REPORT

INTERNATIONAL HEALTH LINKS FUNDING SCHEME EVALUATION

ON BEHALF OF: TROPICAL HEALTH EDUCATION TRUST

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Report produced for:

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CONTENTS

Acronyms 1
Definitions 1
Foreword by THET 2
Executive Summary 4
Background 8
Purpose of Evaluation 8
Scope 8
Evaluation Framework 8
Methodology 10
Findings & Recommendations 11
- Relevance 11
  - Potential for Health Systems Strengthening 12
  - Alignment with National & Institutional Plans 14
  - Best Practice in Capacity Development 16
- Efficiency 18
  - Human Resources & Professional Expertise 18
  - Financial Inputs and Processes 20
  - Partnership, Planning and Management 23
- Effectiveness 25
  - Capacity development approaches and activities 26
  - Reported Change 31
  - Monitoring and Evaluation 33
- Impact & sustainability 38

Comparative Analysis 41
Conclusions and Key Recommendations 43
Case Study 1: Developing Specialist Eye Care Services for the People of Northern Zambia 47
Case Study 2: Partnerships to Improve Outcomes in Critically Ill Obstetric Patients in Uganda 49
Case Study 3: Integrated Emergency Response Service in Mbale Region, Uganda 51
Bibliography and References 54
Annex 1: List of Key Informants 55
Annex 2: Summary Survey Results 57
Annex 3: The Consultant Team 64

Acronyms

CPD	Continuing Professional Development
CME	Continuing Medical Education
DC	Developing Country
DFID	Department for International Development
HMIS	Health Management Information System
HPS	Health Partnership Scheme
HSA	Health Service Assistant
HSS	Health Systems Strengthening
IHLFS	International Health Links Funding Scheme
M&E	Monitoring & Evaluation
MoH	Ministry of Health
MoU	Memorandum of Understanding
NCDs	Non Communicable Diseases
NGO	Non Governmental Organisation
NHS	National Health Service
SOP	Standard Operating Procedure
THET	The Tropical Health and Education Trust
ToT	Training of Trainers
UNDP	United Nations Development Program
WHO	World Health Organization

Definitions

Developing country partner	The partner organisation in a health link based in a developing country.
Health Link (Link)	A long-term partnership between a UK health institution and their counterpart in a developing country. The purpose of a Link is to strengthen health systems and improve health service delivery in both countries by allowing for a reciprocal transfer of skills and knowledge.
Key Informant	Participants at the evaluation workshops in Uganda, Malawi and Zambia and the subset of participants who were interviewed for the evaluation.
Link Coordinator (DC)	The person in the developing country who is the key contact point and coordinator for the health link.
Link Coordinator (UK)	The person in the UK who is the key contact point and coordinator for the health link.
Link Project	A project that was funded under the IHLFS.
Survey respondent	Respondents to the electronic survey sent out as part of the evaluation.

FOREWORD BY THET

THET welcomes the International Health Links Funding Scheme evaluation conducted by Capacity Development International. The IHLFS aimed to strengthen the capacity of health services in developing countries by supporting over a hundred health links, each between a UK health institution and a developing country counterpart. Funded by the UK Department for International Development and the Department of Health, it was jointly managed by THET (lead partner) and the British Council, and provided £1.25 million of support per year between 2009 and 2012.

In light of DFID and THET's ongoing support for health links (now known as health partnerships) we decided it was premature to undertake a formal impact evaluation. Instead, we saw an opportunity to identify successes, challenges and potential barriers for the funded health partnerships, and to elicit lessons and recommendations for the Health Partnership Scheme that has replaced the IHLFS. CDI therefore ran workshops, interviews and surveys to learn about the experience of IHLFS grantees in Uganda, Zambia, and Malawi, where the majority of IHLFS projects have taken place. This report provides both an overview of their experiences and reflections, and detailed examples to illustrate the general points.

These perspectives from developing country health workers both stress the value of health partnerships and highlight ways to strengthen the model further. THET will learn from these observations and consider ways to incorporate them into current and future work, in particular by providing guidance for individual health partnerships and support for learning and collaboration by all stakeholders in the health partnership community. We are delighted to publish the evaluation report in its entirety as a source of reflections and recommendations.

In respect of the report's key recommendations (see page 7):

1. When considering the design of future programmes THET should consider at what level within the health sector they are seeking to strengthen capacity (individual, institutional or system wide).

- THET recognises this point and will consider as recommended.

2. UK link partners should receive more orientation in best practice for capacity development so that appropriate approaches and methods are developed jointly with overseas partners.

- THET encourages, and looks for clear evidence of, overseas partner involvement in project planning, management and reporting by HPS-funded partnerships.

3. THET should consider working with DFID and MoH national level to ensure best practice from health link projects is identified and disseminated; 6. THET should work with national level MoH and DFID country offices to explore opportunities for sharing and dissemination workshops for link projects.

- THET has initiated these relationships and will work more closely with national governments and DFID country offices as the HPS progresses. In addition, individual health partnerships communication and collaborate with MoH offices as appropriate.

4. THET should consider setting up dissemination/advocacy grants to encourage write-up of successful projects in a range of formats for different audiences; 8. Case studies of projects which highlight positive aspects associated with sustainability should be identified, written up as in depth case studies and disseminated to the wider health links community.

- The HPS is encouraging grantholders to generate case studies and guidelines, and THET is also taking an active role in learning and production of information resources. New documents and multimedia pieces appear regularly on the HPS website.

5. THET should advocate with NHS partners to address planning, human resources, finance and governance in needs assessments and subsequent implementation plans.

- The HPS provides for considerably more support to both UK and overseas partners than was possible in the IHLFS. THET has supported HPS grantholders with project planning and evaluation planning, and we will continue to provide management guidance in a variety of ways throughout the programme.

7. More capacity development needs to be undertaken to strengthen M&E with both developing country and UK partners, building on the existing THET M&E toolkit.

- In addition to support for HPS grantholders' evaluation planning, THET has run successful M&E workshops in the UK. THET recognises the importance of expanding this programme to developing countries and aims to do so in 2013.

9. THET should increase their direct communication with developing country partners in order to promote engagement and understanding; 10. Further consultation should be undertaken with developing country partners and key stakeholders to explore how south-south learning can be facilitated through health links.

- THET will expand its programme of visits to developing countries as part of its HPS support in 2013, in part to enhance direct communication with overseas partners and stakeholders, to understand how THET can better support them and enable south-south learning.

Executive Summary

The International Health Links Funding Scheme (IHLFS) is a three-year programme funded by the UK Department for International Development (DFID). It supports Health Links between health institutions in developing countries and the UK. The purpose of a Link is to strengthen health systems and improve health service delivery in both countries facilitating a reciprocal transfer of skills and knowledge. This evaluation was a unique opportunity to represent the voices of developing country partners from Uganda, Zambia and Malawi, where the majority of IHLFS projects have been taking place. This evaluation was not a formal assessment of the projects' impact, rather it served to identify the challenges, successes and potential barriers that Health Links face. The key focus of IHLFS support is on capacity development which, when delivered well, builds local ownership and capacity to sustainably deliver improved health outcomes and strengthen health systems.

Methods

This report evaluates the IHLFS from the developing country partner perspectives, drawing on the experiences, perceptions and insights of those working in Link Projects in Uganda, Zambia and Malawi. Mixed methods were used - participative workshops, semi-structured interviews and an electronic questionnaire - to gather the experiential knowledge of those involved in the IHLFS Scheme.

Forty people representing 23 health link projects participated in the evaluation workshops (68% of IHLFS projects in the three countries). Fourteen key informants were interviewed and 33 people completed the questionnaire (a 49% response rate, representing 74% of all IHLFS projects in the three countries).

Findings

Overall the developing country partners saw real value in being part of the IHLFS scheme and reported capacity development benefits at both individual and institutional levels. There was widespread agreement that trust, equal partnership, ownership, common interest and openness were crucial to effective links. The range of projects was quite disparate making comparisons as to their relative success difficult. However, many reported impressive change on the basis of relatively small amounts of funding, which they believed could be sustained to a large degree over the long term.

Alignment

The IHLFS projects were predominantly focussed on building capacity at the institutional and individual levels and were not primarily designed to influence the wider health system. Project objectives were perceived to align broadly with both national priorities and institutional needs. Institutional alignment was strongly linked to having a shared vision, joint ownership and a clear understanding of each other's institutional structures and context.

Vision

Workshop participants concurred that the most successful partnerships were ones that were based on a vision that was owned by the developing country partner but which invariably gained an added dimension through opportunities to see the NHS in practice.

Working Arrangements

The working arrangements between UK and developing country partner varied widely and presented many challenges in relation to human resources, finances and project management. Many of these challenges were avoidable yet caused a high degree of frustration for both the overseas and UK partners. Insufficient capacity building of the administrative functions of the organisation was frequently cited. Capacity gaps were identified in relation to project management, planning, budgeting, M&E and proposal development. Developing country partners identified a range of enablers and barriers to successful implementation of projects.

Enablers

- Skills, knowledge and expertise from UK
- Funding from different sources
- Joint planning and priority setting
- Involvement of key stakeholders
- Understanding of context
- Equal partnership
- Flexibility in responding to change
- Openness and honesty
- Local ownership & support from hospital management
- Joint development of curriculum and learning materials
- Flexibility in scheduling of training and of travel plans
- Working as a team between partners
- Practical hands-on training
- Exchange visits
- Follow-up after training
- M&E tools for data collection
- Capacity of leaders to do M&E
- Mutual understanding of M&E and its utility

Barriers

- Staff transfers and attrition
- Lack of administrative support to projects
- Lack of familiarity with budget and IHLFS funding rules
- Exchange rates, inflation and fuel prices
- Delays in accessing funds
- Lack of funds for in country travel/transfers
- Lack of control over budget decisions
- Mismatch of expectations and understanding of roles
- Inadequate equipment and infrastructure
- Variable internet access
- Short duration of training & specialists limited time in country
- Inconsistent availability of UK volunteers
- Lack of skills in M&E and IT
- Lack of clarity in communication of targets, goals and outcomes
- Timeframe in which to demonstrate meaningful change
- Making time due to competing priorities

Capacity Development

The extent to which capacity development moved from the individual to the institutional level varied. Some projects embraced the ethos of capacity development, enhancing institutional capacity. Others provided resource transfer (knowledge and equipment) and gap filling (lecturing and training), which in the short term helps fill capacity gaps, but may not have embedded sustainable capacity within the developing country partner institutions. UK personnel who were able to adapt materials, methods and expectations to the institutional, cultural and economic context within which the project was located were highly valued by developing country partners.

Personal and Professional Development

Developing country partners reported that their personal and professional development had benefited at an individual level, empowering them to challenge and change practice. Several projects identified the utility of UK link volunteers mentoring clinicians who had experienced 'professional isolation'. Many senior positions are held by clinicians who are relatively junior, making the opportunity to be mentored by senior clinicians from the UK even more valuable.

Change

The most commonly cited changes were improved knowledge, skills and practice of staff. Being involved in improvements to service delivery and seeing the changes this resulted in, bolstered staff morale and confidence. Informants also noted how health services had become more patient focused. Some projects were able to demonstrate changes in mortality and morbidity, although the difficulty in attributing to what extent IHLFS funding brought about the specific changes was raised. Key informants also reported having data that demonstrated change was both a powerful motivator and a resource to influence senior managers.

Monitoring and Evaluation

M&E presented one of the biggest challenges to projects and was "feared" by many. Informants expressed concerns about their ability to design and implement simple project M&E systems, due to competing priorities alongside lack of experience and tools. M&E was frequently perceived as an administrative duty for reporting purposes rather than as an opportunity for generating and using data to understand and improve project performance.

Impact and Sustainability

The vast majority (91%) of survey respondents reported that the project objectives were largely achieved and were confident that changes achieved could, on the whole, be sustained. They also anticipated their relationship with the UK partner continuing over the long term. A range of strategies were being deployed to sustain and drive change within institutions. However, many were yet to be, or not fully, implemented and hence could not be evaluated. It was also difficult to assess whether the IHLFS projects impacted any further than on the individuals and institutions involved in the link projects and the direct beneficiaries of these projects. Whilst many of the projects could potentially be scaled-up and contribute towards health systems strengthening, better communications and linkages are required with national level MoH.

Best practice

Developing country partners identified and ranked a range of best practice statements based on their experiences of implementing health link projects. The five most prioritised are shown in Table 1.

Table 1 Ranked Best Practice Statements

Best Practice Statements	%
Equal ownership should be developed between UK and overseas partner(s) in all aspects of the project	85%
Projects should seek to develop local capacity to manage and deliver capacity building activities in the future.	67%
Ensure projects fit with your institutional long term vision and take account of partners institutional structures and contexts.	64%
Engage with key stakeholders (eg MoH, local government, clients) from the start and throughout the project.	52%
Curricula and training methods should be developed jointly to ensure relevance to local contexts and needs	48%

Suggested Improvements to the Scheme

Developing country partners identified and ranked a list of suggested improvements to the scheme. The top five responses are listed in Table 2.

Table 2 Ranked Suggested Improvements to the Health Links Scheme

Suggested Improvements to the Health Links Scheme	%
Provide more opportunities for link projects to share experiences and resources to disseminate results	82%
Provide support to improve M&E skills	64%
Allow more flexibility in the budget for items such as administrative support and/or equipment.	58%
THET to communicate directly to both developing country and UK partners.	52%
Provide more scope for south-south links within the partnerships.	45%

Key Recommendations to THET

1. When considering the design of future programmes THET should consider at what level within the health sector they are seeking to strengthen capacity (individual, institutional or system wide).
2. UK link partners should receive more orientation in best practice for capacity development so that appropriate approaches and methods are developed jointly with overseas partners.
3. THET should consider working with DFID and MoH national level to ensure best practice from health link projects is identified and disseminated.
4. THET should consider setting up dissemination/advocacy grants to encourage write-up of successful projects in a range of formats for different audiences.
5. THET should advocate with NHS partners to address planning, human resources, finance and governance in needs assessments and subsequent implementation plans.
6. THET should work with national level MoH and DFID country offices to explore opportunities for sharing and dissemination workshops for link projects.
7. More capacity development needs to be undertaken to strengthen M&E with both developing country and UK partners, building on the existing THET M&E toolkit.
8. Case studies of projects which highlight positive aspects associated with sustainability should be identified, written up as in depth case studies and disseminated to the wider health links community.
9. THET should increase their direct communication with developing country partners in order to promote engagement and understanding.
10. Further consultation should be undertaken with developing country partners and key stakeholders to explore how south-south learning can be facilitated through health links.

BACKGROUND

The International Health Links Funding Scheme (IHLFS) is a three-year programme funded by the UK Department for International Development (DFID), which started in August 2009 and is due to finish in January 2013. It supports Health Links (also known as "health partnerships") between health institutions in developing countries and the UK and is jointly managed by THET and the British Council. The purpose of a Link is to strengthen health systems and improve health service delivery in both countries facilitating a reciprocal transfer of skills and knowledge.

IHLFS supports activities that focus on training health staff and enhancing the capacity of health systems in developing countries. Link activities also benefit the UK partners enhancing staff skills and improving their understanding of and perspective on global health issues. The IHLFS gives grants to Health Links and the IHLFS team (THET and British Council) carry out the grants management function as well as providing advice, resources and project support to Health Links.

PURPOSE OF EVALUATION

Although many evaluations of health link initiatives have been conducted, none have focussed exclusively on the developing country partner perspective. On behalf of THET, Capacity Development International was commissioned to undertake such an external evaluation to supplement the IHLFS team's on-going monitoring and evaluation activities in the UK and internationally. This was a unique opportunity to seek, record and represent the voices of developing country partners in Uganda, Zambia and Malawi, where the majority of IHLFS projects are located. This study was not a formal assessment of the projects' impact, rather it served to identify the challenges, successes and potential barriers that Health Link Projects face, with a particular focus on aspects of health systems strengthening that THET sees as central to the work of Health Links.

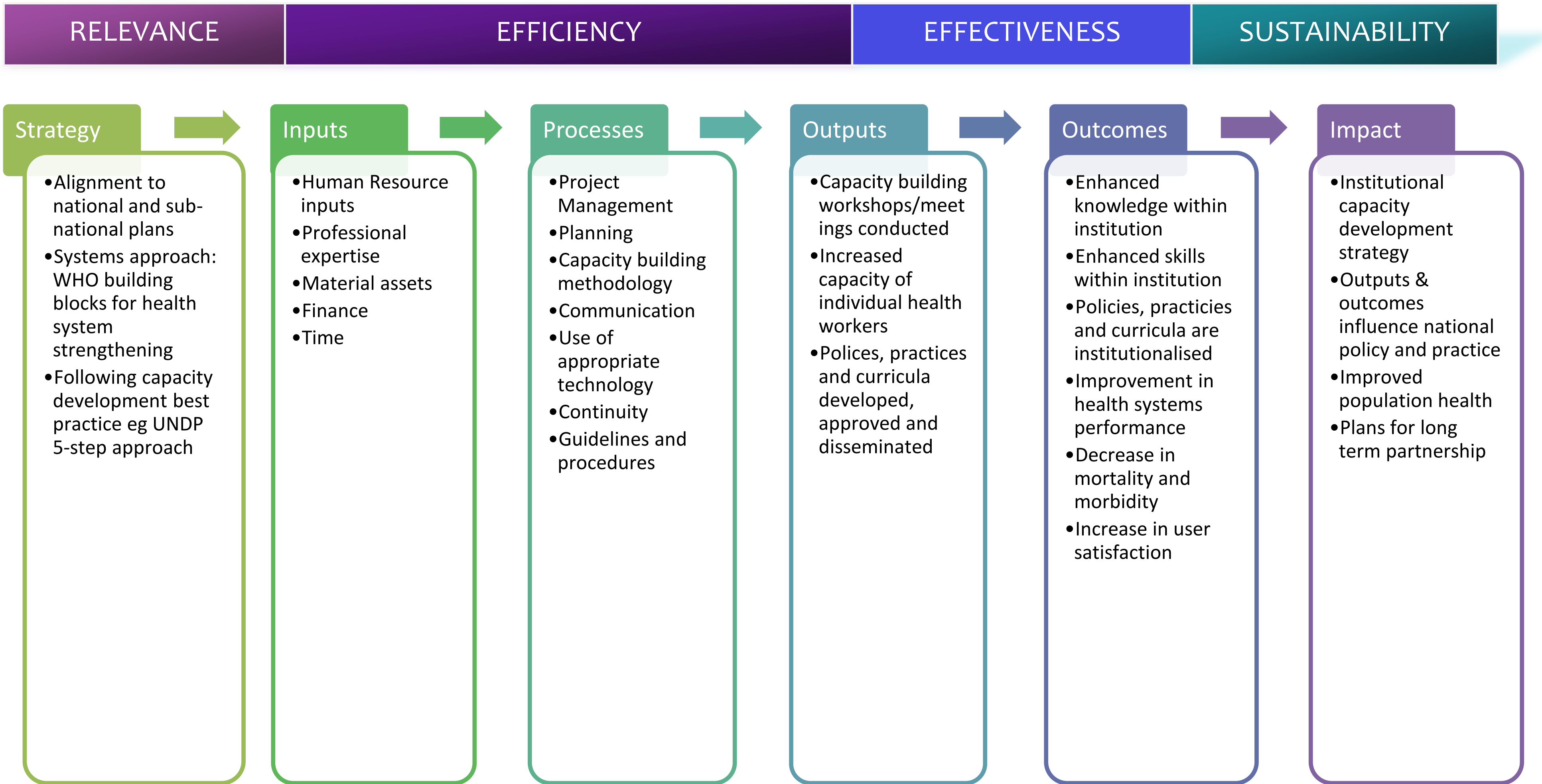
SCOPE

This was a qualitative study, seeking the experiences, perceptions and insights of the developing country partners working in health link projects in Uganda, Malawi and Zambia. The duration of IHLFS projects ranged from 1 to 3 years, making it difficult to focus on impact or even outcomes. Whilst views on the potential impact and sustainability of links were sought, objective verification of these was outside the limits of this evaluation. Initiatives with potential for scale-up and contribution to health systems strengthening were identified which may provide important empirical evidence of how national systems could apply lessons learned from the local level.

EVALUATION FRAMEWORK

A framework for this evaluation was designed to combine the OECD/DAC criteria for evaluating development initiatives with a logic model (see Figure 1).

Figure 1 Evaluation Framework



Methodology

Qualitative data was collected through workshops, semi-structured interviews and an electronic survey with individuals centrally involved in health links from Malawi, Uganda and Zambia.

Document Review

Prior to the in-country data collection, progress reports and other relevant health link documentation was reviewed to extract relevant data and inform the workshop and semi-structured interview design.

In-country workshops

A total of 40 people representing 23 health link projects participated in the workshops. This represented 68% of projects in the three countries (see Annex 3 for list of participants). The workshops were used as a reflective forum to discuss and compare expectations of the IHLFS with their own personal and institutional experiences and to identify lessons learned.

Semi -structured interviews

Fourteen key informants were interviewed using opportunistic sampling in the two days after each workshop, to allow deeper examination of the themes and issues raised. In addition, three site visits were undertaken, and in Uganda the team met with national MoH focal persons for health links and the DFID Health Adviser. All interviews were recorded and transcribed. Due to the small number of informants they are not listed separately from the workshop participants in order to protect confidentiality.

Electronic Survey

Initial analysis of the workshop findings and the semi-structured interviews was used to inform the development of a questionnaire. The purpose of this electronic survey was to engage with a wider group of staff involved in the health link. A total of 67 invitations to complete the questionnaire were sent to 34 link projects: 33 were completed and returned - a response rate of just under 50%. However, this represented 74% of those link projects invited which had a working email contact point.

Analysis

Content analysis was used to draw out the main themes and topics arising from the semi-structured interviews and the workshops. Results from the survey were entered into Excel 2007 and basic descriptive statistics were generated. Results from the survey were triangulated with those from the workshops and semi-structured interviews as a means of validating the findings and to identify a prioritised list of best practices and suggestions for how to further improve future funding schemes for health links. Short and long case-studies that illustrate key themes have been produced to highlight success stories and/or problems encountered by individual link projects. Analysis of the three datasets shows substantial commonality across the three countries. The focus of this report, therefore, is on drawing out the lessons learned and experiences of the participants rather than cross country comparisons.

LIMITATIONS & CONSTRAINTS

The major constraints on the methodology have inevitably been time and cost. The evaluation was based on a self selecting group of targeted informants, from this group a smaller opportunistic sample was interviewed in depth. To counteract bias, an electronic survey was sent to a larger group who were actively engaged in the organisation of health links in the three countries; 74% of the IHLFS links in the three countries took part. The number of questionnaires is, however, too small to undertake statistical significance testing. Hence comparative analysis was done using basic descriptive statistics to indicate areas that might be worth further investigation. Whilst the sampling methods used were appropriate to the task of gaining the perspectives of developing country partners, their views may not be representative of all health links.

Key informants did not differentiate between the link and the specific project funded by IHLFS. Projects were also funded from more than one source hence It was difficult to isolate to what degree the changes attributed to the project were attributable to the IHLFS funding. As the evaluation sought to examine the perceptions of the developing country partner participants in the scheme, their own definition of either the link or link project was accepted. As a consequence the evaluation focuses on the experiences of implementing link projects.

Case studies are largely based on interviews with one individual from the health link and are thus subject to bias.

FINDINGS & RECOMMENDATIONS

A synthesis of key findings and corresponding recommendations are presented under four sections:

- Relevance
- Efficiency
- Effectiveness
- Impact & sustainability

In each section the findings derived from the workshops, interviews and survey are presented. Enablers, barriers, best practice for health link projects and recommendations to THET are summarised at the end of each subsection, where relevant. The full results from the workshops are available in separate Country Evaluation Workshop Reports and Annex 2 contains summary tables of the survey data.

RELEVANCE

This section discusses the potential of health link projects to contribute to health systems strengthening. Relevance is assessed in relation to whether developing country (DC) partners perceived their project to be aligned with their institutional priorities and with national priorities. Finally, the role of best practice in capacity development is examined.

IHLFS supports activities that focus on training health staff and enhancing the capacity of health systems in developing countries. The core concept of health systems strengthening (HSS) is used and interpreted by donors and other stakeholders in different ways although most donors and national governments claim to strengthen health systems.

For the evaluation team, projects have the potential to effect health systems strengthening when they move from individual and institutional capacity building to inter-organisational or sector capacity building and when the interventions are sufficiently underpinned by **all** of the WHO building blocks for health systems strengthening, not just one or two of the building blocks (see figures 2 and 3).

Figure 2 Levels of Capacity Development from James 2002

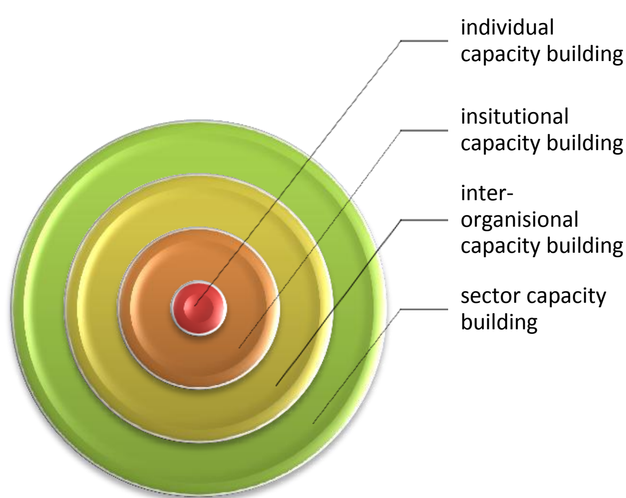
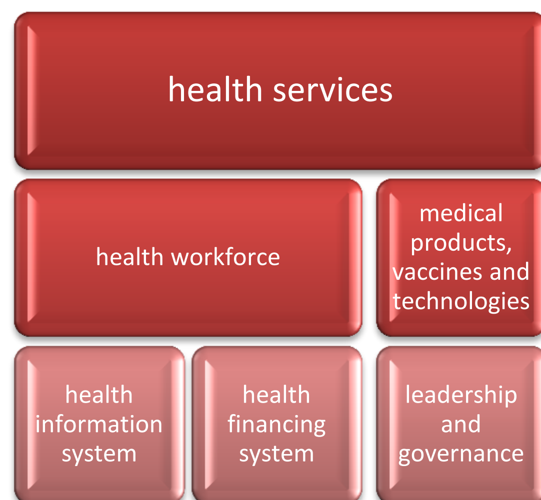


Figure 3 the WHO six building blocks of a health system



Whilst IHLFS projects were focussed on building capacity at the institutional and individual levels and were not specifically designed to influence the wider health system, all interventions have this potential. In order to achieve this, however, capacity needs to be built across the health sector and not just within the institution, requiring dissemination and advocacy to influence decision makers.

The range of projects funded by IHLFS is varied and disparate, which makes it difficult to compare projects and assess potential for scale-up and contribution to HSS. Thematic areas are wide-ranging, including public health, surgery and anaesthesia, maternal and child health, NCDs (cancer, diabetes, hypertension, mental health), palliative care and quality of care. Projects can be broadly categorised as:

- Direct delivery of health services
- Health promotion
- Continuing Professional Development
- Under/post-graduate education
- Support services (facilities/equipment management)
- Research

All provided an opportunity to test interventions and ideas that can be harnessed to improve the health system. There are many known, evidence-based interventions that UK partners can implement with DC partners, but this requires creating capacity to adapt such interventions so that they can work in specific resource constrained settings.

Case Study: In Mulago the development of the maternal High Dependency Unit (HDU) highlights an excellent example of taking an evidence-based intervention from UK and adapting it to the Ugandan context. A 6-bedded maternal HDU was established after doctors and midwives from Uganda visited the Women's Hospital in Liverpool (See Case-Study 2)

We saw that patients were not dying, triage was very good, there was streamlined patient flow, scoring systems were used to monitor patients and we witnessed a more central role for midwives rather than just following doctors.

As a result maternal mortality in Mulago Hospital has reduced and the hospital management have included a budget line for drugs and consumables for the High Dependency Unit . Over 200 people from across the country attended training on the HDU concept and HDU training has been incorporated into the medical post-graduate curriculum at the Hospital. However successful pilot projects are also fragile. Whilst potential for health systems strengthening exists, project staff were unclear about whose role it is to scale-up and rollout successful pilots. Whilst there is a genuine interest in establishing maternity HDUs in all referral hospitals, until this happen Mulago remains an "Island of Excellence" and there are fears it is becoming a victim of its own success with other hospitals referring inappropriate cases to the HDU that threaten to overwhelm the unit.

For projects to influence national policy and practice they need to be aligned with national priorities and plans, be able to show evidence of success and communicate results to the right people at the right time; as a senior health official from the Ugandan MoH commented regarding the IHLFS scheme.

From a gross point of view I would say yes, that all projects do contribute to health systems strengthening. But on an individual basis, unless they [projects] are properly evaluated then it is difficult to say. We want this programme to contribute to our strategic aims but there is a problem with the structure. *(senior health official , MoH)*

His concerns regarding the structure of the programme related to his perception that there should be more involvement of the MoH in ensuring alignment of projects with national plans prior to them being funded by the scheme. In Uganda there is a designated focal person at national level for link projects, although those involved in IHLFS projects were largely unaware of this.

In Uganda, there was a definite desire from both DFID and the national MoH to have a greater role in identification of thematic areas within which they wanted to focus the assistance of UK health links (including links not funded through the THET scheme). It is outside the scope of this evaluation to identify whether this viewpoint is shared in other countries, but there are potential benefits in terms of alignment and the synergies that can be obtained by focusing on a few thematic areas. It is recommended that this is an area for THET to discuss further with DFID country offices and national ministries with a view to informing design of future programmes.

A few projects had discussed with national level MoH the potential for scale up. Taking on a project advocacy role is time consuming and requires good communication skills. Many key informants did not see this as their role - although some did undertake project dissemination. Engaging with national level was seen more as role for THET to take on.

THET should engage more with policy makers to help with project sustainability and influence practice. (key informant)

Where active dissemination had occurred it appeared to be linked to the individual's personal contacts, their networking and advocacy skills and motivation. Whether or not they identified this as their role, many informants believed that their projects should be replicated elsewhere.

It is my wish that this project can be supported and replicated in many other areas of the country since it is the cheapest and yet most important way of keeping diabetic people well over their lifetime. It also reduces hospital costs and workloads. (key informant)

Best practice: Potential for health systems strengthening

- Important that Link partners view their projects from a broader health systems perspective such that they can identify which of the WHO building blocks need to be addressed to ensure continued effectiveness
- Link partnerships should seek to develop their capacity to adapt evidence based interventions from the UK to work in specific resource constrained settings
- Projects should consider at what level within the health sector they are seeking to strengthen capacity (individual, institutional, inter-institutional or system wide)
- Projects need to plan how project results and success stories can be effectively communicated from the outset

Recommendations: Potential for health systems strengthening

- THET has an opportunity to work with DFID country health advisors and national level MoH to highlight and identify successful pilots that have potential for scale-up and rollout
- When considering the design of future programmes THET should consider at what level within the health sector they are seeking to strengthen capacity (individual, institutional or system wide)
- Whilst all projects can potentially strengthen health systems, if this is a priority for future programmes, then THET should facilitate better linkages between National MoH and health link projects

Alignment with National & Institutional Plans

In the workshops and interviews informants described their link projects as being broadly aligned with national policies, however evidence from the workshops and interviews suggested that the focus was on institutional gaps and/or personal priorities during the planning stage. The survey findings show that 94% agreed that their project objectives completely or to a large degree aligned with national priorities.

The National MoH focal person for health links (not just IHLFS) expressed the view that links should be more transparently aligned to national priorities.

> ***... most of the time links are institution to institution and the benefit is to the institutions and individuals. It is not always the interests of the MoH that is being met.*** *(senior MoH official)*

A suggestion to better align projects with national priorities was that project identification should be clearly linked to filling core gaps in thematic areas within national MoH plans. The DFID Health Adviser in Uganda identified thematic areas of importance as non-communicable diseases (NCDs), palliative care and mental health due to limited in-country expertise, experience and coverage. In his view health links should *"capitalise"* working on projects where the UK could bring unique expertise not available within the country or regionally. However, this position was not shared by all informants, some of whom stated that even when expertise did exist within a country it was often so limited that it was not actually 'available' to build the capacity of others, hence gap filling played an important role.

A range of experiences were described by informants in how the link projects aligned with their institutional priorities and plans. In one example the developing country partner described how they had led the priority setting process, ensuring that project objectives met the needs of the local community and the NGO partners involved.

> ***Working through existing community structures and ensuring engagement with community leaders and health workers at the outset ensured that the project objectives met our priorities. Our UK partner was open to dialogue and was very flexible in adjusting to local needs. This also promoted empowerment and efficiency in project delivery.*** *(key informant)*

In contrast, another informant reported that the UK partner did not fully understand the context and imposed their priorities rather than aligning with those of the developing country partner institution.

> ***They did not really understand what was on the ground when they came... But the biggest challenge was that the core aim for the project was not set by us, but imposed on us by our partner and we were somehow going to have to make it happen... This came to haunt us, especially when it came to evaluating the impact of the project.*** *(key informant)*

The survey findings showed that 97% of respondents felt that the project objectives fitted completely or to a large degree with their institutional needs. However, more than a quarter reported that ownership of the project was unequal with the UK partner, and developing country partners noted that 21% of UK partners did not fully understand the context of working with the overseas institution. Institutional alignment was strongly linked to a shared vision, joint ownership and priority setting and a clear understanding of each other's institutional structures and context.

Best Practice: Alignment with national and institutional plans

In the survey respondents were asked to prioritise what they saw as best practice; three of the top four priorities related to ownership, alignment and engagement with national and institutional priorities.

- Ensure equal ownership develops between UK and overseas partner in all aspects of the project (85%)
- Ensure projects fit with your institutional long term vision and takes account of partner institutional structures and context (67%)
- Engage with key stakeholders (MoH, local government, clients) from the start and throughout the project (52%)

Additional best practices identified included:

- Projects should be demand driven with a thematic focus that links to both institutional and national priorities
- When undertaking capacity-building for new service provision ensure it fits within National Health Plans otherwise services may not be sustainable or may divert resources from other priority areas

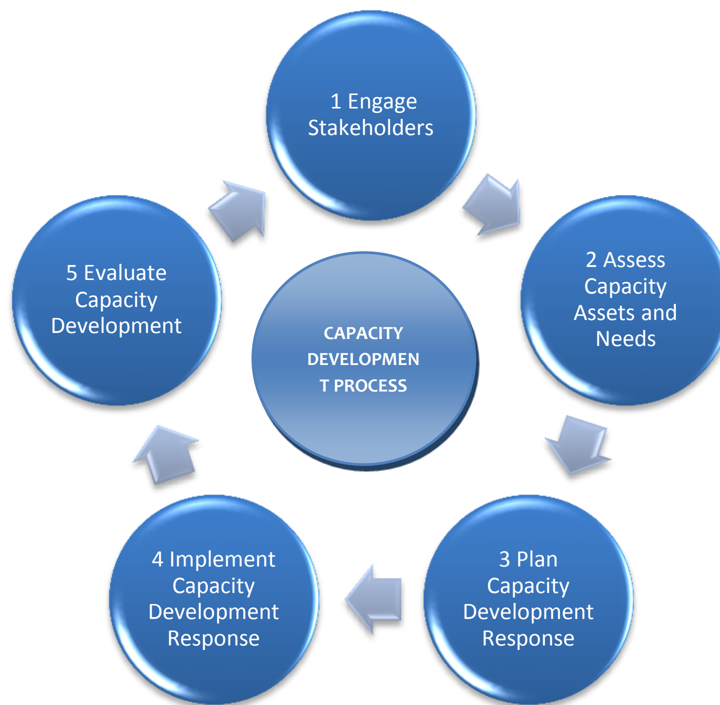
Recommendations: Alignment with national and institutional plans

- THET, working with DFID health advisers, should take on a stronger advocacy and engagement role with national level
- It is important to recognise the conflicting demands on government officials and ensure that engagement (directly or by UK partners) is through an agreed focal person

Best Practice in Capacity Development

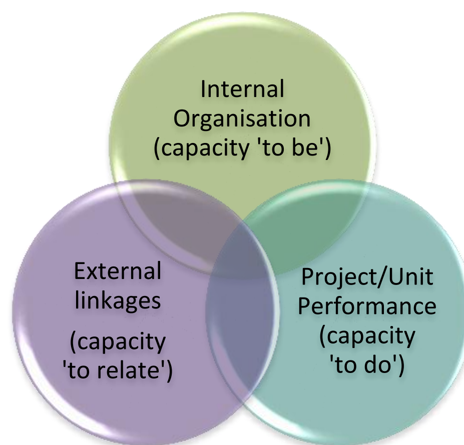
They key focus of IHLFS support is on capacity development to strengthen overall health systems performance. The ethos of capacity development is a move away from the traditional project approach to one where developing country partners own, design, direct, implement and sustain the process themselves in partnership with and facilitated by their technical assistance partners. It is therefore important that all capacity development activities follow best practice in promoting engagement as outlined in the UNDP Capacity Development Process (Figure 4).

Figure 4 The UNDP Capacity Development Process



To build organisational capacity it is not sufficient to focus only on performance - internal organisation and external linkages also need to be considered (see figure 5). Capacity building for the internal organisation may include factors such as leadership, strategy, systems, project management, structures and resources. Organisations also need skills to make the most of their external linkages in order to ".. influence national or local government decisions; gain from the experience of other organisations ... and cooperate systematically with other institutions" (James, 2001).

Figure 5 Building Organisational Capacity (Lipson & Hunt 2008)



Most interventions under the scheme focussed on capacity 'to do', albeit that involvement led to experiential learning in some of the other areas. There is clearly an opportunity both for THET and UK partners to maximise impact by giving consideration to the other dimensions of organisational capacity development.

Some projects embraced the ethos of capacity development, enhancing institutional capacity. Others provided resource transfer (knowledge and equipment) and gap filling (lecturing and training), which in the short term helps fill capacity gaps, but may not have embedded sustainable capacity within the developing country partner institutions. This is further discussed in the effectiveness section which examines the perceived effectiveness of the different capacity development approaches used.

Best Practice: Capacity Development

- Partners should understand when it is appropriate to use gap filling or resource transfer.
- Gap filling and resource transfer should only be used alongside a longer term institutional capacity development strategy.

Recommendations: Capacity Development

- UK Link Partners should receive more orientation in best practice for capacity development so that appropriate approaches and methods are developed jointly with overseas partners.
- THET should encourage partners to consider all the dimensions of organisational capacity development

EFFICIENCY

This section looks at human resources and professional expertise, financial inputs and processes and partnership, planning and management, focussing on the working arrangements between the UK and developing country partners. For most developing country partners it is the UK partner who is their primary contact point and they have less direct communication with THET. There was substantial overlap between best practices described by THET in The International Health Links Manual and the perspectives of DC partners. However, the degree to which these best practices were realised in the working relationship between UK and developing country partners varied widely. Many of challenges highlighted in this section were avoidable yet caused a high degree of frustration for all partners.

Human Resources & Professional Expertise

Key informants were positive about the expertise of the UK volunteers. Those projects which had long term volunteers appreciated the mix of senior specialists repeatedly visiting for short periods combined with the more junior staff on longer term attachments. Those benefitting from this combination agreed that it maximised impact in supporting change and capacity development.

Key informants also identified the importance of continuity of the key personnel, whilst recognising that both UK and developing country staff may move on as part of their normal career progression. A practice of involving more than one person in each of the partner institutions in the core organisation of the link was commended; where this had not been the case, there was evidence of a significant loss of institutional memory, delays and a loss of motivation.

> ***Communication has been the biggest challenge due to the staff changes. In every organisation it has created slippages.*** *(key informant)*

A major constraint identified by DC partners was the time available for personnel to participate in the project. This was identified as a problem for both UK volunteers and developing country staff. The UK volunteers were often taking a combination of study and annual leave in order to visit their partner institution. Inevitably this constrained both the length (usually two weeks or less) and frequency of visits. Many developing country partners stated that the duration of visits (particularly those of a week or less) was too short to realise the aims of the projects: only 14% of survey respondents thought that the length of visits to/from the UK completely met the needs of the project. The amount of time for which NHS staff are released to participate in initiatives of this nature is outside the scope of THET's direct control.

For staff in the developing country institutions key constraints included high workload, staff turnover, inadequate staffing, lack of administrative support and the absence of a culture of delegation. A widely held concern was that change was too reliant on the passion of individuals who ran the risk of burnout. Lack of administrative support was identified as a frequent or constant challenge by 37% of the survey respondents. Examples were identified where the DC link coordinator had been successful in involving a wider team and delegating tasks to great effect (see Case Study 1). However, many links were dependent on an individual (often a skilled medical doctor) who undertook all the organisation, logistics, reporting and M&E for the project. The survey showed 83% of respondents could not complete all work related to the link project within normal working hours. Some partnerships were able to draw on administrative support funded by other projects or through fundraising. Workshop participants argued that being able to part fund administrative support through IHLFS project funding would have significantly improved their efficiency. THET allow a proportion of the grant to cover administrative costs (10%), the perception of key informants was that this was retained by the UK partners.

For both survey respondents and key informants involvement in the IHLFS had contributed to their personal and professional development. Over two thirds of the survey respondents identified significant improvement in their professional knowledge and skills, leadership and management skills and team working skills. Half also reported significant improvement in job satisfaction (see full results in Annex 2).

> ***For me personally it has made a difference. A lot of exposure in proposal writing, putting that into practice and looking at the broad perspective. The participation in the partnership has opened up different opportunities.*** *(key informant)*

Despite skills having been improved through participation in the scheme it was unclear the degree to which this was through a formal approach to capacity development in these areas. Key informants identified a number of areas where they felt that their expertise could be further supported to

> ***I think often funding is given for the activity and not realising that there needs to be an organisation to deliver that activity.... we need to be a model of excellence as an organisation ... otherwise infrastructure lets us down.*** *(key informant)*

increase their efficiency. These were planning, project management, M&E, human resource management, budget management, advocacy and proposal development.

Enablers	Barriers
• Clear roles and responsibilities • Skills and knowledge from UK • Involve the whole team	• Limited time to dedicate to project activities • Lack of administrative personnel • Staff transfers/turnover • Burn out of key personnel • Working long hours • Absence of key personnel • Prioritisation of projects that pay incentives • Unfilled posts/no workforce plan

Best Practice: Human Resources and Expertise

- Be realistic about what can be achieved within the human resource constraints of both the UK and the DC partners
- Have more than one person involved in the organisation of the link in both partner organisations.
- Ensure that links and projects are fully documented to facilitate smooth transition when key personnel leave
- Delegation and clarity of task division will assist in the efficient management of projects
- When identifying training needs also consider the management and administrative capacity that may need to be developed

Recommendations: Human Resources and Expertise

- Consider ring-fencing of funds for project management/administration for the DC partner
- THET should help strengthen capacity in: project management, planning, M&E, advocacy, budget management and proposal development

Financial Inputs and Processes

The evidence presented at the workshops showed that many of the existing link projects have achieved impressive change on the basis of relatively small amounts of funding. The majority of projects had supplemented the funding received via IHLFS through additional grants, fundraising (as encouraged by THET) and use of unpaid staff time. For some projects this was in order to fund items that were not allowed under the IHLFS rules but were required to achieve their objectives - for example equipment, consumables or mobilisation. For others it was to supplement the funding for project activities.

CASE STUDY: Developing Specialist Eye Care Services for the People of Northern Zambia

Dr Seneadza recognised that IHLFS could provide him with an opportunity to access specialist knowledge and skills from the NHS. He then identified other partners who could provide the other elements he needed to achieve his vision: an international NGO provided funds for equipment and mobilisation for retinal eye care, a local mining company also funded mobilisation. Another NGO provided equipment and additional capacity development for paediatric eye care. Swiss Lion provided training and mobilisation for community outreach, employed a staff member to follow up cases and refunded transport costs for patients to attend treatment. (see Case Study 1)

However, whilst it is clear from the Health Links Manual that Links should undertake additional fund raising the developing country partners saw THET much more as a traditional project donor - creating a potential for a mismatch of expectations. Some projects had not managed to spend all of their grant allocation within the required time period: reasons included delays in receiving the funds, insufficient financial information being received from UK partner, difficulty in scheduling visits from the UK and ill health. Key informants who had been in contact with THET to discuss the need to review time scales or budget allocations were positive about THET's willingness to understand their constraints and work together to find solutions.

The experiences of the DC partners varied widely in the process of budget development and/or decision making with their UK partners from full to more limited involvement. This is also evidenced by the survey with 39% having no problems with control over budget decisions while 36% had frequent or constant problems. Very few of the informants had full familiarity with the budget or the funding rules. Of the survey respondents 22% felt that the budget was completely adequate to support agreed activities whilst 22% felt it was not at all adequate. Exchange rates, inflation and rising fuel prices contributed to shortfalls. However, there was also evidence of underestimation in budgeting, including a focus on the total amount without breaking this down across the activities and a lack of understanding of the costs involved in training activities by UK partners. Underestimation in budgeting may also connect to over ambition in scope which is discussed later.

I would focus a lot on the total grant. Because initially we thought the money would be more flexible. Focus on the total grant and see how much we can fit in. But then when it comes to inflation we cannot predict because things went up three times from the start. *(key informant)*

Insufficient budget for workshop allowances was cited by a number of workshop participants, resulting in an inability to meet participant's expectations of travel and per diem payments. This was identified as a frequent or constant challenge by 42% of survey respondents. The lack of budget for in country travel as a constant or frequent challenge for 38%. Some even noted that that they had self funded some travel costs - 41% of the survey respondents stated they had used personal funds for the activities of the link. For many link partnerships there was an expectation and/or agreement that some of these costs should be covered by the developing country partner as part of their contribution in kind. In examples of best practice these agreements were made in a written Memorandum of Understanding. Informants did not disagree with the principle of contributing

In principle when you have a partnership you should contribute something and [airport transfers] would be a fair contribution. If it is clear then [the management] can decide whether or not they can afford it. *(key informant)*

financially, their point was that there should be transparency about what this comprised and level of funds required.

Flexibility across budget lines was a further challenge, with informants not always clear whether the lack of flexibility was as a result of IHLFS rules or those of their UK partners who are the primary grant holders. Where inflexibility was encountered it hampered the ability to respond to changes due to inflation and exchange rate rises and the experimental nature of projects developing new services. Some projects, however, demonstrated that flexibility was possible, and appreciated THET's enabling responsiveness.

Given that not all projects were originally costed in detail it may be that the original budgeting is a significant contributory problem rather than the lack of flexibility in the funding rules. In addition, some informants recommended a relaxation of the ceiling percentages for certain items (eg equipment) if these were crucial to the success of the project. Although it was widely acknowledged that many items should ideally be covered from core funding - for many institutions the reality was that even if the will was there the money was not.

Flexibility to be able to change the budget given the changes on the ground was invaluable and we could not have achieved the capacity building we have achieved without that flexibility. THET opened the door to redo the budget for the 18 months and then redo again for a year. *(key informant)*

The hospital should buy the equipment but they say that they have no money. *(key informant)*

The in depth interviews revealed wide variation in the proportion of funds that flowed from the UK to the developing country partner: one project received the grant in its entirety, others only small amounts in arrears. It is usual practice in resource poor settings to provide advance funding for activities. The provision of a separate bank account, where expenditure can be audited, gave confidence to UK partners to release funds in advance. Where costs were reimbursed in arrears there was a high risk of activities or expenditures being cancelled or significantly delayed. That said delays in funds being transferred from the UK were cited as a frequent or constant problem by a minority of survey respondents (16%).

The beginning was very hard because we did not have any money – we had to use our own money – baseline survey, writing up reports, ethical approvals. Because the money was still in the UK – first with THET then with [our partner]. We managed to find a way of doing things on our own. *(key informant)*

For projects where little money was released to the developing country partner, or only in arrears, a capacity building opportunity in grant and budget management is potentially being missed. In addition, the approach can contribute to a donor-client relationship dynamic rather than one of partnership.

Enablers	**Barriers**
• Funding from different sources • Availability of funds from the outset • Detailed planning • Transparency between partners	• Insufficient funding • Inflexible budget rules • No allowances for mobilisation • No activity based budgeting • Delays in availability of funds • Rising prices and/or exchange rates

Best Practice: Finance & Financial Processes

- Be aware of the power dynamic in terms of who controls the money
- Health links should have a funding strategy which identifies multiple potential funding sources
- Project budgets should be developed by both partners on the basis of full activity costing
- Partners should take time to ensure mutual understanding of funding rules
- There should be transparency between partners on expected funding receipts and contributions
- All items of expenditure should be planned and discussed together openly
- Allow DC partners to manage project funding
- Project funding for Developing Country Partners is best paid in advance rather than arrears
- To protect against exchange rate fluctuation project monies are best held in GBP and paid when required
- Having dedicated bank accounts for projects in both countries with at least two signatories facilitates financial oversight and control.
- Ensure that there is regular and transparent communication of financial expenditure

Recommendations: Finance & Financial Processes

- Expand the material already provided to include signposts to information on proposal writing and sources of grants, managing budget in high inflation scenarios and the role of THET funding.
- Improve materials provided to UK partners to facilitate better budgeting between partners
- Encourage transparency in future grant rounds by requiring applications to show funding allocation and contributions in kind by partner
- Review the current percentage ceilings for administration and equipment
- Make a standard mid-point funding review for projects with scope to reallocate between budget lines

Partnership, Planning and Management

Workshop participants concurred that trust, equal partnership, ownership, a common interest, inclusiveness and openness were crucial to effective links. Participants stressed that success was much easier when built on friendship and that this facilitated open communication - some stated that at first they were less sure of the partnership and therefore more guarded with their opinions.

> ***The relationship has grown significantly - there is more trust. I can comfortably say my mind - which initially I was not able to as I was cautious and did not want to offend in case the project is closed off completely. We have developed oneness with each other ... once you have that working relationship everything else falls into place.***
>
> *(key informant)*

Repeated visits (both to and from the UK) and social events facilitated the development of friendship. The working environments in developing countries are often complex; many noted that repeated visits meant that UK partners gained a deeper understanding, resulting in more appropriate and nuanced support. Whilst few in number, there were projects where the developing country partners felt the common interest between the partners was not well matched. In one case this was due to evolving capacity development needs in the developing country partner not covered by the existing partnership - additional partners were being sought to fill the gaps.

The most successful partnerships for workshop participants were those based on a vision owned by the developing country partner but which gained an added dimension through opportunities to see the NHS in practice. In contrast, partnerships based on chasing funding were considered unlikely to be sustainable. This meant it was important for partners to take the time to understand each other's aspirations and motivations, building project proposals on this understanding. Where this was share with the entire team it became a basis for planning - working backwards to identify the resources, skills, knowledge and infrastructure needed to achieve the vision.

Workshop participants considered this process was best done as a joint activity, preferably whilst sat together around a table, taking into account the existing infrastructure within the institution. Aspects that were not always adequately considered included monitoring and evaluation and dissemination.

Many reported having good communication with their UK link partners using a variety of methods (skype, email, dropbox, mobile phones). However, some developing country partners attributed significant delays in project activities to poor communication by their UK partners - sometimes associated with an absence of a key staff member. A third (32%) of survey respondents reported inconsistent communication as a frequent or constant problem. This was particularly problematic where the link was coordinated and 'owned' by only one staff member in the UK or overseas. Unreliable internet connectivity was a frequent or constant challenge for 31% of respondents.

A vital part of successful project management for workshop participants was detailed planning of logistics, finance and human resource requirements. Survey results show that 65% of projects had a written needs assessment and 82% had a written implementation plan for their project. Although one participant stated "you can't plan too much", more developing country partners reported that limited planning experience or culture within their institution was a major challenge to the smooth

> ***We see this as a central part of the services rather than a project. But we have not got someone to do the administrative overseeing - if you leave it – it slows down. It still needs overseeing even though it is a central part of services.*** *(key informant)*

operation of their projects.

Workshop participants identified the following benefits of having a steering group:

- involving key stakeholders formally
- forum for dissemination

- formal oversight and review
- forums for sharing best practice
- rallying point for advocacy and fundraising
- efficiency as the group can oversee more than one project and/or link

Very few of the workshop participants had accessed the THET tools and materials advising on best practice in managing health links. There was much enthusiasm from the workshop participants for country specific areas on the website to share information about link activities, visits and to share best practice and tools. However, the lack of interaction with the tools already provided by THET means that any provision of further web based information or forums should also be coupled with direct and regular communications highlighting their availability.

Enablers	Barriers
• Trust	• Lack of understanding of role
• Passion and enthusiasm	• Mismatch of expectations
• Common interest and shared vision	• Weak programme management
• Ownership	• Weak planning
• Equal, inclusive and open partnership	• Variable internet access
• Understanding of motivations	
• Regular communication	
• Flexibility to respond to change	
• Detailed activity planning	
• Written agreements	

Best Practice: Partnership, Planning and Management

- The link should not be seen as something outside the core work of the department/organisation
- UK partners need time to really understand the context and develop trust
- Develop and communicate a shared vision
- Appreciate cultural differences in planning and discover ways to work together
- Planning is most effective when both partners do it together rather than trying to do it remotely
- Final decisions should be taken by the developing country partner based on local priorities
- Ensure that there are regular reviews of progress and be flexible when circumstances change
- Find ways of efficiently sharing resources within and between institutions
- Utilise low cost methods of communication between partners
- Steering committees are a good way of managing links and involving stakeholders
- Involve key stakeholders including senior management from the start
- Access available best practice resources

Recommendations: Partnership, Planning and Management

- Regular communication to developing country partners highlighting available THET resources
- Develop the website to enable links to share information about their activities, best practice and tools
- Investigate barriers to use of web resources by developing country partners

EFFECTIVENESS

Effectiveness is assessed in relation to the extent to which link project objectives were reported to have been, or were expected to be, achieved by the end of the project. The three main themes here are effectiveness of capacity development approaches and activities employed, reported change and monitoring and evaluation of project outputs and outcomes.

CAPACITY DEVELOPMENT APPROACHES AND ACTIVITIES

Capacity building activities mainly focused on health service delivery, health promotion, continuing professional development, under/post-graduate education, support services (facilities/equipment management) and research. They included development of new curriculum for under/post-graduate education, training of trainer programmes, training and workshops to deliver new clinical competences and strengthen management skills (theoretical and practical), development of new services and systems, mentoring, exchange visits to observe practice in UK and attending training in UK (see Annex 2 for breakdown).

Developing country partners were very positive about the skills, experience and expertise that the UK volunteers brought to their institutions: 91% of respondents agreed that the UK expertise provided was completely or to a large degree relevant to their institution's requirements and 94% respondents found training content and curricula was completely or to a large degree relevant to the project needs and context.

> ***We were really involved in determining the content of the training. We were very clear about what skills we wanted the nurses to have. The training was done well.*** *(key informant)*

There were, however, examples where curriculum had been developed with little local input resulting in less contextualised content and clinical procedures being taught on a purely theoretical basis.

Whilst this expertise was appreciated by DC partners, it remains an open question as to the relevance and effectiveness of teaching clinical procedures where there are no opportunities to put this into practice in the short to medium term.

> ***When you come from the UK it can be difficult to understand the challenges. You take for granted some things in the UK, although these things should be here as well. It compromises the quality of teaching. Our UK partners came to teach [a lab related topic] when there is no functioning lab. So he just taught from theory - but then hoped in future it could be used.***

Equally, ensuring that the UK volunteers had the right knowledge, skills and experience was crucial to training and capacity building activities being appropriate for the context.

It was difficult on our part to decide who was coming from the UK. The control that we had was that we defined the criteria for the people who came to do the training. The onus was on our partner to select people within those criteria. We felt confident that they would not send us people who were not qualified. (key informant)

Continuity of UK volunteers was also considered a key to the success of link partnerships. The benefits here included a deepening understanding of context, the ability to continually review progress and build strong relationships. Short visits from personnel with little knowledge of the context were lost opportunities of limited value, requiring intensive inputs from the developing country partner for relatively little return. UK personnel with the ability to adapt materials, methods and expectations based on the institutional, cultural and economic context within which the project was occurring were highly valued by developing country partners.

A common challenge encountered in many projects was scheduling of visits and ensuring sufficient time for training, which often depended upon the availability of UK volunteers. Close to half (40%) of survey respondents reported availability of UK staff as a constant or frequent problem. The unforeseen consequences according to participants were that training events were too condensed and/or that too many people, with diverse skills and backgrounds, were invited to take part. Both potentially compromised the efficacy of training.

There was some debate during the evaluation workshops about the selection of participants for training workshops, with ill-defined or ambiguous selection criteria leading to "discontent" and "professional jealousy". However, 80% of survey respondents reported that development and

We hoped every midwife would attend, particularly the weaker staff, as everyone usually sends the high achievers and there is not a culture of sharing after workshops. (key informant)

adherence to participant selection criteria were followed completely or to a large degree.

Staff transfers following trainings was cited as a problem. There was recognition that trainees may be able to use their skills and knowledge elsewhere, but this was not guaranteed.

This seemed to be less of a problem in faith based hospitals, which have more autonomy and decision making power regarding placement of personnel.

We can't hold onto people after they have been trained. So when a nurse had received valuable training in new born care, next year when you come to evaluate, she will be working in the psychiatric ward. (key informant)

We identified core people and upgraded their training skills through CPD sessions as well as degrees in nursing. We also wanted to get people who would stay, so that these people could train others. The hospital recognised that they had a larger role and paid them more. We can do this in an autonomous hospital. The government can transfer them anywhere. I have a problem when people leave within 1 year of training. If they are trained and can stay for 3-5 years you can have a succession plan – I do not have a problem with that. In our hospital we have tried to put in place a clear succession plan – ward managers are paid higher so that they can stay at least 3 years. All the people that we have paid have stayed. (key informant)

Many of the IHLFS projects were involved in developing trainer of trainer programmes to build local capacity within the institution, district and/or region. The extent to which cascade training then occurred varied - one informant noted that there was no plan in place to implement this. Similarly, nearly one quarter of respondents to the survey stated that consistent follow up after training was

There was no follow on plan after the training of trainers. The obstetricians were aware this was happening as well as at the district/province, but there was no clarity about how they would take forward training. Equipment was left with one of the doctors, but professional development does not exist [here], so no one is taking it forward. If they come again (under future funding) then we may use the TOT to deliver, but this is a long gap for trained trainers to use their skills *(key informant)*

frequently or always a challenge to them.

Developing country staff appreciated exchange visits to the UK which were an opportunity to experience first-hand how other health systems are organised and provided motivation to staff for change: observing all aspects of how the institution functioned including leadership and governance, finance, HR and reporting systems. For many link initiators it was exposure to the UK health system that inspired them to see the potential changes they could make to improve the health system in their own country.

Several projects identified the utility of UK link volunteers mentoring clinicians who expressed a feeling of 'professional isolation'. Many senior positions in developing countries are held by clinicians who are quite junior in terms of their experience, making the opportunity to be mentored by senior clinicians from the UK even more significant. The opportunities this presented are illustrated by this doctor.

Learning does not end when you finish college, if you have a colleague who is highly qualified it helps. I am still a young consultant. If I was in the UK I would be a junior - here I am thrown in at the deep-end. You continue to learn - without this link there would not be a opportunity to learn. Here we lack journals - but with link colleagues you can discuss cases and do joint ward rounds. *(key informant)*

Having a second opinion, and the support of senior staff from the UK often gave partners additional weight and back-up with key stakeholders. In one case the UK partner was able to assist in influencing senior hospital management to provide access to blood transfusion services for the project.

When I first came back from the UK I thought should I start this or not - I may not have blood. But the UK Link Coordinator encouraged me and helped talk to the Director to get access to blood. They sat with the Head of the Institution and convinced him that blood transfusions should be prioritised to the burns unit ... So the team from the UK has been instrumental in making things happen. (key informant)

The Hospice Africa Link Project provides a robust example of how UK support focusing on curriculum development, teaching and mentoring strengthened their institutional capacity to deliver a new undergraduate degree programme in palliative care. The UK input was clearly defined to focus on development of modules, review of modules, setting of examination questions, mentoring students and teaching. Some also contributed to clinical practice if visits were for longer than two weeks. There was a clear succession plan of who within the Hospice Africa team would take over teaching responsibility once the funding came to an end enabling them to focus on learning from and observing the UK volunteers during the project.

We identified the gaps where we needed help - so we had lots of people coming out; but this year we have had less coming out so the capacity building has worked - they taught people here to teach. (key informant)

Enablers

- Local ownership & support from senior management
- Joint development of curriculum and learning materials
- Flexibility in scheduling of training and of travel plans
- Receiving certification
- Creating a pool of local master trainers
- Working as a team between partners
- Availability/procurement of equipment and materials for training
- Appropriate expertise & qualifications of volunteers
- Practical hands-on training
- Exchange visits
- Follow-up after training
- Understanding of country and institutional context
- Ongoing mentoring

Barriers

- Lack of local involvement in curriculum development
- Scheduling of training
- Professional jealousy in the selection of staff for training and deployment of staff post training
- Obtaining specialist equipment for training
- High attrition after training
- Short duration of training & specialists in country
- Inconsistent availability of UK volunteers
- Poor follow-up after training
- Range of participants skills and background
- Crammed training due to limited time
- Compromising quality to train larger numbers
- Lack of planning for training roll out

Best Practice

- Important to be aware of existing capacities and build on it
- The provision of expertise should be demand driven from the developing country partner
- Understand the underlying capacity you are seeking to build (individual, institutional, health sector) and whether you are seeking to develop the institution or provide gap filling or resource transfer
- NHS partners need to be cognisant of whether planned capacity building activities are short term gap filling activities or are strengthening both individual and institutional capacity.
- Curricula and training methods should be developed jointly to ensure relevance to local contexts and needs
- Training should include both classroom and practical elements and have follow up to assess application of skills and knowledge
- Involve senior managers in capacity building and planning
- Identify motivated and passionate people to drive capacity building activities
- Selection criteria must include building a sustainable pool of trainers
- Plan where funding will come from and who will be responsible for cascade training post-ToT
- Maximise time of UK visitors when in-country to include a variety of capacity building activities
- Developing country partners should be fully involved in conducting the needs assessment and jointly agree where capacity and assets gaps exist
- Seek opportunities to provide mentoring for 'professionally isolated' developing country staff

Recommendations

- NHS partners may not be aware of best-practice approaches to capacity development in resource poor settings. THET should ensure that UK partners are appropriately signposted to key resource documents (eg UNDP 5-step approach to capacity development)
- In future programmes project proposals/plans should include information on capacity development approaches and that this be assessed against THET's ethos and accepted best practice

Reported Change

Participants reported change at both an individual and project/institutional level - individual change has already been discussed and hence this section focuses on the institutional level. In all three countries, the evaluation workshops focused on changes at institutional level as a direct consequence of the IHLFS Project. Reported changes included:

- **New services developed** including the establishment of a maternity high dependency unit, the development of a new paediatrics prosthetic eye service, and supporting a paediatric oncology unit
- **New systems** including better drug procurement and drug management, to better equipment maintenance to better reporting and documentation systems
- **New approaches** including nurse-led hypertension clinics, mobile phone peer support for diabetes patients and using HSA's to promote mental health
- **New treatments offered** including retinal surgery
- **New undergraduate and post-graduate courses** in a wide range of themes including palliative care, paediatrics care and maternal health
- **Better clinical and technical skills** for technicians, nurses, midwives and doctors through clinical training and Continuing Professional Development (CPD)/Continuing Medical Education (CME)
- **Improved quality of care** through development and/or implementation of new policies, procedures, guidelines, standard operating procedures (SOPs), standards, early warning scoring systems, audit and use of checklists and other tools
- **Reduction in mortality and morbidity** across a range of conditions.

These findings are supported by the survey which asked respondents to identify the three most important changes that have occurred in their institution as a result of the project/link. The most frequently cited responses were:

- Improved knowledge, skills and practice
- Improved quality of care and performance
- Implementation of new guidelines, standards, protocols
- Higher staff morale and motivation
- Institutional capacity to deliver post graduate training and CPD
- New services
- Improved communication and networking skills both internally and externally

Seeing change and being involved in improvements to service delivery were seen to bolster staff

> ***Results have motivated the staff team. Nurses were sure old ways were best but we convinced them through results (reduced length of stay and reduced [inpatient] overflow)*** *(key informant)*

morale and confidence.

Informants also noted how health services had become more patient focused.

> ***Training has increased skills and confidence of the different levels of health workers involved, and they are better able to meet the needs of their patients in an emergency situation. The impact on patients and families is a step changes in being able to access skilled healthcare in time.*** *(key informant)*

Training had improved knowledge and strengthened confidence and ownership.

> ***The midwives are more confident, they feel ownership and they have more clarity about their roles. There is a handout to ever doctor who comes; they are orientated in the HDU by the senior midwife. Our junior doctors are fine with this.*** *(key informant)*

Training had empowered staff to challenge and change practice.

> ***Training gives authority and confidence to challenge practices when faced with difficult circumstances.*** *(key informant)*

Some projects have been able to demonstrate changes in mortality and morbidity. Whilst informants were aware of the difficulty in attributing such success directly to IHLFS funding, their perception was that the scheme had contributed to the improvements.

> ***We have witnessed a tremendous change in the burns unit and shown that we can reduce mortality from 46%to below 20%. Even the nurses have noticed that they do not need to do a lot of dressing... our kids are getting Rolls Royce treatment now... Previously it had been said it was not possible to do early excision of burn wounds, but this programme has shown that it is possible with good results. Patients used to stay for months and we are now also seeing lower infection rates.*** *(key informant)*

Some key Informants noted that whilst both the UK partner and funder wanted to see evidence of change, for some projects this was just not feasible given the time–scale.

> ***Our partner wants to see dramatic change and sometimes they can, but sometimes change is slow... ... in our treatment of childhood leukaemia, we now have about 30% surviving to one year. In the UK this would be about 95%, but we are aiming at 30% given the resources we have. This is a new group that have been treated for the first time in Malawi.*** *(key informant)*

Considerable work was invested in revising policies, implementing early warning monitoring systems and developing and implementing new standards, guidelines and protocols. This was believed to have resulted in improved quality of care. Examples here were reductions in hospital infection rates, adherence to the WHO surgical checklist, better monitoring of patient parameters, use of hand rub and hand washing, better patient records, regular clinical audit, improved management of neonatal

resuscitation, better communication and coordination between departments using agreed protocols and standards and improved triage and access to emergency care.

Having data that documented change was a powerful motivator and could be used to influence senior managers.

> ***Initially the department was sceptical - they did not think that the deaths were preventable. When we started the HDU, in the first 6-8 weeks there were no maternal deaths ... Then we let the department know.***
> *(key informant)*

In general key informants were very positive about the changes achieved in such a short time frame, although they were not always able to substantiate these improvements with hard data[1] - partly due to the difficulty in attributing change due to IHLFS support. However, lack of attention to M&E at project start up as well as limited experience and capacity were also cited as barriers to quantifying change.

Monitoring and Evaluation

M&E presented one of the biggest challenges to projects. Informants expressed concern about their ability to design and implement simple project M&E systems. They identified competing priorities and a lack of experience and tools as key barriers. Whilst THET has developed an excellent M&E manual which can be downloaded from their website, many informants had not used or accessed this resource. Workshop participants sought access to tools and examples of analysis and dissemination documents from other projects. There was lack of clarity about how to develop and use log frames, even though this formed part of the original funding proposal.

> ***There is quite a fear about M&E which needs to be addressed so that it can become part of our daily work.***
> *(key informant)*

Some informants thought projects had been over ambitious, echoed by the finding that only a quarter of survey respondents stated that the scope of their project was completely achievable

> ***At first we thought 20 sites would be easy but in the end it was much harder. In the end we could only do 2 rural hospital sites***
> *(key informant)*

within the budget and timescale.

[1] Project specific results are presented in the powerpoint presentations annexed to the country Workshop Reports available separately.

Informants confirmed the importance of partners having a clear M&E plan and common understanding of targets from the start so that everyone worked towards the same goals. A recurrent theme was that insufficient attention was given to M&E at the start of the project, making it more difficult to capture M&E data as the project progressed, especially when no baseline had been established. The Ugandan Focal person for Health Links, Dr Amone, stressed the importance of evidence and documentation of good practice, if projects were to influence national policy.

We need to document the good practices and have a baseline. If I don't see it, I don't know. Projects should be properly documented so that we have evidence of what works. *(key informant)*

Informants described a common pattern of data being collected by the local partner and then analysed by the UK partner. In other cases basic analysis was done by the DC partner but the UK partner then provided further analysis and visual representations. Where analysis was done without input from the DC partner this created a potential for inaccurate interpretation due to the lack of nuanced understanding of the context.

Nobody was actually analysing data locally due to lack of time -we were not benefiting from the data being collected - it was being analysed in UK outside of the local context - so meaning gained could be quite different to what was relevant to local partners. *(key informant)*

It is also difficult to assess whether data was collected purely for reporting purposes to THET or whether it was actually being used to inform decision making and project progress. M&E was often referred to as being an "*admin task*", inferring that M&E was being undertaken as a project reporting activity to the donor, rather than of adding value to the developing country partner. In the survey, 31% of respondents stated that their institution was not at all involved or partially involved in collecting and analysing project data and 24% stated that there was little or no sharing of M&E data within their institution. These results are not surprising in view of the challenges of data quality, recording and reporting which have been widely acknowledged and documented in low-income countries (WHO, 2011).

We have had very poor record keeping - we know we should be keeping records. We just cannot give any information. Everyone sees M&E as a burden. I have worked on death audits - I designed it but people did not use it. What works is when you have a dedicated person [clerk] to collect and enter data and then sometimes an expert to analyse it. *(key informant)*

Skill deficits in recording, analysing and interrogating data were demonstrated on one site visit when the evaluation team requested data showing results of the project. The link coordinator confessed that the data was not up to date and that it took themselves plus the nurse allocated to M&E many

hours working together to manage to enter and/or produce data from the Excel spreadsheet set up by their UK partners.

A consistent message received in all three countries was the lack of feedback from THET on project reports (and unsuccessful proposals): constructive feedback on project progress would have been

> ***I have not ever got feedback on the reports. Because of my own commitments, the report was done in the UK and I commented on it. I don't know if he got any feedback.*** *(key informant)*

appreciated and might increase commitment to project monitoring.

Most key informants recognised the need to monitor and evaluate projects, however, many were challenged in identifying appropriate indicators. Whilst activity and output indicators were relatively simple to collect, collection of data in relation to outcomes was more difficult and time consuming. Some projects also expressed frustration at what they perceived as unrealistic funder expectations.

> ***It is easy to report on numbers trained, but because the project was aimed at improving child survival we should have agreed to what extent we could measure and attribute. I was a bit surprised when this question came up "Can you estimate how many child lives have been saved?" I saw this as long term, contributing to education giving skills for the future. You can't see improvements in the short term. I believe that new born survival is poor but it is not just to do with skills, there are other aspects*** *(key informant)*

Examples of good practice in M&E were provided with some projects being able to demonstrate robust M&E systems with good data management and use in which both UK and developing country partner were centrally involved. One project highlighted how data has been used to identify the project need, design appropriate interventions, as well as to monitor progress and evaluate success. In this case the unit had external help in establishing a database at its inception, and a long term UK volunteer helped them take responsibility for data analysis. By disaggregating existing data, they were able to identify and prioritise paediatric mortality as an urgent concern.

We applied for the link funding, having seen an urgent need in mortality which was over 50%. Since the inception of our unit we have been collecting data on adults and children. Annually we review total mortality. But then we decided to focus on the appalling mortality in children. The data highlighted a need that otherwise was not easy to see. At every handover [daily] we noticed a death and that is when we trained one of the nurses to collect the paediatric data and process it. The previous data was collected by an audit office from the department but the data was inaccurate. So we created a proforma to collect data on paediatric burns which we entered into the computer and also sent to the UK for analysis. We thought that to reduce incidence of burns we needed to go into the community and we used our database to look at the educational levels of patients who had very low levels of literacy - so prevention we think is the way forward. (key informant)

For M&E of training/educational interventions much of the reporting was activity based (numbers attending training/completed course of study), participant/student evaluations of training as well as using pre/post course theory and practical tests/exams to demonstrate whether learners had gained new knowledge and skills. An example of good practice here is how one project adapted the Kirkpatrick 4-Stage model of evaluation (Reaction – Learning – Behaviour – Results) to evaluate their BSc Programme so that they can follow-up graduates. This example also highlights how M&E can be used to report to the funder and simultaneously inform programme development and sustainability plans.

We are in the process of gathering all the information. It will be threefold, one for THET, but more importantly for us for evaluation as we will have our first graduates in January and thirdly for marketing and for sustainability of the programme. We are going to create an Alumni and follow them through and so they can feedback their impact on the ground. (key informant)

Given the modest funding provided, project M&E should be kept simple and integrated as much as possible into existing reporting systems, otherwise there is a danger of creating parallel reporting systems, burdening staff and consuming additional resources. Case Study 3 outlines a good example of how a multi-partner community intervention integrated simple monitoring and evaluation into their project from the beginning. This needs to dovetail with integrating improvements in M&E skills as part of capacity development. The second most important priority for improvement to the scheme, selected by 64% of survey respondents, was to provide support to improve monitoring and evaluation skills.

Enablers

- Log frame
- Simple M&E tools for data collection
- Having a designated person for M&E
- UK volunteers to audit the process
- Capacity of leaders to do M&E
- Mutual understanding of need to evaluate project

Barriers

- No designated person for M&E/lack of administrative support
- Lack of skills in M&E and IT
- Poor internet access
- Lack of M&E tools for start-up projects
- Lack of clarity in communication of targets, goals and outcomes

- IT – use of dropbox, skype, email to share and communicate data
- Collection/creation of baseline data

- UK partner understanding of local context, in order to design appropriate M&E plans
- Lack of understanding of how THET use M&E data

Best Practice

- Ensure that a baseline survey/measurement is done so that changes achieved can be demonstrated
- Ensure there is a plan and adequate resourcing for data collection, analysis, use and dissemination
- Ensure mutual understanding of project targets so that appropriate support can be provided
- Train the project team in M&E within the local context
- Develop an appropriate M&E plan jointly with UK partner in-country
- Integrate M&E into routine way of working so it is not considered to be an additional burden
- Have a designated person for M&E
- Use existing data wherever possible rather than collecting additional data
- Ensure project activities are accurately documented and results shared with relevant stakeholders
- Joint support visits for M&E to ensure mutual benefit from data such that its analysis is relevant and useful to both partners
- Use data to engage local stakeholders to support project initiatives and build sustainability
- A culture of "data for use" rather than "data for reporting" needs to be encouraged, such that projects understand the value of M&E and use M&E results to both strengthen project implementation and institutional capacity

Recommendations

- THET should further consider its role in strengthening M&E capacity of both overseas and UK partners given that most NHS Institutions will have limited experience of conducting M&E in resource poor settings. THET has already developed an excellent M&E Tool Kit which can be used as the basis of its support in helping partnerships develop more robust M&E systems
- THET should provide routine feedback to all partners on project progress to further support M&E capacity
- THET should consider setting up Dissemination/Advocacy Grants to encourage write-up of successful projects in a range of formats for different audiences

IMPACT & SUSTAINABILITY

It is difficult to measure impact and even outcome within a 1-3 year project timeframe, although it should be noted that many of the link projects were part of health partnerships which had started before the IHLFS funding. This section describes developing partners "perception of impact" and suggests how impact could be maximised through highlighting the strategies that institutions/partners have adopted to successfully sustain health links and projects. No attempt is made in this section to objectively verify impact.

Survey results show that 91% of respondents believed that the project had achieved its objectives to a large degree or completely, 84% thought that that the changes achieved were largely sustainable, with 91% seeing the relationship with their UK partner continuing over the longer term.

Informants described a range of strategies (see below) they were using to sustain and drive change within their own institutions. Projects were only planning one or two of the strategies and most had not been fully implemented.

- Mentorship and continuing professional development of medical, nursing and health staff
- Induction training for new staff to orient them in project activities
- Building local and national capacity through ToT
- Developing institutional capacity through succession planning
- Working with local/regional institutions to provide training and source equipment
- Developing multi-sectoral collaboration and ownership to promote resource mobilisation
- Developing new degree programmes and integrating new modules and technical themes into existing undergraduate and post graduate courses
- Lobbying, advocacy and engagement with senior management within the institution, local government, MoH (National, Regional, District level) and other stakeholders
- Establishing direct dialogue with THET to negotiate more flexibility within the project
- Developing new proposals for further funding
- Disseminating and sharing project findings through various media including community fora, MoH meetings, international scientific meetings and peer reviewed local and international journals

Stakeholders included senior management of the institution, MoH at National, District and Regional levels, local government, NGOs and faith-based medical organisations. The involvement of senior staff from the UK often gave developing country partners additional weight with stakeholders and was seen as a useful influencing strategy. Workshop participants stressed the importance of

involving key stakeholders at appropriate points, including if possible national level MoH before the project was initiated in order to check/gain approval and then to disseminate success when results were clearly identified. This echoes the role identified by the MoH focal person in Uganda.

Our role is to strengthen strategic coordination so that we can be sure that projects are aligned to the national strategy. We need good awareness of the links and projects should be properly documented so that we have evidence of what works. *(key informant)*

For other projects, involvement of key stakeholders as owners of the project from the start has been a strategy to ensure sustainability. This was demonstrated in the Mbale Coalition Against Poverty (CAP) partnership.

CASE STUDY: Integrated Emergency Response Services in Mbale Region, Uganda

In this project a collaborative network of NGOs (Mbale Coalition Against Poverty - CAP), and District Government working with Cwm Taf Health Board successfully developed an Integrated Emergency Response Service in Mbale Region for people with obstetric, medical and trauma emergencies. Strong coordination was key to achieve multi-sectoral collaboration and a Primary Health Care (PHC) committee was established to lead the project, determine plans and priorities, handle administration, and oversee the NGOs as they implemented the work. In this project there was a large capacity building component across all partners.

This project highlighted how integration of health care is key for sustainability and self-reliance using multi-sectoral collaboration to promote effective resource mobilisation. Through using existing community structures (local leadership, community health workers and local health centres) the project was able to promote ownership and improve service delivery and utilisation. Opportunity for dialogue with donors and their flexibility to adjust to the local needs promoted empowerment and efficiency in project delivery of services. (See Case Study 3)

Succession planning was considered by some health link projects as critical to sustainability.

We are doing succession planning - it is an absolute must and is as a direct result of this link. THET funding has allowed us to develop our capacity and to enable us to run this BSc at a good standard. We have enough capacity, but as an institute we still need other funding as running one degree does not create an institute. We are focusing now on developing our research capacity and at the same time we are scaling up numbers on our degree course so by next year our Bsc will be self sustaining. *(key informant)*

Informants discussed scale-up and influencing national policy, believing influence at the national policy level was a key route to core funding particularly for new services. The value of link projects as small pilots was recognised by senior health officials at the national level but they saw a need to strengthen dissemination if they were to be scaled up.

Many things start as small projects which then become national programmes and policies. (senior MoH official)

The Ugandan DFID Health Adviser saw health links as a huge opportunity and expressed an interest in the DFID country office supporting the write up and dissemination of best practices in collaboration with the MoH. Suggestions for improving dissemination included hosting annual national forum and/or slotting link projects into existing fora, using the THET web-site to showcase work, providing grants to present work at international conferences, strengthening skills in writing policy briefs, case studies and papers as well as identifying mechanisms to influence national policy and national curricula.

I think that the potential is there to influence national policy. It is one of my core goals and it is up to us to show our bosses at national level what has worked very well. But the question is can government direct resources to other institutions? I will be selling the idea at national level. (key informant)

In the survey, respondents top suggestion (82%) for improvements to the IHLFS was to provide more opportunities for health link projects to share experiences and resources to disseminate results. Nearly half also ranked the importance of providing more scope for south-south links into the partnerships, which is part of the new Health Partnership Scheme through Multi-Country Partnership funding and long term volunteering.

MoH is interested in what we do. Theoretically we can influence them - depends on people in the MoH and how they see it. Technical working groups are a way in. (key informant)

Almost one-third of survey respondents prioritised support to improving writing, dissemination and advocacy skills one informant noted people's career advancement depended upon these skills.

People's career advancement depends on how many papers are published. It is very important that there is shared authorship of publications with UK partners. For people here, their future depends on it. (key informant)

Recommendations

- Increased use of in depth case studies which highlight positive aspects associated with sustainability should be identified, written up and disseminated to the wider health links community
- THET should work with national level MoH and DFID country offices to explore opportunities for sharing and dissemination workshops for link projects. These could be scheduled adjacent to existing national meetings/workshops to keep costs and time commitments manageable
- As THET are currently in the process of reviewing and relaunching their website there is an opportunity to think about ways in which the current electronic resources and discussion groups can be built upon. THET

should be careful to engage with a small focus group of overseas link coordinators to ensure that any investment they make in electronic communication will be useful and utilised

- THET should consider working with DFID and MoH national level to ensure best practice from health link projects is identified and disseminated
- THET should consider setting up Dissemination/Advocacy Grants to encourage write-up of successful projects in a range of formats for different audiences

Comparative Analysis

The consultant team were asked to undertake comparative analysis to look at any differences in perceptions between projects across a number of parameters.

- Type (hospital, university, ministry)
- Rural versus urban
- Nurse-led, doctor-led, multi-disciplinary partnerships
- Longevity of health links
- Grant award size/type
- The three countries

As the sample size was small we indicated in the design that it may be problematic to draw many conclusions from these comparisons. The sample size does not allow us to undertaken any statistical tests to discover if differences between these parameters are significant or not. Hence this section is only able to indicate areas that would be worth further investigation with a larger sample size. In some cases it is also not possible to do any comparison of responses due to the lack of differentiation in the data. This is true of the difference between Rural and Urban catchments, since 59% of respondents indicated that their catchment was both. In addition, there were too few nurse-led initiatives to undertake any meaningful analysis. Comparisons were made with data per project rather than per respondent, when there was more than one response from a project the data from the link coordinator was used. Data is only presented below where analysis identified differences.

Institution Type

Due to the small sample size comparisons could only be made between Government Hospitals and all other institution types. Government Hospitals showed a larger proportion of projects reporting complete alignment of project objectives with institutional objectives, achievement of objectives, involvement in M&E and UK understanding of their context (Figure 6).

Figure 6 Percentage of Project Respondents by Institution Type who indicated completely to implementation questions

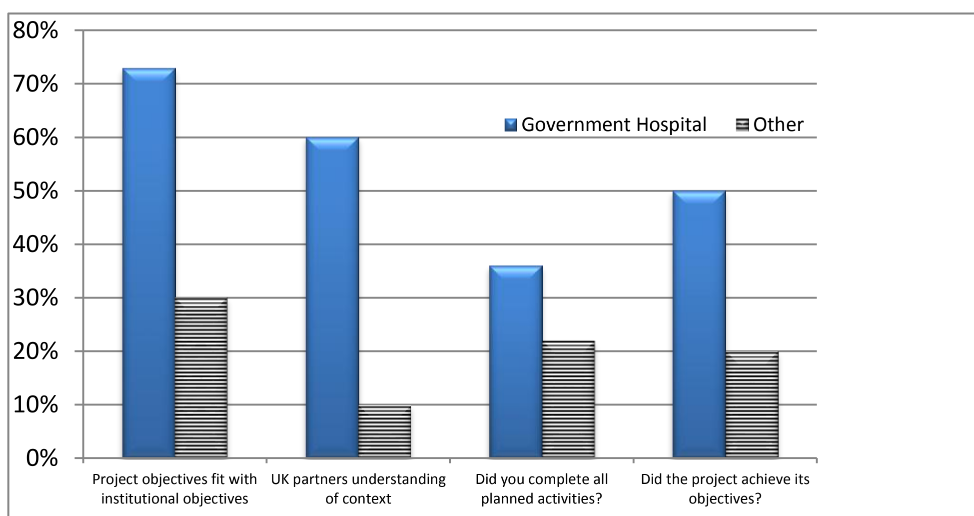
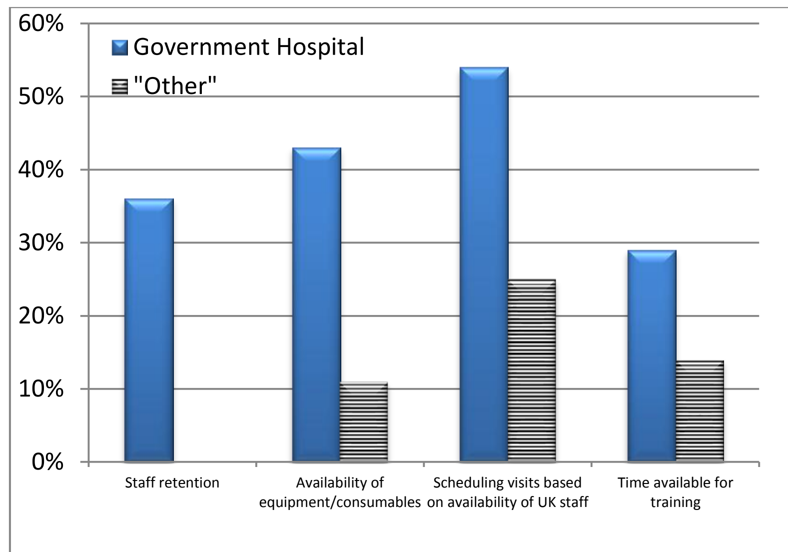


Figure 7 Percentage of Project Respondents by Institution Type who indicated challenge was faced frequently or all the time

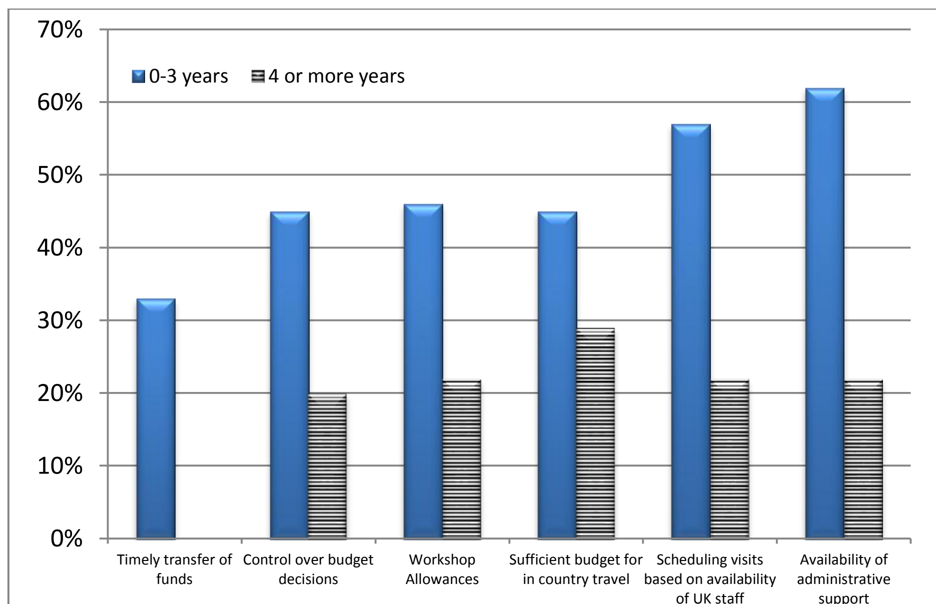


The data seems to indicate that staff retention, availability of equipment and scheduling may be greater challenges to projects based in Government Hospitals (Figure 7). The lack of budget for in country travel was reported as never being a problem for 46% of Government Hospitals based projects whereas for all of the other institutions it was reported as being a problem at least sometimes - this variation may be due to the differences in types of projects undertaken rather than the difference in institution type.

LONGEVITY

Longevity of the link partnership did seem to be associated with a reduction in some of the challenges faced in implementing joint work - echoing the feedback from the key informants. There were less challenges in scheduling, timely transfer of funds, control over budget decisions, sufficient budgets for workshops and travel and the availability of administrative support (Figure 8).

Figure 8 Percentage of Project Respondents by Link Longevity who indicated challenge was faced frequently or all the time



There was less difference in the aspects of implementation that were investigated in the survey between newer and older link partnerships. One area that showed a difference was that 89% of project respondents from links of 4 years or more indicated that training curricula/content was completely relevant to their needs and context compared to 43% of newer links.

Grant Type

Start up grants were not included in this analysis. In general, the variation between grant types appeared to be relatively small in terms of survey data. A larger proportion of large and medium size grant holders felt that the length of visits to or from the UK were only to some degree or not at all sufficient for their needs (45% compared to 25%). Projects in receipt of the smaller amount of funding were associated with higher reports of competing priorities and problems with the amount budgeted for in country travel.

Country

There was little variation in responses to the survey regarding project development, implementation and evaluation between the three countries.

The lack of sufficient budget for workshop allowances and for in country travel was identified as a frequent or constant challenge by two-thirds of the project respondents from Zambia compared to an average of 19% of respondent from the other two countries. Zambia also had more respondents identifying administrative support and availability of equipment as major challenges.

Conclusions and Key Recommendations

Our findings showed that overall developing country partners saw real value in being part of the IHLFS scheme and recognised capacity development benefits at both an individual as well as institutional level. There was significant agreement amongst informants that trust, equal partnership, ownership, common interest, inclusiveness and openness were crucial to effective links. Since projects were quite disparate, comparison of their relative success was problematic. However, many reported impressive change on the basis of relatively small amounts of funding which they felt could be sustained to a large degree in the long term.

The opportunity to engage with staff from the NHS both overseas and in the UK was a valued source of expertise and new perspectives. Developing country partners gained inspiration for envisioning how their services could develop; UK volunteers gained insights into how to adapt evidence based practice to resource poor contexts. But many in the NHS are new to the accumulated learning of what works in terms of developing capacity in resource poor contexts. Whilst THET has made much of this learning available to the partnerships in the Health Links Manual, it is clear from this evaluation that best practice is variably applied between partnerships. Hence, there is an opportunity for THET to find other routes to encourage partners to align their work with its ethos of capacity development and working in partnership.

Key Recommendations

The health links model

The scheme has some challenges that the evaluators would define as structural. These include the time NHS staff are able to commit to overseas visits; the tension between fostering long term partnerships with long term objectives and the need to demonstrate project results; and the wide spread of projects both geographically and thematically. The IHLFS projects were focussed on building capacity at the institutional and individual levels and were not primarily designed to influence the wider health system. For health links to participate in broader health systems strengthening the process of identification, evaluation and monitoring of health link projects would need to be re-engineered to ensure a greater alignment and engagement with national MoH. The success of individual projects is very much dependent on the approaches to capacity development used by the individual partners from both the UK and Developing Country. If the scheme is to contribute positively to strengthening capacity it must be based on accepted best practices.

- When considering the design of future programmes THET should consider at what level within the health sector they are seeking to strengthen capacity (individual, institutional or system wide)
- UK Link Partners should receive more orientation in best practice for capacity development so that appropriate approaches and methods are developed jointly with overseas partners

Health Systems Strengthening

Health link projects have demonstrated improvements in health services within institutions, however gains have not always been optimised or are sometimes fragile, because projects cannot be expected to address underlying structural problems within the institution and/or the wider health system. For projects to be sustainable wider institutional capacity needs to be built. All health link projects have the potential to strengthen health systems, but in order to do so capacity needs to be built across the health sector and not just within the institution, which requires dissemination and advocacy at national level.

- THET should consider working with DFID and MoH national level to ensure best practice from health link projects is identified and disseminated
- THET should consider setting up Dissemination/Advocacy Grants to encourage write-up of successful projects in a range of formats for different audiences

Better addressing local needs

Whilst health links have demonstrated successful implementation of effective evidence-based interventions this has to be supported by strengthening institutional capacity. This includes planning, human resources, financial management and governance. Whilst the evaluation team recognise that a comprehensive capacity development programme is beyond the scope of THET funding, there is still an opportunity to address this need.

- THET should advocate with NHS partners to include these aspects in needs assessments and subsequent implementation plans
- THET should ensure that both partners access existing resources highlighting best practice in these crosscutting areas

Bringing the right people together to share solutions.

There is a real opportunity for health links to learn from each other which is currently not being exploited. Key informants expressed a strong desire to be part of regular learning and evaluation fora, which could include national workshops and sharing information via websites and social media. Key informants were keen to learn about other partnerships that were based in their country and also those in their particular field. They sought access to tools, guidelines, protocols and successful proposals that had been developed by other partnerships.

- As THET are currently in the process of reviewing and relaunching their website there is an opportunity to think about ways in which the current electronic resources and discussion groups can be built upon. THET should be careful to engage with a small reference group of overseas link coordinators to ensure that any investment they make in electronic communication will be useful and utilised
- THET should work with national level MoH and DFID country offices to explore opportunities for sharing and dissemination workshops for link projects. These could be scheduled adjacent to existing national meetings/workshops to keep costs and time commitments manageable

Monitoring, Evaluation, and Learning

Whilst there is recognition of the need for effective monitoring and evaluation, in practice the skills and resourcing for M&E in DC institutions was inadequate. Unless this capacity gap is addressed, it is extremely difficult for projects to advocate for core funding and influence policy and practice.

- More capacity development needs to be undertaken to strengthen M&E with both developing country and UK partners, building on the existing M&E Toolkit
- THET should develop a resource of tried and tested M&E tools and reports using examples from Health Links who have demonstrated simple but robust M&E systems.

Potential for sustainability

It is beyond the scope of this evaluation to provide evidence of which aspects of health links provide the strongest potential for sustainability. However, projects that adhered to best practice principles of capacity development were identified as having the strongest potential for this as evidenced by strong engagement with stakeholders, succession planning, institutional capacity building, working with other local service providers, integrating project activities into routine work and a culture of monitoring and evaluation. These projects were also unique in attempting to address the building blocks of health systems strengthening and seeking to integrate their services into the wider health system. Lack of ownership by the DC partner was the single most underlying cause that participants associated with poor sustainability.

- Case studies of projects which highlight positive aspects associated with sustainability should be identified, written up as in depth case studies and disseminated to the wider health links community.

Southern engagement

Developing country link coordinators expressed a strong for THET to communicate directly with them and provide written feedback on progress reports. There was a keen interest in developing south-south partnerships, although no clear model was offered for how this might be achieved.

- THET should increase their direct communication with developing country partners in order to promote engagement and understanding
- THET should regularly repeat important messages to DC partners to allow for staff turnover and effect of information overload
- Further consultation should be undertaken with DC partners and key stakeholders to explore how south-south learning can be facilitated through health links

Case Study 1: Developing Specialist Eye Care Services for the People of Northern Zambia "Ownership comes from vision and planning"[2]

Partnership between Kitwe Central Hospital and Frimley Park Hospital NHS Foundation Trust

Realising a vision through partnership

In 2006 Dr Seneadza had a vision that Kitwe Central Hospital should offer specialist services in retinal and paediatric eye care for the people of Northern Zambia. He identified that in order to realise his vision he needed support to build the capacity of the staff of his unit, to purchase equipment and to fund mobilisation so that the community could access the new services. He also knew that if he improved theatre management it would contribute to strengthening both retinal and children's eye care. For the future he also wanted to develop research capacity in the department to understand the burden of diabetes and eye problems in the North of Zambia. He needed the support of the senior management at the hospital, the provincial medical office and the community in order to achieve his vision.

Working with the International Centre for Eye Health and liaising with colleagues who had already experienced the benefits of a health link, Dr Seneadza identified that IHLFS could provide him with an opportunity to access specialist knowledge and skills from the NHS. He was, after a period of time, matched with a retinal eye surgeon at Frimley Park Hospital NHS Foundation Trust in whom he found the commitment and expertise he was looking for. He then identified other partners who could provide the other elements he needed: CBM (an international NGO) provided funds for equipment and mobilisation for retinal eye care, a local mining company (KCM) also funded mobilisation. The NGO ORBIS provides equipment and additional capacity development for paediatric eye care. Swiss Lion provided training and mobilisation for community outreach, employed a staff member to follow up cases and refund transport costs for patients to attend treatment.

A steering group was formed In Zambia and in the UK. In Zambia the group included representatives from the department, the hospital senior management, Provincial Medical Office, donor companies and NGOs and representatives of the community were invited. Both steering groups fund-raise to cover additional costs particularly for travel. Written agreements were made between the partners regarding which costs they would be responsible for covering.

"The steering group shows commitment. Creates a platform for review, planning ahead and a way of sharing perspectives"

Planning is Crucial

The link is seen as part of the core work of the department and everyone in the department is involved. Staff in the unit see the link as a positive opportunity and it has improved motivation. Dr

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[2] All quotes in this case study are from Dr Seneadza.

Seneadza has ensured that work is delegated within the department so the load is shared and is not dependent on his constant presence.

Activities and training are planned and reviewed in detail. Dr Seneadza's department outlines the broad training objectives for the next visit. The UK team then work on the details of the training content and materials in liaison with the Zambia team. The host country develops the detailed programme of activities which is then agreed by the visitor(s). At the end of each visit the action plan and feedback from the visit are reviewed. Areas of training that need revisiting or new training needs that have been identified are then added to the action plan for the next visit. In this way the team constantly review and build on the actual capacity of the staff team. This process relies upon continuity of involvement from a core team in both Zambia and the UK.

Capacity Building

The UK partner sends multi-disciplinary teams to Zambia who use a range of capacity building techniques including: practical and theoretical training, joint clinics, observation and mentoring. They have been able to train a large number of staff in a range of skills. Staff from Zambia have also had the opportunity to visit the UK. For Dr Seneadza the visits of staff from his team to the UK was a vital part of creating a shared vision of what they could achieve.

"Extremely motivating for staff to see the UK - people now understand why I want things to be like this. When they see it themselves, they see that it can be done, see what is possible."

Dr Seneadza is careful to keep the UK team engaged in the work of his department - he ensures that he communicates the impact of training that they have undertaken and outcomes for patients that have been treated by the UK team. He sees the value of keeping the partnership strong through maintaining regular communication and the feeling of mutual engagement and joint achievements.

Improved services for Northern Zambia

The team has now developed capacity in retinal and paediatric eye care, in theatre management and in retinal imaging. These skills combined with the equipment and funds for mobilisation have allowed the hospital to offer services to the people of Northern Zambia that did not previously exist and in some cases are not offered elsewhere in Zambia. The team have treated 287 people with retinal laser treatment, 236 with intravitral injections for retina disease and 70 have undergone retinal surgery. They have undertaken 159 paediatric cataract operations, 162 paediatric surgeries and 168 treatments for paediatric refractive errors. This is having a measureable effect on the health of the people of Northern Zambia. For the future Dr Seneadza wants to focus on some of the areas that still need further work: follow up of patients, diabetic screening, research capacity and sharing his experiences with other eye care departments.

The secret of success

Dr Seneadza proposes that links need good planning, regular communication, transparency, honesty and a good team who are fully engaged. For him the key to success is leadership - *"you need commitment and dedication"*.

Case Study 2: Working in Partnership to Improve Outcomes in Critically Ill Obstetric Patients in Uganda - Integrating new Services into Routine Health Service Delivery and Sustaining Change

Partnership between Mulago Referral Hospital and Liverpool Women's Hospital NHS Foundation Trust

Inspired by a new model of care

The Liverpool-Mulago partnership was established in 2008. Dr Sarah Nakabulwa was the first Doctor from Mulago to go on an exchange visit to the Liverpool Women's Hospital. A year later her colleague Dr Mark Muyingo visited Liverpool this time accompanied by two midwives. Subsequently further exchange visits have taken place. What most inspired Sarah and Mark was observing the High Dependency Unit (HDU) in Liverpool.

"We saw that patients were not dying, triage was very good, there was streamlined patient flow, scoring systems were used to monitor patients and we witnessed a more central role for midwives rather than just following doctors….. In Uganda I can spend four hours operating on a ruptured uterus only to find out later that my patient died on the ward – a death that was preventable."

This led to developing an application for funding under the IHLFS scheme and within a short timeframe the Mulago 6-bedded HDU was equipped and operational with doctors, nurses and midwives trained in protocols adapted from Liverpool Women's Hospital.

The Power of Data

Initially there was some scepticism as to whether the HDU could actually save lives. Within the first two months, however, there were no maternal deaths. Once the department saw these results, the number of midwives was increased from four to twelve, and since 2011 the HDU has had a separate consumables and drug budget line within the hospital's budget, its own portable oxygen supply and blood supplies have been prioritised for the unit. M&E figures are compiled on a monthly basis and weekly maternal death audits are conducted.

High Level Support for Sustainability

Team leadership has been crucial. The Head of Department took on a mentoring role and the Medical and Nursing leadership have worked as a team to support and operationalise the project. Lobbying from senior management has helped ensure that appropriate resources (human, material, equipment) are prioritised. Midwives work as a team and are now more confident with improved clinical skills. They are using the early warning scoring system and are able to interpret scores and start treatment according to protocols and senior midwives now orient the junior doctors who come into the department on rotation. Audit is being used to check that staff are following protocols and regular training updates are conducted when problems are identified.

FRAGILITY OF NEW SERVICES

However successful pilot projects are also often very fragile. The new unit requires a senior doctor and midwife to drive change and keep it on track as well as administrative support to assist with monitoring and evaluation and to identify funding opportunities. Even with senior management lobbying and hard evidence that the new services are working, currently only two of the six beds have monitoring equipment which slows down clinical response time. Some equipment from the HDU was diverted to the main surgical theatre as they were lacking. Very sick patients who do not meet the criteria of admission are being referred to HDU which potentially blocks bed availability for other critically ill obstetric patients (normally a patient expects to stay in HDU for 24-48 hours). There is now overflow of patients into other wards creating pressure on the HDU nursing staff. Mulago Hospital ran a workshop outlining the concept and success of the HDU which was attended by 200 health care professionals. Clearly there is a genuine interest in establishing maternity HDUs in other referral hospitals. However until this happens Mulago remains an "exemplar" and could become a "victim of its own success" being overwhelmed by referrals. The hospital now see the HDU as a central part of its services, rather than a project, but this also means that it has to compete with other hospital departments for scarce resources.

POTENTIAL FOR ROLL-OUT AND HEALTH SYSTEMS STRENGTHENING

The evidence of what can be achieved provides a powerful message about the potential for health systems strengthening. The development of the Obstetric High Dependency Unit (HDU) highlights an excellent example of taking a known effective intervention from UK and adapting it to the Ugandan context. However this example also demonstrates the fragility of introducing new services and the importance of building sustainability plans for new services.

CASE STUDY 3: INTEGRATED EMERGENCY RESPONSE SERVICE IN MBALE REGION, UGANDA - "OWNERSHIP AND RESPONSIBILITY"

Partnership between Mbale Coalition Against Poverty (CAP) and Cwm Taf Health Board

THOROUGH NEEDS ASSESSMENT THROUGH STAKEHOLDER ENGAGEMENT

Five NGOs in Uganda discussed with village communities the key barriers that they faced in accessing skilled healthcare. The priority to be addressed emerged as transportation. The coalition then discussed the idea of meeting the transportation needs of the community with the three local District Government health departments. A project was outlined for motorbike and push bike ambulance provision. As well as identifying the technical problem that needed to be solved the coalition also looked at the capacity of the NGO staff and health centres to deliver the project.

MOBILISING EXISTING RESOURCES

The five NGOs agreed the project plans and their specific roles in supporting the ambulance service in the future (supervision and sensitisation of the community). Existing community health workers were identified as a sustainable resource that could manage the call out and use of the ambulances without the need for increased investment. The District Governments helped to carry out the training and in one health centre increased staffing to provide the midwifery services for the community to access via the ambulance service. The collaboration and involvement of many stakeholders in the planning process resulted in a high degree of commitment to implement the plans. Roles and responsibilities between the partners were also clearly outlined. Coordinating multiple partners with different approaches and priorities was a challenge to the team. In addition, the team also needed to manage the expectations of the community, local NGOs and the District Government - particularly regarding the amounts of funding that were available and what therefore they would be able to achieve.

COORDINATION

Strong coordination was key to achieve multi-sectoral collaboration and a Primary Health Care (PHC) committee was established to lead the project, determine plans and priorities, handle administration, and oversee the NGOs as they implemented the work. The PHC Committee was also the point of liaison with the UK link partner. The PHC committee was the primary decision making body for the project and the UK partner "honoured" decisions made by the committee.

"The committee felt engaged and motivated as the coordination body for the project in Mbale. There was a strong sense of ownership and responsibility"

There were challenges faced by the committee - keeping all the stakeholders engaged given that their time was given voluntarily, facing infrastructural problems at health centre levels (lack of power) and meeting the expectations of UK volunteers in terms of the activities they could undertake during their visits.

"Adhering to high standards of governance may lead to delay but we are clearly committed to adhering to these standards of integrity."

Implementing the Project

In this project there was a large capacity building component across all partners which:

- Built knowledge of emergency response systems with the PHC Health Links Co-ordinator and District Government Health Officer through a visit to the UK
- Strengthened and built capacity of health centre and hospital staff through training in handling emergencies (eg resuscitation and first aid) using the course curriculum developed by UK volunteers
- Built capacity and skills of community health workers through training in obstetric and other emergency recognition and response
- Trained ambulance drivers in effective vehicle maintenance

"Training has increased skills and confidence of the difference levels of health workers involved, and they are better able to meet the needs of their patients in an emergency situation. The impact on patients and families is a step change in being able to access skills health care in time."

Monitoring and Evaluation

The type of data needed was agreed with project partners at the start of the project. Data was collected from ambulance driver 'journey sheets' and community health worker logbooks. Some baseline data was collected from health centres, District Government health offices and national reports. Monthly supportive supervision included coaching on data recording. Data was collected and analysed on time and has been used to guide decision making processes in project interventions. One challenge that they had not anticipated was the difficulty of collecting data in multiple formats without an easy system for data collation.

Health Systems Strengthening

This project highlighted how integration of health care is key for sustainability and self-reliance using multi-sectoral collaboration to promote effective resource mobilisation. Through using existing community structures (local leadership, community health workers and local health centres) the project was able to promote ownership and improve service delivery and utilisation. However, there are still some challenges to overcome - the maintenance of the ambulances after the end of the project still needs to be negotiated.

Lessons Learned by the Mbale CAP PHC

- Transparency and accountability within the partnership network is key for the success and sustainability of the project
- Inflation can have a big impact on running costs of a project, e.g. affecting fuel and repairs
- Regular dialogue is needed between project partners to monitor project delivery
- Mentoring, coaching, supporting and collective planning through dialogue meetings promotes a spirit of ownership and self reliance
- For an emergency intervention to be successful you must focus on both staffing and equipment needs for communities, transfers and health centers

- Integration of health care is key for sustainability and self reliance
- Multi-sectoral collaboration promotes effective resource mobilisation
- Use of existing community structures (local leadership, community health workers and local health centres) promotes ownership, effective service delivery and utilisation
- Dialogue with donors and their flexibility to adjust to local needs promotes empowerment and efficiency in service delivery.

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Annex 1: List of Key Informants

The following tables list the workshop participants, semi-structured interviews occurred with a subset of the workshop participants: 6 in Uganda, 3 in Malawi and 3 in Zambi**a**. Due to the small number of people involved we have not indicated their names in order to protect their confidentiality.

Additional Interviewees

Dr Amandua Jacinto, Commissioner Clinical Services, Ministry of Health, Uganda
Dr Jackson Amone, Assistant Commissioner, Integrated Curative Services, Ministry of Health Uganda
Jyoti Shankar Tewari, Health Advisor, DFID Uganda
Dr. Tonny Tumwesigye, Link Coordinator until May 2012, Kisiizi Hospital, Uganda.

Uganda

				Day One	Day Two
HL P.27 P3.51	Faculty of Medicine, Gulu University	Professor Emilio Owuga	Gulu		
HL P.07	Hoima Referral Hospital	Sister Joyce Lucy Atim	Hoima	x	x
HL P.07	Hoima Referral Hospital	Florence Acheng	Hoima		x
HL S.53 L.58 P3.27	Kisiizi Hospital	Dr Gabriel Okumu	Kbale	x	x
HL S.53 L.58 P3.27	Church of Uganda Kisiizi Hospital	Wilber Tukamuhabwa	Kbale	x	x
HL P.16	Mbale District Health Office	Mr Fred Chemuko	Mbale	x	x
HL P.16	Mbale District Health Office	Esther Nandutu	Mbale	x	x
HL M.28	Mbarara University of Science and Technology	Dr Julius Kiwanuka	Mbarara	x	x
HL P3.30	Uganda Society of Anaesthesia	Dr Stephen Ttendo	Mbarara	x	
HL P3.30	Uganda Society of Anaesthesia	Dr Joseph Kiwanuka	Mbarara	x	x
HL P3.41	Environmental Health Workers Association of Uganda	David Katwere Ssemwanga (Mr)	Kampala	x	x
HL P3.41	Environmental Health Workers Association of Uganda	Francis Kyakulaga	Namutumba	x	x
HL L.23 P.31	Butabika Hospital	Dr David Basangwa	Kampala		
HL L.23 P.31	Butabika National referral Mental Hospital.	Dr Harriet Birabwa	Kampala		
HL P.36	Mulago Hospital	Dr Mark Muyingo	Kampala	x	
HL P.36	Mulago Hospital	Dr Sarah Nakubulwa	Kampala	x	x
HL M.31	Mulago Hospital	Dr Nambuya Agatha Petua	Kampala	x	x
HL M.31	Mulago Hospital	Dr Fred Nakwagala	Kampala	x	x
HL P.31	Butabika National referral Mental Hospital.	Dr. Julius Muron	Kampala		
HL L.17	Hospice Africa Uganda	Zena Bernacca	Kampala		x
HL L.17	Hospice Africa Uganda	John Alex Muyita	Kampala	x	x
HL S.139	Uganda Cancer Institute	Mrs Allen N Mayanja	Kampala		
HL S.139	Uganda Cancer Institute	Dinah Namusoke	Kampala		
				15	15
		Total Number attended over workshop			17

Total attended for workshop: 17 attendees representing 13 links.

Zambia

Link	Institute	Location	Name	Day one	Day two
M.50	Zambian Institute of Environmental Health	Lusaka	Bernadette Mumba	X	X
M.50	Zambian Institute of Environmental Health	Lusaka	Mr Chabala Chanda	X	
P.02	St Francis Hospital	Katete	Mr Jeremiah Nyirenda	X	X
P.3.14	St Francis Hospital	Katete	Ms Liz Hosegood	X	X
P.3.15	Kitwe Central Hospital	Kitwe	Dr Asiwome Seneadza	X	X
S.142	Livingstone General Hospital	Livingstone	Dr High Namani Monze	X	X
M.26	University Teaching Hospital	Lusaka	Dr Grace Chipalo-Mutati	X	X
				7	6

Total attended for workshop: 7 attendees representing 6 links.

Malawi

Link	Institute	Location	Name	Day one	Day two
P.53	Queen Elizabeth Central Hospital	Blantyre	Professor Elizabeth Molyneux	X	X
P.53	Queen Elizabeth Central Hospital	Blantyre	Dr George Chagaluka	X	X
S.141	Queen Elizabeth Central Hospital	Blantyre	Dr Gavin Dreyer	X	X
S.141	Queen Elizabeth Central Hospital	Blantyre	Enos Banda	X	X
L.60	Queen Elizabeth Central Hospital	Blantyre	Aubrey Filimoni	X	X
L.60	Queen Elizabeth Central Hospital	Blantyre	Dr Kumpiponjera	X	
M.15	Queen Elizabeth Central Hospital	Blantyre	Sheila Mailano	X	X
M.15	Queen Elizabeth Central Hospital	Blantyre	Lydia Kaduya	X	X
S.131	Thyolo District Hospital	Thyolo	Dr Andrew Likaka	X	x
S.131	Thyolo District Hospital	Thyolo	Dr Michael Murowa	X	X
M.47	Zomba Mental Hospital	Zomba	Mr Phiri	X	X
S.126	Zomba Mental Hospital	Zomba	Mr Chitsanzo Mafuta	X	X
P.53	Queen Elizabeth Central Hospital	Blantyre	Winnie Likoleche	X	
P.53	Queen Elizabeth Central Hospital	Blantyre	Felista Chisale	X	
P.53	Queen Elizabeth Central Hospital	Blantyre	Edith Rose Mumba		X
P.53	Queen Elizabeth Central Hospital	Blantyre	Agatha Thundu		X
				14	13

Total attended for workshop: 16 attendees representing 7 links.

Annex 2: Summary Survey Results

	Number	Response Rate
Total individual responses	33	49%
Number of unique projects responded	25	74%
Total emails sent out	67	n/a
Number of unique projects emailed	34	n/a

PROFILE OF RESPONDENTS

Country	Number	%
Uganda	16	48%
Zambia	10	30%
Malawi	7	21%

Role	Number	%
Doctor	18	55%
Other Health	9	27%
Nurse	3	9%
Finance professional	2	6%
Education professional	1	3%

Institution	Number	%
Government hospital	16	48%
Association	6	18%
Faith based hospital	5	15%
NGO	2	6%
University	1	3%

Rural/Urban Catchment	Number	%
Rural	10	30%
Urban	4	12%
Both	19	58%

FOCUS ACTIVITIES OF LINK PROJECTS IDENTIFIED BY RESPONDENTS

	Number	%
Professional training	19	59%
Delivery of health services	18	56%
Health Promotion	11	34%
Facilities/equipment management	4	13%
Under/postgraduate education	3	9%
Research	3	9%

RESULTS OF LINK PROJECTS IDENTIFIED BY RESPONDENTS

	Number	%
Changes in Practice	28	88%
Better quality of care for patients	25	78%
New or strengthened continuing professional development	24	75%
Better staff motivation	23	72%
Procurement of new equipment	18	56%
Development of new systems	15	47%
Development of new curricula	15	47%
Implementation of new polices	13	41%
Implementation of new guidelines	13	41%
New Services available to patients	12	38%

MISCELLANEOUS QUESTIONS

Use of Personal Funds: 29 respondents of whom 12 (41%) stated Yes and 17 (59%) stated No.

HEALTH LINK PROJECT DEVELOPMENT, IMPLEMENTATION AND EVALUATION

		%				Number		
		1 Completely	2 To a large degree	3 To some degree	4 Not at all	N/A	Don't know	Total responses*
B1	Did the project objectives fit with your institutional needs?	55%	42%	3%	0%	0	0	33
B2	Did the project objectives align with national priorities	56%	38%	6%	0%	1	0	32
B3	Did you feel that your institution had equal ownership of the project with the UK partner?	45%	27%	24%	3%	0	0	33
B4	Was the budget adequate to support all agreed activities?	22%	28%	28%	22%	0	1	32
B5	Was the UK expertise relevant to your institution's requirements?	58%	33%	6%	3%	0	0	33
B6	Did the UK partners understand the context of working in your institution?	36%	42%	21%	0%	0	0	33
B7	Was there clarity about the purpose and expected outputs for each visit to/from the UK?	52%	38%	10%	0%	4	0	29
B8	Was the length of visits to/from the UK sufficient for project needs?	14%	48%	28%	10%	3	0	29
B9	Were you able to complete your work on the project during normal working hours?	17%	30%	30%	23%	1	0	30
B10	Did you complete all planned activities for the project?	39%	32%	21%	7%	1	1	28
B11	How involved was your institution in collecting and analysing the project M&E data?	38%	31%	24%	7%	2	2	29
B12	Was the project M&E data shared within your institution?	55%	21%	10%	14%	3	1	29
B13	Were clear participant selection criteria developed and adhered to for training activities?	45%	35%	19%	0%	2	0	31
B14	Was the training content/curricula relevant to your project needs and context?	66%	28%	6%	0%	1	0	32
B15	Did the health link project achieve its objectives?	41%	50%	9%	0%	1	0	32
B16	Do you think that the changes achieved by this project are sustainable?	32%	52%	16%	0%	1	0	31
B17	Do you feel that the project was a worthwhile use of your institution's resources?	81%	13%	6%	0%	1	0	32
B18	Do you see the relationship with the UK partner continuing in the long term?	69%	22%	9%	0%	0	1	32
B19	Did you think the scope of the project was achievable given the budget and timescale?	26%	58%	16%	0%	1	0	31

*Total responses refers to those responses coded 1-4 only.

CHALLENGES FACED

		%				Number		
		1 Never	2 Sometimes	3 Frequently	4 All the time	N/A	Don't know	Total responses*
C1	Staff retention	21%	58%	13%	8%	5	1	24
C2	Scheduling of visits based on availability of UK staff	17%	43%	13%	27%	2	0	30
C3	Consistent communication with UK partner	47%	22%	13%	19%	0	0	32
C4	Making time due to competing priorities of other projects	16%	59%	22%	3%	0	0	32
C5	Time available for training	32%	46%	14%	7%	3	1	28
C6	Consistent follow up after training/project activities	17%	60%	13%	10%	2	0	30
C7	Time frame in which to demonstrate meaningful change	17%	45%	21%	17%	3	0	29
C8	Timely transfer of funds required for local spending	36%	48%	4%	12%	6	1	25
C9	Control over budget decisions	39%	25%	29%	7%	3	1	28
C10	Currency devaluation/fluctuation/fuel price rises	7%	36%	43%	14%	2	2	28
C11	Sufficient budget for workshop allowances	21%	38%	21%	21%	2	1	29
C12	Sufficient budget for in country travel/transfers	25%	38%	17%	21%	4	3	24
C13	Availability of equipment/consumables for the project	20%	50%	23%	7%	2	0	30
C14	Reliable internet access	9%	59%	22%	9%	0	0	32
C15	Availability of administrative support for the project	10%	53%	17%	20%	1	1	30

*Total responses refers to those responses coded 1-4 only.

PERSONAL AND PROFESSIONAL DEVELOPMENT

		1 Significant Improvement	2 Some Improvement	3 No improvement	Responses
D1	Professional Knowledge and Skills	65%	35%	0%	26
D2	Leadership and Management Skills	64%	36%	0%	28
D3	Education and training skills	58%	42%	0%	26
D4	Understanding of the UK health system	21%	63%	17%	24
D5	Problem solving skills	48%	48%	4%	25
D6	Team working skills	75%	21%	4%	28
D7	Finance/budget management skills	50%	46%	4%	24
D8	Monitoring and Evaluation skills	37%	48%	15%	27
D9	Proposal writing skills	28%	60%	12%	25
D10	Communication skills	44%	44%	11%	27
D11	Partnership working skills	52%	44%	4%	27
D12	Promotion prospects	21%	54%	25%	24
D13	Job satisfaction	50%	35%	15%	26

RANKED BEST PRACTICE STATEMENTS

		Number	%
E1	Equal ownership should be developed between UK and overseas partner(s) in all aspects of the project	28	85%
E5	Projects should seek to develop local capacity to both manage and deliver capacity building activities in the future.	22	67%
E2	Ensure projects fit with your institutional long term vision and take account of partners institutional structures and contexts.	21	64%
E10	Engage with key stakeholders (eg MoH, local government, clients) from the start and throughout the project.	17	52%
E4	Curricula and training methods should be developed jointly to ensure relevance to local contexts and needs	16	48%
E3	Training should include both classroom and practical elements and have follow up to assess application of skills and knowledge.	13	39%
E8	Ensure that a baseline survey/measurement is done so that changes achieved can be demonstrated.	12	36%
E7	Fully cost project activities and ensure transparency between partners about financial contributions.	11	33%
E6	Ensure that more than one person from each partner is fully engaged in the link management and administration.	10	30%
E9	Ensure there is a plan and adequate resourcing for data collection, analysis, use and dissemination.	10	30%

RANKED SUGGESTED IMPROVEMENTS TO THE SCHEME

		Number	%
F1	Provide more opportunities for link projects to share experiences and resources to disseminate results	27	82%
F2	Provide support to improve monitoring and evaluation skills	21	64%
F4	Allow more flexibility in the budget for items such as administrative support and/or equipment.	19	58%
F5	THET to communicate directly to both overseas and UK partners.	17	52%
F8	Provide more scope for south-south links into the partnerships.	15	45%
F6	THET to provide more feedback in response to project progress reports and/or unsuccessful proposals.	12	36%
F3	Provide support to improve writing/dissemination/advocacy skills	10	30%
F7	Review and streamline the reporting process.	7	21%

COMPARATIVE DATA: ONE RESPONSE PER PROJECT

By Institution

	Completely		Large Degree		Some degree/Not at all		
Implementation	Government Hospital	Other	Government Hospital	Other	Government Hospital	Other	Responses
Project objectives fit with institutional objectives	73%	30%	27%	60%	0%	10%	24
UK partners understanding of context	60%	10%	33%	70%	7%	20%	22
Did you complete all planned activities?	36%	22%	45%	33%	18%	44%	20
Did the project achieve its objectives?	50%	20%	50%	50%	0%	30%	24
How involved was your institution in collecting and analysing M&E data?	38%	25%	46%	13%	15%	63%	21

	Never		Sometimes		Frequently/All the time		
Challenge	Government Hospital	Other	Government Hospital	Other	Government Hospital	Other	Responses
Staff retention	17%	17%	50%	83%	36%	0%	18
Availability of equipment/consumables	14%	22%	43%	50%	43%	11%	23
Scheduling visits based on availability of UK staff	13%	13%	33%	63%	54%	25%	23
Time available for training	14%	29%	57%	57%	29%	14%	21

By Project Length

	Never		Sometimes		Frequently/All the time		
Challenge	0-3 years	4 or more years	0-3 years	4 or more years	0-3 years	4 or more years	Responses
Timely transfer of funds	11%	56%	56%	44%	33%	0%	18
Control over budget decisions	27%	60%	27%	20%	45%	20%	21
Workshop Allowances	23%	22%	31%	56%	46%	22%	22
Sufficient budget for in country travel	36%	29%	18%	43%	45%	29%	18
Scheduling visits based on availability of UK staff	0%	33%	43%	44%	57%	22%	23
Availability of administrative support	0%	22%	38%	56%	62%	22%	22

Implementation	Completely 0-3 years	Completely 4 or more years	To a large degree 0-3 years	To a large degree 4 or more years	To some degree/Not at all 0-3 years	To some degree/Not at all 4 or more years	Responses
Relevant Training Curricula/Content	43%	90%	43%	10%	14%	0%	24

BY GRANT SIZE

Challenge	Never Project Grant	Never Medium/Large Grant	Sometimes Project Grant	Sometimes Medium/Large Grant	Frequently/All the time Project Grant	Frequently/All the time Medium/Large Grant	Responses
Sufficient budget for in country travel	20%	27%	20%	36%	60%	36%	16
Competing priorities	20%	9%	30%	82%	50%	9%	21

BY COUNTRY

Challenge	Never Uganda	Never Zambia	Never Malawi	Sometimes Uganda	Sometimes Zambia	Sometimes Malawi	Frequently/All the time Uganda	Frequently/All the time Zambia	Frequently/All the time Malawi	Responses
Sufficient budget for in country travel	29%	17%	60%	43%	17%	20%	29%	66%	20%	18
Workshop allowances	10%	33%	33%	60%	0%	50%	30%	66%	17%	22
Availability of equipment/Consumables	20%	14%	17%	60%	29%	67%	20%	57%	17%	23
Availability of administrative support	20%	0%	0%	50%	17%	67%	30%	83%	33%	22

Annex 3: The Consultant Team

Capacity Development International develops the potential of individuals and institutions to effectively deliver technical assistance (TA) that strengthens health systems in middle and low income countries. We do this through consultancy, evaluation and training programmes based on accepted best practice and our experience. We aim to demonstrate that effective technical assistance contributes to improved health outcomes and does not waste public and charitable funds. Vicki Doyle and Ema Kelly formed Capacity Development International out of their passion for getting technical assistance right.

Capacity Development International can

- Develop and deliver courses on commissioning, management and delivery of TA
- Facilitate the development of TA strategies
- Provide bespoke support to strengthen capacity to deliver technical assistance
- Design quality assurance into TA programmes
- Evaluate international health technical assistance programmes

Dr Vicki Doyle is a senior international health consultant with more than 20 years technical and management experience across both the public and private sector. She has delivered and managed technical assistance in Latin America, Africa, the Middle East and Asia, working from global to community level. She has a wide range of publications including global guidance and national strategy documents, policy briefs, training manuals, book chapters and international peer reviewed journal articles. Core areas of expertise include capacity development, quality improvement in health care and health systems strengthening.

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Ema Kelly is a senior manager with more than 15 years experience in social enterprise, NGOs and the private sector. She has managed consultancies and multi-million pound health programmes in Africa, Asia and the Middle East. She has developed management systems & processes, operational manuals and capacity development programmes for commercial and NGO organisations. Core areas of expertise include strategic and operational planning, capacity development, consultancy services management, project management, systems development and financial management.

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OUR VALUES

We aim to demonstrate an ethical and professional approach through:

- Responding to client's needs and expectations
- Enabling local ownership
- Finding best fit solutions
- Developing organisational and individual potential
- Giving value for money
- Challenging ourselves to constantly improve quality
- Enjoying our work