THET PROGRAMME 2019 – 2020

GRANT APPLICATION FORM

This document should be read in conjunction with **THET Programme 2019–20 Call for Applications** document and **THET Programme 2019–20 Questions and Answers** document. Further questions will be answered during the **THET Programme 2019-20 Launch Webinar** held on Wednesday 16th January 2019, and subsequently available through the THET website.

Please be as clear and succinct as possible and ensure that any acronyms and technical terms are fully explained.

This Grant Application Form and the Budget Template (see separate Excel document), along with letters of support from each of the lead partners and any managing partners, should be completed and submitted to Grants@thet.org **by midnight on xx. If you do not receive an acknowledgment of your application from us within 48 hours, please assume we have not received your application and re-submit with evidence of your earlier submission such as a dated email.**

1. SUMMARY DETAILS

Lead UK or Irish partner organisation	[redacted]		
Lead Low and Middle-Income Country partner organisation	[redacted]		
Project title	[PROJECT NAME]		
Please indicate which thematic stream you are applying to:			
☒	Stream 1: Surgical and Anaesthetic Care	☐	Stream 2: Community Healthcare
Project budget total (£15,000-£50,000)	32,512.31		
Project duration (6 - 16 months)	16 months		
Project start date[1]	May 2019		

[1] Grants can begin from 1st January 2018 onwards. All activity must be complete by 30 April 2019

2. PARTNERSHIP

2.1 Please provide contact details for *all* partners involved in this application. If there are more than two partners involved (UK/Irish and overseas), add more boxes as necessary to include all.

Lead UK or Irish partner (contract holder and overall project lead)	
Lead UK or Irish Partner	[redacted]
Project co-ordinator (name and position)	[redacted]
Organisation/ Institution	[redacted]
Department	[redacted]
Address	[redacted]
Email	[redacted]
Telephone number(s)	[redacted]

Lead LMIC partner (lead LMIC partner and in-country coordinator)	
Lead LMIC partner	[redacted]
Project co-ordinator (name and position)	[redacted]
Organisation/ Institution	[redacted]
Department	[redacted]
Address	[redacted]
Email	[redacted]
Telephone number(s)	[redacted]

Managing/additional partner (supporting the delivery of the project)	
Managing partner	[redacted]
Project co-ordinator (name and position)	[redacted]
Organisation/ Institution	[redacted]
Department	[redacted]
Address	[redacted]
Email	[redacted]
Telephone number(s)	[redacted]

2.2 Tick the box that best describes each organisation. Please also add registration numbers where relevant. Please note that if you fail to complete this table, your application will be ineligible.

Lead UK or Irish Partner			Lead LMIC Partner	
☐	Health Delivery Institution		☒	Health Delivery Institution
☒	Health Education Institution		☐	Health Education Institution
☐	Regulatory Body (health sector)		☐	Regulatory Body (health sector)

☐	Professional Membership Association	☐	Professional Membership Association
☐	UK Registered Charity **Registration no:**	☐	Registered Non-Governmental Organisation **Registration no:**
☐	Ireland Registered Charity **Registration no:**		

2.3 Please list any other project partners or stakeholders that will play a role in the delivery of the project. *(Maximum 200 words)*

The **Hôpital** [redacted] agrees partnership strategy and activities at the hospital level. It has been the key partner for [redacted] from the outset. **The Hôpital** [redacted], [redacted] and [redacted] are the three other main government hospitals in the province and will participate in ongoing stakeholder engagement, training of trainer sessions, workshop delivery, and a safer surgery community of practice. The [redacted] the medical school in **[CITY NAME]**, will host a mini module on safer surgery for its undergraduate students, in order to familiarise the future doctors of the province with safe surgical practices.

Commented [THET1]: This question allows us to better understand roles and responsibilities of sub-partners.

This answer could have been more detailed on what is meant by "ongoing stakeholder engagement", but is otherwise explains well who else is involved and why.

It's important when answering this question that the role of any partner listed is described in relation to the project itself.

2.4 History of partnership and project implementation

Please describe the partnership's experience of implementing projects together. Please also describe any individual partner's experience of implementing projects in low- or middle-income countries. Please note, by partners we mean the organisations rather than individuals. *(Maximum 500 words)*

[redacted] works to help governments to improve health care and its outcomes by empowering people, strengthening organisations and enhancing systems. We work by invitation, are embedded within our national, public sector partners and are responsive to their needs in a long-term commitment. By engaging as peers, such as doctor-to-doctor, or nurse-to-nurse, we are consistent and trusted, and work to achieve meaningful and lasting change.

[redacted]'s mission is to support local partners to improve trauma health outcomes through developing a trauma system, delivering clinical care, providing training and mentoring, and supporting ground- breaking research.

[redacted] won a THET start-up grant in 2015 to build relationships, gather information, and conduct the start-up activities necessary to develop a partnership working to improve trauma care in **[PROVINCE NAME]**. Initial partnership work was carried out during short term trips and then by an in-country volunteer from August 2016 to August 2017. Working closely with partners at the [redacted], [redacted] has completed the following activities:

- Delivered six 2-day Primary Trauma Care (PTC) courses to 120 healthcare workers and trained 12 [redacted] PTC instructors, who are now delivering PTC courses independently to doctors and nurses throughout the province.
- Developed and piloted a trauma registry at the [redacted]
- Delivered a 2-day basic surgical skills pilot course for junior doctors at the [redacted].
- Delivered a 2-day course on analgesia and hand washing for nurses at the [redacted].
- Supported clinical care at the [redacted] including the establishment of a weekly trauma and orthopaedic Multidisciplinary Team Meeting, the development of clinical protocols for trauma, and the use of clinical posters for use in the emergency room.
- Regularly trained and mentored specialists, junior doctors, and nurses in the orthopaedic department at [redacted], and supported their weekly structured teaching.
- Delivered a half-day research methodology course to undergraduate students at the [redacted]
- Delivered the trauma and orthopaedic curriculum at the [redacted], along with a week-long summer school for [redacted] undergraduate students.
- Delivered a 2-day Safe Surgery Symposium to 13 delegates (senior surgeons and senior OR staff) from **[PROVINCE NAME]**, covering the WHO checklist, basic surgical skills, hand hygiene, safe OR practice and quality improvement methods.
- Built relationships with key stakeholders such as the Minister of Health for the province and the Chief of the Provincial Department of Health.

Commented [THET2]: Being detailed in this question is important, as in addition to judging the proposal on its own merit, we also have to make a judgement on the capabilities of the lead partners in successfully completing the project. By outlining past achievements and how the partnership has worked together, the panel is able to make more informed judgements on the viability of the partnership. When presenting past achievements and work, it is also better to tailor it to the Call for Applications where possible.

This answer was good in concisely presenting past activities, although there is an emphasis on what was delivered and not what was achieved. It could also be improved by giving a better insight into the partnership itself and how it has developed. Partnerships with long histories often mature and become stronger, which we want to see evidence of. Questions that partnerships can ask themselves are:

'What are we most proud to have achieved together?'
'How have the organisations developed as a result of the partnership?'
'What lessons have we learned?'

Please note that new partners who cannot provide a detailed history of their partnership will not be marked down. Rather, we would advise detailing the separate institutions' past achievements that would indicate effective project delivery.

3. JUSTIFICATION

3.1 Please describe how the partnership assessed the need for this project. This might include a formal needs assessment, desk-based research, or face to face meetings. *(Maximum 300 words)*

Meetings with provincial and national ministry representatives has revealed that, while there is a desire to improve patient outcomes through skills-based training and professional development, there is no funding for training, and limited funding for health at all. The national emergency and disasters preparedness government working group met with key national and international stakeholders in 2017 to discuss strategies for emergency surgical preparedness and it was recognised that training of healthcare workers is a key component of this. Meetings with the provincial medical inspectorate have highlighted the need for improved patient safety particularly in the area of surgical care.

The *WHO Situational Analysis Tool to Assess Emergency and Essential Surgical Care (TSAAEESC)* was used to measure the partner hospital's capacity to deliver surgery and anaesthesia services in 2017. The analysis found a baseline level of proficiency in surgical and anaesthetic care, but concluded there is much room for improvement. The tool has now also been used to assess services at the three other hospitals in the province with similar results.

[redacted] led an adapted basic surgical skills course in April 2017 and an infection and hand hygiene course in May 2017 at the [redacted] With lessons learnt from these training sessions, a safe surgery workshop was run at the WHO training facility in Matadi for key stakeholders from the four main hospitals in the province. The senior surgeon, senior anaesthetic care provider and senior theatre nurse attending the training spent time working in groups to articulate needs particular to their learning environment and how the teaching would be directly relevant to their context.

Commented [THET3]: This is a strong answer for several reasons. Firstly, highlighting engagement with the Ministry of Health or equivalent and other local stakeholders is crucial. It signals that the project is tailored to the specific context it will be working on, while stakeholder buy-in is instrumental for long-term sustainability of the benefits of the project.

Secondly, references to internationally recognised gold standard measurements, such as the WHO TSAAEESC in this case, ensures methodical steps have been taken in the needs assessment process. References to considerations of existing government documents and frameworks are also beneficial in showing the panel that steps have been taken to ensure that this project is not duplicating or impeding upon existing efforts in the country.

Thirdly, other visits and engagements that have been undertaken are explained clearly in terms of their usefulness in adapting the project to the context.

This answer could be improved by outlining what role each of the partner played in the needs assessment process, as it gives us more insight into how the partnership dynamic works. Unequal partnerships are seen unfavourably as we want to encourage equal and mutually beneficial partnerships. To see more on this, visit this link https://www.thet.org/principles-of-partnership/

3.2 Describe the need that was identified through this process and the problem that this project is trying to address. *(Maximum 500 words)*

Please include key contextual issues that are relevant to this application, including:

- The operational environment at LMIC institution(s).
- An explanation of how the needs are aligned to overseas government priorities and plans.
- Any barriers that may prevent women and girls, and people with disabilities benefitting from the project.

[PROVINCE NAME] has a very high burden of trauma cases due to road traffic collisions along **[ROAD NAME]**, which runs directly through the province. Despite the significant number of patients requiring surgery, surgical services are ill equipped to deal with the number and extent of injuries, causing high morbidity and mortality.

There are six million people in the province, but only four main hospitals with one post-graduate trained surgeon based at each hospital. Emergency surgical care is often provided by medical officers with no postgraduate surgical training. In addition to the lack of post-graduate trained surgeons, there is a profound lack of resources for teaching rurally-based medical officers. There are structures in place for a national surgical training programme, but this is poorly coordinated and under resourced. There is no reliable yearly pool of trained surgeons in **[COUNTRY NAME]**.

Junior doctors in **[PROVINCE NAME]** report an over-emphasis on didactic methods rather than practical teaching and non-existence of teaching and mentoring, translating into a lack of basic surgical skills. With no opportunities for continuing professional development, there is little chance of improving these skills. Despite this, junior doctors and experienced nurses routinely conduct incision and drainage of abscesses, C-sections, laparotomies, wound closures, and management of open fractures with little or no supervision. With only one post-graduate trained anaesthetist in the province, anaesthetic care is primarily provided by nurses and technicians.

Patient safety is also threatened by a lack of steps taken to ensure basic hygiene before, during, and after surgical procedures. For example, appropriate gloving and gowning procedures are not followed (or do not exist), hands are rarely washed, and equipment is irregularly or inappropriately sterilised. With the current EBV outbreak in eastern **[COUNTRY NAME]**, measures to ensure outbreak preparedness are vital.

There is an expressed need for training around audit and quality improvement methodology. The MIP is responsible for assuring quality of patient care but there is little reliable data collection or structured audit. Audit and quality

Commented [THET4]: This question is the applicant's chance to fully explain the problems that the project is addressing. We advise having one short paragraph that succinctly summarises the need that is being addressed.

A few things to keep in mind when answering this question are:

1) The review panel is a mix of medical experts and non-experts, so while being detailed is encouraged, please also try to explain everything in simple terms. This would include medical terms and technical jargon.

2) Conveying the scale of the problem is important in this section. During the review process, panelists will weigh up the scale of the problem and priority versus the funding requested and planned activities in the proposal in terms of appropriateness.

3)This question should be focused on presenting all the different aspects of the issue that the project will address, which means introducing aspects that will not be relevant for the project is discouraged.

https://www.thet.org/resources/gender-and-social-inclusion-toolkit/

improvement methodology does not form part of the undergraduate curriculum.

Health workers at the four provincial hospitals and representatives from the MPSE have expressed the need to improve surgical safety as part of an overall package to improve trauma outcomes in the province. Improved provision of surgical services is not only a priority in **[COUNTRY NAME]**, but also at the national level, as discussed in a recent Ministry of Health meeting on the role of emergency medicine in the country. Health policies are devolved to provincial governments and the key alignment is to the plans of the Ministry of Health.

Women tend to fill nursing rather than medical roles; those who do become doctors are less likely to pursue surgery. Bearing this in mind, all training to date has endeavoured to engage and support women. Men and women are equally encouraged to participate, but as elsewhere, men are overrepresented in surgical training.

Mothers and new-borns are disproportionality affected by poor hygiene and unsafe surgery. A high proportion of surgery undertaken relates to caesarean sections. Disabled people form another large portion of surgical cases, particularly considering the high road traffic and trauma burden. Improved surgical safety would substantially increase positive outcomes for both populations.

3.3 Based on your answer to the above question, please explain in more detail how your project is relevant and appropriate to the local context. *(Maximum 300 words)*

Our project is relevant and appropriate to the local context because it was co-designed by our partners, at both frontline clinical level and also within provincial government, and in relation to the needs outlined above. It fits with Ministry plans to raise the skill levels across the whole province.

Through previous trips and trainings participants identified the need for further and deeper training, and to allow future interventions to be tailored to the exact needs of the province. This project has subsequently been designed to better integrate within hospital structures, and begin the process of continued professional development, particularly around the lack of clinical skills and safe surgical practices. The project builds on preceding work and integrates lessons, discussed below, about the most appropriate delivery mechanisms to support sustainability. The trainings offer a different approach to the traditional didactic model, and encourage cascading and onwards learning to other staff members.

The interventions are a collective package which will provide for systematic improvements around safer surgery across the region, and ensure a sustainability and provincial ownership of these changes. By structuring training around institutional implementation of a quality improvement and audit model, the project supports leadership and management within the hospital and marries with the importance of increased ownership from senior staff.

Commented [THET5]: This answer is excellent as it clearly presents how the local context has been considered in the project plan and implementation. The fact that it was co-designed by local partners and stakeholders means local voices and views have been actively engaged, which increases chances of success and sustainability. It also conveys a sense of equal partnership, which THET values highly.

The aspects that can be included and the level of detail is very flexible and dependent on the specific project. What panelists value are clear signs that the necessary steps have been taken to maximise the chances of success and sustainability of the project in a given context with genuine local ownership of design, implementation, and outcomes.

4. PROJECT DESCRIPTION

4.1 Clearly describe up to four changes you expect to see by (a) the middle and (b) the end of the project in relation to your project goal. Name all institutions cited. Ensure the changes clearly relate to the purpose of the AGP. See the grant Q&A document for examples and guidance. Do not add more lines to this table. *(Maximum 300 words)*

Project goal:	Improved delivery and monitoring of safe surgical practice at 4 **[PROVINCE NAME]** hospitals
(a) Changes by the middle of the project:	
1. 4 hospitals in region have 60 people trained in safe surgical practice, including WHO checklist and infection prevention and control	
2. 4 hospitals in region have 60 people trained in quality improvement methodology	
3. Develop and establish a data system for audit of surgical cases	
4. Run a two-day course for university medical students	
(b) Changes by the end of the project:	
1. 4 hospitals in region implementing safe surgical checklist on monthly basis, 75% of months at a WHOBARS score of 4	
2. A quality improvement/audit committee has been appointed at each of the 4 hospitals	
3. A minimum of 7 people at each of 4 hospitals who are observed being able to identify surgical site infections	
4. A minimum of 7 people at each of 4 hospitals who have completed a quality improvement project or audit	

4.2 Please describe how you will collect evidence that your project has achieved its changes and goal. Please consider:

What data will you need?

- Who will collect it, when and how?
- How will you analyse it?
- How will you monitor any unexpected outcomes?
- Will you have a research element to this project?

We will add to our existing baseline information in each of the areas by collecting data on current training levels of staff in terms of safe surgery and anaesthesia, current implementation of the safe surgical checklist, and undertake the baseline study of surgical case burden

Data collection and analysis will then be built into the audit and quality improvement mechanisms being implemented as part of the project. This provides an in-built sustainability, and encourages deeper partnership working through sharing of information. The in-country Administrator will provide ongoing support and monitoring of this, particularly relating to the regularity of meetings and actions.

As part of training, we will undertake self-assessment of learning and knowledge. We will also monitor on-the-job performance, particularly related to WHOBARS.

All data collection will be disaggregated by gender, to support better understanding of the outputs of this project.

4.3 Activity plan – List the main project activities. These must contribute to achieving the changes listed above, or to strengthening the Health Partnership during the project implementation period. Mark an X in the quarter(s) in which the activity will take place. Add more lines if necessary.

Commented [THET6]: The best way to present your goals is in a SMART way:
S – Specific
M – Measurable
A – Achievable
R – Relevant
T – Time-bound

There should also be a logical flow between changes by the middle and end of the project. For example, the answer for a1 (4 hospitals in region have 60 people trained in safe surgical practice, including WHO checklist and infection prevention and control) relates directly to b1 and one can see how b1 builds upon a1 in a logical manner.

It is also important that these targets are reflected by the activity plan in 4.3. As a general rule, the panellists will want to see overall cohesion between outcome, activities planned, budget, and time-frame throughout and this section is an important component of that.

One thing that could have been improved in this answer was to specifically include behaviour change at the outcome level. With interventions like these, the impact of projects is often hard to measure and sustain, but with ingrained behaviour change it has more likelihood of being embedded as part of the work culture.

Commented [THET7]: Clearly describing the type of data which will be collected and why they are collecting it are very important elements that panelists are looking for in this question. However, this answer could be improved by including more detail, such as who will be collecting the data and what methodology is used to collect data. If they had answered all the sub-questions in order it would have been more comprehensive.

The emphasis here should be on presenting the MEL plan concisely and ensure they relate to the targets set. We want to know what you are planning on measuring, whether that is appropriate for your targets, and how you plan to measure it.

THET are also consistently looking for evidence that sustainability has been considered in all aspects of project planning. Where applicable, we want to know that MEL processes are embedded to the project site and can be useful to hospitals beyond the project lifetime. For example, if a method of measuring patient outcomes is introduced, it would be preferable if that system could then be used by the hospital after the project has ended. An example we would advise against is having a data collection system conducted exclusively by the UK partner. We are also looking for evidence that applicants have considered how they might encourage, and then measure, behaviour change and retention of knowledge over time.

Commented [THET8]: The main point of emphasis for this question is feasibility, i.e. given the time and budget constraints, do we think the project could achieve X. It also gives an insight into the appropriateness of the planned activities and we want to see evidence of a logical cohesion of activities quarter-to-quarter in relation to achieving the overall project goal(s) as well as in relation to the needs identified in 3.1 and 3.2.

Activity	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 5 *(+1 month if until 31 August 2020)*
Training around: implementation of WHO safe surgical checklist; QI and audit methodology and IPC and surgical site infection, and doing a workshop on safer surgery and QI for senior staff, course for medical students		X			
Follow up trip to undertake training around: implementation of WHO safe surgical checklist; QI and audit methodology and IPC and surgical site infection			X		
Establishment of online and app-based training structure to provide offline continuous learning	X	X	X		
Continued data collection of use of WHO safe surgical checklist	X	X	X	X	X
Operative case load data collection		X	X	X	X
Set up of regular review of operative case load data through QI committee			X	X	X
Monitoring and evaluation trip to explore impact of training and mentorship, and repeat WHO TSAAEESC tool					X

4.4 Please fill in the table below with disaggregated data on your proposed project. If you do not know the exact figures, please estimate the number of people who you are aiming to reach.

	Number
Break down total number of health worker trainees by cadre. *e.g. Nurses x 5 etc.*	Nurses : 25 Doctors with surgical responsibilities (usually when on-call) : 30 Post-graduate trained surgeons : 3 Anaesthetists: 3 Anaesthetic technicians : 3 **Total : 64** We are not currently able to disaggregate by gender, but will do as part of reporting.
Of this number, how many will be trained as trainers? (*Please break down by cadre*)	Identified and supported as advocates and trainers: 3 per hospital, 12 in total (even distribution of doctors, nurses, and anaesthetic staff)
Estimated number of patients who will access improved service within the project duration, including women and children.	850 patients requiring surgery at [redacted] every year; women represent a larger proportion of inpatients: 600* at [redacted] 600* at [redacted] 600* at [redacted] *Figures are estimates, as data for these hospitals are not available.
Number of UK / Irish staff who will volunteer overseas.	8 volunteers

Commented [THET9]: This section is the applicant's opportunity to convey the scale of the project and demonstrate that thorough scoping has taken place already. For the scale, the number of health care workers and cadres reached will be weighed against the budget, time-constraint, and planned activities in terms of appropriateness.

We also want to see evidence that the health workers bring targeted have already been identified, indicating that the project intervention has been tailored and is thus more likely to achieve the desired outcomes. By incorporating different cadres, it also gives us an idea of the degree of multidisciplinary teams involved in the project and how that has been considered in other aspects of the project.

Disaggregating by gender, if applicable and possible, also gives reviewers a better idea of the extent to which gender inequalities have been considered and balanced for in the project. However, we also understand the limitations of just looking at numbers for this and this will be considered alongside other gender considerations throughout the application.

Number of days in total UK / Irish volunteers spend overseas.	4 trips 110 volunteer days

4.5 Describe how you will utilise multidisciplinary teams, and in particular how you will engage with nurses, midwives, or clinical officers. *(Maximum 200 words)*

Good teamwork and multidisciplinary working is integral to delivering safe surgical care; it must involve different disciplines and different cadres of healthcare workers. The situational analyses and training around safe surgery we have conducted already have targeted all cadres of health workers. We have trained doctors (including clinical officers), nurses (including anaesthetic officers) and theatre staff and they have actively contributed to the design of the existing programme.

All proposed training will be multidisciplinary with continued involvement of medical staff (acting surgeons, junior doctors, anaesthetists) and nursing staff (perioperative care practitioners, theatre staff, anaesthetic officers). We will also include senior midwives in each hospital in the safe surgery training workshops.

An informal link with the International Federation of Perioperative Nurses (IFPN) and the UK Association of Perioperative Practice (AFPP) is helping design training that is appropriate for nurses and perioperative care practitioners. Their expertise, particularly in contexts similar to **[COUNTRY NAME],** is a valuable in designing context appropriate training.

4.6 Please describe how your project will be overcoming barriers that women, children and underserved populations may face when accessing healthcare. *(Maximum 200 words)*

We work with government hospitals and these institutions traditionally serve the most under resourced populations. Certain treatment is free or subsidised (emergency c-section, HIV/ TB/ malaria treatment) but surgical care is out of pocket user fee based. The fees at our partner hospital are lower than in private treatment centres and for destitute patients, unofficial loans may be provided. Other hospitals in the region are faith-based organisations but which sit within the government healthcare infrastructure.

Our work is targeted at the main government hospitals but the majority of staff working in these hospitals also work in smaller health centres based in the community that may offer minor interventions and c-sections. These small health centres provide treatment in local communities for patients who cannot afford treatment in a larger institution or who are not able to travel to one of the bigger cities due to the poor travel infrastructure.

We actively engage women in the PTC course and within the training we provide more generally, conscious of the historical barriers to their engagement. The fact our lead is female, and many of our key partners also are, does provide role-modelling to encourage greater engagement.

4.7 Please explain how you will ensure that the project changes are sustained beyond the lifetime of the project, including other government and non-governmental bodies you intend to approach or collaborate with in the host country. *(Maximum 300 words)*

The project has been requested by and is built into development plans led by the local Ministry of Health and key regional hospitals. Activities have consequently been designed to support national ownership and ongoing sustainability beyond the lifespan of the project. Related to our value for money framework below, this is not only about the long-term sustainability of the project, but the effectiveness of delivery within its lifespan.

Establishing quality improvement and audit practices and skills, in particular, is a key methodology towards long-term ownership of change. By embedding the concept of change within regular management processes within the hospitals, the project will encourage and facilitate the hospitals and their staff delivering that change into the future. For the hospitals, this provides the process for regularising change and an accountability mechanism for ensuring it continues implementation. For individuals involved, this provides the opportunity and motivation – in terms of recognition – for helping support that.

The project also undertakes a train-the-trainers approach for key elements of skills development, providing individuals with

Commented [THET10]: This question elaborates on the multidisciplinary aspects of 4.4 in a qualitative way. A good answer will show understanding and clear articulation of the importance of multidisciplinary teams and targeted training for each cadres' specialised roles.

This answer was well-received as it showed strong understanding of the importance of multidisciplinary teams by the partnership and they have demonstrated that in their work so far. They also described how they will ensure their training is relevant and appropriate for other cadres by engaging with other specialists in the field. This shows that they recognise that training needs to be specifically tailored for different cadres.

Commented [THET11]: In an otherwise strong application, this answer could have been more clearly answered. While articulating the current situation that underserved populations face, the applicants do not propose how their project considers these and overcomes them.

Ideally, we would like to see evidence of these considerations in the project design phase and clear plans as to how these will be tackled throughout the project.

At the same time, we understand that it is difficult to tackle broad, often societal issues. However, just articulating sentiments such as "we will actively engage women" and "most of our nurses in the project are already female" would not be considered as measures against overcoming social barriers.

THET's gender toolkit can give Partnerships more information and ideas on how they can ensure that their project is gender sensitive and gender transformative: https://www.thet.org/resources/gender-and-social-inclusion-toolkit/

Commented [THET12]: This is an important aspect of projects that THET values highly and answering this question well is crucial to any successful application. It is also arguably one of the more difficult aspects to clearly articulate. This answer is good at incorporating many of the aspects that are valuable when answering this question. Below, there will be a brief explanation of these aspects mentioned:

- Involving the Ministry of Health (or equivalent body). Involving and receiving input from the Ministry of Health is a strong way to gain long-term buy-in from senior health officials and increases chances of cascading of benefits to other parts of the country, and can also lead to formalised guidelines, curricula, policy documents, etc.

- Embedding into existing systems. By tailoring the intervention into the specific context (hospital-level or region-level), it increases the chances that the positive outcomes remain past the lifetime of the project as it becomes ingrained into the work-culture. Gaining senior management buy-in is also an effective way of sustaining changes beyond the lifetime of the project.

- Training of Trainers. This involves strategically choosing certain members of the hospital/clinic staff to be trained as trainers who can go on to train other health care workers both during the project and after the project has finished. This is an effective and simple way to cascade the benefits of the intervention to new employees, other hospitals, and other regions for a longer time.

the capability and further motivation to facilitate further learning within and across their institutions.

This ongoing learning and the project changes will be sustained beyond the lifetime of the project because of the provincial government interest in embedding this change. The request for these interventions has come from the provincial government, and as a consequence they have been co-designers of the project.

Commented [THET13]: An aspect that could have improved this answer is to include how these interventions will ensure behaviour change. In our experience, behaviour change plays an important part in long-term improvements, but we also realise that this is not always appropriate for projects to pursue.

5. PROJECT MANAGEMENT AND SUPPORT

5.1 Describe the systems that currently exist or will be put in place to support the implementation of this project. Add more rows as necessary.

Systems	What, How and Who
Governance Structures	[redacted]
Decision Making	At the local level, decisions are driven by our in-country partners and supported by [redacted]. In London, decisions will be made by the Partnership Lead and the management in [redacted].
Formal Agreements	There is already an MoU and a Programme of Work between the [redacted] and [redacted].. Since the ministry staff have been entirely replaced since signing the former Ministry MoU and Programme of Work, work is in progress for a new formal agreement to be signed by the incoming administration.
Communication Strategies	WhatsApp is used to communicate with partners in **[COUNTRY NAME]**; this has proven to be the most effective manner of communication. While the Partnership Lead and other volunteers are in-country, regular calls are held with the London management team. Further communication occurs through formal reporting and trip reflections.
Financial Systems	[redacted]
Administrative Support	UK based Administrative Assistant is providing administrative and coordination support to the Partnership, ensuring administrative systems for programmatic activities and volunteer databases are maintained, while coordinating with in country partners in French.
Risk and Safety	Robust risk assessments and emergency protocols are in place and have been tested and refined during previous trips and during the year-long in country period. They are reviewed and updated quarterly, and before every volunteer deploys.
Volunteer Support	Volunteer support begins with careful selection of volunteers; it's important that they have previous experience working in low income settings and appreciate the sensitivities of working in a country with FCO travel warnings. We take our duty of care to the volunteers seriously, recognising that **[COUNTRY NAME]** is a challenging environment. Every volunteer receives a handbook and undergoes a thorough pre-departure induction. Upon return to the UK, volunteers receive a debrief with the Administrative Assistant and Operations Officer and are encouraged to provide feedback on the above processes to strengthen them going forward.

Commented [THET14]: This section is an opportunity for the partnership to demonstrate the formal structures in place. Robust plans and mechanisms for project management are just as important as the design of an intervention for positive project outcomes. We particularly value partnerships where all partners feel equally engaged and empowered throughout the different aspects of the project, which you can read more about here: THET's own Principles of Partnership framework

In the past, partnerships without these formal mechanisms in place have often struggled with strategy and overall cohesion of the project. In conjunction to this, THET also encourages partnerships to fund appropriate personnel (both in the UK and the LMIC) who are responsible for the project management, or at least the administrative aspects. Explicitly stating policies or project management systems is strongly encouraged, but for partnerships that do not have such structures in place, we advise presenting the discussion and plans for how they will come about.

While not always relevant, something to include is the external communication strategy in addition to internal, e.g. how you are planning to disseminate your results/learnings to others.

5.2 Complete the table below outlining the role each partner organisation will play in the delivery of this project and how they as an organisation will benefit from their involvement in the project. All partners named in Section 2 should be included here.

Partner	Role	Benefit
[redacted]	Oversight of interventions to improve trauma outcomes in **[PROVINCE NAME]**	Improved resources for Health
[redacted]	Responsible for healthcare workforce planning, postgraduate training and governance of provincial health zones.	Improved resources for Health
[redacted]	The main hospitals in the province will participate in ongoing stakeholder engagement, hosting the training of trainer sessions, workshop delivery, and a safer surgery community of practice.	Strengthened health workers who drive improved surgical outcomes
[redacted]	The [redacted] Lead and other volunteers will co-deliver safer surgery courses and provide the ongoing mentorship and support of the community of	Improved management abilities, interpersonal skills, and intercultural awareness, and the development of a

Commented [THET15]: THET's Principles of Partnership framework is also encouraged to be thought of when answering this question. This question ensures that roles and responsibilities in the partnership are distributed equally.

This answer would have been better with more specific details, such as elaborating on who the beneficiaries are and in what capacity. Where relevant, it is advised to include measurable benefits in this regard, such as stating how many health workers are expected to be strengthened. Note that some donors are also especially interested in how the benefits of the project impacts UK health systems, therefore articulating this is useful.

	practice. Colleagues at the [redacted] will provide support with strategic oversight, reporting, and logistics.	blueprint for the development of further global health work in **[COUNTRY NAME]**

5.3 What do you anticipate will be the biggest challenge or risk for your partnership in managing this project, and how will you address it? *(Maximum 200 words)*

We anticipate the following potential challenges in managing this project:

Ensuring safer surgery approaches are spread to other hospital staff: we are minimising the chance of this occurring firstly by engaging the senior leadership at each hospital to set role model safer surgery to the staff they oversee. Because we also want the direction of influence to occur from below, we will identify and support safer surgery advocates who will help develop a culture of safer surgery.

Maintaining interest and engagement throughout the project and beyond: we will work to maintain engagement by offering health workers professional development opportunities through workshops and roles as advocates.

Maintaining momentum and political will: we have had good contact with stakeholders thus far and our work is recognised within the province and at a national level. Our workshops will focus on the need to develop robust systems that become embedded in routine clinical care. The safer surgery advocates will understand the need for sustained good practice, regardless of changes in leadership.

Commented [THET16]: This question is an opportunity for applicants to demonstrate that they can anticipate and plan to overcome possible obstacles and risks associated with the project. Including elements such as the process that went into identifying and evaluating anticipated risks, as well as basing the answer on a separate risk register is something we advise.

At a later stage in the application process, THET will need to see a completed risk register, so this question is a good place to start completing one.

5.4 Describe the processes by which staff / volunteers will be recruited or selected and managed. If your response suggests that you have policies and procedures in place, THET will ask to see copies of these should your application proceed.

General explanation of processes *(Maximum 200 words)*		
Volunteers will be identified through existing [redacted] networks and additionally through the extensive networks developed by [redacted]. Candidates will go through a CV screening and a formal interview process to assess experience and suitability. Additionally, DBS checks will be performed for every volunteer recruited. Every volunteer will receive a handbook and undergoes a pre-departure induction in London, which includes safeguarding and security training. While in the **[COUNTRY NAME],** the volunteer will be supported by the Partnership Lead and any other team members traveling during that time. Each volunteer will receive a debrief upon return to the UK with the Administrative Assistant and the Operations Officer.		
Specific considerations around staff and volunteer safety *(Delete Yes or No as appropriate)*		
Do you provide insurance for all staff and volunteers?	Yes	
Are the areas in which you propose to work completely free of UK Foreign & Commonwealth Office travel warnings?		No
Will the project be deploying staff and volunteers for short-term visits only? (i.e. less than 6 months)	Yes	
Within the UK organisation(s) are there formal mechanisms in place to support staff who want to take time off to engage in voluntary work?	Yes	
If the answer to any of the above is No, please explain what will be done to support staff and volunteers *(Maximum 200 words)*		

Commented [THET17]: This question is an opportunity for the partnership to elaborate on their overall volunteer management strategy, including evidence of formal processes for identifying, managing, and supporting volunteers. This includes evidence of having fair means of selecting volunteers, adequate support and safety protocols for overseas trips, and processes for support upon return to ensure the parent institutions can benefit from any learnings.

THET is also checking whether there are safeguarding policies in place and other internal policies related to deployment. Similar to the risk register, these will be required at a later stage in the application process, so using this question to either create them (if not in place) or revisit them (in case they are outdated) is advised.

In line with our emphasis on cohesive project design, elaborating on the role that volunteers will be playing in the project and how volunteers will benefit is also strongly encouraged.

Commented [THET18]: Please note that it is not a problem if you answer 'no' to any of the above, but panelists are looking for evidence that associated risks have been evaluated appropriately and that there will be procedures in place to mitigate them.

The UK Foreign & Commonwealth Office's recommendation for the [**CITY NAME**] province is that travellers read its travel advice before travelling. With a long history of working in conflict and post-conflict settings, [redacted] has robust risk assessments and algorithms that it updates regularly for its work in [**COUNTRY NAME**]. The algorithms have worked well during previous visits and during the year that the Partnership Lead (ET) lived in country.

Before each volunteer deployment, the assessment is reviewed by the [redacted], with advice from the Foreign & Commonwealth Office. Prior to travel, all UK volunteers are fully appraised of the situation during a thorough induction that includes safety training.

While in-country, the [redacted] is kept up to date on any changes in the risk environment by the FCO, external risk management agencies, and in-country contacts. Exit interviews are carried out with all volunteers and psychological support is offered to volunteers on their return to the UK.

6. BUDGET

6.1 Please explain how you will ensure that your project is good value for money. Please base your answer around the 4 e's- efficiency, effectiveness, equity, and economy. *(Maximum 300 words)*

We strive to maximise the value of every pounds spent on our work and follow the DFID 4Es framework:

- Economy: Engaging volunteers improves the economy of this project. Money is saved using volunteers to teach. Surgical Checklist implementation and following up with the use of an online and app-based training structure to provide offline continuous learning will also prove economical and sustainable post-project
- Efficiency: We demonstrate efficiency through working collaborative working with all our partners. We are an example of how integrated, locally-owned projects are efficient in achieving outputs through collaboration.
- Effectiveness: Our work is effective because local partners fully own, lead, develop, and implement our collectively-designed projects with support from our team. Because of this, change is immediately embedded, and progress towards expected outcomes is tangible and sustainable. We have seen how this approach has led to the continued use of co-developed systems when our support is reduced, such as Congolese delivery of Safe Surgery workshops/ courses.
- Equity: In implementing this project we have carefully considered issues of equity, with working at government hospitals as opposed to private health centres, we are making sure that development results are targeted at the poorest. Additionally, this intervention's objectives directly target/ affect women as improved surgical practices directly reduce the risk for complications during emergency obstetric procedures.

Commented [THET19]: On the aspect of equity, we want partnerships to consider the issues surrounding gender equality and social inclusion in their project. Where appropriate, THET would encourage specifically budgeting to mitigate any obstacles that may arise related to gender equality and social inclusion during the project.

https://www.bond.org.uk/sites/default/files/resource-documents/assessing-and-managing-vfm-main-report-oct16.pdf