# In our mutual interest

# About THET

The World Health Organization estimates that the world will need to recruit and train an additional thirteen million health workers in the coming decades in order to fulfil citizens' right to health. THET is a UK-based NGO, which aims to address the challenges of this health worker gap by supporting health partnerships between UK and overseas health institutions such as hospitals, universities and research centres. We are currently the managing agent for the Health Partnership Scheme, a £30million six-year programme funded by DFID. The driving force behind this scheme is the notion that health partnerships should be equitable for all partners and should deliver mutual benefit for both the UK and the LMICs with whom they partner. THET also champions a health partnership model that aims to improve health systems and health services and is based on a commitment to equal partnership and co-development between actors and institutions from different countries. The health partnerships that are developed are intended to be long-term but not permanent and, perhaps most importantly, are based on principles of reciprocal learning and mutual benefit.

# In our mutual interest

## Table of contents

# Introduction

We are entering an era in which traditional approaches to overseas aid are giving way to new forms of development, involving new sources of finance and new partnerships, which speak to the concepts of mutual benefit, co-development and co-learning. The UK health partnership movement is at the forefront of these changes.

*In our mutual interest* shares the learning acquired by THET over many years working at the heart of the health partnership movement. Examining the opportunities and challenges associated with this approach, this report points to the huge benefit that can be derived by both the UK and our partners and governments overseas when the right balance is struck between our own organisational and national interest, and the interest of people living in some of the world's poorest countries.

We hope this report will be of value to our colleagues across the UK health community who are either already working or are thinking about working in low- and middle-income countries (LMICs), and to policy makers across Whitehall and the NHS who have a vital role to play in facilitating this extraordinary work.

We would like to acknowledge our debt to the significant guidance received from our Steering Group of very eminent thinkers. Their role was to advise. Ours was to write. Any faults or shortcomings therefore firmly reside with us.

**Graeme Chisholm,
Elaine Green and Ben Simms**

# Foreword



**Prof Dame Sally C Davies,
Chief Medical Officer**

Health is global.

We have known this for a long while of course, in the etymology of our patients and from the nationality of our colleagues.

Less well known perhaps, is the work UK health workers within the NHS, social care, academia and beyond have been doing, largely on a voluntary basis, in low- and middle-income countries across Africa and Asia.

Known as 'health partnerships', there has been a burgeoning of this activity in recent years, thanks to the work of THET, and generous government ODA funding.

This report brings together the knowledge THET has acquired in recent years and encourages us all – as individual practitioners and policy-makers – to look at how we could be doing even more.

And there is genius in this argument. Not only is this good for countries overseas, who deserve our support to overcome the poverty they face, it is also good for the UK. Those who travel overseas, bring home fresh ideas about leadership, innovation and service-delivery, which directly benefit our work in the UK. I know this from my own experience.

This report is in part a tribute to the 7,000 health workers from across the UK who have taken part in health partnership work. And in part, it is a call to arms. We could be doing so much more and we could be gaining so much more.

Whether or not you are already involved in health partnerships, I urge you to read this report.

# Executive Summary

The UK has long been a leader in delivering official development assistance (ODA). In 2013 the UK became one of only six countries to have met the global commitment to spend 0.7% of gross national income (GNI) on ODA and in 2015 this commitment was enshrined in law[1]. In an era of austerity, the UK's commitment to meeting the 0.7% GNI target is perhaps even more impressive. Austerity has, however, emboldened its opponents. In March 2016 the *Mail on Sunday* sponsored a petition to overturn the enshrinement in law of the 0.7% GNI on ODA commitment and garnered more than 235,000 signatures in support[2].

Partly in response to this opposition, the defenders of the 0.7% commitment have placed a growing emphasis on demonstrating how ODA delivers benefits that are in the UK national interest. This is the central theme of the Department for International Development's latest aid strategy[3] and was reinforced by The Rt Hon Priti Patel MP on her appointment as Secretary of State for International Development in July 2016.

Within the health sector, there are many opportunities for delivering ODA that can also serve the national interest. Opportunities range from reducing global health security threats through opening up markets to export the UK's expertise on healthcare globally, to building a more responsive, motivated and innovative workforce for the NHS.

The health partnership approach, which has brought large numbers of UK institutions into the development space in recent years, is one such platform for demonstrating the kind of mutual benefit described in the UK aid strategy. The challenge however, as our experience of managing health partnerships has shown, is to strike the right balance in delivering ODA that furthers our organisational or national interests whilst also placing poverty eradication at its heart.

Specific challenges that may arise from an over-emphasis on our own organisational or national interest include:

1) Rather than being a global leader in setting good practice for international development, we could undermine agreed principles of aid effectiveness.

2) Rather than ensuring well-designed aid, we could fail to deliver effective programmes or sustainable development outcomes.

3) A lack of policy coherence between the policies and actions we pursue in our domestic and international activities could undermine the potential of the impact we seek to have.

In this report we explore in detail how health partnerships serve as a case study throwing light on the challenges of striking the right balance between our own organisational or national interest and the benefit given to host institutions and countries. We also review the policy environment across the UK health system and explore how specific changes can support quality scale-up of health partnership programmes.

By overcoming these challenges, the UK can maximise the huge potential that exists for ensuring that UK ODA is delivering programmes that are of mutual benefit to both the UK and the low- and middle-income countries (LMICs) the UK supports.

Contributing to the achievement of Sustainable Development Goal 3 (SDG3) presents, in particular, a golden opportunity for the UK to demonstrate its leadership and expertise in health systems strengthening, through both the leadership of DFID in international development, and through the experience, expertise and lessons that can be drawn out of the NHS for an era in which universal health coverage (UHC) is the guiding vision.

Now is the time to overcome these challenges and to seize the opportunities. We therefore recommend the following actions for the UK Government, the UK's health system, and for current and future managers of health partnerships:

# For the UK Government:

## RECOMMENDATION 1

To ensure that UK ODA for health delivers sustainable benefits the UK Government should be encouraged to promote policy coherence across all government departments through the development of a new Global Health Strategy that will help orient effective UK-wide engagement in global health.

## RECOMMENDATION 2

The UK Government should consider scaling up its investment in health partnership programmes, recognising the particular value they hold as a tool for strengthening health systems in LMICs whilst also advancing the UK's national interests.

More specific recommendations for how the UK Government can strengthen future health partnership programmes include:

- Supporting future health partnership programmes to coordinate technical assistance from the wide range of UK health professionals in the NHS, Government and beyond (including clinicians, technicians, managers, administrators, education specialists, suppliers, etc.). This coordination of technical assistance can be conducted both directly by recruiting and managing volunteers and indirectly by working in partnership with NHS local workforce action boards (LWABs), Royal Colleges, Arms-Length Bodies such as Public Health England and Health Education England, together with their counterparts in Devolved Administrations. This will support a more systemic and consistent strengthening of LMIC health systems.

- Supporting future health partnership programmes to strengthen the UK environment for engaging in global health 'at the grassroots' level. This can be achieved by continuing to identify and support individual partnerships – small and medium sized NHS, NGO as well as private sector organisations - to scale-up for greater impact through a more

systemic approach. This will help nurture, in a coordinated way, the growing interest in global health.

- Supporting future health partnership programmes to explore models of increased ownership by LMIC partners whilst still ensuring good value for money and quality grant management. This has many potential benefits and could help address structural barriers to securing mutual benefit such as transparency.

- Supporting future health partnership programmes to demonstrate the co-development of the healthcare workforce within the UK and LMICs. This will promote lifelong learning and will generate relationships and skills, which will benefit not only the populations of LMICs but also improve the skills, competences and behaviours of the UK healthcare workforce and improve the quality of care for UK patients.

# For the UK health system:

## RECOMMENDATION 3

In order to prepare and support a responsive and motivated UK health workforce the development of a culture of global health learning, which values volunteering and overseas experience, is vitally important.

Progress in establishing global health competencies has seen recent welcome progress with pioneering work being achieved to establish global child health competencies for paediatricians.

Therefore:

- The Academy of Medical Royal Colleges and medical training organisations should facilitate a similar process whereby other medical specialities develop similar competencies for use by those who train overseas during part of their specialist training, and build on existing guidance to include in general training curricula.[4]

- As international engagement during training becomes increasingly common in other health professions such as nursing, midwifery, physiotherapy and occupational therapy, universities should establish clear processes and guidance to support these health workers with input from regulators and support from the respective professional associations.

## RECOMMENDATION 4

The General Medical Council (GMC) should accelerate its efforts to establish a revalidation system that enables UK doctors working overseas to revalidate their skills and return to the UK fit to practise within the NHS.

To achieve this:

- The GMC should work with an International Non-Governmental Organisation (INGO) or consortium of INGOs to clarify the legal framework of liability associated with an INGO or consortium becoming a Designated Body tasked with revalidating doctors working in LMICs for extended periods of time.

- The GMC should develop and disseminate widely guidance to ensure that all doctors who work overseas for extended periods of time are aware of who their Responsible Officer and Designated Body is along with the steps required to successfully revalidate.

The Royal College of Nursing and the Royal College of Midwives are developing guidance in-conjunction with MSF and VSO to support nurses and midwives who work overseas to revalidate.

- Recognising this, the Nursing and Midwifery Council should continue to work with the Royal College of Nursing and the Royal College of Midwives and INGOs to resolve issues that may arise and provide further guidance to ensure that all nurses and midwives who work overseas may revalidate and return to the UK fit to practise in a UK setting.

## RECOMMENDATION 5

Recognising the progress that has been made in other parts of the UK, in particular Wales, we offer the following recommendations to the NHS in England to support further quality assured scale-up in global health.

- One NHS local workforce action board (LWABs) from each of the four English regions should work in partnership with THET to develop a strategy for internationalisation as part of their sustainability and transformation planning process. This will support the NHS to explore quality assured philanthropic and commercial opportunities for engaging in global health in low-income countries through future health partnership programmes, in middle-income countries through, for example, the Prosperity Fund, and in higher-income countries through working, for example, with Healthcare UK.

- The Department of Health's Standards of Good Practice should be further developed and tested within NHS local workforce action boards (LWABs) from each of the four English regions as part of their strategy for internationalisation. A portfolio of case studies should be made available through Health Education England and Public Health England. These steps will help to ensure that UK health institutions interested in working through health partnerships with LMIC partners have a better understanding of the risks and opportunities inherent in this activity.

# For health partnerships:

## RECOMMENDATION 6

- As part of THET's continued engagement with the wider partnership community we recommend that health partnerships sign-up to the Principles of Partnership, which commit partnerships and those new to partnerships to apply best practice in the design, implementation and evaluation of health partnerships. This will help to address the challenges inherent in health partnerships, as documented in this report.

# Methodology

The research process and evidence gathering for the development of this report comprised three main approaches. A rapid literature review of published and grey literature was conducted to gather a wide range of evidence to inform the key topics of this report. In addition to this, a review of learning was carried out. This consisted of analysing evaluation reports, consultations and surveys conducted throughout the lifetime of THET's Health Partnership Scheme and its predecessor scheme. To ensure this report reflects the experiences of practitioners in the UK and in the Health Partnership Scheme's partner countries, semi-structured interviews were also conducted with 19 key informants from Ethiopia, Myanmar, the Republic of Ireland, Switzerland, Tanzania, Uganda and the UK.

In order to guide the development of this report, a steering group of leading figures in global health was convened. Steering Group members included representatives from the World Health Organization, the International Confederation of Midwives, the Government of Tanzania, the Royal College of Paediatrics and Child Health, Johnson & Johnson, King's College London and the UK's All-Party Parliamentary Group on Global Health.

# Section 1: Global health in our mutual interest

## 1.1 Official development assistance in our national interest

The UK has long been a leader in delivering official development assistance (ODA). In 2013 the UK became one of only six countries to have met the global commitment to spend 0.7% of gross national income (GNI) on ODA and in 2015 this commitment was enshrined in law[5]. ODA must, under internationally agreed rules, have the promotion of the economic development and welfare of LMICs as its main objective[6].

In an era of austerity, the UK's commitment to meeting the 0.7% GNI target is perhaps even more impressive. Austerity has, however, emboldened its opponents. In March 2016 for example, John Wellington of the *Mail on Sunday* sponsored a petition aiming to overturn this law and garnered more than 235,000 signatures in support, triggering a Westminster Hall Debate[7].

Partly in response to this opposition, the defenders of the 0.7% commitment have placed a growing emphasis on demonstrating how ODA delivers benefits that are in the UK national interest. Indeed, this is the central theme of the November 2015 aid strategy, *UK aid: tackling global challenges in the national interest.*[8] It was also the theme emphasised by The Rt Hon Priti Patel MP on her appointment as Secretary of State for International Development in July 2016:

> "We invest UK aid firmly in our national interest, while keeping the promises we've made to the world's poorest people."

In the field of health, *UK aid* highlighted numerous connections between UK interests and investments in ODA. Most dramatically, in 2014 the West African Ebola outbreak reminded us of the lessons about global health security threats that had somehow been unlearnt from the HIV and AIDS crisis.

The health partnership approach, which has brought large numbers of UK institutions into the development space in recent years, has also provided a platform for the kind of mutual benefit described in the *UK aid* strategy, creating opportunities both to export UK health expertise and to build a more responsive and motivated health workforce within the UK's health system. It is this experience that forms the basis of this report.

## 1.2 The challenges of investing health aid in our national interest

The UK Government's increasing emphasis on demonstrating UK national interest represents a shift in emphasis from its historic focus on poverty eradication, as enshrined in the 2002 International Development Act[9]. It may be helpful, however, to view this shift in emphasis as an evolution in government thinking rather than a complete break with the past.

> "It is increasingly clear that international development is not (if it ever was) about 'us' and 'them' but about mutual interest. A healthy, inclusive, and sustainable global economy is good for everyone." Myles Wickstead[10] (2015)

Mutual benefit and mutual respect form important aspects of effective aid, but are also drivers of the concept of global self-interest that has long influenced development thinking. Evidence of the importance of this concept can be seen in many development policies and actions, from commitments at the Gleneagles G8 Summit in 2005 to significant reports from the Commission for Africa, declaring that it is in "our common interest to make the world a more prosperous and secure place"[11].

The emphasis on working together in 'our common interest' helped to invigorate the Millennium Development Goals and is at the heart of the Sustainable Development Goals (SDGs).[12]

Recent decades have seen the gradual erosion of the concept of "development aid", whereby a wealthy donor country gives aid (with or without conditions) to a poorer, low-income country. Instead, this rather out dated notion is being replaced with a recognition that all countries in the world, whether rich or poor, have a role to play in lifting the poorest people out of poverty and that all countries, whether high-, middle- or low-income, have responsibilities for generating the necessary resources to achieve this.

The SDGs, based on the principle of universality, clearly reflect this shift in international development thinking.

Similarly, over the last decade development financing has shifted from the traditional 'donor' to 'aid recipient' paradigm to one in which LMICs and international development agencies are viewed as 'development partners'. This has heralded a new, more complex, era of international development finance that goes far beyond traditional bilateral agreements between international development agencies and national governments. The Addis Ababa Action Agenda[13] epitomises this shift and highlights four strands of development financing, all of which are necessary if the SDGs are to be achieved: domestic public finance; domestic and international private business and finance; international development cooperation (or the more traditional notion of 'aid'); and international trade as an engine for development.

In this context, Owen Barder and Alex Evans have written, "Above all, DFID needs to be understood not as an organisation that argues for the interests of poor people against the British national interest, but as an organisation that argues for things that are in British interests – both directly, and because they contribute to long-term global prosperity which in turn benefits Britain."[14]

The challenge, however, as our experience of managing health partnerships has shown, is to strike the right balance.

There is a risk that placing too much focus on our own organisational or national interest undermines the potential to bring about sustainable and equitable development outcomes.

The response, as detailed in section two of this report, is careful programme design that respects aid effectiveness principles along with policy interventions, that secure mutual benefits.

Specific challenges that may arise from an over-emphasis on organisational or national interest include:

1) Rather than being a global leader in setting good practice for international development, we could undermine agreed principles of aid effectiveness.

2) Rather than ensuring well-designed aid, we could fail to deliver effective programmes or sustainable development outcomes.

3) A lack of policy coherence between the policies and actions we pursue in our domestic and international activities could undermine the potential of the impact we seek to have.

## 1) The principles of aid effectiveness

The principles of aid effectiveness were agreed at the Paris High Level Forum on Aid Effectiveness (2005) and reinforced in the Accra Agenda for Action (2008). They include Ownership, Alignment, Harmonisation, Managing for Results, Mutual Accountability, Inclusive Partnerships, and Capacity Development. They were born of a recognition that ODA was not delivering results as quickly or effectively as necessary, in part because of the very different approaches and conditions being imposed by the multitude of governments and institutions involved. The whole was becoming less than the sum of its parts. To improve the impact of ODA and make faster progress towards poverty reduction, it was therefore necessary to broker improved partnerships between high- and low- or middle-income countries.

The UK was instrumental in developing the agreed principles of aid effectiveness in the health sector, as evidenced by the UK's role in establishing the International Health Partnership and Related Initiatives (IHP+)[a]. This initiative aims to reduce fragmentation and duplication of efforts and investments in the health sector by ensuring all ODA for health is harmonised and aligned with national health plans, strategies and budgets.

These themes were explored further in Lord Crisp's ground breaking 2007 report '*Global Health Partnerships: The UK contribution to health in developing countries*', which looked at how, as part of a global health community, the UK should engage with LMICs.

The report identified the fact that successful international, national and local partnerships needed to be based on country ownership and mutual

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a    http://www.internationalhealthpartnership.net/en/

respect and highlighted that it would not be possible to see sufficient progress in the health-related Millennium Development Goals unless:

> "Developing countries are able to take the lead and own the solutions – and are supported by international, national and local partnerships based on mutual respect" *Global Health Partnerships: The UK contribution to health in developing countries, 2007*[15]

Since then, the importance of country ownership has, if anything, increased as we have entered an era 'beyond aid' characterised by a more pluralistic development financing landscape and more complex partnerships[16].

In section two of this report we will explore in more detail how health partnerships rise to the challenge of effectively addressing partner countries' needs whilst delivering mutual benefits for partner countries as well as for the UK. We will also hear directly from partners in LMICs about how key factors such as transparency, ownership and sensitivity are central to successful health partnerships, which respect aid effectiveness principles.

## 2) Well-designed aid

"What we are suggesting is a new kind of development, based on mutual respect and solidarity, and rooted in a sound analysis of what actually works"[17] 2005

International development in the Sustainable Development Goal era requires collaboration and coordination in order to build mutual respect and global solidarity. As new actors enter the world of development, many of them undertaking relatively small projects, good project design and delivery is essential if we are to avoid unsustainable projects that deliver poor value for money.

We will explore in the following section of this report how health partnerships are increasingly abiding by principles of good practice, which support effective project design and in turn deliver sustainable outcomes. We will also hear directly from partners in LMICs how effective communication, recognising health system challenges, and

strong interdisciplinary team working are all vital contributors to success.

## 3) Policy coherence

The SDGs invite an era of policy coherence, in which the policies and actions we pursue in our domestic and international activities are looked at together. SDG17[b], for example, specifically highlights policy coherence as a systemic issue that must be addressed in order to achieve the SDGs. Improving policy coherence is expected to contribute to improving global macro-economic stability, whilst also respecting national policy space and leadership for the implementation of policies to eradicate poverty and promote sustainable development.

Within the health sector, one of the most obvious examples of the challenges we face in achieving policy coherence is in the field of health worker recruitment. The UK is one of the countries that relies heavily on recruiting health personnel from LMICs to help fill gaps in its own health workforce. To ensure it causes no harm to already weak health systems in LMICs, which face their own devastating shortages in health workforce[18], the UK developed its own code of practice for international recruitment of health workers, which closely reflects the WHO code of practice[19].

The UK's contribution to global health goes far beyond that delivered by DFID alone, as was clearly recognised by the development of the cross-governmental 'Health is Global' outcomes framework[20]. The Department of Health and the NHS are increasingly engaging in global health efforts and in the last five years, we have seen 124 NHS Trusts engaging in development projects through partnerships.

The rising interest from UK organisations in international development is to be welcomed, especially given the opportunities to advance the UK's national interest. However, as the UK government moves to implement its 2015 Manifesto commitment to "boost partnerships between UK institutions and their counterparts in the developing world"[c] there remain barriers to entry to international development activities for UK health

b    SDG17: Revitalize the global partnership for sustainable development.

c    Page 79 https://www.conservatives.com/manifesto

workers and UK health institutions. Despite the growing engagement in global health by NHS Trusts, there remains a lack of awareness among some NHS board members about the value and benefits of such partnerships and a limited amount of support provided to NHS employees engaging in global health activities[21]. Policy coherence is therefore critical to ensure that the potential benefits of health partnerships are maximised by NHS employers.

We will explore in section two of this report practical ways in which future health partnership programmes can support the UK government's Manifesto commitment to boost partnerships and how future health partnership programmes can deliver mutual benefits whilst striking the right balance for the UK and its partner countries.

## 1.3 Securing mutual benefit

So far, we have highlighted a number of the potential challenges associated with striking the right balance in bringing benefit to overseas countries and our own. We will now concentrate on the huge opportunity we have as a country by engaging effectively in international development, looking at three examples:

### Global health security

We are living in a world where health challenges are spreading beyond national borders and require global efforts to both respond to health emergencies and prevent future health crises. The West African Ebola outbreak, the spread of the Zika virus, and the rise in anti-microbial resistance are all examples of recent and current challenges that have precipitated a global response. The UK Government clearly recognises the potential risk of such global health challenges for the UK population's own health and as a result DFID has committed to invest £2.5 billion in two new funds aimed at improving global health security. The £1.5 billion Global Challenges Research Fund will enable the UK to harness the country's expertise and leading research base to strengthen resilience and response to global health crises, while the £1 billion Ross Fund will enable the development and testing of vital vaccines, drugs, diagnostics, treatments and other technologies to help combat the world's most serious diseases in LMICs[22].

### Exporting the UK's health expertise

Supporting the achievement of SDG3[d] presents opportunities for the UK to demonstrate its leadership and expertise in health systems strengthening, through both the leadership of DFID in international development and the experience, expertise and lessons that can be drawn out of the NHS for an era in which universal health coverage (UHC) is the guiding vision. Among the targets for SDG3 are achieving UHC and supporting the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect LMICs. The UK can continue to play a leading role in health globally – in research and education, public health, healthcare, life sciences, policy-making, international development, philanthropy and the NGO sector[23].

### A responsive, motivated and innovative UK health workforce

A culture of global health learning is central to the successful delivery of the UK's international response to ensure that our actions are well considered, that those individuals and institutions involved are well prepared, and that we can reflect and learn from our experiences over time. More than this, however, is the value that engaging UK health workers in global health activities brings for improving the skills of the UK's own NHS workforce. Experience from the Health Partnership Scheme[e] has shown that working in complicated, challenging and resource-poor settings enables health workers to consolidate and develop a range of skills. Health workers participating in the Health Partnership Scheme have strengthened their skills in a wide range of areas including clinical practice, management, communication and teamwork, patient experience and dignity, policy development and academic research. In addition to these skills, which can be directly applied to their clinical practice, participants in the Health Partnership Scheme have experienced gains in personal satisfaction and a growth in interest in global health, thus improving their personal motivation and their awareness

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d     SDG 3: Ensure healthy lives and promote well-being for all at all ages.

e     The Health Partnership Scheme is a £30million programme funded by DFID and managed by THET. The scheme aims to improve health outcomes for poor people in DFID priority and other low-income countries by supporting health partnerships to deliver projects aimed at improving the skills and education of health workers.

of global health challenges, including potential health security threats[24]. Those involved with the Health Partnership Scheme note that an increase in leadership development skills has been a particularly valuable outcome for the NHS arising from UK health workers' participation in this scheme [25]. Evidence of innovations and care processes developed by low-income countries being introduced back into the UK, however, can be harder to define[26] and while reports[27] suggest that reverse innovation[f] would be one way of finding cost savings for the NHS there still appears to be further work required to realise these ambitions[282930].

We will explore further how the UK can seize the opportunity to support global efforts to deliver universal health coverage whilst also serving the national interest in section two of this report.

As we have seen, there are clear benefits and opportunities associated with ensuring that the UK's aid is delivering programmes that are in the national interest and of mutual benefit to both the UK and the LMICs the UK supports, from reducing global health security threats through opening up opportunities to export the UK's expertise in healthcare globally, to building a more responsive, motivated and innovative workforce for the NHS.

The next section will look in detail at the health partnership approach, and how this provides lessons in how to strike the right balance.

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f    Reverse innovation, a term coined by Vijay Govindarajan, denotes practices developed in low-income country settings introduced back into a high-income context. The term, although considered by some as pejorative, does usefully however denote directionality between two geographical contexts.

# Section 2: Learning from the Health Partnership Scheme

## 2.1 Health partnerships

In the first section of this report we explored the challenges that we face in investing health aid in our national interest and have found that abiding by the principles of aid effectiveness, improving policy coherence and delivering well-designed aid that ensures sustainability and value for money, are all vital ingredients for success.

In this section of the report we will explore in detail how health partnerships serve as a case study throwing light on the challenges of striking the right balance between our own organisational or national interest and the benefit given to host institutions and countries. We will then review the policy environment across the UK health system and explore how specific changes can support quality scale-up.

"Partnership, what a wonderfully elastic concept, with expected strands of equality and shared ownership and threads of equal access to money, power and recognition!" David Levesque[31] (2008)

"Increasingly … people in LMICs are gaining access to education and beginning to work on their own issues, while their countries are developing new approaches and ideas. The relationships need to develop into different sorts of more equal partnerships – recognising that richer countries also benefit enormously from their citizens working and experiencing different conditions and cultures elsewhere." Nigel Crisp[32] (2015)

At THET, we use the following definition of partnership:

"Health Partnerships are a model for improving health and health services based on ideas of co-development between actors and institutions from different countries. The partnerships are long-term but not permanent and are based on ideas of reciprocal learning and mutual benefits."

The DFID-funded Health Partnership Scheme established in 2010 has provided £30 million funding over six years. Over 130 health institutions have been strengthened through strong partnerships between UK institutions and their counterparts in LMICs, with more than 50,000 health workers

trained and over 60,000 UK health worker days spent volunteering.

Health partnerships have enjoyed significant funding over the last eight years from successive governments. This body of evidence, along with an increasing interest from UK health institutions to build effective health partnerships with LMICs, means it is a timely moment to examine what we have learned.

## HEALTH PARTNERSHIP SCHEME IN NUMBERS

### 50,000
HEALTH WORKERS TRAINED

### 34
COUNTRIES

### 1,700
UK VOLUNTEERS ENGAGED IN PROJECTS

### 157
PARTNERSHIPS FUNDED & SUPPORTED

## 2.2 The challenges addressed - striking the right balance

Organisations based in LMICs, whether they be local community-based organisations, national NGOs, or government partners at national, district or community level have extensive experience of the challenges that we explored in the first section of this report.

We will now hear directly from practitioners in these organisations to further explore these challenges and learn how they have been addressed.

### 2.2.1 Principles of aid effectiveness

**Addressing country need**

A critical challenge for the development of health partnerships is the need to ensure that the partnership delivers mutual benefit for the UK and for the partner country. This mutual benefit is one of the hallmarks of this model of intervention, which sets it apart from more "traditional" ways of delivering ODA. One of the ways in which this can be achieved is by ensuring that the partnership objectives meet locally identified needs. A key challenge for health partnerships, however, is that the UK partner institution holds clear and fixed ideas regarding the benefit they need to derive from the relationship. If the UK partner fails to understand the local context and imposes (or is perceived to impose) their own identified priorities rather than aligning them with those of the local partner institution this will very likely result in an ineffective and failing health partnership that risks undermining rather than strengthening the health system.

*"The biggest challenge was that the core aim for the project was not set by us, but imposed on us by our UK 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"[33] Low-/middle-income country partner*

Even when health partnerships harmonise their projects with counterpart institutions there still remains a danger that these projects are developed in isolation from the host country's national and district health plans.

*"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."[34] Low-/middle-income country Ministry of Health*

The relevance of Health Partnership Scheme projects to local health needs and plans is reported as good, if variable, across all projects. Conducting thorough and early needs and capacity assessment of countries, national partners and project sites can help to further strengthen alignment with the needs of participating countries. Ensuring close engagement of country partners by the UK lead throughout the proposal development process can also result in a better "fit" of expectations and needs for both sides of the partnership. Regular reviews of partner engagement help to maintain commitment, while ongoing processes such as annual planning workshops and the use of hospital briefs from country partners to match volunteers to placements also maintains the relevance of the project to expressed needs.

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### Case study of good practice

**Partnership plans build on an institution's strategic health plan**

*Aligning partnership plans with an institution's strategic health plan*

"The sooner you can get out and do a visit, the better. You do not understand the context until you get out there." Partnership practitioner

The partnership between the Royal College of Midwives and the Ugandan Private Midwives Association worked to ensure that their project plan was relevant to the UPMA's strategic plan. Communication proved key to getting this right and the process of aligning project with strategy is an on-going one.

**Read more at www.thet.org/pops.**

### Transparency

*"The lack of transparency in the way grant resources are used, [leaves us feeling used]; that our UK partner may have benefited more than us, even though it may not be so." Low-/middle-income country partner*

Transparency within partnerships is seen as a critical factor influencing the success of health partnerships. Of particular importance is the need for transparency in the development and management of budgets, and transparency in defining the different roles and responsibilities of all members of the partnership and how these interact with each other. A lack of transparency, such as a failure to declare a conflict of interest, can undermine partnerships by building up resentment among the different partners at the same time as breaking down trust. In Uganda and Malawi, for example, failing to declare conflicts of interest had a negative impact on partnership. A particular weakness of health partnerships is a lack of transparency regarding the selection of country level partners and a lack of transparency in the process of developing, negotiating and signing contracts. This can mean that LMIC partners are less aware of the direct benefit that the Health Partnership Scheme brings to their organisation or community.

An additional challenge caused by a lack of transparency is confusion over roles and responsibilities of different partner organisations. In Malawi, this was highlighted as a particular issue, which also led to confusion regarding policy priorities and a lack of clarity as to whether the UK and Malawian partners were pursuing the same or differing priorities.

In Tanzania, on the other hand, an open and transparent approach to a partnership from both the UK and its Tanzanian counterpart institution has made it possible to be clear on what the partnership can and cannot deliver and has enabled all partners to respond rapidly when challenges do arise.

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#### Case study of good practice

**Partnerships have clear, stable governance structures that are not over reliant on individuals**

*Governance structures in Dodoma and London*

The partnership between Central and North West London NHS Foundation Trust and Mirembe Hospital, Tanzania has carefully planned its governance structure to include committees with broad membership, accountability to senior personnel in their institutions, and champions responsible for the different strands of their work.

**Read more at www.thet.org/pops.**

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### Ownership

A sense of ownership has also been identified as a key factor contributing to successful health partnerships. In some countries where health partnerships operate partners based in the LMIC setting have expressed the view that they are sometimes seen as 'sub-contractors' rather than equal partners. This appears to be more significant in partnerships where there are multiple UK-based partners as well as LMIC based partners.

A recent survey indicated that whilst partners based in LMIC settings felt that they had good ownership of project implementation, this sense of ownership was not as strong when it came to project planning and project management. In some situations a lack of ownership can be closely linked to a lack of transparency, with one of the primary ways of strengthening ownership being identified as ensuring the inclusion of partners at all stages of proposal design and programme implementation. Furthermore, partnerships that promote a sense of equitably shared responsibility and ensure joint planning and implementation foster a stronger sense of ownership among all partners.

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#### Case study of good practice

**Partners clearly define roles and equitably share responsibility for project planning, management and implementation**

*An equitable partnership*

Starting with a needs assessment, the partnership between The Royal College of Nursing and the Zambia Union of Nurses Organisations could decide on priorities and plans and use their steering committees to define roles and responsibilities.

**Read more at www.thet.org/pops.**

### Sensitivity

Results of semi-structured interviews and recent national and international consultations have all indicated that addressing sensitivity, whether towards local, cultural and financial contexts or towards national and local health priorities presents a challenge for the health partnership approach.

In Ethiopia, for example, a lack of understanding of the local culture and local economy, especially with regard to attitudes towards time keeping and reimbursement for additional tasks, resulted in tensions between different members of a health partnership.

In Malawi, a country where there are many different actors in the health sector, it was felt that one health partnership did not meet the most pressing local or national health priorities. Given that health systems strengthening is a priority for many LMICs, programmes could have a much greater impact if they were to more closely align with national and local health plans and priorities, and with other DFID funded organisations to ensure harmonisation across UK-funded aims within countries.

### Communication

Clear, regular and open communication is a key success factor for health partnerships.

Interviewees from Ethiopia, Tanzania, Uganda and Myanmar all emphasised the critical importance of effective communication, whilst those from Ethiopia and Uganda highlighted in particular the need to establish a clear communication mechanism that can help to ensure clarity on roles and responsibilities of all partners and that should be respected at all stages of project implementation.

As one interviewee highlighted,

*"Mutuality should encompass joint planning and implementation; aiming to achieve together and address challenges together; and being accountable and respectful of each other." Low-/middle-income country partner*

An effective, well-functioning communication mechanism can help to ensure this becomes a reality. In a recent survey, the opportunity for shared learning and exchange of knowledge between partners was identified as one of the benefits of participating in health partnerships. Effective communication is critical to ensuring this shared learning and exchange of knowledge is able to take place. Furthermore, it is widely recognised that establishing strong relations with UK partners through clear communication streams, open discussions and shared goals is a critical success factor for health partnerships and that,

*"Consistent communication from both sides is essential, as ongoing feedback helps [us to] think of ways to improve the partnership." Low-/middle-income country partner*

### Case study of good practice

**Partners respect each other's strengths and weaknesses, and engage frankly and positively with difficulties in their relationship and external challenges**

*Developing a respectful partnership*

For the Butabika Partnership, understanding each other's strengths and weaknesses is built into the way in which they deliver their work, from informal feedback to more formal debriefing sessions.

**Read more at www.thet.org/pops.**

## 2.2.2 Well-designed aid

### Investing in effective projects

One of the critical questions to ask at the outset of any project is 'What is the likelihood of a partnership achieving its project's objectives?' A curriculum being developed with little local input, resulting in less contextualised content, alongside clinical procedures being taught on a purely theoretical basis is an example of a less than optimal approach. What is the relevance and effectiveness of teaching clinical procedures where there are no opportunities to put this into practice in the short to medium term? It is essential, therefore, for health partnerships to consider the wider health environment in which the local partner is operating to ensure that projects are effective and that the risk of poor investments of time and money are minimised.

The question 'to what extent do training of trainer programmes cascade training?' is an important example of where more research is required to examine our assumptions around appropriate capacity development approaches.

*"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"[35] "[36] Low-/middle-income country partner*

Monitoring and evaluation presents one of the biggest challenges for health partnership effectiveness. A lack of capacity to design and implement monitoring and evaluation systems amongst LMIC partners, competing priorities, a lack of experience and a lack tools are some of the bigger barriers.

*"There is quite a fear about M&E which needs to be addressed so that it can become part of our daily work."[37] Low-/ middle-income country partner*

Ownership of data collection and analysis is an ongoing challenge. Common patterns have emerged whereby data is collected by the LMIC partners but analysed by the UK partner or where basic analysis is conducted by the LMIC partners while the UK partner provides further analysis and visual representations. Imbalances of input and lack of ownership of data analysis creates potential for inaccurate interpretation due to the lack of nuanced understanding of the context.



## Case study of good practice

**Partnerships explicitly recognise barriers and challenges to health systems strengthening, such as health worker movement and unreliable supplies**

*Recognising health system challenges*

"Step back, stand on one leg, and take a look around for at least a month or so; it's only then that you can put your second leg down and actually start doing stuff. One important thing to remember is that your relationships are more important than the tasks." Partnership practitioner

Every partnership involved in health systems strengthening will encounter barriers and challenges. The approach taken by the RCPCH's Global Links Volunteer Programme is to develop a culture in which it is acceptable to talk frankly about those barriers so that they can be addressed or accepted.

**Read more at www.thet.org/pops.**



## Case study of good practice

**Partnerships work together to identify what works, what doesn't and what can be learned from this**
*Developing a culture of learning in Malawi*
For the York-Zomba partnership, it began with designing their monitoring and evaluation system collaboratively so that all stakeholders were committed to the principle of learning and how monitoring and evaluation is integral to it.
**Read more at www.thet.org/pops.**

### Delivering sustainable projects

One of the key questions a health partnership should ask itself is 'are this project's outcomes likely to be sustained after funding ends?'

Whilst funding has been critical to the successful delivery of many projects through the Health Partnership Scheme there exists a major challenge when funding ends. The question not only of what has been achieved but of what happens next is critical.

*"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." Low-/ middle-income country partner*

*"Many things start as small projects which then become national programmes and policies." Low-/ middle-income country partner*

*"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." Low-/ middle-income country partner*

*"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." Low-/ middle-income country partner*

To ensure that projects supported by the Health Partnership Scheme deliver sustainable results a range of strategies have been adopted to drive change at an institutional level. Examples of these strategies include:

- Developing institutional capacity through succession planning;

- 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 postgraduate courses;

- Developing new proposals for further funding;

- Lobbying, advocacy and engagement with senior management within the institution, local government, MoH (National, Regional, District level) and other stakeholders;

- Disseminating and sharing project findings through various media including community fora, MoH meetings, international scientific meetings and peer reviewed local and international journals[38]; and

- Committing to projects until the host country's defined need is met.

## Case study of good practice

**Partnerships are made-up of interdisciplinary teams to encourage resilience and adaptability to changing priorities**

*Building a strong interdisciplinary team*

"Skills sharing and mutual respect are the key ingredients that make the partnership work. Everybody has something to learn from each other," Partnership practitioner.

The Wessex-Ghana Stroke Partnership includes medical and nursing staff, occupational therapists, physiotherapists, dieticians, pharmacists, speech and language therapists, clinical psychologists, as well as managerial and administrative staff. Each discipline has skills and experience to offer the partnership as well as the patients in their care.

**Read more at www.thet.org/pops.**

## 2.2.3 Policy coherence to secure mutual benefit

A growing number of UK organisations wish to work in LMICs. This is to be welcomed especially given the increasing opportunities to advance our national interests. However, there exists a lack of coherent policy at a number of levels of the UK health system to support this scale-up.

### Government

Recognising the global nature of many health issues, combined with the UK's expertise in health systems strengthening and the emphasis within the SDGs on achieving universal health coverage, the UK has an opportunity now to deliver a cross-governmental global health strategy to succeed the 'Health is Global' outcomes framework. This will enable the UK to maintain its leadership on improving health in low-income countries whilst also demonstrating to the global health community the extensive expertise of the NHS and the wider health system.

### Regulators

As the engagement of UK health workers in global health grows, it is becoming increasingly important to ensure the following:

- That UK health workers are not discouraged from making a contribution to global health,

- That they continue to be as efficient and effective as possible while overseas,

- That they remain fit-for-practice upon their return to the UK.

The GMC should accelerate its efforts to establish a revalidation system that enables UK doctors working overseas to revalidate their skills and return to the UK fit to practise within the NHS.

The Nursing and Midwifery Council should continue to work with the Royal College of Nursing and the Royal College of Midwives and INGOs to resolve issues that may arise and provide further guidance to ensure that all nurses and midwives who work overseas may revalidate and return to the UK fit to practise in a UK setting.

## Educators

A culture of global health learning is central if we are to build a more responsive and motivated UK health workforce.

In recent years undergraduate medical training programmes have seen a surge of interest in global health, evidenced by the increasing number of elective modules and international health intercalated courses, and growth of student and medical postgraduate organisations such as Medsin and Alma Mata[39].

Integration of global health modules at the postgraduate level has also seen recent welcome progress in the UK and elsewhere[40]. For example, pioneering work has been achieved in the establishment of global child health competencies for paediatricians[41] and is expected to be rolled-out in 2017. Postgraduate global health capabilities have also recently been developed by the Global Health Curriculum group on behalf of the Academy of Medical Royal Colleges[42] and there is progress in Royal Colleges looking to incorporate these into postgraduate training curricula.

## Employers

UK health workers and UK health institutions still face challenges as they prepare to increase their engagement in global health.

Despite progress, in particular in Wales (see boxed text), a feeling still persists that there is a need to keep health partnership activity 'under the radar'[43]. Even in UK organisations where the senior leadership are fully supportive and where programmes are externally funded, many still experience nervousness about engagement.

> *"Even though the board recognise what we're adding, we've been told to keep a low profile"*
> Partnership practitioner

Why is this the case? It is partly due to a concern that this type of activity will detract from the focus on delivering services for patients in the UK and also due to concerns about risk and lack of coherent policy. Moreover, whilst senior leadership buy into the notion in theory, managerial staff may well not share the vision or see the benefit of such

In Wales, the International Health Coordination Centre, underpinned by the Welsh Government's policy framework45 has provided a solid foundation for sustainable, institutional health links between Wales and a wide range of LMICs. The recent Charter for International Health Partnerships in Wales has helped consolidate this work further.

The Charter is intended to establish a standard level of partnership working that ensures that the broader principles and values of the NHS are reflected in international health activity. Wales' commitment to evidence-based practice, shared learning and partnership based on equality and the pursuit of mutual, tangible benefits can be seen to clearly extend to international activity.

**Benefits**

The Charter benefits Wales by ensuring that engagement in international activity is carried out in a way that protects and enhances Wales' international reputation, and produces demonstrable gains both to Wales and its partners abroad. It is designed to establish such working as a legitimate, recognised part of the way that Wales operates in the modern world.

**Who is the Charter for?**

The Charter is aimed at helping those working in international health partnerships in Welsh health organisations and beyond to achieve the best possible results for themselves and those they are working with. Signatories are Welsh health organisations working in international health partnerships that are committed to strengthening Wales' commitment to this work.

engagement either in terms of corporate and social responsibility or as a learning opportunity for staff.

*Engaging in Global Health[44]*, the guidance given by the Department of Health to the UK Health Sector for voluntary engagement in global health, describes existing NHS policy and sets out standards of good practice for health partnerships.

## 2.3 Ensuring quality for scale-up

## 2.3.1 Delivering effective health partnerships

Over the lifetime of the Health Partnership Scheme a large body of evidence on effective partnership approaches has developed. Almost 200 partnerships have reflected on important issues such as effective management, stakeholder engagement, accountability and advocacy. There are also numerous reflective accounts of health partnerships and a large body of grey literature from implementing organisations.

Most recently, emerging questions about the mechanisms, efficiency and effectiveness of health partnerships have prompted a growing number of published evaluations and research papers from clinicians[46], social scientists[47], and others.

THET has also developed a set of Principles of Partnership, in conjunction with the health partnership community, with the express purpose of improving the quality and effectiveness of partnerships between UK and LMIC health institutions. The application of these principles can help address the challenges described in this section of the report.



COMMITTED TO JOINT LEARNING

STRATEGIC

FLEXIBLE, RESOURCEFUL AND INNOVATIVE

HARMONISED AND ALIGNED

**PRINCIPLES OF PARTNERSHIP**

RESPONSIBLE

EFFECTIVE AND SUSTAINABLE

ORGANISED AND ACCOUNTABLE

RESPECTFUL AND RECIPROCAL
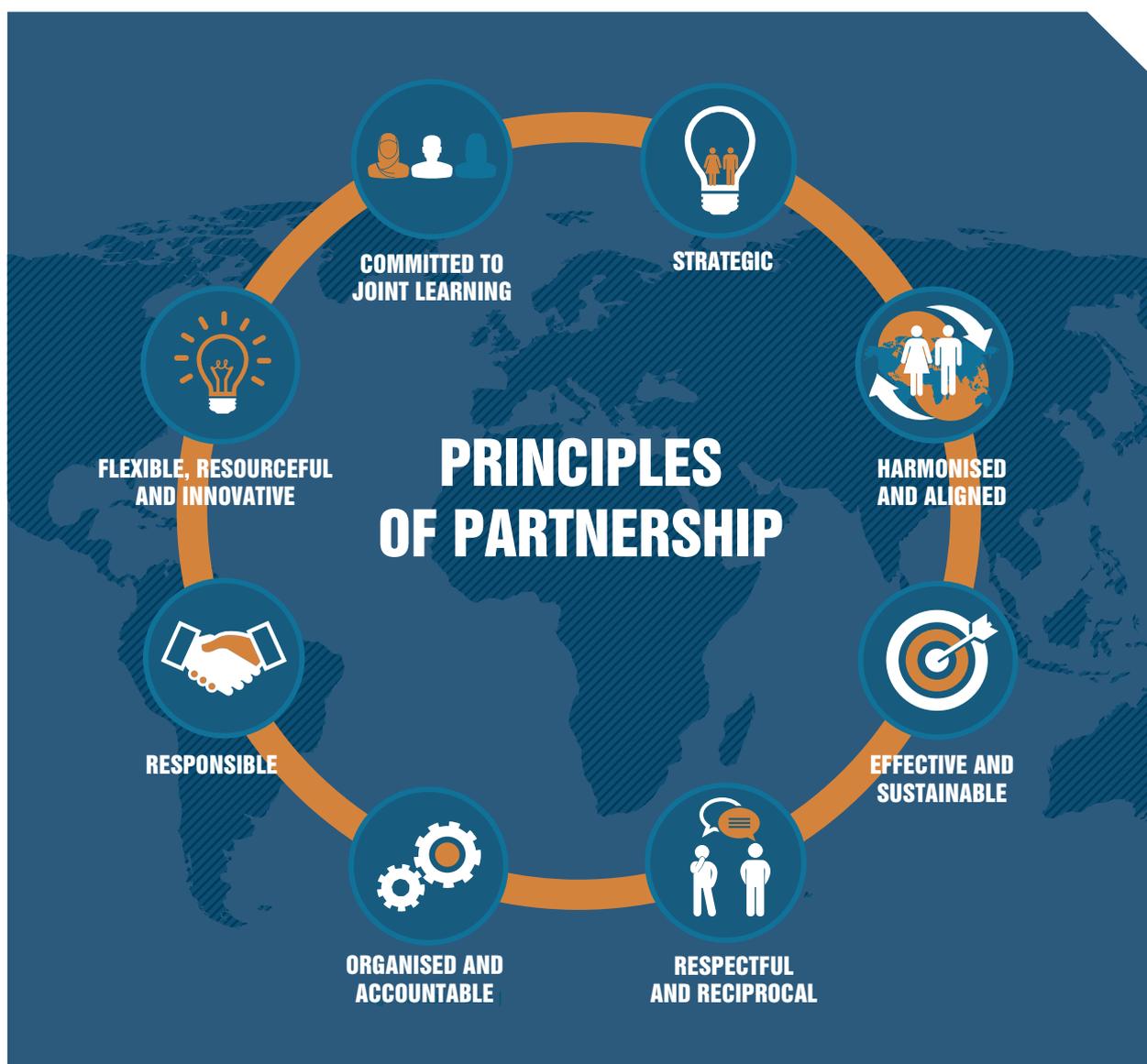
There are eight principles, each of which is accompanied by a set of hallmarks of good practice which highlight the behaviours, systems and processes that should be in place to support effective partnership working.

1. **Strategic:** Health partnerships have a shared vision, have long-term aims and measurable plans for achieving them and work within a jointly-agreed framework of priorities and direction.

2. **Harmonised and aligned:** Health partnerships' work is consistent with local and national plans and complements the activities of other development partners.

3. **Effective and sustainable:** Health partnerships operate in a way that delivers high-quality projects that meet targets and achieve long-term results.

4. **Respectful and reciprocal:** Health partnerships listen to one another and plan, implement and learn together.

5. **Organised and accountable:** Health partnerships are well-structured, well-managed and efficient and have clear and transparent decision making processes.

6. **Responsible:** Health partnerships conduct their activities with integrity and cultivate trust in their interactions with stakeholders.

7. **Flexible, resourceful and innovative:** Health partnerships proactively adapt and respond to altered circumstances and embrace change.

8. **Committed to joint learning:** Health partnerships monitor, evaluate and reflect on their activities and results, articulate lessons learned and share knowledge with others.

All of the hallmarks are accompanied by case studies, tools, templates and other resources designed to support health partnerships to improve their effectiveness.

## 2.3.2 Scaling up health partnerships for greater impact

### A future NHS

The NHS is well known as one of the best examples of a publicly funded health system offering universal health coverage to its population. It is less well known for its expertise in building complex but effective systems and its ability to train very large numbers of health workers to serve ever-changing healthcare needs. These achievements, which take a great deal of time and money, have not been without their political and ethical challenges, not least around recruitment of health workers from less-developed parts of the world.

It is not the core business of NHS organisations to focus on improving the quality of care in resource-poor settings in other parts of the world. Additionally, the current resource-constrained situation of the NHS investing in overseas health programmes may not seem to be a priority. However, experiences from the Health Partnership Scheme do show that health partnerships can still support core business.

The NHS's Five Year Forward View[48] sets out the direction for NHS England to take over the coming years. It is driven by the need to make cost savings whilst delivering the care the UK population needs now and in the future. Key themes underlying this plan include the merging of health and social care and a move away from the old paternalistic view of healthcare towards a culture of the UK population taking ownership of their own care. This process has begun to create a new, more outward-looking culture within the NHS.

It has also brought about significant structural changes in the way that the English healthcare system is organised. For example, Health Education England and NHS England have set-up local workforce action boards (LWABs) across the four English health regions to deliver Sustainability and Transformation Plans (STPs)[g] involving all of care – health and social – primary, secondary, tertiary, and commissioning. These plans are expressly designed to ensure the health workforce is fit for purpose and to help realise a vision for the future NHS.

g    There are some 40 LWABs and 42 STPs across England

If the UK health system knows how to provide universal health coverage, is a health systems expert, can train an effective workforce but is increasingly looking outward to seek greater efficiencies and new ways of delivering care, then what part can health partnerships play in this future NHS?

There exists a golden opportunity for the NHS to promote its global expertise and 'brand' to serve the national interest whilst also supporting global efforts to deliver universal health coverage.

### Towards the ideal health partnership

Through the lifetime of the Health Partnership Scheme, we have learned that small health partnership projects are a crucial element of the health partnership approach, both reflecting and strengthening individual and institutional relationships, generating immediate benefits for all partners and with the potential to improve health services for poor people, and demonstrating innovative models of capacity building.

However, their small size means that they are able to tackle just a few of the constraints to health workforce strengthening and health systems strengthening.

### Future health partnerships

*Broader HRH support*

Health partnerships can however take a broader approach by engaging a greater range of stakeholders and collaborators in LMICs and the UK than we have seen through existing Health Partnership Scheme-funded health partnerships.

These larger health partnerships could seek to strengthen the performance of the health workforce, addressing all factors that influence recruitment, performance and retention of health workers. The goal of this type of partnership would be that LMIC partner institutions are helping to develop the health workforce they require to deliver specified health services, if other health system building blocks are in place.

Leadership and governance would be a crucial focus, and such partnerships should incorporate a strong element of LMIC partner institutional strengthening,

not just in health workforce strengthening but also in finding and managing health partnerships and other resources.

### Integrated health systems strengthening

However, to strengthen consistently LMIC health systems and services and so achieve the ambition of UHC requires a more systemic approach than the typical, small health partnership projects supported by the Health Partnership Scheme.

Larger health partnerships could support priority populations or areas, such as those identified in national health plans and the UK's bilateral health programmes.

They could include a mixture of interventions and support to address multiple constraints to health system function, largely through technical assistance from UK volunteers working on leadership and governance, health workforce performance and retention, information and research, service delivery and some aspects of public and community-based health.

This approach requires active cooperation with LMIC governments and other agencies addressing other building blocks such as health system financing, health workforce recruitment, medical products and technologies (especially purchasing and supply chains) and broader determinants of health. Traditional, faith-based and community-based organisations, and perhaps international NGOs, could be well-placed to address the last of these.

A step further on from this would be to create institutional partnerships, which could reach across government in the UK and overseas to address weaknesses in health systems more generally, in addition to the weaknesses of the health workforce. The UK government's commitment to developing institutional partnerships, and the imminent creation of the GREAT for Partnership facility in the UK offers increasing opportunities for a less-segmented approach to using partnerships in health systems strengthening.

## Future UK engagement in global health through health partnerships

Given the constraints and opportunities that are present in the web of relationships that exist between health systems in LMICs and in the UK it can be seen that new forms of health partnership - mindful of the importance of transparency of governance and sustainability, whilst maximising impact and delivering value for money, and that are mutually beneficial to all - are in fact possible.

The new approaches described above would make it easier to focus on priority groups and areas as defined by LMICs. A health systems approach, and projects run by senior management in LMIC institutions and supported by senior management in UK institutions, can potentially achieve greater change, sustainability and resilience than smaller health partnership projects. Compared to supporting many small health partnerships, there are significant economies of scale in this approach, and savings could be channelled into greater rigour in planning, managing volunteers and activities, policy engagement, monitoring and evaluation, research, learning and improvement cycles.

Future health partnership programmes should, therefore, aim to harness and promote the unique values, experience and expertise of the NHS, and to explore how the UK can play a key role in building the strong health systems that are essential in the global move towards universal health coverage whilst at the same time ensuring that partners in LMICs remain firmly in the driving seat.
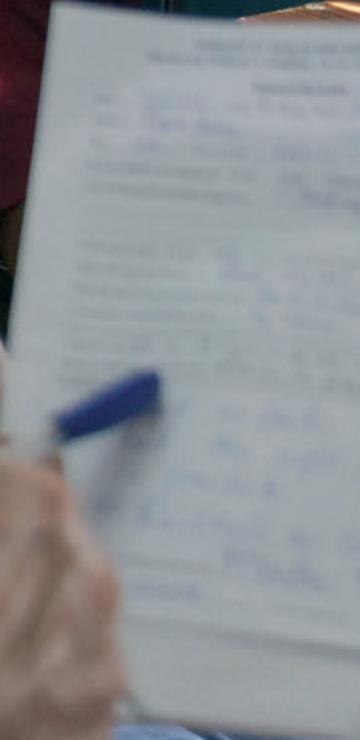
# Section 3: Recommendations

The UK has long been a leader in ODA. And it is clear that the UK stands to benefit enormously from the ODA it disburses. In the health sector such opportunities include: addressing global health security threats, as illustrated by the UK's support in tackling the West African Ebola outbreak; creating opportunities to export UK health expertise overseas; and building a more responsive and motivated health workforce within the UK's NHS.

Although the UK Government's increasing emphasis on demonstrating UK national interest represents a shift from its historic emphasis on poverty eradication it is helpful to view this shift in emphasis as an evolution in government thinking rather than a complete break with the past.

We have highlighted the challenges that this poses, more generally as well as from our experience of managing health partnerships. However, there is a risk that placing too much focus on our own organisational or national interest undermines the potential to bring about sustainable and equitable development outcomes. The response, as detailed in this report, is careful programme design, that respects aid effectiveness principles along with coherent policy interventions, which secure mutual benefits.

There are clear opportunities to ensure that the UK's aid is delivering programmes that benefit both LMICs and the UK. Contributing to the achievement of SDG3 presents, in particular, a golden opportunity for the UK to demonstrate its leadership and expertise on health systems strengthening, through both the leadership of DFID in international development, and the experience, expertise and lessons that can be drawn out of the NHS for an era in which universal health coverage is the guiding vision.

In order to maximise the opportunities and tackle the challenges that we have highlighted in this report, we recommend the following actions for UK Government, the UK's health system, and for current and future health partnerships.

## For the UK Government:

### RECOMMENDATION 1

To ensure that UK ODA for health delivers sustainable benefits the UK Government should be encouraged to promote policy coherence across all government departments through the development of a new Global Health Strategy that will help orient effective UK-wide engagement in global health.

### RECOMMENDATION 2

The UK Government should consider scaling up its investment in health partnership programmes, recognising the particular value they hold as a tool for strengthening health systems in LMICs whilst also advancing the UK's national interests.

More specific recommendations for how the UK Government can strengthen future health partnership programmes include:

- Supporting future health partnership programmes to coordinate technical assistance from the wide range of UK health professionals in the NHS, Government and beyond (including clinicians, technicians, managers, administrators, education specialists, suppliers, etc.). This coordination of technical assistance can be conducted both directly by recruiting and managing volunteers and indirectly by working in partnership with NHS local workforce action boards (LWABs), Royal Colleges, Arms-Length Bodies such as Public Health England and Health Education England, together with their counterparts in Devolved Administrations. This will support a more systemic and consistent strengthening of LMIC health systems.

- Supporting future health partnership programmes to strengthen the UK environment for engaging in global health 'at the grassroots' level. This can be achieved by continuing to identify and support individual partnerships – small and medium sized NHS, NGO as well as private sector organisations - to scale-up for greater impact through a more systemic approach. This will help nurture, in a coordinated way, the growing interest in global health.

- Supporting future health partnership programmes to explore models of increased ownership by LMIC partners whilst still ensuring good value for money and quality grant management. This has many potential benefits and could help address structural barriers to securing mutual benefit such as transparency.

- Supporting future health partnership programmes to demonstrate the co-development of the healthcare workforce within the UK and LMICs. This will promote lifelong learning and will generate relationships and skills, which will benefit not only the populations of LMICs but also improve the skills, competences and behaviours of the UK healthcare workforce and improve the quality of care for UK patients.

## For the UK health system:

### RECOMMENDATION 3

In order to prepare and support a responsive and motivated UK health workforce the development of a culture of global health learning, which values volunteering and overseas experience, is vitally important.

Progress in establishing global health competencies has seen recent welcome progress with pioneering work being achieved to establish global child health competencies for paediatricians.

Therefore:

- The Academy of Medical Royal Colleges and medical training organisations should facilitate a similar process whereby other medical specialities develop similar competencies for use by those who train overseas during part of their specialist training, and build on existing guidance to include in general training curricula.[49]

- As international engagement during training becomes increasingly common in other health professions such as nursing, midwifery, physiotherapy and occupational therapy,

universities should establish clear processes and guidance to support these health workers with input from regulators and support from the respective professional associations.

### RECOMMENDATION 4

The General Medical Council (GMC) should accelerate its efforts to establish a revalidation system that enables UK doctors working overseas to revalidate their skills and return to the UK fit to practise within the NHS.

To achieve this:

- The GMC should work with an International Non-Governmental Organisation (INGO) or consortium of INGOs to clarify the legal framework of liability associated with an INGO or consortium becoming a Designated Body tasked with revalidating doctors working in LMICs for extended periods of time.

- The GMC should develop and disseminate widely guidance to ensure that all doctors who work overseas for extended periods of time are aware of who their Responsible Officer and Designated Body is along with the steps required to successfully revalidate.

The Royal College of Nursing and the Royal College of Midwives are developing guidance in-conjunction with MSF and VSO to support nurses and midwives who work overseas to revalidate.

- Recognising this, the Nursing and Midwifery Council should continue to work with the Royal College of Nursing and the Royal College of Midwives and INGOs to resolve issues that may arise and provide further guidance to ensure that all nurses and midwives who work overseas may revalidate and return to the UK fit to practise in a UK setting.

### RECOMMENDATION 5

Recognising the progress that has been made in other parts of the UK, in particular Wales, we offer the following recommendations to the NHS in England to support further quality assured scale-up in global health.

- One NHS local workforce action board (LWABs) from each of the four English regions should work in partnership with THET to develop a strategy for internationalisation as part of their sustainability and transformation planning process. This will support the NHS to explore quality assured philanthropic and commercial opportunities for engaging in global health in low-income countries through future health partnership programmes, in middle-income countries through, for example, the Prosperity Fund, and in higher-income countries through working, for example, with Healthcare UK.

- The Department of Health's Standards of Good Practice should be further developed and tested within NHS local workforce action boards (LWABs) from each of the four English regions as part of their strategy for internationalisation. A portfolio of case studies should be made available through Health Education England and Public Health England. These steps will help to ensure that UK health institutions interested in working through health partnerships with LMIC partners have a better understanding of the risks and opportunities inherent in this activity.

## For health partnerships:

### RECOMMENDATION 6

- As part of THET's continued engagement with the wider partnership community we recommend that health partnerships sign-up to the Principles of Partnership, which commit partnerships and those new to partnerships to apply best practice in the design, implementation and evaluation of health partnerships. This will help to address the challenges inherent in health partnerships, as documented in this report.

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# Acknowledgements

THET would like to acknowledge the support of the Charities Aid Foundation through the CAF Advocacy for Development (A4D) Fund in the development and the dissemination of this report.

**THET expresses its sincere thanks to all those who contributed to this review, without whom this report would not have been possible.**

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Dr David Weakliam, Board Chair, European ESTHER Alliance

Dr Bhanu Williams, Royal College of Paediatrics and Child Health, UK

Susan Williams, Royal College of Nursing, UK

### We would also like to acknowledge the guidance and support provided by:

Professor Louise Ackers, University of Salford, UK

Dr Paula Baraitser, King's College London, UK

Hassan Osman, University of Salford, UK

Rob Yates, Chatham House, UK

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