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# REPORT

**REVIEW ON EFFECTIVENESS OF INSTITUTIONAL HEALTH PARTNERSHIPS  
ON BEHALF OF: EUROPEAN ESTHER ALLIANCE**

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## ACRONYMS

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<b>AIHA</b>	American International Health Alliance
<b>EEA</b>	European ESTHER Alliance
<b>EEWG</b>	ESTHER Evidence and Effectiveness Working Group
<b>GP</b>	General Practitioner
<b>IHP</b>	Institutional Health Partnership
<b>M&amp;E</b>	Monitoring and Evaluation
<b>NCD</b>	Non Communicable Disease
<b>NHS</b>	National Health Service
<b>OOP</b>	Overseas Out of Programme
<b>PHC</b>	Primary Healthcare
<b>RCT</b>	Randomised Controlled Trial

## EXECUTIVE SUMMARY

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Whilst those who are actively engaged in institutional health partnership programmes believe that this approach is a valid, cost-effective and complementary form of technical cooperation, it is recognised that there is a lack of high quality evidence and inherent difficulties in measuring the effectiveness and additionality of partnership work. In April 2014 the European ESTHER Alliance approved its Strategic Framework 2015-2020, of which strategic goal 1 is to “set standards for and generate evidence on the effectiveness of institutional health partnerships”. In November 2014, the ESTHER Evidence and Effectiveness Working Group (EEWG) commissioned this review to identify the current evidence and gaps in both grey and published literature, on the effectiveness and additionality of institutional health partnerships (IHPs).

This review identifies and summarises:

1. Evidence and gaps on effectiveness and additionality of institutional health partnerships
2. Existing frameworks and methods used for evaluating partnership effectiveness
3. Types of evidence of value and interest to different stakeholder groups

### Part One: Existing Evidence and Gaps in Knowledge

A rapid, “broad brush” review of both peer-reviewed and grey literature was conducted in December 2014/January 2015. Forty-four documents were included in the review, of which 27 articles were from peer-reviewed journals and 17 from the grey literature. The analysis of literature was “content neutral” of specific interventions, since these are rarely comparable and specific educational, clinical, and management interventions are already well documented in the international scientific literature.

Limitations of the studies reviewed included small sample size, self-reported evaluations, retrospective reporting and measurement of activities and outputs rather than outcomes and impact. No studies used control groups, comparison groups or tested for repeatability. Currently there is no shared definition of the term “institutional health partnership” that is consistently used in research and the much of the literature reviewed did not specifically evaluate the IHP model, but alluded to benefits and effectiveness of using a partnership approach.

Of the studies reviewed, much of the literature is written by those facilitating or advocating for IHPs. Unsurprisingly there is strong support for the IHP approach and a firm belief that this form of technical cooperation brings a wide range of benefits to both northern and southern institutions and individuals. However, there is wide recognition that existing literature does not meet the high standards of formal academic rigour, hence there is an urgent need to develop greater methodological rigour in reporting and evaluating the costs, benefits, effectiveness, outcomes and impact of this approach. In particular there is a call for more rigorous evaluation frameworks, baselines and a mix of qualitative and quantitative indicators. Key challenges identified in the literature include measuring impact, attribution to a specific intervention due to multiple sources of funding, focus on capacity building of which impact is often indirect and long-term, lack of baseline surveys and lack of expertise in monitoring and evaluation (M&E).

Gaps in knowledge about what is effective exist at individual partnership level, facilitating body level and in looking at the impact on health services and systems where multiple partnerships are operating.

There is also limited evidence that link benefits to the process of partnership. Thus there is a need for more robust primary research that then can be analysed and synthesised to form conceptual frameworks that can then be tested and validated. Therefore there is limited benefit in conducting further reviews on the effectiveness and impact of IHPs until more high quality research has been conducted in this field, unless such reviews are aimed at developing conceptual frameworks and models for evaluating IHPs.

## Part Two: Methods, indicators and frameworks

The frameworks and methods included in this review have been drawn from both the health and wider development literature including programme evaluation and implementation science fields. There are numerous frameworks and conceptual analyses that could be used to further develop thinking on the effectiveness of IHPs and how they benefit and impact on institutions and health systems. Models and frameworks identified related to evaluation methods, stratification of partnerships, effectiveness frameworks, conceptual thinking on benefits/additionality of partnership working and impact evaluation models.

## Part Three: Evidence and advocacy

Advocacy is a deliberate process that involves identifying persuasive entry points for a range of stakeholders. Different audiences require different types of evidence packaged in different ways. This review broadly outlines the evidence requirements and advocacy products by audience.

## Next Steps

Given the dearth of high quality primary research and evidence based frameworks coupled with the rich potential of linking to frameworks and thinking from other fields, there is both a huge need and opportunity to develop research on the role, effectiveness and impact of IHPs focusing on individual partnerships, facilitating bodies with a portfolio of partnerships and impact on health services and systems where there is a constellation of partnerships. The following next steps should provide a firm foundation for strengthening the evidence base and deepening arguments for the effectiveness and benefits of Institutional health partnerships:

1. Develop a shared definition of IHPs that can be consistently used in research
2. Create an evaluation framework for IHPs building on existing evaluation frameworks and best practice
3. Test and validate the evaluation framework on a select number of IHPs within the European ESTHER Alliance (EEA)
4. Disseminate the framework and promote its use among IHP programmes
5. Identify benefits attributed to IHPs that are of particular interest to potential funders
6. Foster relationships with research institutions/academics to undertake more in-depth studies on benefits/impact of IHPs and conduct comparative studies with other forms of technical cooperation.

## PART ONE: EXISTING EVIDENCE AND GAPS IN KNOWLEDGE

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## BACKGROUND

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Whilst those who are engaged in the oversight, management or delivery of institutional health partnerships (IHPs) believe that they form a cost-effective form of technical cooperation that complements traditional efforts in development cooperation and addresses many of its shortcomings – not all development cooperation actors are convinced. Their association with volunteering can lead some to label them as being development naive which at worst do harm or at best are gap filling. In the current era of accountability and results, providing evidence is important to the partnership community to ensure continuing support from funders and the international development community.

## PURPOSE OF REVIEW

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To undertake a review of grey and published literature, to establish what evidence is already available on the effectiveness and additionality of institutional health partnerships and identify knowledge gaps.

## WHAT CAN WE EXPECT IN TERMS OF EVIDENCE?

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The hierarchy of evidence was developed to demonstrate the effectiveness of clinical interventions. There has been much discussion of the extent to which this hierarchy and in particular randomised controlled trials (RCTs) are applicable in complex social systems where concepts such as baselines and controls are at best approximate. Change is normal within institutions and social systems and not everything can be controlled for. In addition, the expense and complexity of trials often makes them unfeasible. Rychetnick (2002) advocates cluster RCTs as still the best form of evidence even for complex public health interventions implemented with flexible strategies, but these expensive forms of evaluation should only be used after the intervention has yielded satisfactory results using simpler cheaper designs that can develop instruments to ensure programme implementation processes and outcomes are satisfactorily captured. Petticrew (2013) argues that in other sectors there is much less emphasis on trials and a wider range of types of evidence predominates to inform decision making about outcomes. In short research methods need to be appropriate to the question, but the sophistication and precision that are required to supply a “good enough” answer also need to be taken in to consideration. We should expect strong evidence to support expenditure. Robust methods of evaluation, evidence based theories of change and comparative studies with other forms of technical cooperation are all feasible within the IHP movement. We should also be mindful of what evidence decision makers need or want in order to be able to make funding and priority choices. Section Three outlines the different types of evidence of use and interest to different audiences.

## METHODOLOGY

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A “broad brush” review of both peer-reviewed and grey literature was conducted in December 2014/January 2015. Grey literature was included since there are still very few published papers in this area and unpublished documentation in the form of project/programme evaluations, policy documents and case studies are likely to make a significant contribution in this emerging and complex field.

Inclusion criteria and study parameters were discussed and finalised with the ESTHER Evidence and Effectiveness Working Group (EEWG) which included discussion and debate on the terms institutional health partnership, effectiveness and additionality of institutional health partnerships. It was agreed



that our analysis of literature would be “content neutral” of the specific interventions described in the literature since these are rarely comparable.

Inclusion criteria were published or grey literature on institutional health partnerships where:

- One partner is in a high-income country and its counterpart/s is/are in a low or middle-income country
- Relationship is more than a one-off project (long term partnership)
- Activities have a health focus
- There is reference to effectiveness or additionality in at least one of the three levels (individual, institutional or national)
- Published within the last 5 years (some flexibility in terms of the year of publishing was exercised)

### Electronic database search

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Two electronic databases were searched separately via Ovid MEDLINE (Medline) and Web of Science, using a standard set of search terms. Three categories separated by the Boolean operator “AND” were used:

1. **Institutional health partnership** (range of terms including health link, health partnership, hospital partnership, institutional partnership, paired partnership, institutional health partnership, twinning partnership, hospital twinning, collaborative link, collaborative partnership, North-South Partnership)
2. **Geographical location** (developing country, low and middle income countries, Africa, Asia, Latin America)
3. **Effectiveness/additionality** (range of terms including effective, additional, benefit, evaluation, sustainability, ownership, flexibility, mutual, frontline, peer, cost, economic)

The titles and abstracts of all initial search results were screened and all articles unrelated to institutional health partnerships were excluded. All articles were then screened again to determine that they met the agreed inclusion criteria.

### Unpublished literature

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CDI has conducted a range of evaluations of Institutional Health Partnerships since 2012 and is already familiar with much of the grey literature in this field; these documents were added to the review. The search of unpublished and published literature was supplemented by requesting ESTHER members for additional key documents including:

- Published literature regarding effectiveness/additionality of IHPs
- Formal evaluations of IHPs or partnership programmes
- Any other grey literature on effectiveness/additionality of IHPs (eg unpublished research, think pieces, case-studies, conference presentations etc.)

### Final selection and citation-mapping

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Literature which did not meet the inclusion criteria was excluded. However one significant evaluation of a non-health related EU twinning programmes was included (Bouscharain et al, 2012) because it was

a robust, large-scale review specifically evaluating institutional partnerships. A significant numbers of papers on north-south research partnerships were excluded from the review as being different in nature from IHPs working between health services (particularly in how they are funded and the benefits to partners). Manuals and handbooks written for Institutional Health Partnerships were also excluded from this review. However there may be much to learn from this literature and it should be taken into consideration for developing a framework on assessing effectiveness and benefits of IHPs.

Following collation of all documents that met the inclusion criteria and removing all duplications, bibliographies were reviewed and references that were of potential relevance were assessed against the criteria. Due to time limitations, once more than 40 documents had been collated only those deemed to be extremely relevant were included.

### Evidence assessment

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All documents were assessed for the level of evidence they provided. The traditional hierarchy of evidence scoring was not used since the IHP literature is “research scanty”. Also partnership programmes are often aimed at improvements to institutions and their workforce that are complex, change in time and are context specific. These do not lend themselves easily to the types of research that are at the top of the evidence hierarchy. Therefore an adapted scoring system (<http://giving-evidence.com>) was used.

**Level 0:** Expert opinion/advocacy

**Level 1:** Coherent description of what was done and why it matters (logical and convincing)

**Level 2:** Includes data that shows change, but attribution not proven

**Level 3:** Demonstrate causality through use of control or comparison group

**Level 4:** At least one replication studied independently (shows repeatability)

**Level 5:** Systematic review

### Data extraction and analysis

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All published papers and short (<15 pages) grey literature documents were scanned in their entirety. For longer documents (mainly programme evaluations), initially the executive summary was reviewed and then only relevant other sections of the document. Short summaries were produced for each document reviewed (see separate annotated bibliography). Key data extracted included:

- Document type: published/unpublished
- Independence of evidence: self/independently reported
- Scope: describing single/multiple IHPs
- Quality of evidence: Level 0 – Level 5
- Results: short summary of key project activities/outputs/outcomes achieved
- Framework/model/methods/indicators: brief description
- Robustness of design: comments on sample size, methods, models etc.
- Summary of partnership effectiveness
- Factor contributing to effectiveness (no evidence)
- Evidence of effectiveness
- Summary of benefits/additionality
- Factors contributing to benefits (no evidence)
- Evidence of benefits/additionality

- Future research priorities/questions

Since the majority of research/evaluation studies identified used mixed methods or qualitative methods (document review, focus group discussions, interviews, surveys, observation) thematic analysis was used to synthesise the findings in relation to factors contributing to effectiveness and additionality/benefits of using a partnership approach.

### Limitations & constraints

The review conducted was not a full systematic literature review and synthesis of the current evidence. Instead robust methods have been used to undertake a rapid review of current grey and published literature. It is possible that key documents may have been missed due to the more limited search strategy employed in this review.

The analysis has been content neutral of specific interventions since these are rarely comparable. This review has not focussed on challenges except when they point to a clear indicator for success, although challenges and failures form an important form of evidence when looking at effectiveness.

## RESULTS

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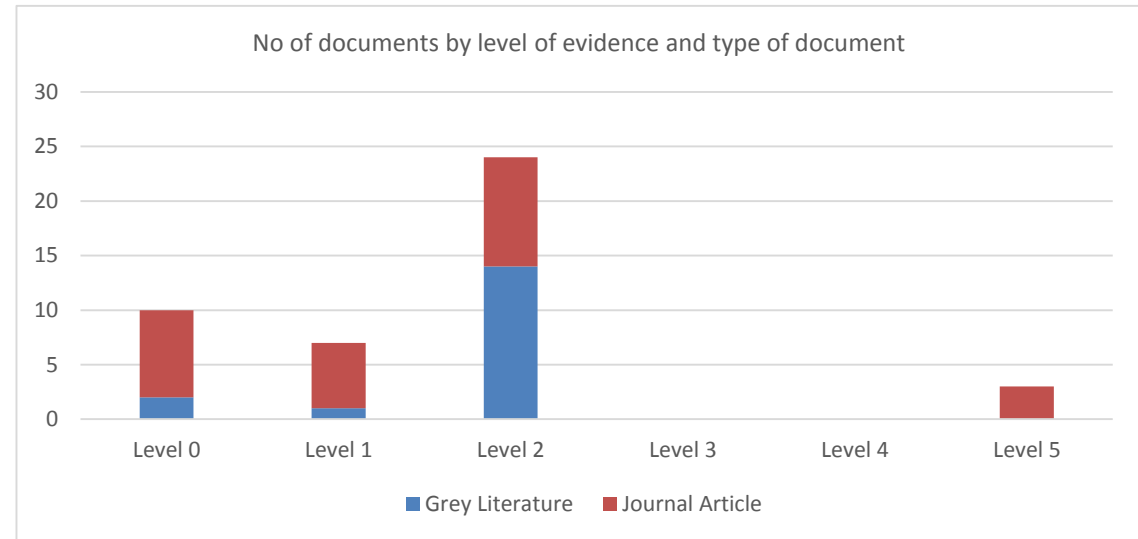
A total number of 44 published and grey literature documents were included in the review. Of this 27 articles were from peer-reviewed journals and 17 from the grey literature.

For the database searches (no year limits), MEDLINE produced 49 hits and Web of Science 98 hits. After excluding those that did not meet inclusion criteria and deleting duplicates, 18 published journal articles were included from the initial database search. An additional 9 published articles were included after citation searching and review of documents supplied by CDI and ESTHER members.

The grey literature search returned a total of 42 documents retrieved from CDI's previous work on IHPs and supplied by ESTHER members from UK, Ireland, France, Germany and Norway. After excluding those that did not meet inclusion criteria and deleting duplicates, a total of 17 grey literature documents were included.

Figure 1 shows the number of documents, level of evidence and type of document, highlighting that no "level 3" or "level 4" evidence documents could be identified. Figure 2 summarises the level and quantity of evidence from all sources.

Figure 1 No of documents reviewed by level of evidence and type of document



	Level 0: Expert opinion/advocacy	Level 1: Coherent description of what was done, why it matters, which is logical and convincing	Level 2: Includes data that shows change, but attribution not proven	Level 5: Systematic review	Grand Total
<b>Grey Literature</b>	<b>2</b>	<b>1</b>	<b>14</b>		<b>17</b>
<b>Independent</b>	<b>2</b>		<b>10</b>		<b>12</b>
Multiple Partnerships	2		10		12
<b>Self Reported</b>		<b>1</b>	<b>4</b>		<b>5</b>
Multiple Partnerships			1		1
Single Partnership		1	3		4
<b>Journal Article</b>	<b>8</b>	<b>6</b>	<b>10</b>	<b>3</b>	<b>27</b>
<b>Independent</b>	<b>8</b>		<b>4</b>	<b>3</b>	<b>15</b>
Multiple Partnerships	8		3	3	14
Overseas Experience			1		1
<b>Self Reported</b>		<b>6</b>	<b>6</b>		<b>12</b>
Multiple Partnerships		1			1
Single Partnership		5	6		11
<b>Grand Total</b>	<b>10</b>	<b>7</b>	<b>24</b>	<b>3</b>	<b>44</b>

Figure 2 Level and type of documents reviewed

## Editorials, commentaries, advocacy and think pieces

Ten “level 0” (editorials, commentaries, advocacy and think pieces) articles were reviewed and analysed of which 8 were published and 2 were grey literature. Whilst these documents are of limited evidentiary value, they are normally written by recognised experts in the field and provide a balanced overview on what has already been published as well as critically challenging and/or identifying weaknesses in methodology and gaps in the evidence. Well-written “level 0” documents can play an important role in persuading politicians and in advocating for more resources/support from the international development community.

Smith (2012) distinguishes between two main types of literature; those published by IHPs themselves and more independent evaluations. He discusses the challenge of attribution particularly for small-scale partnerships in complex organisations, in which the partnership may have a varying focus over time. He clearly identifies the need for more published evidence on both the effectiveness of the IHP approach as well as identifying which interventions are effective and why.

*"Despite the expansion in the number of health links, there has been little published evidence about their effectiveness and impact, and there have been calls for stronger evidence showing which types of intervention are effective and the impact of health links on the processes and outcomes of health care."*

Similarly Ritman et al, (2012) argue the case that RCTs, the gold standard in medical research are “incompatible with socially complex service interventions” and instead suggest that the simple qualitative tools (surveys, interviews, feedback, observation) currently used by IHPs can both improve partnership performance but also provide information to develop indicators for future more rigorous studies of effectiveness. They argue that most partnerships do not have the resources to conduct or commission such complex studies.

Of these 10 documents reviewed there is overarching support for the IHP approach and a firm belief that this type of technical assistance brings a wide range of benefits to both northern and southern institutions and potentially strengthens health systems. However there is also a wide recognition of the need to develop greater methodological rigour in evaluating the outcomes and impact of this approach.

## Case Studies and reviews

Twelve reviews and case-studies were included in the study, six of which were “level 1” evidence articles and six “level 2”. The majority (11 out of 12) were self-reported of individual IHPs which maybe subject to bias. The “level 1” case-studies provide useful insights and lessons learned with good descriptions of the process of implementation, but are largely limited to activity and output reporting. Whilst the “level 2” papers report change and present higher levels of analysis, the evidentiary value on the effectiveness and additionality of IHPs is limited and attribution of change unproven.

Hopkins describes international twinning partnerships as an effective method of improving diagnosis, treatment and care for children with cancer in low-middle income countries (Hopkins et al., 2013). He identifies the importance of a long-term strategy and planning when working in partnership and uses

the World Cancer model that supports going to scale as well as eventual exit from the partnership. In this review clear benefits to both developed and developing countries are identified although the strength of the evidence is weak. Haglund describes a surgical capacity building twinning partnership in Uganda and by conducting baseline measures of the number and complexity of surgery performed is able to demonstrate longer term and trickle effects of undertaking short-term inputs (Haglund et al 2011). Corbin describes an innovative model - Bergen Model of Collaborative Functioning - which is used to map the successes and failures of one organisation's North-South partnership experiences that provides a robust analysis not typically captured in routine evaluations. This study highlights the importance of acknowledging and reporting on both positive and negative processes to maximize learning in North-South partnerships (Corbin et al.; 2013). Busse et al. (2013) analyses the first two years of a twinning partnership in emergency medicine using the American International Health Alliance (AIHA) six phase twinning partnership model. The paper gives a large number of lessons learned framed within the six phase twinning model but cannot prove how or why these factors contributed to the success of the partnership and its work. This paper suggests that long term IHPs can build equitable partnerships and contribute to health systems strengthening.

*"The short-term achievements of using a twinning model could suggest that long-term, institution-to-institution collaborations, driven by local stakeholders are an effective strategy to create equitable relationships and build sustainable health system." (Busse et al. 2013)*

Horton identifies that there are very few detailed and theoretically grounded case studies of partnerships and that most research is based on secondary data, questionnaires surveys or personal impressions (Horton et al 2009). In spite of these identified weaknesses, these documents provide useful insight on approaches and on the process of establishing, sustaining and evaluating IHPs using a range of different models.

## Evaluations

Ten independent evaluations were reviewed of which eight were externally commissioned evaluations of IHP/exchange programmes. In general these are more comprehensive evaluations of multiple IHP programmes and have clearly defined methodologies with greater depth and quality of analysis although only half of the evaluations report the use of an evaluation framework. All evaluations reviewed were rated at "level 2" quality of evidence, in that the attribution of change is not proven. In general the evaluations rely on secondary data review and supplement this with mainly qualitative primary data collection using surveys, interviews, workshops, focus group discussions and observation. The southern partner voice is less represented in these evaluations, except for Doyle & Kelly (2012) and measurement of impact is limited to personal impressions reported by those involved in the partnership programmes. In depth analysis of individual IHP programmes are not included in these evaluations.

Paterson et al. (2007) provides a comprehensive evaluation examining 28 primary healthcare (PHC) partnerships, using a logic model and 3 tier "population - sample - case" evaluation model. Effectiveness and impact of the PHC partnerships is measured and analysed across 7 categories including appropriateness of partnership objectives, programme outcomes and impact, care delivery strengthening, management strengthening, partnership effects on professionals, organizations, and

society and sustainability and replication. This report identifies a wide range of benefits, lessons learned and factors of effectiveness. It also acknowledges the problem associated with measuring impact and identifies the need to develop well-organized and categorized qualitative and quantitative baseline data that can support pre/post-project comparisons and analysis as well as developing tools for monitoring sustainability.

Bagauley et al. (2006) evaluate 14 IHPs using semi-structured interviews with 22 coordinators (13 north and 9 south) to assess what constitutes an IHP, how they are supported, their perceived benefits and challenges. This article identifies a lack of published data evaluating IHPs, due to their varied nature and complexity and the expense of objectively assessing their impact. Bagauley suggests further research is required on the impact of IHPs on processes and outcomes of health care.

Kiernan et al. (2014) evaluate the overseas out of programme (OOP) training experiences for UK trainee general practitioners (GPs) and examines the benefits to trainees on their transferable knowledge and skills. Whilst this evaluation does not attempt to evaluate IHPs it suggests a larger study looking at the sustained impact on professional development of trainee GPs using a standardised questionnaire to be completed before and after trainee overseas placements, linked to an e-portfolio learning log to verify learning and benefits of overseas training placements.

More recent evaluations Doyle and Kelly (2012, 2013) provide comprehensive evaluations of UK and European IHP programmes across sub Saharan Africa, Asia and Latin America, combining the project logic model with the OECD DAC evaluation framework. Both evaluations identify the need to generate more robust evidence on the effectiveness and added value of IHPs in comparison with more traditional project based technical assistance programmes. They identify that there is no shared understanding of how institutional partnerships contribute to health systems strengthening and suggest the need to further develop thinking on categorisation of partnership programmes by scale and thematic focus. They conclude that bodies coordinating partnership programmes need a coherent theory of change that can then underpin the development of a more robust evidence base.

*“There is a need for the partnership model to move from faith to science. To date much of the funding for partnership initiatives has been on the basis of a belief that this form of working is effective and cost effective. The partnership movement needs to understand why interventions work and underpin this with a robust evidence base.”* (Doyle & Kelly, 2013)

Bouscharain et al., (2012) conduct a comprehensive evaluation of the EC Institutional Twinning Instrument, an 8 year programme of 175 twinning projects in 12 countries covered by the European Neighbourhood Policy. This evaluation concludes that twinning is an extremely effective instrument that is more effective than other types of project technical assistance. Whilst this is not a review of health related twinning programmes, the robust nature of the evaluation both in terms of sample size and thorough use of mixed methods combined with the OECD/DAC evaluation framework resulted in useful and robust findings in relation to effectiveness and benefits of twinning programmes.

Thus the evaluation literature largely consists of externally commissioned evaluations that generally rely on secondary data review and supplement this with mainly qualitative primary data collection. The evaluations recognise the limitations of evaluating both effectiveness and impact of the partnership approach and call for more rigorous evaluation frameworks, baselines and a mix of qualitative and



quantitative indicators by which to do this.

## Research

Seven research papers/reports were included in the review, all rated as a “level 2” for quality of evidence. Of these, none were specifically focused on the effectiveness or impact of the IHP approach.

Beran (2010) provides an example of a rigorous assessment of a health partnership with baseline and six year follow up, using a qualitative approach. Whilst the assessment was not conducted to specifically evaluate the IHP approach, findings demonstrate benefits of this approach and identifies the potential of how IHPs can influence policy and bring about changes in areas of health that are not traditionally donor funded such as non-communicable diseases (NCDs).

Several research studies look at the personal and professional benefits to developed country practitioners of participating in international work (Longstaff, 2010, Smith et al. 2012, Busse et al., 2014).

Longstaff (2010) conducts a robust piece of small-scale research that highlights evidence of professional and personal development for participants in IHPs to persuade NHS institutions of the value of IHPs. She provides a framework for linking professional development to the NHS competency framework and leadership framework that could be used to undertake wider study. Busse et al., (2014) also researches the personal and professional impact among global health volunteers of working in specialist Hospital in Ethiopia. She concludes that professional and personal learning happens and suggests further developing their framework for assessing reverse innovation from developing countries to developed countries. Smith et al., (2012) also reports moderate or significant development in leadership, personal and clinical care domains of NHS competency and leadership frameworks.

Abualela (2014) conducted a literature review and document review of 4 multi-country partnerships in partial fulfillment for the award of a Master’s in International Public Health. She derives a best practice framework based on a literature review of UK IHPs and wider literature on IHPs and capacity development. Her research concludes that there is a need for stronger evidence on the effectiveness of partnerships and that further research should be conducted in relation to what IHPs can achieve in terms of individual and institutional capacity building and their contribution to health systems strengthening. Her best-practice framework would need further refinement and piloting in active IHP programmes in order to assess its validity and value.

Thus, it is widely recognised that there has been very limited if any high quality research conducted on the effectiveness and impact of using an institutional partnership approach in health. This may partly be due to the incompatibility of using randomised control trials (RCTs) or other higher level forms of evidence production and also to the challenge of attribution particularly with modest/small IHPs, which may change the focus of their effort over time.

## Systematic reviews

Three systematic reviews were included in this study, each rated at a “level 5” for evidence. The reviews recognise that the current standard of literature does not meet the high standards of formal academic rigour with little published or unpublished literature on the effectiveness and impact of IHPs.



The reviewers identify an urgent need for more rigorous and standardised methods and tools for reporting costs, benefits, effectiveness, outcomes and impact.

Smith (2013) concludes that there is limited evidence on whether UK IHPs improve health outcomes in developing countries, reflecting the lack of high quality research in this area. Of the nine articles included in Smith's review he notes that reporting health outcomes was not the primary intention of these papers. Challenges for IHPs include measuring impact, attribution to a specific intervention due to multiple sources of funding, focus on capacity building of which impact is indirect and long term, lack of base-line surveys for comparison and follow up and lack of expertise in M&E. He concludes that there is little strong evidence, but a broad trend that UK IHPs improve health outcomes. He suggests that RCTs are not feasible, but that with careful study design it might be possible to compare health outcomes served by an IHP with a control population in a nearby district.

Jones et al., (2013) reviews the benefits and costs of health partnerships to UK individuals, institutions and the NHS to understand how volunteering within partnerships might impact on workforce development and service delivery. Jones concludes that there is a strong theoretical argument that the skills acquired through volunteering are transferable to service delivery within the NHS and that the benefits to individuals and institutions could be maximised when volunteering is formally embedded within continuing professional development processes. However evidence for benefit on institutional level was weak and the level of skills attained that were transferable was impossible to map as literature was mainly reporting subjective improvement.

Syed et al., (2012) conclude that the benefits to developed countries working in IHPs are largely "soft" benefits that influence health workforce education and training. The study did not find evidence for the broader 'impact' of these benefits on health systems. Syed et al., provide narrative examples of 'reverse innovation' and potential ways in which 'reverse innovation' could be stimulated in the future however acknowledge that this area of research is still in its infancy.

*"However the global pool of knowledge in this area is virgin and further work needs to be undertaken to advance understanding of health innovation diffusion"* (Syed et al., 2012)

There is limited benefit in conducting further systematic reviews on the benefits, outcomes and impact of IHPs until further high quality research has been conducted in this field.

### Summary of documents reviewed

Limitations of the documents reviewed included small sample size, self-reported evaluations, retrospective reporting and measurement of activities and outputs rather than outcomes and impact. No studies used control groups, comparison groups or tested for repeatability. Many of the documents reviewed did not specifically evaluate the IHP model, but alluded to benefits and effectiveness of using a partnership approach. Therefore this review has focused on arguments and evidence of effectiveness and additionality, areas requiring further research and methods from the literature that could be used to produce more robust evidence in the future. Refer to Annex 2 for areas of future research identified from the studies reviewed.

## Effectiveness

Whilst many of the papers reviewed reflected on the factors that influenced the success of IHPs, very few did this using any framework and much of the literature was based on personal reflection rather than a systematic analysis. The lack of consistency in approach also means that it is difficult to compare the results – the fact that an indicator is not mentioned within a paper does not necessarily mean that it was not important. It may just mean that it was not focused on or a question was not asked about it. The factors identified as indicators for success from the studies reviewed are shown in Figure 3.

Most of the studies reviewed provided indicators that were listed as best practice but lacked a robust methodology for identifying them. Those studies which demonstrated more rigorous methodology included Abualela (2014) who assessed four partnerships against a best practice framework with 8 defined areas and a comprehensive set of indicators developed from a literature review. Doyle and Kelly (2012 & 2013) and Paterson & Telyukov (2007) used a logic model to assess IHPs. Bouscharain & Moreau (2012) applied a robust methodology using mixed method data collection and a framework based on the DAC criteria with additional criteria of coherence/complementary and EC value added to review institutional twinning instruments in the countries covered by the European Neighbourhood policy.

A list of success factors could be the first step in identifying or building an evidence based framework of what makes an effective partnership.

Ref	Success Factor	Frequency quoted
1	Southern ownership/Demand led	19
2	Alignment with national strategies/plans/government commitment	16
3	Communication	13
4	Monitoring, evaluation and feedback/communication of performance/baseline	11
5	Sustained funding/adequate overheads for both partners	10
6	Longevity of partnership/relationship/commitment	10
7	Personal Commitment	9
8	Common goals/transparent expectations	9
9	Adaptation to context/Cultural sensitivity	9
10	Equality between partners (working towards/addressing capacity gaps)	9
11	Administrative/project management support (not done by clinicians)/capacity to support partnership	9
12	Institutional Commitment	8
13	Collaboration (wider than partnership)/Harmonisation	8
14	Multidisciplinary approach	8
15	Leadership/champions	7
16	Governance/accountability/transparency	7
17	Trust/Respect	7
18	Regular review and improvement of strategies and plans of the partnership/flexibility	7
19	Continuity of staff involvement	6
20	Enabling policies and systems for involvement in partnership	6
21	Openness to learn, develop new skills, adopt new methods/Mutual learning	6
22	Involvement of people with relevant/appropriate skills, experience and attitude	6
23	Vision/Long term view	5
24	Whole institution support/Embed knowledge in institutions	5
25	Systems thinking approach/Whole system view	5
26	External dissemination and advocacy	5
27	Stakeholder engagement	5
28	Integrate work with existing systems	5
29	Avoid over-reliance on key individuals	4
30	Length and frequency of visits/exchanges	4
31	Friendship	4
32	Pragmatism	4
33	Values-led partnership/Ethics	4
34	Alignment with institutional priorities/plans	4
35	Value the processes and needs of the partnership not just the intervention	3
36	Capacity building/orientation in development best practice	3
37	Rigorous needs assessment/capacity gap analysis	3
38	Perseverance	2
39	Formal agreements between partners	2
40	Facilitative approach from northern partner/Local solutions	2
41	Bi-directional visits/exchange	2
42	Joint decision making	2
43	Evidence based interventions/practice	2
44	Programmatic approach	1
45	Absorption capacity of beneficiaries	1

Figure 3 Success factors from the document review by frequency of reference

## Benefits/Additionality

Due to the wide range of outcomes from IHPs such as improved service delivery or increased clinical knowledge/skills, improved education/training which are not comparable across partnerships we have focussed on looking at evidence of added value beyond the project outcomes. Project M&E should give evidence of partnerships ability to achieve their stated objectives eg reduction of maternal morbidity in x hospital. There were more robust studies and evaluations that addressed one or more

benefits of working in partnership. Most of these studies, however, identified that more research was needed before any conclusions could be drawn. Figure 4 highlights the benefits/additionality that were contained in the reviewed papers. A full list of the references of these papers is included in Annex 1.

	Level 1	Level 2	Level 3	Level 4	Level 5
Sustainability		8			
Ownership		4			
Flexibility		5			
Mutual Benefit		12			2
Frontline		2			
Peer-to-peer		4			
Institutional strengthening		5			
Value for money		3			
Innovation		4			1
Personal and Professional Development		8			2
Knowledge and skills transfer		10			2
Reach less well funded areas of need		4			
Motivation		7			1
Cultural competency		8			
Influencing policy		2			

Figure 4 Number of documents containing evidence of benefits or additionality

## DISCUSSION

### Purpose and definition of IHPs

One of the challenges in identifying the current evidence on the effectiveness of IHPs is that there is still a need to conceptualise IHPs and their particular place in development cooperation. This would then form the framework within which a research programme could be built in order to demonstrate effectiveness, benefits and impact. Currently there is no shared definition of IHPs that is consistently used in research. Reaching a robust, shared definition and identifying what makes IHPs distinct from other forms of development cooperation is an important first step in enabling good quality research to be conducted.

The word partnership is often overused and misused and distinguishing IHPs from other forms of technical cooperation is not necessarily straight-forward. Whilst there is a set of values shared by the partnership movement they are not exclusive to it. Doctors, nurses and other health professionals work in international development through a variety of routes including NGOs and more traditional volunteering programmes. Whilst some IHPs show a true institution to institution commitment, others are run by a small number of committed individuals largely outside their normal institutional responsibilities.

Horton et al. (2009) provides a useful literature review on partnership, and its definitions could be a good starting point to develop a shared and consistent definition of IHPs for the purposes of research and evaluation. We also need to be clearly define what are we seeking to be effective for? What is the purpose of IHPs? Framing the niche that IHPs should take within the global health development portfolio provides the context to the questions we are seeking to answer. Are we interested in the effectiveness of partnerships in contributing to improving the health workforce? Improving health

systems? Improving the effectiveness of institutions? Improving frontline service delivery? Improving close to practice research? If IHPs are a complementary form of technical cooperation how should they relate to other forms of technical cooperation?

## What do we mean by effectiveness of IHPs?

### Health outcomes and good partnerships: two sides of one coin

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Effectiveness is about what makes interventions or institutions or systems work. In order to investigate effectiveness we also need to be able to identify whether or not something has been a success – whilst this is relatively straight forward with clinical interventions it is less easy to identify in terms of a partnership. If a partnership delivers a successful change within an organisation or a service; does that make it a successful partnership? Many of the evaluation frameworks used for partnerships identify the need to evaluate both the outputs and outcomes of the partnership activities as well as the partnership itself. A need to look at both results and process. It is arguably the nature of the process within partnerships that may lead to many of the added values attributed to IHPs such as increased ownership, motivation and innovation.

### Results

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Even when evaluating the results of a partnership there is a need to have a nuanced view depending on both the stage of development of the partnership and the purpose of the partnership's activities. Young partnerships may not be as effective as more mature partnerships; partnerships that are coming to the end of their usefulness will also look very different. Partnerships that are experimenting with new approaches may see failure as an important success in informing knowledge of what works and what does not.

There are also issues of attribution when looking at the results of partnerships that are working in complex organisations within which many different projects, partnerships and development actors are working. There are issues of the time period within which you assess the results of a partnership – some interventions can have short-term positive impact but then be overwhelmed by unintended consequences (danger of creating islands of excellence). Other interventions may only have measurable positive impact over a long time period and those impacts may be diffuse– particularly when they are addressing more structural issues (see further discussion regarding health systems strengthening and impact in Part 2: Methods, Indicators and Frameworks).

### Barriers to getting robust results

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The size and funding of many IHPs preclude complex or resource intensive methods of monitoring and evaluation. In addition, the problems of attribution and time scales for measuring impact are additional barriers to producing robust results. Therefore, there is a role for facilitating bodies both to provide advice to partnerships on pragmatic monitoring and evaluation but also to look for ways to fund larger studies across partnerships that can seek to address some of the evidence gaps.

Many partnerships only provide data at activity and output level and success is measured against the project framework. Currently most published case studies are of 'successful' partnerships which are

largely self-defined as successful. External evaluations may highlight more variability in results of partnerships but they do not provide a single way of defining whether or not a partnership has been successful. This methodological challenge is the same for other similar forms of technical assistance and is not singular to the partnership experience.

## Role of facilitating bodies

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The effectiveness of IHPs is also influenced by the support and guidance provided by the body facilitating the partnership (eg ESTHER national secretariats, THET ...). This review focuses on evidence regarding what makes an effective partnership. However, the role of the facilitating body should not be overlooked when developing research questions. In particular, the facilitating body may assist partnerships in addressing some of their knowledge and skills gaps in relation to project management, development cooperation, cultural competence and monitoring and evaluation. The effectiveness of the facilitating body in meeting these needs should have an impact on the effectiveness of the partnerships they facilitate.

### What do we mean by benefits and additionality of IHPs?

There are numerous assertions made within the current literature regarding the added value of working in partnership although there is little evidence beyond the anecdotal. In this study we look for evidence or indicators that related to aspects of additionality and we have produced an expanded list of added value, given by partnerships from the content of the documents reviewed. Little is written about how or why partnerships should be associated with particular benefits. Further research could develop conceptual frameworks of how these benefits are linked to the process of partnership.

### What do we mean by the impact of IHPs?

Impact evaluation assesses the changes that can be attributed to a particular intervention and is notoriously difficult to assess within complex social systems. Sometimes it is only possible to measure outputs and outcomes - then impact can only be estimated through a robust theory of change as to how those outputs and outcomes should result in change in the particular system being evaluated. Theories of change allow the links and assumptions between elements in the theory to be examined and evaluated even when a comprehensive impact evaluation is not feasible.

## GAPS IN THE EVIDENCE

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Much of the literature is written by those facilitating or advocating for health links and there is very limited evidence on the effectiveness, outcome or impact of IHPs other than evaluations of specific interventions within partnerships which were not included in this review. The three systematic reviews included in this work all identify the scantiness of the literature and included grey literature of weak to fair quality in these reviews.

With regards to benefits and additionality there are some robust evaluations and studies corresponding to Level 2 in the hierarchy used in this review. But there is still little evidence of synthesis or conceptual frameworks that link benefits to the process of partnership. There is a need for more

robust primary research that then can be analysed and synthesised to form conceptual frameworks that can then be tested and validated. These frameworks can then form the basis of comparative studies that move evidence up the hierarchy – in particular being able to conduct comparative studies comparing IHPs with other forms of technical cooperation. Until there is better quality evidence at the lower levels it is not useful to conduct systematic reviews unless they are aimed at building such models.

Horton et al (2009) identify a number of gaps in partnership knowledge and practice as they relate to the context of international agricultural research, however, we would argue that the gaps are equally as relevant to IHPs. Hence we still have gaps in knowledge about what is effective at:

- The level of individual partnerships
- The level of the organisation that manages a portfolio of partnerships
- The level of the impact on health services and systems where constellations of partnerships are found.

## CONCLUSIONS AND KEY RECOMMENDATIONS

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Given the dearth of high quality primary research or evidence based frameworks coupled with the rich potential of linking to frameworks and thinking from other fields, there is a huge need and opportunity to develop research on the role, effectiveness and impact of IHPs. We propose a staggered research agenda in three streams. However, all of these streams depend on placing the research within a frame of what IHPs are and what they are best placed to do within the development cooperation landscape (definition and utility of IHPs). This may involve stratification of studies on partnership to account for different roles for different types of partnership. Different types of evaluation are also appropriate at different stages of partnership development. The three streams relate to the level of individual partnerships, the level of facilitating bodies with a portfolio of partnerships and then the level of the impact on health services and systems where there is a constellation of partnerships. Figure 5 shows these three streams and suggested areas of focus.

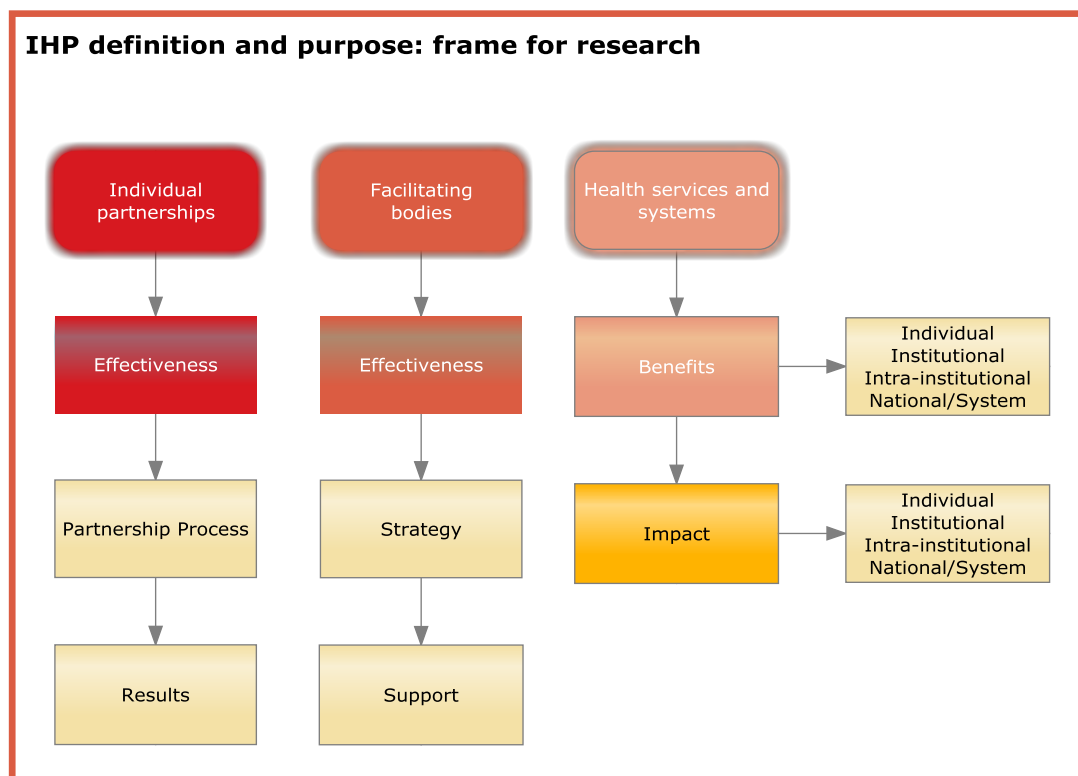


Figure 5: Three streams of research focus

There is a need to sequentially move up the evidence ladder. This means initially focusing on developing or adapting evaluation frameworks that can be used systematically across a number of different partnerships (section two of this report outlines frameworks that were identified in the literature that may be useful to this process).

This can then provide evidence by which the frameworks can be refined and give enough primary evidence that further synthesis can occur. These can then be validated through a combination of survey research among experts and case study research evaluating the results of evaluations made using the framework. Martz (2009) outlines a low cost methodology for undertaking this type of research.

When looking at the benefits of IHPs, the aim should be to move towards doing comparative studies. Does partnership working foster more innovation than other ways of delivering technical cooperation? What is the evidence for greater sustainability with a partnership approach? Impact studies are notoriously difficult and it is advised that this is the last and most complex step to take and would involve working closely with impact evaluation academics.



## ROUTEMAP FOR ESTHER

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1. Define IHPs, their purpose in improving health care/outcomes and their role within international development cooperation to form the frame for the research agenda.
2. Commission a 3 month research study focusing on developing an evaluation framework for IHPs and facilitating bodies through systematic review of best practice literature, research papers and existing evaluation frameworks.
3. Test and validate the evaluation framework on a select number of IHPs within the EEA.
4. Publish the evaluation framework and encourage IHPs to use it within evaluations, particularly those that will be published – this will help grow the evidence base for more systematic synthesis and review.
5. Identify those benefits attributed to IHPs that are of particular interest to potential funders – sustainability, innovation, institutional strengthening, motivation, knowledge and skills transfer.
6. Foster relationships with research institutions who can undertake in depth studies of how these benefits link to the partnership process and comparative studies to compare IHPs with other forms of development cooperation to provide evidence of these additionalities.
7. Foster relationships with academics working in impact evaluation to develop thinking, tools, theories of change and studies to demonstrate the impact of IHPs.



## METHODS, INDICATORS AND FRAMEWORKS

Currently there are no frameworks being consistently used to assess the effectiveness or benefits of working in an IHP. Also very few of the frameworks that we have identified are evidence based, with many requiring further testing or validation. We therefore broadened our search for methods, indicators and frameworks by also reviewing journals from the programme evaluation and implementation science fields. There are numerous frameworks that could be used to further develop thinking on the effectiveness of IHPs and how they benefit and impact institutions and health systems. The following section outlines some of the useful frameworks that could be of value to future research identified from this review and including additional literature from programme evaluation and implementation science fields.

### Evaluation methods

The more robust studies in this review used mixed methods to assess either the effectiveness or benefits of working in IHPs. The American International Hospital Alliance (AIHA) uses a three-tier evaluation framework linking methods to the population under review.

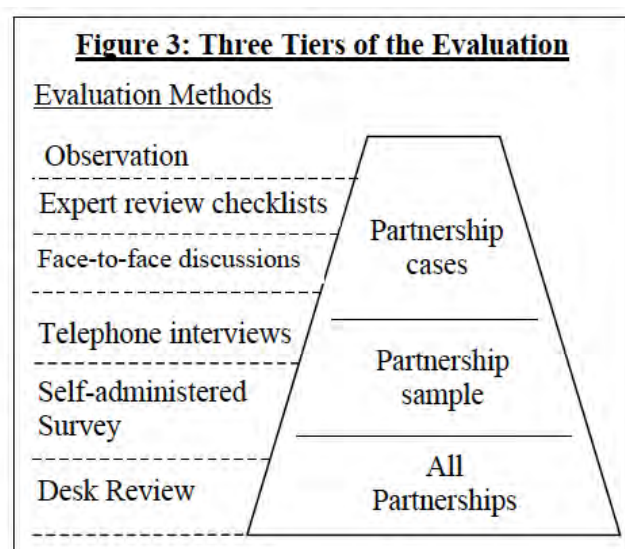


Figure 6 AIHA 3 tier model 'population – sample case' evaluation framework (Paterson et al 2007)

Klitgaard (2004) quoted in Horton et al (2009) discusses three levels of evaluation:

- Evaluating the benefits and costs for a specific partner
- Evaluating the partnership as a whole
- Evaluating the conditions that influence the emergence and functioning of partnerships

The OECD/DAC evaluation criteria for development projects and the logic model were used by a number of evaluations of IHPs.



Figure 7 OECD/DAC Criteria for Evaluating Development Assistance

The DAC criteria form a useful framework for evaluating specific programmes/partnerships but require development of indicators within each criteria which are often specific to the programme/partnership. Hence it is often difficult to use evaluations using the framework comparatively. However, it would be possible to use the framework to develop a set of common indicators which would need to be content neutral in order to facilitate comparison across partnerships. The indicators developed could draw on some of the other frameworks outlined within this study.

### Stratification of partnerships

There were a number of approaches to stratifying partnerships identified in this review. Rosenberg et al (2010) quoted in Busse et al (2014) has a continuum by the degree of collaboration within the partnership moving from coordination to close collaboration.

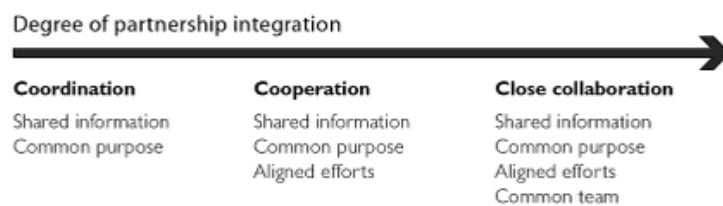


Figure 8 Degree of partnership integration (Rosenberg et al 2010)

Busse (2013) uses the AIHA six-phase model of partnership: Initiating a partnership, developing a workplan, implementing a workplan, programme monitoring, evaluation of results, sustainability and dissemination. The World Cancer Care develops a 5-10 year strategy for each of its partnership projects also using a six-phase model: identify, nurture, develop, expand, scale, exit (Hopkins et al 2013). Both of these have obvious parallels with the project cycle framework.

Doyle & Kelly (2013) propose a categorisation of partnership portfolios by scale and thematic focus.

		Programme Scale	
		Small	Large
Thematic Focus	Wide	Experimentation or Innovation Approach	Portfolio Approach
	Narrow	Incremental Learning Approach	Programme Approach

Figure 9 Categorisation of partnership portfolios by scale and thematic focus (Doyle & Kelly 2013)

For the purposes of evaluating effectiveness or impact we would propose that it would be important to stratify partnerships in terms of their maturity, purpose (innovation/experimentation, service improvement, workforce improvement) and scale (individual, institutional, intra-institutional or national).

## Effectiveness frameworks

There have been a number of frameworks proposed to look at the effectiveness of partnerships but few of them have been thoroughly tested or widely applied (Horton et al 2009). Very few evaluation frameworks look both at results and process.

Atkinson 2005 used an action research approach to develop an evaluation framework for partnership working that seeks to bring together process and outcomes/impact. Each domain in the framework is further broken down into a number of sub-domains.



Figure 10 Evaluation framework for partnership working (Atkinson 2005)

Patel et al 2012 identify a number of factors that contribute to collaborative work after a comprehensive literature review across many different fields of study. The main factors are context, support, tasks, iteration processes, teams, individuals and overarching factors.

Factors (main and sub-factors) of collaborative work									
Main factors	Sub-factors								
Context	Culture	Environment	Business climate	Organisational structure					
Support	Tools	Networks	Resources	Training	Team building	Knowledge management	Error management		
Tasks	Type	Structure	Demands	Decision making					
Interaction	Learning	Coordination	Communication	Common ground					
Processes									
Teams	Roles	Relationships	Shared awareness/knowledge	Group processes	Composition				
			Wellbeing						
Individuals	Skills	Psychological factors	Experience	Goals	Incentives	Constraints	Management	Performance	Time
Overarching factors	Trust	Conflict							

Figure 11 Factors of Collaborative Work (Patel et al 2012)

Mahanty et al (2009) adapts Brinkerhoff's (2002) key factors in assessing partnership performance in three domains:

- Partnership conditions and formation
- Partnership functioning
- Partnership outcomes

Implementation science attempts to unlock the black box of what factors lead to the successful implementation of interventions in any field. Ogden and Fliksen (2014) state that the central issues are the “what”, “how” and “who” of the work of implementing with “what” equating to evidence based programmes or practices and the “who” being change agents or facilitators. Research in this field has shown that implementation principles appear to be content neutral. Thus, a separate implementation science is not required for mental health or child welfare or health or business (Ogden & Fliksen, 2014). Ogden & Fliksen highlight Meyers, Durlak and Wandersman 2012 systematic review of implementation science frameworks which resulted in 6 thematic areas and 14 common dimensions (Figure 12).



Figure 12 Implementation Framework (Meyers, Durlak and Wandersman 2012)

Fixsen's (2005) research synthesis reported in Ogden and Fixsen (2014) states that the best evidence in implementation is for what does not work – namely diffusion of information and training alone are ineffective implementation methods. The strongest research support was found for longer term multilevel approaches that included skill-based training, coaching and assessment of practitioner performance. This research would seem to offer support to the longer term facilitative approach to capacity development taken by high performing partnerships.

Mapping the indicators of success from our review against the frameworks outlined above show that whilst there are many areas of overlap (Figure 13), there are still a substantial number of indicators outside of these frameworks. We suggest that undertaking this type of review more systematically could lead to the development of a more robust framework. This could then be tested and eventually provide an evidence-based evaluation framework for IHPs regardless of the specific intervention being implemented. The results of the intervention could be measured using more traditional evaluation frameworks such as logic models and robust M&E.

Patel et al 2012	Review factors	Meyer et al 2012	Review factors	Mahanty et al 2009	Review factors
Context	9, 20	Assessment	37, 45	Partnership conditions and formation	8, 12, 15, 16, 20, 34, 39, 42
Support	5, 11	Adaptation	9	Partnership Functioning	4, 10, 17, 18, 33, 35
Tasks	43	Capacity Building Strategies	2, 11, 12, 19, 20, 21, 34	Partnership outcomes	13
Interaction processes	1, 3, 16, 21, 35, 36, 42	Structure for implementation	18		
Teams	6, 8, 10, 19	Implementation support systems	22, 36, 40		
Individuals	22	Continuous improvement	4		
Overarching factors	4, 17, 18				
Outside model	2, 7, 12, 13, 14, 15, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 37, 38, 39, 40, 41, 44, 45 (n=25)	Outside model	1, 3, 5, 6, 7, 8, 10, 13, 14, 15, 16, 17, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 35, 38, 39, 41, 42, 43, 44 (n=30)	Outside model	1, 2, 3, 5, 6, 7, 9, 11, 14, 19, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 36, 37, 38, 40, 41, 43, 44, 45 (n = 30)

Figure 13 Matching success factors identified in Figure 3 to three frameworks

In looking at the effectiveness of IHPs within development cooperation, it does not just depend on the effectiveness of individual partnerships, but also on the strategies employed to fund, nurture, direct and support partnerships and the resultant portfolio of partnerships within particular geographical and/or thematic areas. Whilst there have been a number of evaluations of partnerships programmes there is no published literature looking at partnership programmes themselves. Doyle and Kelly (2013) propose a typology of partnership programmes, linked to the level of support and funding available to them (figure 14). We would argue that the wider impact of partnerships will be a function of the strategy used by funders, support provided by facilitating bodies and the effectiveness of individual partnerships.

		Level of funding			Characteristics	Strengths	Weaknesses
Level of support	Substantial	Minimal	Substantial	Catalysing	<ul style="list-style-type: none"> <li>Low levels of support available</li> <li>Low/no funding available</li> <li>Focus on promoting self financing hospital partnerships</li> </ul>	<ul style="list-style-type: none"> <li>Low cost</li> <li>Partnerships self reliant</li> <li>Minimal requirement for bilateral funding</li> </ul>	<ul style="list-style-type: none"> <li>Difficult to attract partnerships to join</li> <li>Difficult to influence partnerships (best practices)</li> <li>Impact likely to be localised</li> </ul>
				Harnessing	<ul style="list-style-type: none"> <li>Substantial support provided to partnerships</li> <li>Low/no funding available</li> <li>Focus on promoting best practices amongst self financing hospital partnerships</li> </ul>	<ul style="list-style-type: none"> <li>Low cost</li> <li>Partnerships self reliant</li> <li>Focus on promoting best practices</li> </ul>	<ul style="list-style-type: none"> <li>Influence may not be as great as external funders</li> <li>Strategy based on implementing partner priorities</li> <li>Difficult to attain thematic or geographical focus</li> <li>Requires investment for support to partnerships - often difficult to 'sell' to donors</li> </ul>
	Minimal			Fueling	<ul style="list-style-type: none"> <li>Provides funding to partnerships</li> <li>Light touch management and support</li> </ul>	<ul style="list-style-type: none"> <li>Management time light</li> <li>Partnerships appreciate light touch</li> </ul>	<ul style="list-style-type: none"> <li>Partnership quality likely to be variable</li> <li>Assumes partnerships understand capacity development in development cooperation</li> <li>Partnerships responsible for alignment and visibility</li> </ul>
		Catalysing	Fueling	Steering	<ul style="list-style-type: none"> <li>Co-develops strategy for partnerships</li> <li>Provides funding for partnerships</li> <li>Participates in implementation of partnerships</li> </ul>	<ul style="list-style-type: none"> <li>Able to work closely to southern government priorities</li> <li>Able to maximise impact by focusing geographically and/or thematically</li> </ul>	<ul style="list-style-type: none"> <li>Opportunity cost of not harnessing motivated health service professionals in areas outside thematic/geographic focus</li> <li>Highest cost</li> </ul>

Figure 14 Typology of Partnership Programmes (Doyle & Kelly 2013)

The ESTHER European Alliance provides a unique field of research to look at strategy and the role of facilitating bodies given the differences in approach of its members.

None of the frameworks outlined above have an evidence base that has been tested on IHPs – all of them would seem to have elements that are of use in thinking about effectiveness. Hence there is a need for further research to develop or adapt appropriate evidence-based frameworks of effectiveness for IHPs and for their facilitating bodies.

## Benefits/additionality

Whilst there was much agreement in the documents reviewed about the added value or additionality that partnerships bring, there were very few conceptual frameworks, synthesis or analysis of how these benefits link to the process of partnership.

Benefits were seen as accruing to different actors as a result of the partnership – individuals (north and south), institutions (north and south) and health services and systems (north and south). Some papers also identified the dis-benefits or costs, usually unintended of partnership work. Often these issues are not widely reported in the partnership literature but are a valuable source of learning for the partnership community.



Bloch (2014) undertook a study to explore the additionality for recipients of research grants - additionality was explored in the following areas: research (or project) effects, output effects, behavioural effects, career effects and environment/institution effects.

The Bergen model of collaborative functioning (Corbin 2013) provides a very different focus and methodology on how to evaluate partnerships. The model includes additive results and antagonistic results encouraging evaluators to explore the ways in which the partnership has had unintended negative consequences.

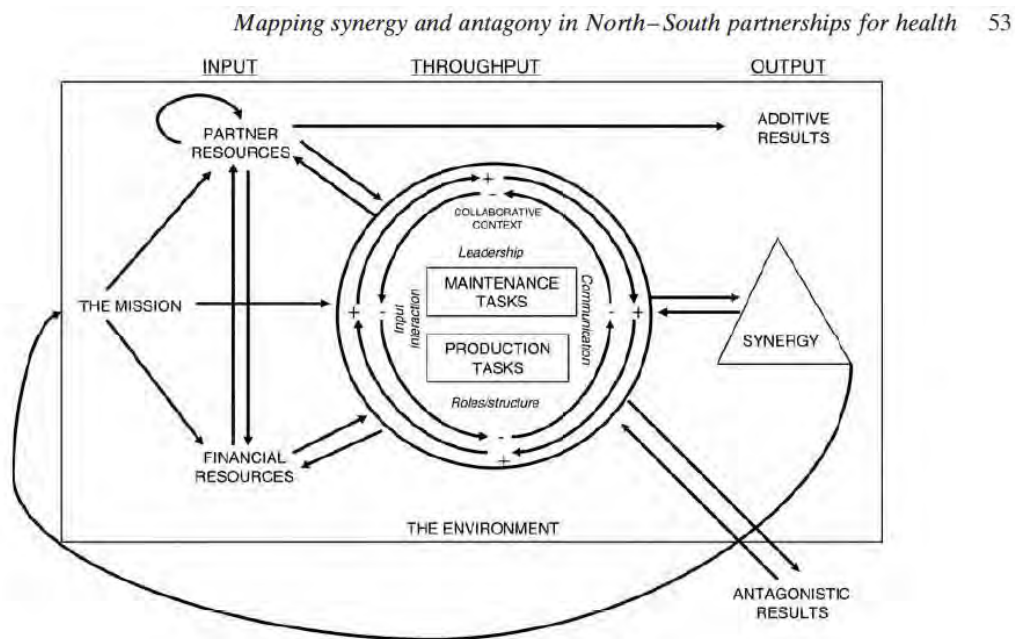


Figure 15 Bergen Model of Collaborative Functioning (Corbin 2013)

There has been a recent increase in the number of publications addressing benefits to northern individuals and institutions and the process of ‘reverse innovation’ of improvements in service flowing from the south to the north. Syed et al (2013) used Boydell’s Partnership evaluation tool which categorises the benefits of partnerships working into benefits associated with connections, learning, action and impact.

There have been a number of studies looking at the skills and competencies accruing to medical professionals from the north engaging in IHPs or overseas work. Longstaff 2010 and Kiernan 2014 both have tools and frameworks that could be used with larger study cohorts to demonstrate skills acquisition and map this onto national frameworks for competency and leadership for health services.

Jones (2013) conducts a systematic review of the literature in relation to skills and competency acquisition by individuals from the north. Out of this review a framework first developed by Wales for Africa has been further developed and refined to provide a conceptual framework for the opportunities given by IHPs to develop competencies and then how those competencies benefit health professionals, organisations and the health system (Figure 16). In particular, the model highlights the conditions needed for those competencies to be effectively transferred into those domains. This framework forms a basis for potential future research in seeking to track one aspect of the benefits and impact of involvement in IHPs.

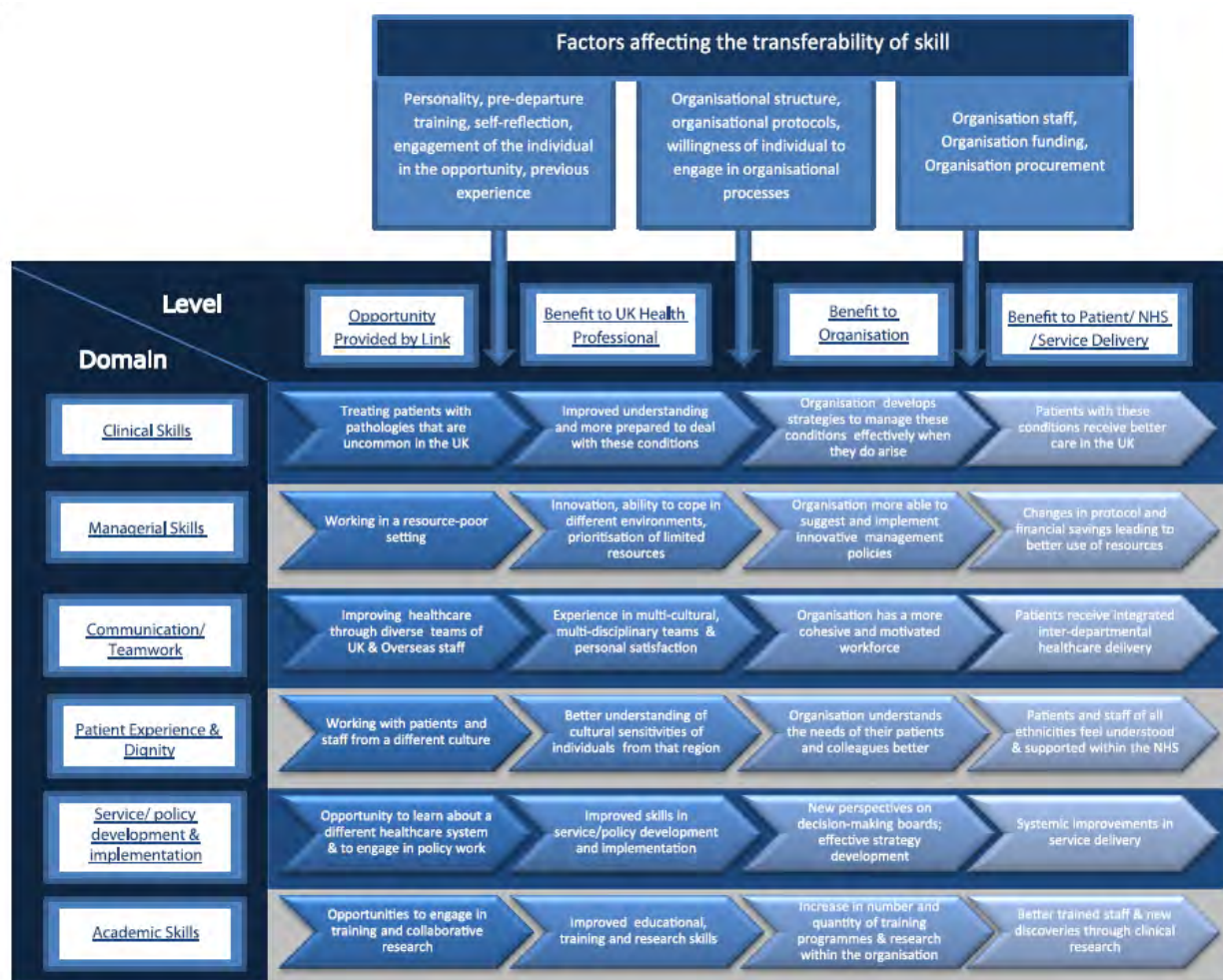


Figure 16 Transmission of health partnership opportunities into improvements in service delivery and patient experience (Jones 2013)

Using a similar approach of systematic literature review and conceptual modelling followed by action research - to understand individual benefits from IHPs, how they relate to the process of partnership and how those benefits can be transferred/embedded/sustained within individuals, institutions or health systems - would be of great benefit to the research supporting IHPs. In particular, the way in which partnerships result in sustainable change, innovation, motivation and institutional strengthening would seem fruitful areas of study.

Value for money is an important theme when providing evidence of the benefits of IHPs to donors. THET is currently in the process of commissioning a study on value for money and the methodology used within this study will be of interest to the rest of the partnership community.

The scale and scope of these studies is beyond that of the individual partnership but needs to be conducted instead across a number of partnerships that have already demonstrated their effectiveness and have shown positive outputs and outcomes. Whilst investigation of less effective partnerships will garner much of value to the question of what makes an effective partnership they will confound any study of the added value or key benefits of working in partnership.

## Impact

Maselli et al. (2006) provide a model showing the impact chain and attribution gap adapted from Herweg & Steiner (2002). This model takes the outputs of a particular intervention and then proposes that utilisation and then effects (including drawbacks and benefits) lead to impact. In measuring along this route the attribution gap widens until it becomes very difficult to attribute impact to any particular intervention. Many studies of IHPs occur during or immediately after the intervention in question that often means that effects are missed as they have not yet occurred.

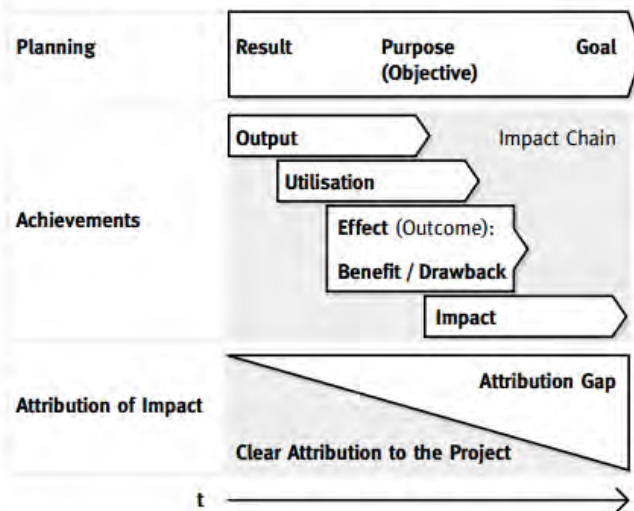


Figure 17 Impact chain and attribution gap (Maselli, Lys & Schmid 2006)

The UNDP framework for measuring capacity development links institutional changes in performance, adaptability and stability to the achievement of national goals (Figure 18).

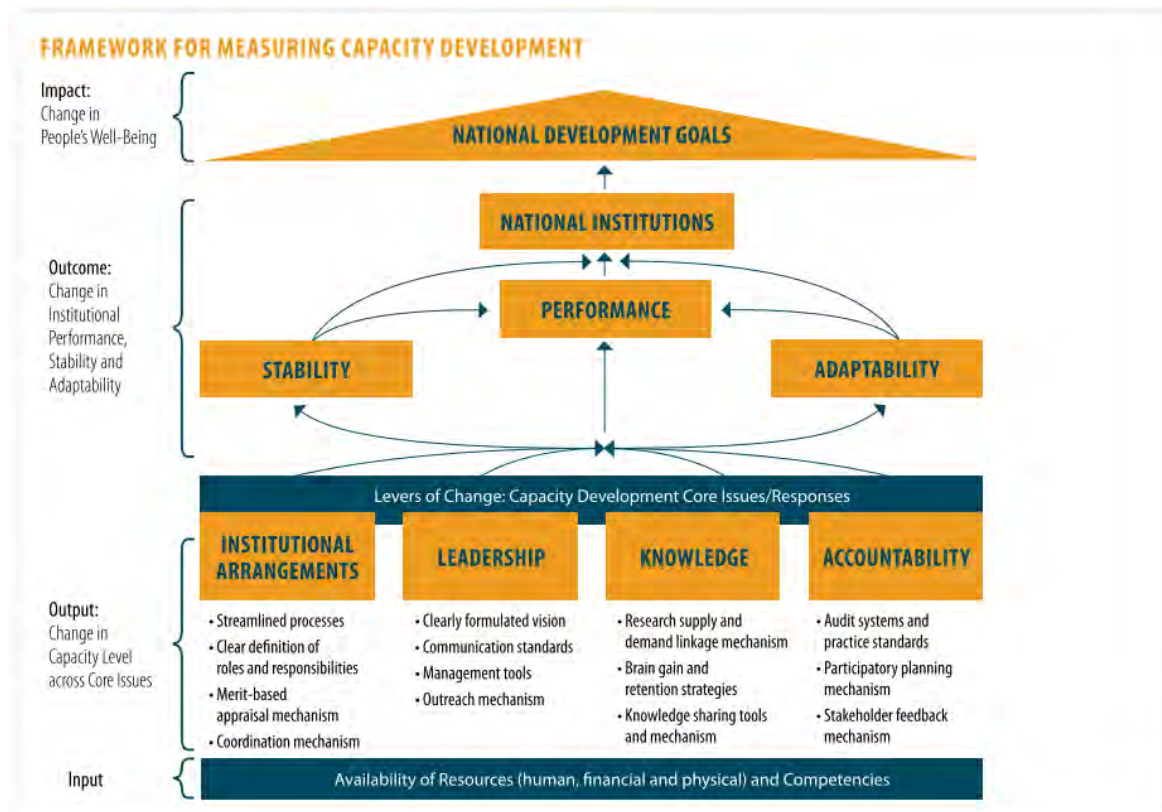


Figure 18 Framework for measuring capacity development (UNDP 2009)



Impact is closely associated with scale and scope. The UN model of transformational change links such change to long term inputs that reach beyond individuals and institutions into systems. Change has more impact when it is over a longer time period and involves many entities rather than few.

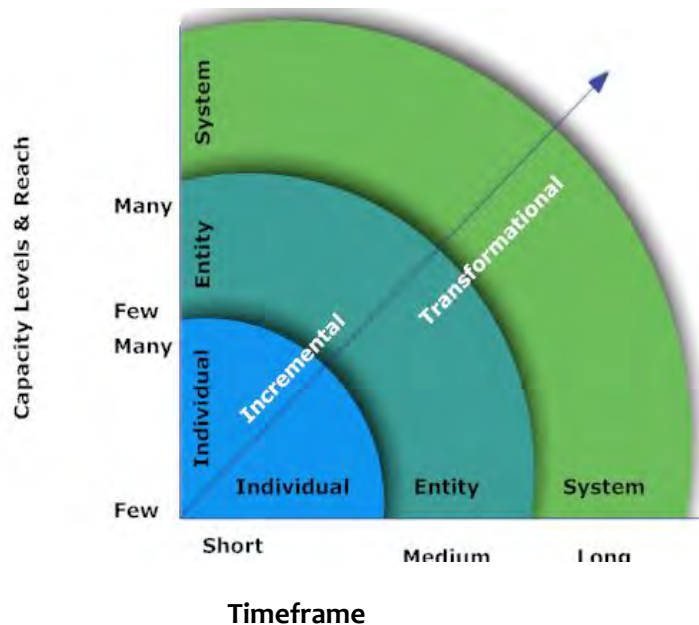


Figure 19 Achieving transformational change through capacity development (UNDP 2007)

The concept of health systems strengthening is partly a result of the failure of many interventions to have the impact that was expected of them. Failure of interventions was seen to be due to the failure to understand the ways in which the system would impact on the intervention, how the intervention would affect the wider system and the other elements of the system that needed to work in order to support the intervention.

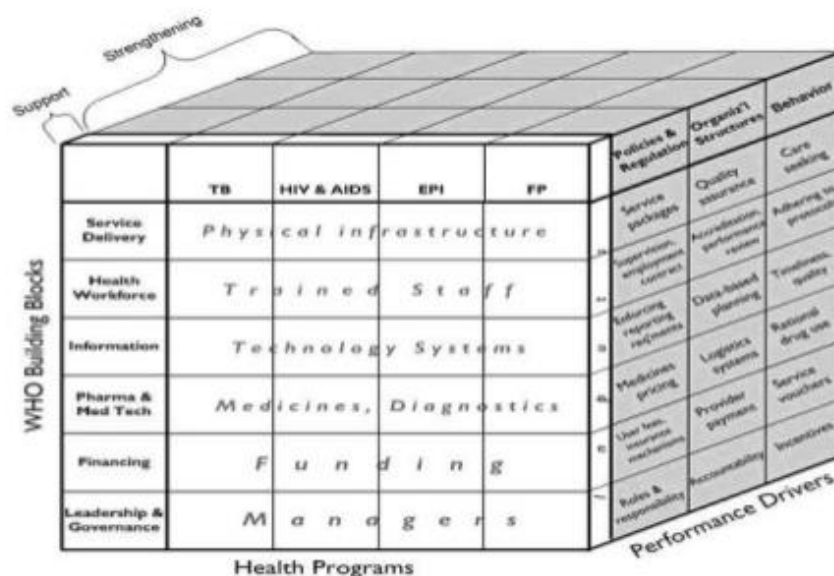


Figure 20 Health Systems Strengthening Cube (Chee et al., 2013)

The health systems strengthening cube has been developed to show the difference between health systems support which focuses on inputs and health systems strengthening which seeks to address performance drivers of the system itself.

From these two models we can see that there are two ways to understand the potential impact that the work of individual partnerships can have: the level at which they are likely to have impact and whether or not that impact will be deep (systems strengthening) or shallow (systems support).

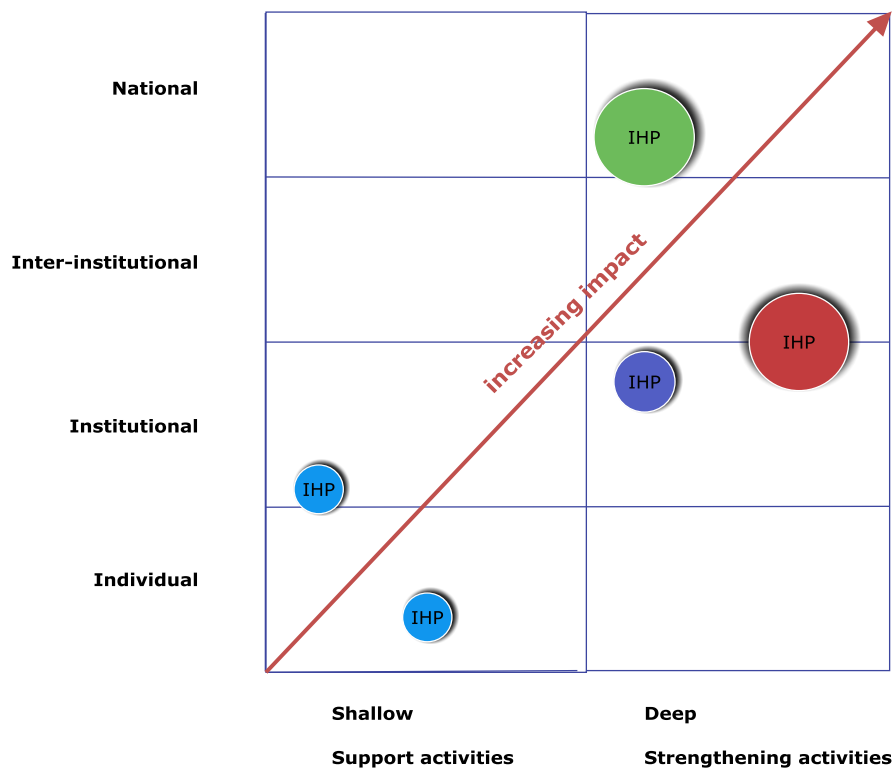


Figure 21 Demonstration of how a portfolio of IHPs could be plotted to show potential impact

Whilst this model does not give a way of measuring impact it does give an interesting way of looking at the potential impact of a portfolio of IHPs. Impact is of particular importance to donors and southern governments who are seeking ways to transform health systems which are currently failing populations in need. It is also an area which has been used to question the role of IHPs within the development cooperation toolbox. Being able to conceptualise and provide a credible argument as to the role and potential impact of IHPs on health systems is hence an important goal of any research and evidence strategy.



## EVIDENCE NEEDS OF DIFFERENT AUDIENCES

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### Politicians

High-level, short summaries of key evidence and impact. Focus on delivering benefits and value-added aspects of institutional partnership approaches. Key statistics relating to health outcomes and value for money which align with policy objectives.

- Credible description of intervention (IHPs) that fits with their world view
- Presentation of hard data and/or evidence in simple summary showing how it addresses a quantifiable real/relevant problem
- Hard numbers/compelling arguments relating to impact
- Hard numbers /compelling arguments relating to value for money
- Real people experiences – beneficiaries.

#### KEY PRODUCTS AND OUTPUTS:

Fact sheets and Information Notes, presentations and contributions to wider health and other policy debates, building supportive alliances across health sector.

### Donors/policy makers

Both high-level and key technical components focused on health impacts and value for money, showing how the intervention can be scaled and critical characteristics underpinning its success. Impact reports, contextually relevant information within broader development and health debates and initiatives.

- Evidence of the effectiveness of the intervention (IHP)
- Potential impact of the intervention – ‘bang for buck’ – issues of scale
- Value for money
- How this intervention relates to other potential interventions/modes of working – where does partnership fit within global health portfolio
- Compelling arguments for alignment and harmonisation of approach
- Credible theory unpinning intervention (IHP)

#### KEY PRODUCTS AND OUTPUTS:

Summary documents, fact sheets and Information Notes. Use of case studies to explain modes of working and links to global health debates. Presentations and one-to ones.

## Southern governments

Developed arguments and evidence showing contribution to effectiveness and efficiency of health systems and delivery, demonstrating where IHPs enhance outcomes, coherence and meet identified need.

- Potential impact of the intervention
- How it does not contribute to fragmentation
- How it contributes to the ability to solve local problems at the frontline of health care delivery
- How it aligns with national priorities
- Estimate of costs to southern institutions/government.

### KEY PRODUCTS AND OUTPUTS:

Summary documents focused on improved problem solving, fact sheets, case studies and regular updates. Technical summaries of interventions and how they operate. One-to-one interaction, workshops and alliance building across the sector.

## Northern host organisations

Developed arguments and evidence on benefits and ease of adopting IHP approaches, showing how it helps meet development and health priorities whilst benefiting individuals and organisations. Cost benefit analysis where possible, with examples, technical approaches and modes of operation clearly explained.

- True cost of involvement to the organisation (including risks)
- Benefits to the organisation & individual professional development.

### KEY PRODUCTS AND OUTPUTS:

Regular updates focused on progress and outcomes. Close interaction and relationship building, helping host make the case for IHPs to other stakeholders. Research studies describing technical approaches.

## Southern host organisations

Developed arguments and evidence on benefits and ease of adopting IHP approaches, showing how it helps meet development and health priorities whilst benefiting individuals and organisations. Cost benefit analysis where possible, with examples, technical approaches and modes of operation clearly explained.

- True cost of involvement to the organisation (including risks)
- Benefits to the organisation & individual professional development.

### KEY PRODUCTS AND OUTPUTS:

Regular updates focused on progress and outcomes. Close interaction and relationship building, helping host make the case for IHPs to other stakeholders. Research studies describing technical approaches.



## Wider international development community

Both high-level and key technical components focused on health impacts and value for money, showing how the intervention can be scaled and critical characteristics underpinning its success. Contextually relevant within broader development and health debates and initiatives.

- Evidence of the effectiveness of the intervention
- Potential impact of the intervention – ‘bang for buck’
- How this intervention relates to other potential interventions or modes of working – where does partnership fit within global health
- Credible theory unpinning intervention

### KEY PRODUCTS AND OUTPUTS:

Contribution to debates on media platforms, conferences and development groups. Case studies and short project summaries set within broader development context. Unpacking key technical approaches showing how these have wider relevance.

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## ANNEX 1: LITERATURE GIVING EVIDENCE OF THE BENEFITS OF IHPS

	Level 1	Level 2	Level 3	Level 4	Level 5
<b>Sustainability</b>		Baguley et al 2006 Corbin et al 2013 Haglund et al 2011 Doyle & Kelly 2013 Doyle & Kelly 2012 Thomas et al 2012 James et al 2008 Paterson & Telyukov 2007			
<b>Ownership</b>		Corbin et al 2013 Doyle & Kelly 2013 Doyle & Kelly 2012 Paterson & Telyukov 2007			
<b>Flexibility</b>		Corbin et al 2013 Doyle & Kelly 2013 Doyle & Kelly 2012 James et al 2008 Paterson & Telyukov 2007			
<b>Mutual Benefit</b>		Baguley et al 2006 Busse et al 2014 Longstaff 2012 THET 2014 Corbin et al 2013 Hagen et al 2009 Smith et al 2012 Doyle & Kelly 2013 Doyle & Kelly 2012 Thomas et al 2012 James et al 2008 Paterson & Telyukov 2007			Jones 2013 Syed et al 2012
<b>Frontline</b>		Doyle & Kelly 2013 Paterson & Telyukov 2007			
<b>Peer-to-peer</b>		Doyle & Kelly 2013 Doyle & Kelly 2012 Thomas et al 2012 Paterson & Telyukov 2007			
<b>Institutional strengthening</b>		Baguley et al 2006 Corbin et al 2013 Doyle & Kelly 2013 Doyle & Kelly 2012 Paterson & Telyukov 2007			
<b>Value for money</b>		THET 2014 James et al 2008 Paterson & Telyukov 2007			
<b>Innovation</b>		Baguley et al 2006 Doyle & Kelly 2013 Doyle & Kelly 2012 Paterson & Telyukov 2007			Syed et al 2012
<b>Personal and Professional Development</b>		Baguley et al 2006 Busse et al 2014 Longstaff 2012 THET 2014 Doyle & Kelly 2013 Doyle & Kelly 2012 James et al 2008 Paterson & Telyukov 2007			Jones 2013 Syed et al 2012
<b>Knowledge and skills transfer</b>		Busse et al 2014 Longstaff 2012 THET 2014 Corbin et al 2013 Haglund et al 2011 Smith et al 2012 Doyle & Kelly 2013 Doyle & Kelly 2012 James et al 2008 Paterson & Telyukov 2007			Jones 2013 Syed et al 2012

	Level 1	Level 2	Level 3	Level 4	Level 5
<b>Reach less well funded areas of need</b>		Corbin et al 2013 Doyle & Kelly 2013 Doyle & Kelly 2012 Paterson & Telyukov 2007			
<b>Motivation</b>		Longstaff 2012 Haarberg et al 2011 Smith et al 2012 Doyle & Kelly 2013 Doyle & Kelly 2012 James et al 2008 Paterson & Telyukov 2007			Syed et al 2012
<b>Cultural competency</b>		Busse et al 2014 Longstaff 2012 Corbin et al 2013 Hagen et al 2009 Doyle & Kelly 2013 Thomas et al 2012 James et al 2008 Paterson & Telyukov 2007			
<b>Influencing policy</b>		Doyle & Kelly 2013 Paterson & Telyukov 2007			

## ANNEX 2: AREAS OF FUTURE RESEARCH HIGHLIGHTED IN LITERATURE

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### Role in development cooperation

(Easterbrook 2011) Why is the university sector important for sustaining partnership (tripartite strength uniquely positioned).

### Effectiveness

(Smith 2012) Need more evidence on effectiveness, cost effectiveness, sustainability and equity of IHPs. Also need evidence on the alignment of partnerships with good practice in international development. There is a challenge of attribution particularly for small scale partnerships working in complex organisations.

(Ritman & Zegeye 2012) Development of methodologies and indicators for more rigorous studies of effectiveness – but this may be outside the scope of individual partnerships.

(Kinnear et al 2013) Need for more published experiences of IHPs and how to set things up for others to learn from.

(Costello 2000) What makes an equal research partnership? – need for southern led partnerships.

(Doyle & Kelly 2013) More robust evidence on effectiveness of IHPs and added value in comparison with traditional TA. How do IHPs contribute to health systems strengthening? Need studies on value for money.

(Abualela 2014) Need for stronger evidence on the effectiveness of IHPs. Need for evidence of what IHPs can achieve in terms of individual and institutional capacity development and health systems strengthening.

(Corbin 2013) Do negative processes overshadow partnership efforts in a way that impedes synergy?

### Benefit to the north

(Smith et al 2012) Why does international work provide a unique context to learning? How do competencies best transfer to the UK setting?

(Jones et al 2013) Impact of volunteering within health partnerships to UK individuals and institutions - more work required to develop a structure for measuring skill development during placements. What affects the transferability of skills to services when returning to UK? Comparison of engagement in links to alternative methods of health workforce development using existing competency frameworks and baseline measures.

(Busse et al 2014) Developing a framework to assess reverse innovation.

(Crisp 2014) Greater understanding of how to encourage reverse innovation.



(Syed et al 2012) Understanding of innovation diffusion processes between developed and developing countries.

(James et al. 2008) Need to better capture benefits to northern employers of staff working in IHPs.

## Results and impact

(Baguley et al 2006) What is the impact of health links on processes and outcomes of health care?

(Smith 2013) Do IHPs improve health outcomes? - use a control district

(Doyle & Kelly 2012) How to assess the contribution of IHPs to health systems strengthening. How to attribute change in health outcomes to the work of IHPs?

(Crisp 2007) Commission an evaluation of the potential impact of partnerships to understand why works where and why.

## ANNEX 3: THE CONSULTANT TEAM

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

### **Capacity Development International can**

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

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

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

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### **Our Values**

We aim to demonstrate an ethical and professional approach through:  
Responding to client's needs and expectations

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