming from projects – and this should include qualitative data that is being collected by partners. Because the outcome and impact indicators are all quantitative there does not appear to be a framework or systematic way for partners to report some of the interesting stories that are emerging on HSS and improvement in service delivery. For impact data, it is likely that more data will be qualitative and it is important that this is reported, as there are limited baselines and quantitative endline measurement.

- UK partners who have not developed their M&E plans with their southern partners should be required to share the plans and discuss how best to adapt to the needs of the partner institution data collection and management.
- Develop more systematic ways of collecting data on the development of the partnership, also highlighting challenges and learning. This could be linked to the work on rationalising the Principles of Partnership to be more user friendly.
- Start collecting data on coordination and synergies between partnerships, projects and programmes (both HPS and other programmes).

(xii) It is not recommended that the logframe be completely re-designed at this stage because there is only one year left for the programme and the logframe is on the whole a useful way of collecting quantitative data. Also projects are already set up to collect this data and a change at this stage would not be good value for money in terms of the time that THET and the partners would need to re-orient data collection. However, it would be useful to enable more interesting stories of change to be collected in line with the theory of change (which does tie in with and could illustrate some of the logframe indicators) – see recommendation (xi) for more on this. Also collection in the logframe could be streamlined – specifically with regard to the following:

- Delete impact indicator 3 as it is almost impossible to measure accurately and relevantly for this programme, and is also a bit meaningless as the figure could mask all sorts of institutions that only had very limited improvement in health outcomes. Ensure that key data of MNCH outcomes or proxy service utilisation indicators such as skilled birth attendance (for which there is ample evidence to demonstrate a link with improved health outcomes) is collected for the projects that are able to collect this data.
- Output Indicators 2.3 and 2.4 could possibly be merged.

9. Learning

Given that this evaluation includes a focus on learning for future programming, this section provides further learning that can be used in research and design of future UK partnership and other international partnership programmes. It follows on from the conclusions, so does not repeat the learning mentioned in that section.

Suggestions from volunteers to improve the effectiveness of the HPS programme included:

- "Longer secondments in country. True twinning with Cambodian midwives spending time in the UK",
- "Better continuation of tasks and projects between each cohort of volunteers",
- "Support to influence at national level"
- "To have a regional or country specific network of all the HPS funded programmes so that we could share expertise and findings."
- "The recent establishment of an in-country THET office in Uganda and Zambia may offer opportunities to facilitate more successful networking or knowledge sharing between HPS partners working in the same country, as well as more effective or efficient ways of working"

9.1. Enhancing partnership and project effectiveness

One of the key strengths of the HPS is the way it has provided **funding that has generated a large number of nascent experimental partnerships, while at the same time encouraging a more developmental approach**. This has resulted in some larger and more established partnerships implementing projects that have started to impact on health systems and service delivery. There are also examples of newer and smaller partnerships building effective approaches. The funding of projects through partnerships and in combination with a structured partnership strengthening approach has been essential for the growth seen in this approach to health system strengthening. It is also an excellent way of ensuring high calibre UK (or other developed country) expertise is available for building health systems globally and for networking around global health excellence.

Partnerships that have linked up, established synergies and become more strategic should be encouraged through future funding mechanisms, while at the same time maintaining the creativity and voluntarism that is flourishing under the current HPS. In particular a new approach could learn from the following:

- The provision of the right environment and encouragement for partnerships to build linkages and wider consortia in order to complement each other's work and to build on their learning from previous projects and to build synergies (rather than requiring partnerships to link up) thereby maintaining the bottom up and entrepreneurial²⁴ approach to partnership work.
- Build skills for understanding wider health system strengthening, identifying key health system constraints and designing innovative approaches to address them (e.g D2.40 Uganda).
- Where a partnership is working directly with a whole hospital or a whole health district there is potential to take a more systems approach, work with management and leadership and influence a whole cadre within the context, which could then go on to influence the national context.
- Ensure new initiatives have a strong emphasis on strengthening and expanding partnerships that have already been successful during the HPS and ensure that long-term funding is available for them.

Ensure that the type of partners (professional association, health education institution or health delivery institution) is taken into account in the design of approaches. For example professional associations should connect further with employers and other institutions in the sending country to (i) develop preferred partners who make a specialism out of sending staff abroad; (ii) develop relationships with organisations who can complement their specialist areas and (iii) learn how the overseas work has influenced the volunteer performance in when back in their sending country post. There is also an argument for linking professional associations together which would tackle one of the big drawbacks of working with PAs - that they can only work in their expertise area, so when they come across other challenges they are not necessarily the best

²⁴ The word entrepreneurial is used in the social enterprise sense of the word, where the sought after profit is more to do with social return on investment.

people to address them (even though they are usually mid-high level experts in their particular area). In this way they may not be best placed to generate whole hospital system change. These findings suggest that PAs should either partner with others to develop their approach or link with existing programmes for synergies. As an example, DFID Myanmar are trying to do this and hosted a meeting with all the Royal Colleges in order to discuss how they might work together to build a more comprehensive programme.

Design the future approach to be more strategic and in line with international strategies and goals for the Sustainable Development Goals (SDGs) and Universal Health Coverage (UHC) agenda by:

- Developing funding streams to strategically support particular focus countries where there are a large number (5+) of active partnerships (currently Uganda, Zambia, Kenya, Malawi, Ethiopia, Ghana, Tanzania, Rwanda and Sierra Leone and Mozambique) or where there is a keen DFID interest in supporting the development of partnership programming (e.g. Myanmar). The funding stream could be designed to receive proposals from a combination of partners working together or coordinating across complementary health areas and institutions. Preparation for the design of this funding stream would need to ensure that a full scoping of the health system and governments' priorities would be undertaken in each of the target countries. This should include analysis of the main health system constraints, the partnership capacity within the country, other donor and partnership programmes, government and population priorities and gender inequality and social exclusion related barriers to HSS and access to services. This information can then be used to prioritise areas for particular focus in the request for proposals (RFP). This would also enable volunteers to focus on their specialist technical area – while the partners and the funding mechanism would be responsible for context analysis and updating.
- Providing longer term funding, with lower transaction costs, building on what works well in key strategic areas. The fund could also consider some “core” funding with key milestone based payments.
- Considering which health topics are more pressing by country and aligning also with international priorities (such as nutrition)
- Considering how to design the programme in order to better tackle some of the underlying human resource constraints such as recruitment, deployment and retention and develop systems for governments to better manage this. Share any partnership good practice for best effectiveness in HRH strengthening in host country.
- Including the potential for cross sectoral partnerships (e.g. between education, WASH, health) for health outcomes
- Developing approaches that link the health system with communities, support community engagement and that introduce or strengthen social accountability systems.
- Developing capacity and learning on how best to link the work in secondary and tertiary hospitals with work in primary health care facilities and in communities.
- Providing targeted funding for some highly specialist areas, such as general and specialist surgery, which would not otherwise be supported with the kind of technical skills that have been available under HPS partnerships (e.g. RCSEd urology surgeons and Cambridge Addenbrookes pathologists). The specialist partnerships could be offered by the region if it will enhance uptake and relevance.

More informed funding will help the funding mechanism to plan delivery of technical assistance to partners based on need. This means that more information will need to be collected at proposal development stage.

- Require more information about the partnership and the skills and expertise of the organisations to be able to do the job (in particular information about their international experience to gauge the amount of extra support they might need during implementation), and their volunteer recruitment strategy and the skills and expertise they are looking for.
- The proposal should also have a gender and social inclusion strategy that responds to the issues identified for them and communicated in the RFP. Guidance and practical solutions should also be provided in the RFP.

Consider how to encourage partnerships to work together with aid programming (e.g. in tenders and consortia) in order to build hybrid aid programming that draws on the best of partnership and integrates it into larger, more integrated health systems strengthening aid programming. This might include developing networking opportunities between key HSS suppliers and partnership organisations, or specifically inviting

partnerships to early market engagement events (EMEs), or including partnerships in the early days of programme design at country level.

Ensure there is a consistent UK (or other developed country) image or brand for development programming and that communications within developing countries are well coordinated to ensure consistent messages and minimise transaction costs for national governments and organisations.

Given that many of the UK partner organisations are governmental or quasi-governmental, there is an even greater requirement to ensure that UK partners are working in a coordinated way that reflects the UK government aid policies. It is also important to present high quality standards across all of UK partnership programming to ensure the development of a good reputation. The previous points within this section give a good starting point for coordination and joint working, but it would also be useful for HMG to consider how best to develop a consistent image for UK health partnership support in the host countries.

9.2. Ensuring efficiency in project management (contributing to VfM)

Partnership initiatives needs to be supported with the range of management structures that have been put in place by HPS project partners. In particular guidance on planning and financial management could be provided, as well as supporting realistic inception periods.

- Support the lead partner with more realistic budgeting given the learning that volunteer recruitment and deployment can be challenging and time consuming (the main reason for delays in expenditure).
- Consider setting up volunteer recruitment during proposal development
- Consider having an inception period in order to develop a more realistic budget, do recruitment and ensure southern partners are fully engaged with project planning and development of M&E systems. This would be particularly appropriate for larger and longer projects.
- The budgeting and expenditure needs to be updated on a 6 monthly basis or even a quarterly basis with a good record of previous period utilisation in order to improve management planning.
- Aim to record the true cost of the partnership projects in order to better plan and learn from implementation. Support southern and northern partners to develop budgets that include their own project expenditure and other in-kind contributions.
- Consider allowing partnerships to decide whether the southern or the UK partner is the lead organisation.
- Consider how best to use competition in the funding process so that stretched health institutions are not compelled to spend a lot of time on applications that is not necessary or have low chances of success. Ensure competitive processes are designed to enhance collaboration and joint working.

9.3. Volunteering and the UK health system

Long-term systemic change is more likely when volunteering placements are coupled with a systematic and long-term dedicated partnership and technical collaboration between the UK health system and LMICs at the systems level - as concluded in the iDSI health systems strengthening report (Baxi, 2015). However, whilst partnership projects of this nature all need volunteers, not all organisations that provide volunteers necessarily need to be the organisation which develops the partnership or manages the project. There needs to be a specialism around developing partnership projects and it should be nurtured – but volunteers can be sourced from anywhere with any system – as long as there can be some system for building in learning and bringing back new skills to their employer.

Support partnerships to have a more strategic approach to volunteer learning and health system strengthening in the UK by considering the following:

- Strategic approaches to volunteering could be developed on a partner by partner basis (e.g. as the RCPCH has done for their own fellows). New funding mechanisms could support with guidance and good practice stories.
- Alternatively the NHS or HEE could develop a national approach to volunteer learning that others could sign up to or adopt.
- It would be useful if the NHS were to develop a partnership and volunteering strategy that specifically sets out the extent of volunteering that the NHS can cope with and desires for strengthening health services in this country – with particular focus on equity and inclusiveness. An NHS strategy can then

be used to promote volunteering in a more systematic way throughout the NHS that is supported within health workers contracts and pension schemes. There is a need for specific targets, and recognition of the limitations, to minimise risks to the health service in this country. The potential for impact on the UK volunteer's skills and career development could be further highlighted in order to encourage volunteering and get more support/buy-in from line managers. The NHS volunteering strategy could be better cascaded to NHS Trusts, so they are able to publicise the benefits of volunteering and promote its value, whilst also remaining aware of the potential costs and limitations.

- Consider also supporting UK patient groups to visit some of the volunteering sites as part of the partnership arrangement. This way UK service users can raise awareness of the challenges in other health systems – thereby building appreciation of the NHS.

There is a need to design more strategic and more systematic volunteering programmes that feed into both partnership development and UK organisational development (including employee or member skills development):

- Any volunteering placement should be within a CPD framework and volunteer skills should be formally assessed after long-term placements.
- Increased feedback loops – from the overseas partner to the UK – are recommended. Feedback on the volunteer's performance should be used to inform the next placement as well as the volunteer's performance appraisal in the UK. This also triangulates with the LSTM study on 'Benefits of NHS staff volunteering overseas' which highlights the use of the HEE toolkit for 'collecting evidence of knowledge and skills gained through participation in an international health project.'
- On their return, volunteers need more support to use their new skills within the NHS.

9.4. Development of the Monitoring, Evaluation and Learning (MEL) system

Focus on health systems strengthening and human resource capacity strengthening as objectives may not fully capture the higher level aspirations of the health partnerships around global health. It would be useful to ***explore an objective (or outcome/impact) that fully expresses the potential for building global health excellence through partnerships, shared expertise and networking at a global or country to country level.***

Monitoring, evaluation and learning (MEL) has improved considerably during the lifetime of the HPS. However the complex nature of the programming, with multiple objectives and potential outcomes, and with the desire to provoke changes in a complex adaptive system (HSS) means that MEL could also be complex. However the best MEL approaches within the HPS have been designed with and by the southern institution. They are ***embedded within the system, focused on specific practical areas and concentrated on measuring and using data as a management approach rather than just for upward reporting.***

- Any new MEL system needs to enable these kinds of approaches that are empowering for southern partners and other institutions.
- It also needs to ensure practical reporting of changes for volunteers and the UK health system as part of CPD.
- MEL plans could be developed as part of the project proposal development or during an inception period, but should be developed in a participatory way in the country, with the national partner.
- Data collection should be led by country partners so on occasion research skills will need to be developed and the system may require follow up and support, either from local experts or from the UK partner. It may also be possible to develop innovative online or mobile data collection systems for ease of use and reporting. Data collection methods should also take into account local context and culture in order to ensure results are reliable.
- In some cases it might be appropriate to replace M&E with robust research, and also generating evidence for learning and adaptation is essential (e.g. D43). For example it would be useful to learn more specifically about organisational change within the hospital setting (e.g. for IPC or medical equipment projects) and how this might link with and support the development of primary and community health care.
- Strengthen measurement of improvements in clinical practice, for example, through regular tracking of adherence to standard protocols. This should be part of an ongoing systematic supportive supervision process in any health facility. Also, outcome indicators showing improved performance

could include better adherence to clinical standards and protocols. Such indicators would need to be clearly defined at the start of projects and regularly monitored to provide evidence of change.

- Improve data capture for value for money monitoring – for example, develop a simple IT platform, possibly supported by a mobile App, through which data is entered directly by volunteers (both UK based and overseas). This would provide real time information to inform management decision making, enhance consistency and accuracy, and might reduce the reporting burden on grant recipients.
- Introduce measurement of institutional strengthening and partner capacity strengthening in order to better assess and manage how southern partners are benefitting from the partnership.

One of the challenges of this evaluation was that we were not able to undertake a technical assessment of health worker skills for some of the more technical areas (such as pathology and urology surgery). One of the partners also mentioned that they were looking for a consultant who could provide external verification of skills development and they had not been able to find someone with sufficient technical medical skills. It might be a good idea to **develop a roster of high level medical expert volunteers through the Royal Colleges to do some peer monitoring and evaluation** and spot checks for other organisations that are in partnerships. It may also make sense to pay these experts an honorarium for their time.

Managing adaption is an important part of the MEL cycle and needs to be more carefully planned in the new partnership funding mechanism. In some cases adaption has meant that the project or partnership veers away from its original purpose, and while there might be good reasons for this, it sometimes could mean that the partnership is no longer the best approach, or the best organisations to implement.

- Ensure continual monitoring of the country and health system context, especially in countries with dynamic and changing donor environments, which has grown in complexity in some countries (Myanmar and Sierra Leone).
- Embed learning cycles so that there is a clear path from the generation of evidence, learning and adaption.
- If UK partners find that they are implementing or asked to implement something outside of their core expertise area they should (i) search for a local organisation that would have the expertise or (ii) search for another UK partner. It might be that they would have to consider several options and compare them.

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The Department for International Development:
Leading the UK government's fight against world poverty.

Department for International Development
22 Whitehall
London
SW1A 2EG
UK

And at:

Abercrombie House
Eaglesham Road East
Kilbride
Glasgow
G75 8EA
UK

Tel: +44 (0)20 7023 0000

Fax: +44 (0)20 7023 0016

Website: www.dfid.gov.uk

Facebook: www.facebook.com/ukdfid

Twitter: @DFID_UK

Email: enquiry@dfid.gov.uk

Public enquiry point: 0845 3004100 or +44 1355 84 3132 (if you are calling from abroad)

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