International Health Links: an investigation into health partnerships between Wales and Africa.

February 2011

Dr Kathrin Thomas MRCGP FFPH

Jasmin Chowdhury BA Hons

Dr Hugo Van Woerden MRCGP FFPH

Views expressed in this report are those of the researchers and not necessarily those of the Welsh Assembly Government.

For further information please contact:

Name: Jenny Allen

International Sustainable Development and Wales for Africa Team

Welsh Assembly Government

Cathays Park

Cardiff

CF10 3NQ

Email: jenny.allen@wales.gsi.gov.uk

Table of contents

Acknowledgements	4
Executive Summary	5
Purpose, aims and objectives	11
Background	13
Introduction	16
Methods	19
Results	21
Discussion	47
Conclusions and Recommendations	50
Appendices	54
References	57

Acknowledgments

Many thanks to the many people who are active in Health Links in Wales and in Africa and who willingly gave us their time for this research.

The investigation was commissioned and funded by the Welsh Assembly Government *Wales for Africa* Program. The authors wish to thank the valuable support given by Jenny Allen and Jon Townley from this department. They also wish to thank the Welsh Assembly Government Department of Public Health and Health Professionals for their support for this work.

We wish to thank the members of the steering group who provided valuable review of the project proposal, the questionnaire and interview guide and the final report: Cath Taylor, Sue Bowker, George Karani, and Ed Howarth. We wish to thank Robyn Phillips for reviewing and proof reading the final report.

Executive Summary

This investigation aimed to provide an overview of activities of Health Links between Wales and sub-Saharan Africa. Mixed methods were used including an electronic questionnaire and semi-structured interviews with Welsh and African individuals active in Health Links. The investigation was based solely on the perceptions of those involved in working in a Link and looked at the personal and organisational benefits of international health partnership working. The investigation was not able to differentiate sufficiently between larger scale and small scale Links, or to evaluate any single Link or the overall impact of Health Links' activity.

Methods

For the purpose of the investigation Health Links were defined as partnerships between institutions or organisations in Wales and a sub Saharan African country that focussed primarily on health. A questionnaire was developed and piloted. An email invitation to complete the questionnaire was sent to Link members from both sides of the partnership. A sample of these members was also interviewed in more depth by telephone. The draft report was shared with all participants to allow feedback into the final version.

Response

The questionnaire analysis is based on responses from 45 people. This includes 36 Welsh Link members (some of whom did not answer every question) and 9 African Link members (of whom one person did not answer every question). Seven Welsh and three African Link members were also interviewed by telephone to supplement the questionnaire data with richer and more in-depth information.

Key findings

Beginnings

- Most of the 17 Health Links in the study are relatively new with 13 (75%) being less than 5 years old.
- Most Health Links developed through a Welsh member who had returned from working or visiting in a sub Saharan African country, or an approach from a Welsh partner to a potential African partner.
- 35% of Health Links said that a grant had helped them start up, 20% of these grants from the Welsh Assembly Government and 15% from the Tropical Health and Education Trust (THET).

Activities

- All Welsh and African respondents gave training as the most common activity in which they were involved. Training was primarily focused on maternal health and mostly delivered during visits by Welsh members to their African partner. Distance learning did not seem to be a common method of delivery of training or education.

Benefits

- For both Welsh and African respondents two of the top three benefits of the Link were *Experience of different cultures and Support and friendship with your overseas partner.* The next top aspect for Welsh respondents was *Putting UK problems in perspective* while for African respondents the next top was *Sustainability of services.*

- Respondents were asked if they felt their involvement in a Health Link had made a difference to their usual job. The majority agreed or strongly agreed that their problem solving, leadership/management and educational skills had improved. In particular, 89% of Welsh respondents agreed that their problem solving skills had improved and 74% reported they had found resource-saving ideas which were likely to directly benefit their employers and hence the people of Wales.

- Interviewees made positive comments throughout about their personal satisfaction and benefits from involvement in a Health Link and all were committed to continuing the work in the future. These gains were mostly expressed in terms of changes in attitudes, knowledge and/or skills.

- 98% (42/43) of all respondents agreed or strongly agreed that they had personally gained from their involvement in a Health Link. 31 Welsh respondents gave at least one example, 25 gave two examples and 17 people gave three, the most common examples being in the areas of *prioritising with limited resources, problem solving* and *team working*. Typical answers given were: *"I have reorganised the way our practice rota works. I have helped develop the use of nurse practitioners in the practice. I am far happier in my work" "Improved improvisation and problem solving", "Greater targeting of training appropriate to resources of recipient (as applicable in Wales as in Africa)", "It has developed my leadership skills I cope better with uncertainty I have learnt how to apply for grants"*

- The main skills gained were cited in terms of the soft skills such as increased confidence, organization and management, leadership and team-working. Welsh respondents felt that the benefits to the Welsh partner were clear but should be secondary to that of the African partner as the aim of their work was to improve health in the African setting.

Communication

- Communication between partners fell mostly into two distinct patterns: *active communicators* (7 Links) and *infrequent communicators* (5 Links).Email was given as the most common method of communication for all Health Links. Among the five *infrequent communicators* the Welsh partner reported using email only every few months and no other method of communication was used more frequently.
- Strong personal relationships were felt to be a very good facilitator of effective partnership working while the lack of them led to frustration and lack of action.

Processes

- Documented processes were not always in place, for instance a third of Welsh respondents were not aware that they had a Memorandum of Understanding with their African partner and half did not know if there was a monitoring system. Only two thirds of Welsh respondents were aware of the Strategies and Priorities of their African partner's Ministry of Health although all African respondents believed that their individual Welsh Link was aware.

Gender

- Many respondents brought up the fact that there was a relatively high participation of women in many Health Links, both in Wales and in Africa.

Challenges

- When asked about challenges faced by their Link, *dependence on too few key individuals, communication difficulties* and *visa problems* appeared to be the most common challenges for Welsh respondents. African respondents however felt that few of the listed potential challenges had been an issue for their Link; they identified *visa problems* and *communication difficulties* most commonly.
- In response to a list of options that might help a Health Link most respondents expressed an interest in the majority of options with *advice on applying for grants*, *fundraising* and *opportunities to network with other Links* being the most popular.

Conclusion

There is strong evidence that those who are involved in Health Links, both in Wales and in Africa, believe that they gain personal and professional benefit from their involvement, particularly in terms of problem solving, team working and organisational skills. Investment by the Welsh Assembly Government in Health Links is believed by participants to be contributing to professional development and consequently providing benefit to the Welsh health organization by which participants are employed.

Recommendations

For Health Links

1. Increase good practice in partnership working and governance.
2. Invest in communication between partners, particularly in building personal relationships and increasing frequency and methods of communication
3. Ensure processes are in place based on good practice guidance such as the THET *"International Health Links Manual"* , in particular:
    a. Establishing Aims and Objectives and including these in a Memorandum of Understanding
    b. Ensuring processes are negotiated and established with both partners.
    c. Ensuring plans are based on needs assessments and have monitoring and evaluation built in from the beginning.
    d. Ensure major activities are supported by evidence-based good practice and effective delivery models
4. Ensure plans are in place for sustainability, particularly where the Link perceives it is relying on too few individuals.
5. Make the most of available support to capture long term, quantitative and qualitative information for outcome evaluation and impact assessment.
6. Consider modern, distance based, sustainable methods of shared learning to reduce reliance on one-off short visits between partners for delivery of training.

For support organisations (for example the Wales for Africa Health Links Network, THET, SMIDOS, WACL and others)

7. Provide opportunities for networking and shared learning between members of Health Links, for both Welsh members and their African partners.

8. Support good practice and good governance in partnership working, for instance through guidance, facilitation of shared learning, training programs and toolkits.

9. Support good practice relating to the most common major activities, particularly delivery of training and education and provision of equipment.

10. Support the development of modern, distance based, sustainable methods of shared learning between partners to reduce reliance on one-off short visits for delivery of training.

11. Support Health Links in needs assessments, monitoring and evaluation.

12. Support research into how to measure the impact of Health Links' activity

13. Consider commissioning the development of standard templates for a range of documents that underpin best practice for Wales for Africa Health Links including Memoranda of Understanding and Monitoring and Evaluation Tools.

For Government, Health Boards and Universities

14. Ensure grant schemes include monitoring, evaluation and impact assessments with reports at the end and possibly mid-point, of the grant period.

15. Encourage the sustainability and scaling up of Health Links that have demonstrated success as much as supporting new Health Links.

16. Mainstream the learning opportunities of Health Links so that more public sector staff use the opportunities and the learning is effectively captured for the benefit of Wales.

17. Recognise the skills and experience gained by professionals involved in Health Links as integral to their continuing professional development.

18. Consider the cost effectiveness and value of the involvement of NHS and public sector staff in Health Links as an alternative to current spending on organisational development and leadership and management training.

19. Consider providing administrative support and logistic support to Health Links.

20. Develop a clear policy on study leave/ professional leave with national consistency.
21. Consider how to integrate research that benefits African populations into Health Links' activity and that enables them to increase their impact.
22. A Charter Mark or Award should be developed that could be awarded to Health Links that met agreed standards.

Purpose of this report

The Welsh Assembly Government launched its International Sustainable Development Framework, the *Wales for Africa Program*, in 2006[i]. This Framework:

> "..outlines the ways in which the Welsh Assembly Government will make a distinctive contribution to delivery of the UN Millennium Development Goals and to responding to disasters and emergencies overseas."

The Welsh Assembly Government *Wales for Africa Program* is particularly interested in finding out more about how international health partnership working between Wales and Africa can support meeting the UN Millennium Development Goals[ii].

It is also keen to identify what the benefits are, particularly for the people of Wales and to identify the support needs of Health Links. Those involved in the work of Health Links are passionate advocates of the approach but there is limited evidence about good practice in Links and little evaluation of their outcomes and impact. Therefore, the Welsh Assembly Government *Wales for Africa Program* has commissioned this report as a first step in investigating these aspects.

Aims and Objectives

Aim

To provide an overview of activities of Health Links between Wales and sub-Saharan Africa.

Objectives

1 Identify and describe Health Links partnerships between Wales and sub Saharan Africa

2 To assess whether Welsh participants believe that there has been personal and organizational benefit to health services in Wales

3 Undertake an assessment of current practice in Links' working and their perceived support needs for:

- Monitoring and Evaluation skills
- Teaching and training skills
- Fundraising skills
- Communication skills

4 Develop an evaluation proforma for each Link to include in the annual Health Links Network report.

5 Produce a public Report for *the Wales for Africa* Health Links Group.

This investigation is an initial exploration to identify the extent of International Health Links Partnerships between Wales and Africa. It did not set out to monitor or to evaluate any single Link but to establish the baseline characteristics of Welsh Links with Africa and to identify support needs.

Background

There is a long history of informal health-related links between individuals and institutions in the UK and developing countries. These have become increasingly formalized and institutionalized, with good practice supported by many international development and health organizations such as the Tropical Health and Education Trust (THET), one of the earliest and best-known networks for health links with developing countries.

The definition of International Health Links

THET defines Health Links as:

"….. long-term partnerships between UK health institutions and their counterparts in developing countries. The aim of Links is to improve health services in developing countries through the reciprocal exchange of skills, knowledge and experience between partners in the UK and those overseas."[iii]

The range of aims and objectives and activities engaged in by these partnerships is wide, with many different models of delivery.

Wales for Africa

There have been Welsh international health links with countries all over the world for many years. Following the devolution settlement in the UK in 1999 many functions were devolved, including health, however international development and foreign policy remained the remit of the Westminster government. The Welsh Assembly Government however was keen to continue and increase its contribution to international development and to helping the effort towards meeting the UN Millennium Development Goals. It therefore launched the Framework for Sustainable International Development, including the *Wales for Africa* program, in 2006 with the aim of supporting more people in Wales to do more and better quality work in international development. It chose to focus on a region, sub-Saharan Africa, rather than focus on a single country partnership. As a part of this movement, International Health Links have received explicit support from successive First Ministers:

> *"Through these links, people in Wales are playing their part in being active global citizens and the Welsh Assembly Government is proud to be supporting their efforts."*

Carwen Jones AM, First Minister for Wales

The Welsh Assembly Government has also provided direct funding, such as an annual £270,000 grants scheme from the Wales for Africa International Sustainable Development Program[iv] for all international

development organisations in Wales and an annual £50,000 grants scheme from the NHS Directorate specifically for Health Links.

Health Links working with partners in sub Saharan Africa have increasingly supported each other. The first *Wales for Africa* Health Links conference in 2007 led to the development of an informal Network, the *Wales for Africa* Health Links Network, which offers regular meetings, a website[v] and events such as an annual conference.

Wales has also led the way in exploring the possibilities of community linking between developed and developing countries for mutual benefit and has seen significant growth in these activities by supporting the *Wales for Africa Community Links*[vi] (formerly *Goldstar Communities*). This has become the model of such an approach for the UN; some of these community links include health activities.

UK Policy context

The former UK Prime Minister, Tony Blair, asked Sir Nigel Crisp to investigate "What the NHS can do for Africa" which led to the report "*Global health partnerships: the UK contribution to health in developing countries*"[vii] in February 2007. Partner countries told the Crisp investigation where "they thought UK experience and expertise could help:

- Strengthening public health, health systems and institutions
- Providing education and training for health workers – and retaining the ones they have.
- Making knowledge, research, evidence and best practice accessible to health workers, policy makers and the public alike"

Sir Nigel states that in engaging in global health partnerships, "the UK can:

- Learn a great deal for itself about how to meet its own health needs.
- Broaden the education of health professionals in the UK.
- Build stronger relationships across the globe that will stand the UK in good stead in a changing and risky world."

The UK Government response to the Crisp report supported the Links movement to become stronger, with greater numbers and larger-scale partnerships than ever before. The devolved administrations have taken differing approaches to health and international development, depending on the scope of their devolved powers, for instance Scotland began by developing a country partnership with Malawi which has now broadened out to include activities in other countries.

There has also been greater investment in supporting international health partnerships such as that provided by the UK Department for International Development (DFID)[viii], through the British Council/ THET administered grant scheme and the International Health Links Center in the Liverpool School of Tropical Medicine. In June 2010, DFID announced a further £20 million investment in a new International Health Partnerships Scheme to support existing and new partnerships and health worker volunteering.

Introduction

Health Links are low-cost small scale operations when compared with other players in the international development field such as International NGOs, donors and governments. Evaluation of such partnerships is not easy with many outcomes being difficult to measure and any contribution that the Health Link has made in achieving these outcomes being very difficult to attribute to particular interventions. One appropriate outcome would be measurable reductions in mortality and morbidity in the partner country, but even in the UK these are difficult to measure and to attribute to single interventions. Benefits to the UK partner in Health Links are also difficult to measure in terms of gains for those individuals involved, their organisations and the UK population they serve. However, there is increasing evidence that certain good practices are more likely to result in desirable outcomes so that it becomes useful to measure implementation of this good practice.

Health Links are unlikely to reach a scale where impacts will be measurable so evaluations have tended to be based on process measurements. Few evaluations of processes, outcomes or of impact have been published in peer reviewed journals, although there are several reports in the “grey literature” and there is more evidence in the international development sector but this is not specifically about Health Links.

Previous evaluations

Several evaluations have focused on the effect on NHS staff of involvement in Links activity and the benefit gained by them in terms of personal and professional development as well as gains for their employing organizations in the UK. These have shown perceived benefits in many areas, summarized for the Framework for NHS involvement in International Development[ix] : a better return on investment in training; enhanced leadership and professional skills; enhanced reputation of the organisation among the public, staff and the media; staff engagement and motivation which leads to greater staff satisfaction and improves retention and productivity; and more.

An evaluation of North to South Health Links, commissioned by the DfID Health Resource Center in 2008[x], looked at 12 partnerships in the UK with three countries in Africa, one of which was a Welsh-based Link. This evaluation found that there was considerable variation in the effectiveness of Links, for example Links established by individuals with prior experience of working in Africa appeared to be most successful and there was greater impact on outcomes when southern partners determined the nature of the support provided. In researching the impact for southern partners it was found that the continuity of longer-term support provided by experienced UK staff was most valued and that a multiplicity of short-term inputs, for example two week visits, were, with the exception of specifically-requested technical areas, poorly regarded. Health Links can do harm and have unintended consequences, which the report describes in some detail.

THET commissioned several reports into different aspects of international Health Links. The most in depth was by Datta, Ajoy and Katie Dimmer in 2007[xi] which suggests that a range of outcomes and impacts are possible by Links. They found that there were weaknesses in the evaluation methods available and used by Links and recommended better monitoring and evaluation. The report also highlights the importance of gathering baseline information from the inception of a Link.
A Department of Health, England, survey in 2005[xii] found benefits to UK NHS staff:

> *"Benefits of links were seen as wide-ranging, with increased cultural awareness being the most frequently cited benefit (notable given recent DH initiatives around diversity and the health of BME groups). Other highly rated benefits included individual personnel development and staff motivation. Barriers to links were (in order) lack of knowledge of the opportunities, lack of time/finance and lack of NHS policy support.*
> *In conclusion, links with less developed countries appear to be widespread within the NHS, benefit Trusts in priority areas and could be further promoted through networking, providing further guidance for staff and creating a supportive policy framework."*

Less research has been done into the perceptions of the overseas partners of UK Health Links. However, a THET evaluation of four Health Links active in one country, Ethiopia, extensively interviewed the Ethiopian partners and made seven recommendations:

> "*There is need for: stronger and more sustainable structure; clearly defined strategy; joint responsibility and ownership; more effective communication; transparent expectations; a system of monitoring and evaluation; and increased Link networking."*

Baguley et al (2006)[xiii] report on a qualitative study that interviewed UK and overseas coordinators of 22 International Health Link Coordinators (13 UK and nine overseas). They found that:

> *"Links offer opportunities for mutual benefits in terms of shared skills and the promotion of global awareness. They can act as important catalysts to stimulate increase in institutional capacity for research and training".*

Baguley et al also found that *"the main challenges arose from cultural differences funding problems, communication difficulties and bureaucracy".*

Few individual Health Links have published evaluations of their activities in peer-reviewed journals. One that has however, Wright at al[xiv] report on the outcomes of a 10 year public health partnership between the UK and Swaziland that resulted in many service improvements which were established and embedded and likely to improve health outcomes such as a community TB service, chronic disease program for epilepsy, implementation of ART programs and nurse-led ART clinics. They recommend 6 principles which emerged out of their experience: sustainable partnership; robust measurement; evidence-based practice; patient focus; systems approach to getting research into practice; researchers as implementers and implementer as researchers.

Good practice guidance

There are resources for collecting evidence of good practice and translating it into practical guidance such as the THET produced *International Health Links Manual* [xv](second edition 2009) and their *What difference are we making?: a Toolkit on Monitoring and Evaluation for Health Links.*(2008). The Department of Health England has produced a *Framework for the Involvement of NHS staff in International Development*[xvi]*,* which gives guidance on the key principles for effective involvement in international development and good practice for organisations, individuals and employers. The *International Health Links Centre (IHLC)* [xvii] website provides links to resources and also a Directory of Health Links.

Summary

There has been some research into the activities of international health partnerships which demonstrates some of the outcomes in terms of benefits and also some of the potential harms and unintended consequences. Research has looked at outcomes for both partners and several studies have looked specifically at benefits for UK staff.

The heterogeneity of such partnerships and that many are embedded in a culture of volunteerism, increases the difficulty of evaluating them. Impact measurement is at a very early stage. There has been an increase in good practice guidance and support which is being made much more easily available.

In view of the considerable government and public sector support and investment in such partnership working, the drive to demonstrate outcomes and impact for funders and supporters will no doubt increase.

Methods

For the purpose of this study any partnership between an institution or organisation in Wales and a sub Saharan African country that focuses primarily on health, was included. Partnerships between individuals only, or those working across countries and without specific named partners, were excluded. The investigation also excluded Links between Wales and any other region, other than Sub Saharan Africa, because of the remit of the Welsh Assembly Government *Wales for Africa* Program.

Links were identified through the mailing list of the *Wales for Africa* Health Links Network, and by approaching participants in the *Wales for Africa* Health Links annual conference. Coordinators of each Link were identified and asked for the email address of anyone active in their Health Link in Wales and also the email address of up to three people active in their Link in Africa.

A questionnaire was developed using responses to previous evaluations and research on international health partnerships, in particular that of Baguley et al (2006) [xiii] and James et al (2008) [x]. The questionnaire was subsequently piloted on a small number (6 people) of Health Links participants and outside experts. Once a database of people active in Health Links had been established, an email invitation containing a link to the electronic questionnaire was sent to each of them. The questionnaire for respondents in Africa was identical, with the exception of one question which was UK specific. Two email reminders were sent to all respondents.

All respondents were asked if they would be willing to be contacted for an in-depth telephone interview and a sample of these was contacted and interviewed within three months of return of the questionnaires. This sample was selected purposively to include as many different Health Links and as many Link coordinators as possible.

Analysis of the questionnaires was undertaken in two ways. For questions about activities, methods of communication and how the Health Link was started, the answers from only one person from each Link were analysed (17 Welsh and 7 African respondents). These people were chosen as either being the only respondent from their Link, or where there was more than one person from a Link, the person known to be the Link's coordinator was chosen. For the remaining questions concerning perceptions and understanding, answers from all respondents were analysed.

7 Welsh partners and 3 African partners were also interviewed by an independent researcher (JC) who was previously unknown to them. Again, these people were chosen as either being the only respondent from their Link, or where there was more than one person from a Link, the person known to be the Link's coordinator was chosen. Several of these respondents were however unavailable to be interviewed in the given timescale. All interviews were conducted over the telephone and varied in length from 40 minutes to an hour and a half. Written notes were kept by the interviewer and transcribed for analysis. Analysis was

undertaken on the written notes which were not complete transcripts of the interviews. Themes and codes within the written notes were identified until no new themes or codes emerged (saturation).

The results are presented under the headings of the major themes using data from the survey questionnaire and informed by the responses gathered through the semi-structured interviews with a smaller proportion of respondents.

The draft report was shared with all participants to allow feedback into the final version of the report.

Results

20 International Health Links were identified. 76 people were identified who had a connection with at least one Health Link. 37 (49%) responded to an email invitation to complete an online questionnaire however one subsequently opted out and two partially completed the questionnaire. There was at least one response from 17 of the 20 Health Links.

18 people from African partner countries were identified, of whom 9 (50%) responded to an email invitation to complete the same online questionnaire. These nine were from 7 different Health Links.

The questionnaire analysis is therefore based on responses from 45 people. This includes 36 Welsh people (some of whom did not answer every question) and 9 African people (of whom one person did not answer every question).

Beginnings

Most of the 17 Health Links in the study were relatively new with 13 (75%) being less than 5 years old. Only 4 (24%) have been established for longer than 6 years. (See Figure1)

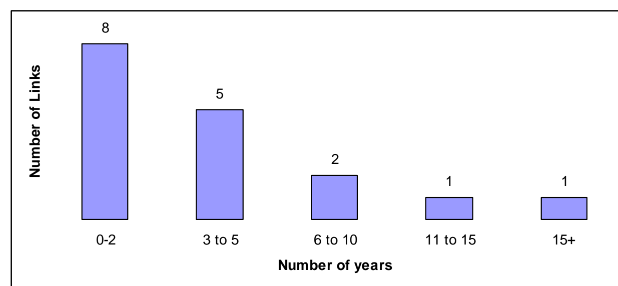


Figure 1 Years since Link was established (Welsh respondents)

Most Links developed through a Welsh member, who had returned from working in, or visiting, a sub Saharan African country, or an approach from a Welsh partner to a potential African partner. Interviewees talked about the inspiration to begin a Health Link arising from the experience of personal witness:

> *"During the famine in Ethiopia in the 70's – a group of Doctors from Wales were keen to do something. (We) went out to a camp there. The idea of a community Link emerged through discussions at the local churches in Pontypridd. The Link was formally made in 2005. I became involved in 2004 through exploratory partnerships with, local small organisations."*

Welsh respondent

It was much less common for an African partner to take the initial approach, although two had done this through the Tropical Health and Education Trust (THET) or the International Centre for Eye Health (ICEH). One Health Link grew within a larger people and organisation-based link between Wales and Lesotho.

There appeared to be two common spurs to action for the Welsh originator of a Link. This was either a perception of a need that could be addressed in an "already found" partner, or a perception that the originator had a particular skill that they wished to "find a partner to share with":

"(My) initial purpose for joining Health Link was to stand alongside colleagues to improve Healthcare"

Welsh respondent

"Made contact with MRC Unit in …… (about) women's health - (in particular) prevention of cervical cancer"

Welsh respondent

Funding was also seen to be an aid to starting a Health Link; 35% of Links said that a grant had helped them start up, 20% of them from the Welsh Assembly Government and 15% from THET. Of the 16 Welsh Health Links partners that selected a choice of Link's descriptions (based on previous research), the most often chosen was *Link between hospitals* (4, 25%). Interestingly, there was sometimes disagreement between Welsh and African partners of the description of the same Link, for example, one Welsh partner chose *links between hospitals* but one of their African partners chose *link between primary health care centres*, which may reflect the major activities of this Link. One Welsh Link chose *Link between communities, including some health activities* while their African partner chose *Link between individual health workers.*

However, the majority of Welsh respondents (6, 37%) did not choose any of the suggested categories, opting to describe their complexity in their own words, for instance:

"...it is on a Country to Country basis aimed at developing friendship at all levels and covers different sections including health, churches, education, voluntary sectors"

Welsh respondent

"Independent registered UK Charity, formed as an Educational Trust, forming education partnerships with health services in countries in Sub-Saharan Africa."

Welsh respondent

“Link between NHS (mainly hospital) health professionals in Wales with Primary health care at health post & health centre, rural community, district and regional hospital, Zonal and regional Health authority and University”

Welsh respondent

There was a large variety of jobs among the 35 Welsh respondents who gave their own profession although most commonly cited were hospital specialists (13, 37%) and nurses (8, 23%). There were also four managers, three GPs, three Higher Education Professionals and one midwife. Of the ten who were not health care or higher education professionals, most were working in, or retired from, the public sector, primarily in health-related areas.

Among the 8 African respondents who answered this question there were two hospital specialists (one of whom was also a Higher Education Professional), one Nurse/Midwife who was also a Chief Executive of a Professional organisation, one General Practitioner, one Health Officer, one Higher Education Professional, one employee of a UN agency and one was a manager/ coordinator for the Link.

Activities

Respondents were asked which of a list of activities they were involved in and to rate the activities as a "major activity" or carried out "sometimes", "rarely" or "never". All Welsh and African respondents gave *training* as the most common activity in which they were involved. Welsh respondents gave *providing equipment* (88% as "major" or "sometimes" activity) and *facilities repair* as the next most common activity (52% "major" or "sometimes" activity). African respondents gave *direct service delivery* (67% "major" or "sometimes" activity) and *providing equipment* (83% "major" or "sometimes" activity).

Few Welsh respondents said that they were involved in *donating money* or *research*, although the African respondents cited this more commonly.

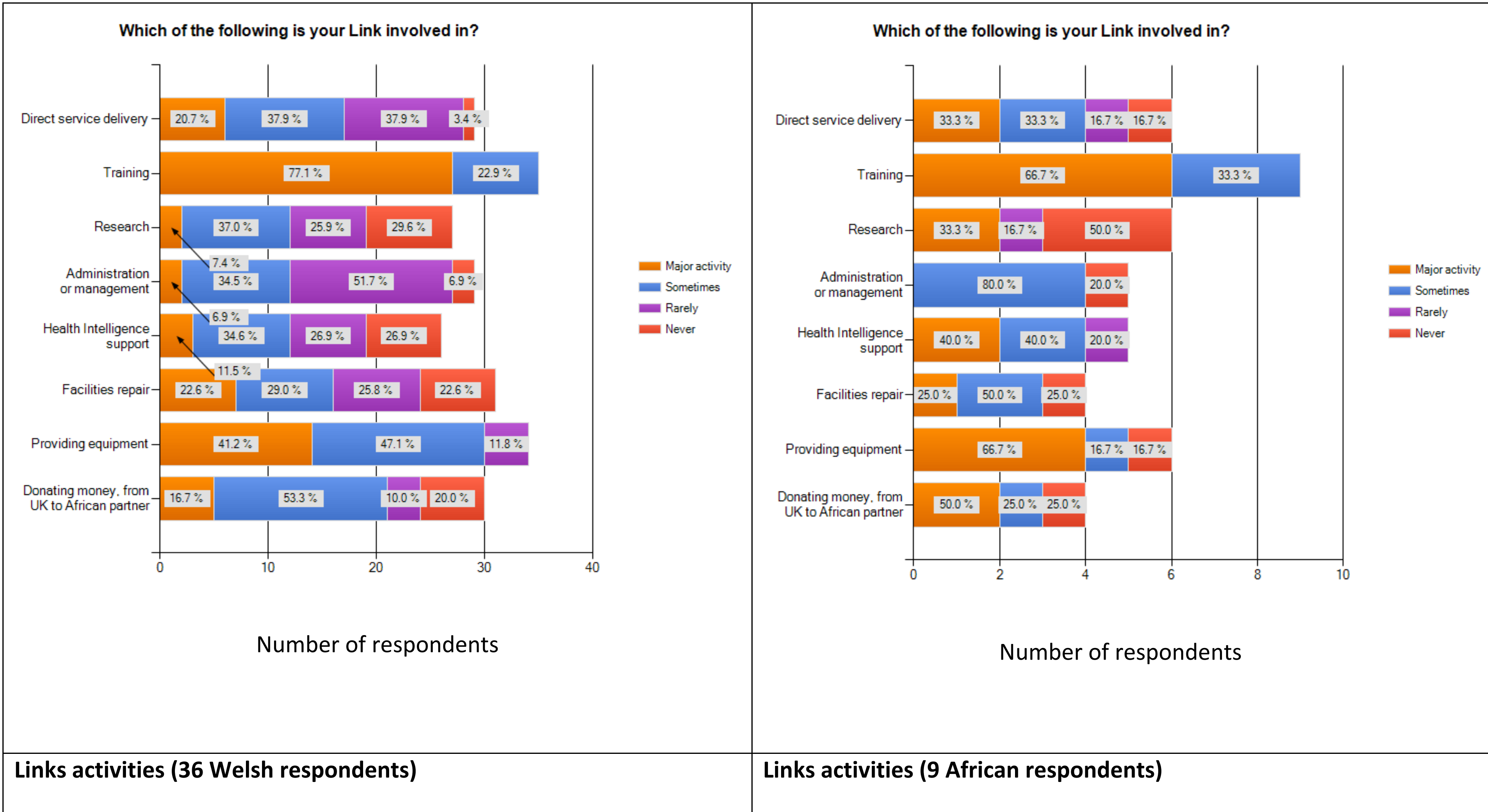
Some added comments about other activities in which they were involved, for instance providing e-learning packages, providing medication, or standard setting, monitoring and assessment.

Training appeared to be focused primarily on maternal health in many Links and most of this training is delivered during visits by Welsh members to their African partner as either 'one offs' or less often, as part of a regular program of training. A few respondents mentioned distance learning but this did not seem to be a common method for delivery of training or education.

Several interviewees gave considerable detail about their work in delivering, funding and supporting training and continuing professional development which they said was their main and most useful activity, including training programs for community health workers, midwives, doctors and environmental health workers. One Link, for example, had initiated a *Masters in integrated Emergency Surgery and Obstetrics for non Doctors* and is running "training the trainer" courses for 20-40 midwives every year in addition to supporting continuing professional development (CPD) for laboratory technicians and Health Officers.

> *"Most useful outcomes include rural capacity building. People came from (…….in Wales) to provide continuous professional development training on maternal health. Training and monitoring on midwifery has commenced. This helps to make sure people get a quality service."*

African respondent



Links activities (36 Welsh respondents)

Links activities (9 African respondents)

Figure 2 Links activities

Some training programs were delivered as a 'one off' during visits to Africa and others were regular rolling programs. Several interviewees mentioned evaluation of training.

> *"Most useful: Training for midwives, they are interviewed afterwards and they are very happy and it's very helpful. (Also) training for health extension workers"*

African respondent

Welsh interviewees described providing equipment such as books, microscopes and motorbike ambulances which they said were among their most useful activities. One African interviewee mentioned equipment in relation to setting up an internet connection.

Benefits

Benefits of international health links are difficult to define and capture as they can be explored in terms of personal and professional development of the individual, or gains by their organization/ employer. Most difficult to capture are the impacts on health outcomes.

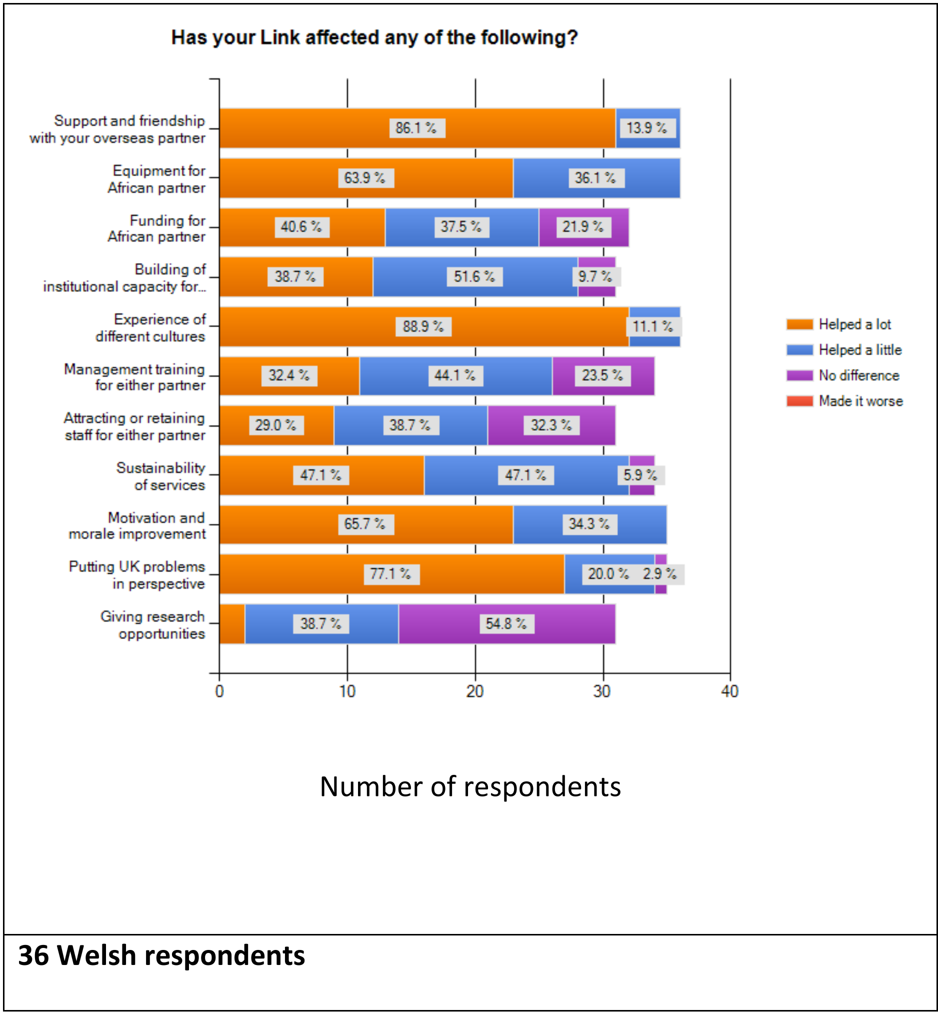
> *"It's not always easy to cite examples. I developed skill by developing the links, and the ability to think differently. (I lead) education in own team at all levels to achieve and enable people to flourish"*

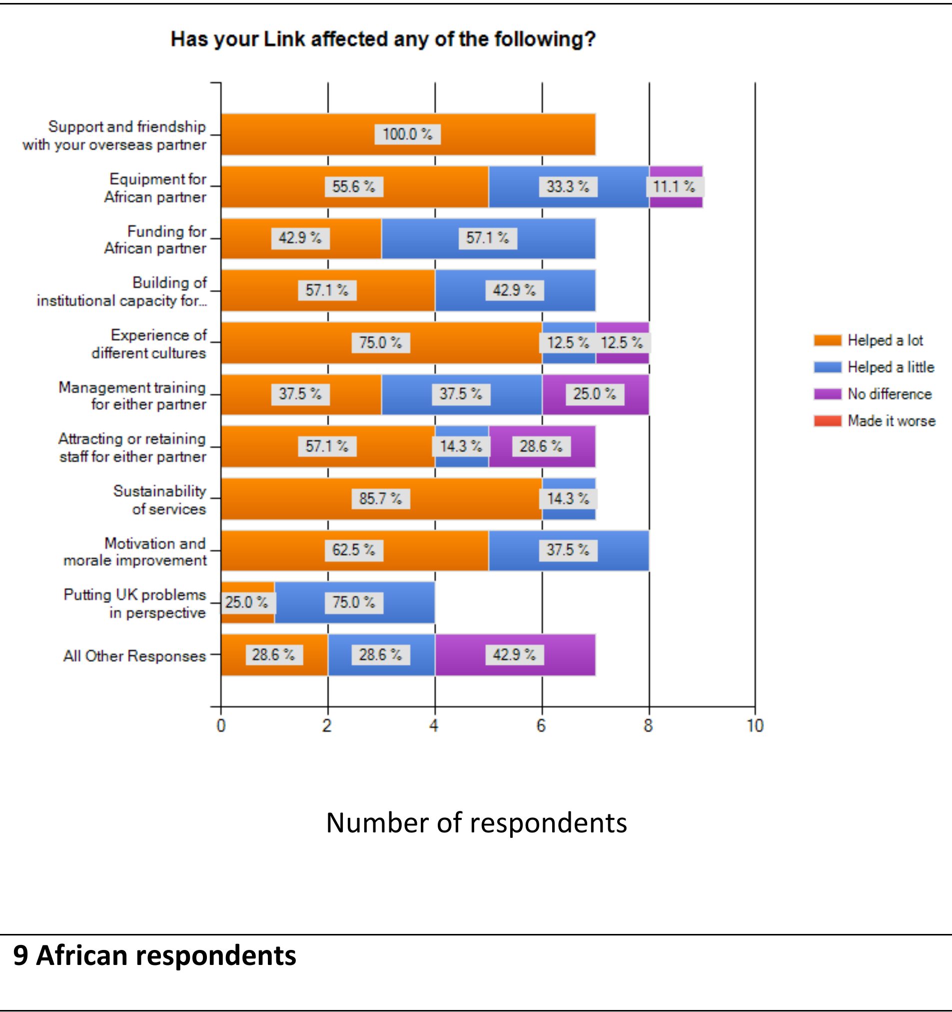
Welsh respondent

Respondents were asked whether they felt their Link had affected any of a list of previously identified benefits and challenges and to place these in four categories: "helped a lot"; "helped a little"; "made no difference"; "made it worse". No respondent stated that any aspect had been made worse by the Link between the two partners. For both the Welsh and African respondents two of the top three benefits of the Link were:

- *Experience of different cultures*
- *Support and friendship with your overseas partner*

However, for the Welsh respondents the next top aspect/benefit was *Putting UK problems in perspective* while for African respondents *Sustainability of services* was of key importance





36 Welsh respondents	9 African respondents

Figure 3 Which of these has your Link affected?

Otherwise, African and Welsh respondents were largely in agreement on the relative importance of the main aspects/benefits of Health Links.

Interviewees made positive comments throughout about personal satisfaction and benefits from their involvement in a Health Link and most were committed to continuing the work in the future. Most interviewees also talked about the benefits in terms of their professional development and thus as a benefit to their own organisation and country. These gains were mostly given in terms of changes in attitude, knowledge and/or skills. Respondents described learning about different cultures, such as how to work in a health system that has much less or many more, resources. They also talked about learning how other health systems worked and how this either influenced them to value their own country more or to apply lessons learnt.

The main skills gained were cited in terms of the soft skills such as increased confidence, organization and management, leadership and team-working. Welsh respondents felt that the benefits to the Welsh partner were clear but should be secondary to that of the African partner as the aim of their work was to improve health in the African setting.

> *"People in Wales form one global village, people gain a lot; it's not them and us. People (in African partner country) just get on despite so many hardships in life. It is reciprocal. (The benefits) to people in Africa: training, MDG (Millennium Development Goals) to reach targets."*

Welsh respondent

> *"Benefits for Wales are raised awareness in citizenship and responsibility. Working closely together with others, and by being involved In the Link, gives enormous personal satisfaction, skills, and confidence. For Africa: enabled them with an outside view and money to work together to recognise skills they have to make changes for themselves. People are encouraged by seeing somebody who cares. People in the community have better health and better standard of living"*

Welsh respondent

The African partners were all positive in their remarks about the benefits; some also described benefits for their Welsh partner as well as their own country:

> *"Benefits of Link to people in Africa: Quality of service delivery has improved; accessibility has improved, getting the global picture, forming friendships and learning about each other. Benefits to people in Wales: at the last visit our friends said they realised how they were taking what they had for granted. Told them it was a blessing to have all services so near. They see different perspective and the global picture"*

African respondent

Respondents were asked whether they personally, their organization, or their country had benefited from their involvement in a Link. 98% (42/43) of all respondents agreed or strongly agreed that they had personally gained from their involvement in a Health Link. The main skills developed were: *prioritizing with limited resources; problem solving; organization, management and leadership skills; team-working.* There was a slightly less strong response regarding gains to the organization, with 81% of all respondents (34/42) agreeing or strongly agreeing that there were benefits, however, 86% (31/ 36) of the Welsh respondents agreed or strongly agreed that their employing organization in Wales had gained from their involvement in a Health Link. (See Figure 4). African respondents were more likely to be neutral on the gain for their organization or to simply agree that the Link had met their expectations.

89% of Welsh respondents agreed that their problem solving skills had improved, and 74% agreed that they had found resource-saving ideas.

Some added free text comments explaining the gains to their employer:

> *"I am quite sure that we have raised awareness of global health issues within our health board and Trust."*

Welsh respondent

> *"Members of the link group have benefitted by developing new skills and making new contacts. There have been some considerable challenges, but most of the work has been very enjoyable."*

Welsh respondent

Learning lessons to use in the "day job"

Respondents were asked if they felt that their involvement in a Health Link had made a difference to their usual job. The majority agreed or strongly agreed that their problem solving, leadership/management and educational skills had improved. In particular, 89% of Welsh respondents agreed that their problem solving skills had improved and 74% agreed they had found resource-saving ideas which were likely to directly benefit their employers and hence the people of Wales.

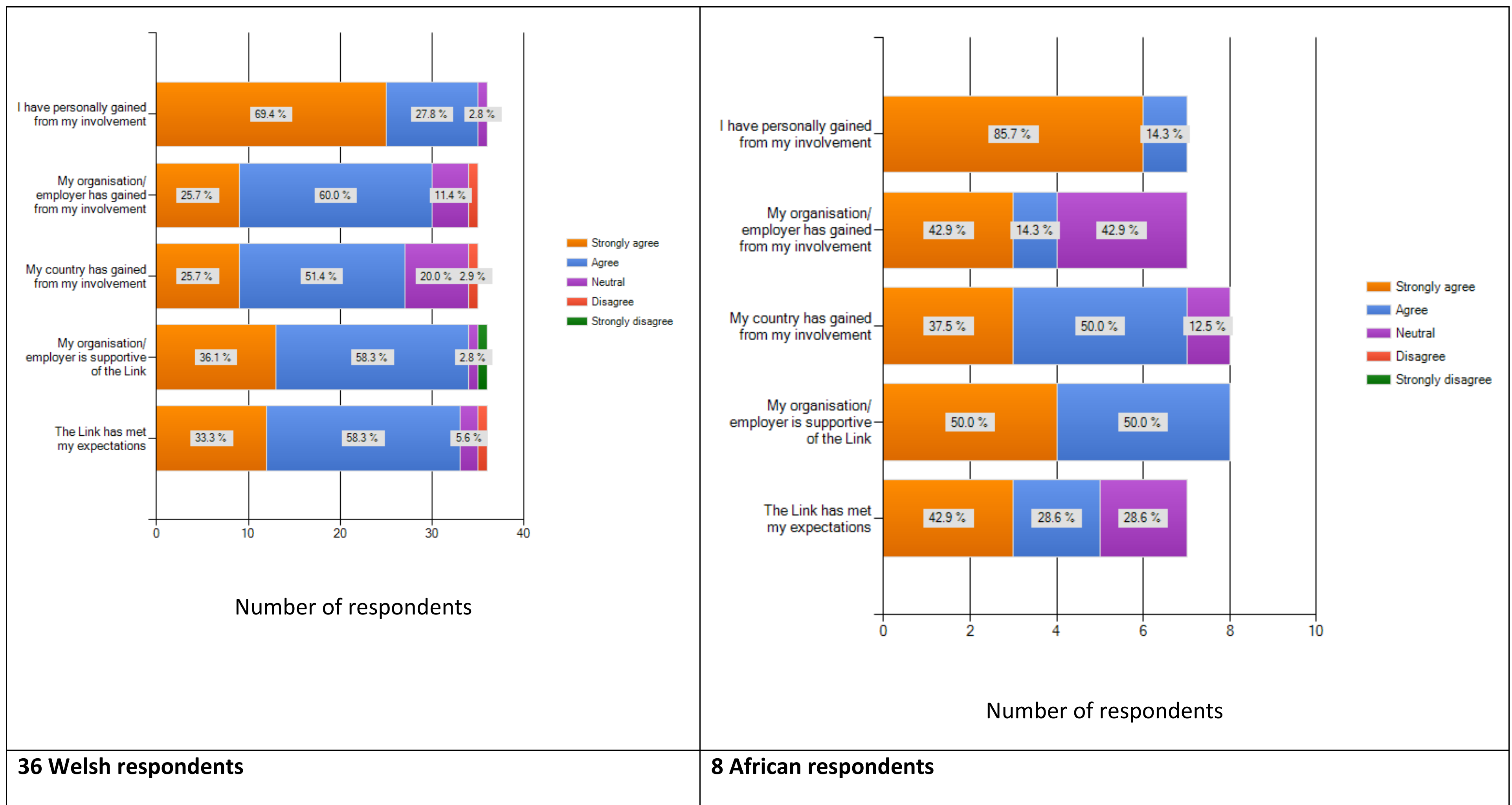
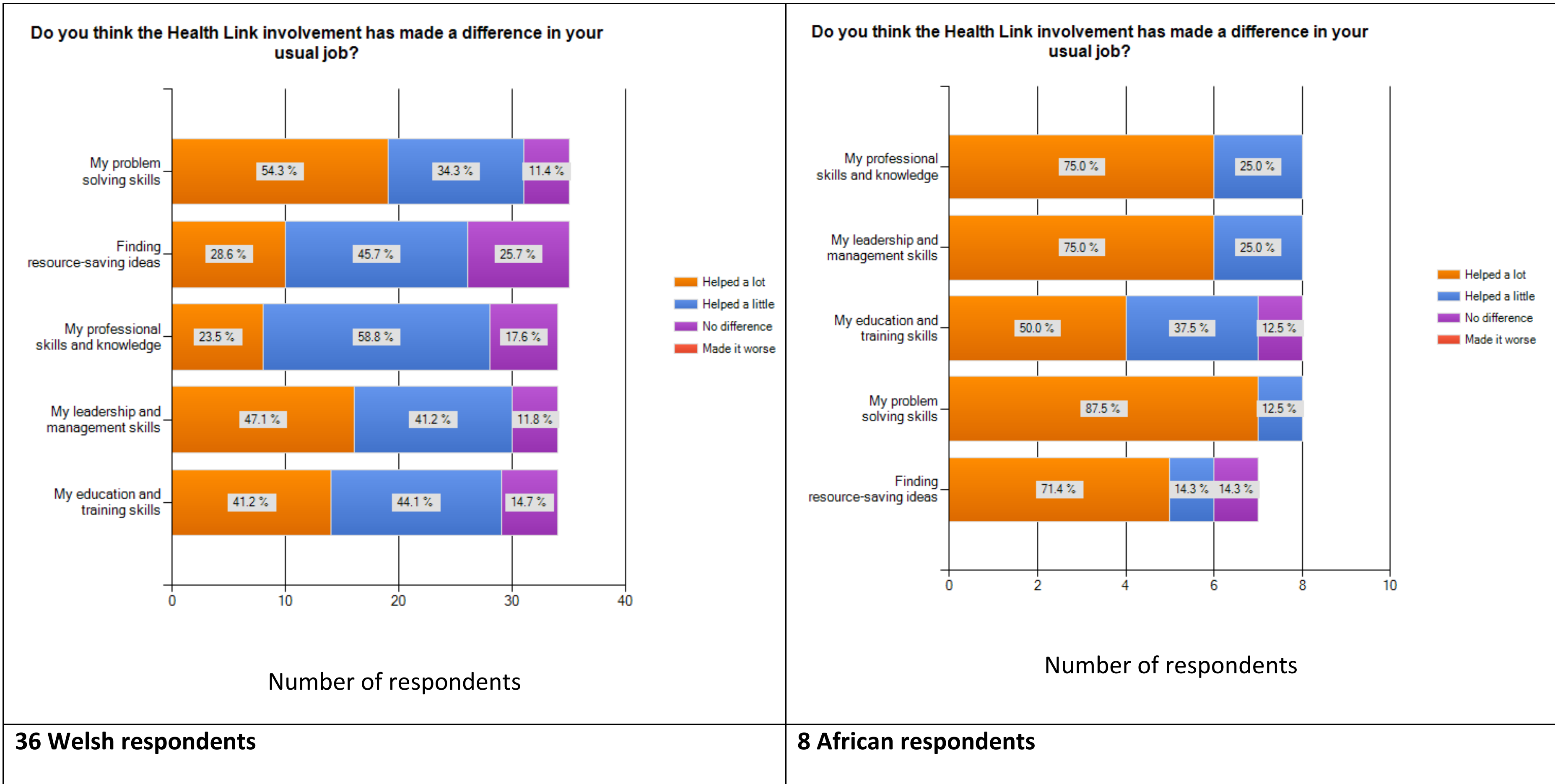


Figure 4 Agreement with statements on benefits of involvement in a Health Link.



36 Welsh respondents	**8 African respondents**

Figure 5 Has your Link's involvement made a difference to your usual job?

Respondents to the questionnaire were asked to give up to three free text examples of key changes in their own practice that had been made as a direct result of their involvement in a Link. 31 Welsh respondents gave at least one example, 25 gave two examples and 17 people gave three. These answers were grouped into themes, of which 23 emerged. Table 1 shows the top 10 changes in practice:

Key change in own practice	Number of mentions
Prioritising with limited resources	9
Problem solving	7
Team working	7
Leadership/ management	6
Improved perspective on UK problems	6
Education/ training skills	5
Cultural awareness	5
Communication skills	3
Dealing with complexity	2
Increased knowledge	2

Table 1 Key changes in own practice as a direct result of involvement in a Link (Welsh respondents)

Some examples given were:

> *"More able to cope with emergencies involving failure in equipment in the UK because of experience in Africa"*

"I have reorganised the way our practice rota works. I have helped develop the use of nurse practitioners in the practice. I am far happier in my work"

"Improved improvisation and problem solving",

"Greater targeting of training appropriate to resources of recipient (as applicable in Wales as in Africa)",

"It has developed my leadership skills I cope better with uncertainty I have learnt how to apply for grants"

"Vastly improved resource and personnel management skills"

"Close bond with other disciplines in my own workplace through working as team in the link activities"

"Much greater acceptance of fundamental importance of good health needs assessment"

"Teaching skills greatly developed"

"It has been an immense challenge being involved with this link, which has probably developed my skills and deepened my understanding in all sorts of areas."

Interviewees expanded on these ideas, and all said that they felt they had been able to transfer knowledge and skills gained to their usual work outside Link activity:

"Made impact on my own practice -I now have a better understanding of organisation, planning for future, thinking long-term to develop small to big. Technical skills – I was teaching before but when you go there –there is no better way than teaching somebody else"

Welsh respondent

"Better management of time and resources; I have become a better manager;. Better at tackling issues; Thinking out of the box"

African respondent

Communication

Methods

Respondents were asked which method of communication they used and asked to place the frequency of use in four categories: "weekly or daily"; "every few weeks"; "every few months"; "never". Historically, visits between partners have been the mainstay of communication in Health Links. Indeed, 16 of the Links said there were visits from the Welsh to the African partner country every few months and 9 said there were visits from the African partner country to Wales. In latter years, other methods of communication have become more feasible across Africa and so respondents were asked which of these methods they used and how often.

Among the Welsh respondents there appeared to be two distinct groups: *active communicators* (7 Links) and *infrequent communicators* (5 Links).

Email was given as the most common method of communication with seven Links using this daily or weekly. Of these, five also used telephone and texting relatively frequently and two used Skype weekly or daily.

Among the five infrequent communicators the Welsh partner reported using email every few months and none of these used any other method of communication more frequently.

There therefore appears to be several "active" Health Links that use multiple methods of communication and unsurprisingly, three of the more longstanding Links were among these. There also seems to be a much less active group who use little communication outside visits. More of the 9 African respondents were involved with the "active" Links.

There was a relationship between frequency of contact between participants in Wales and Africa and the length of time for which a project had been going. Projects that had daily/weekly contact had been going on average 3.7 years longer ($p = 0.026$, Wilcoxon test).

There was a strong association between respondents who reported daily/weekly communication and also reporting benefits to one's own educational needs (compared with reporting "only a little" or "made no difference") ($p=0.022$, Chi square test).

There was a statistically significant positive correlation between those Links that had more frequent communication (daily or weekly) and the involvement of a hospital specialist ($p=0.014$).

Among the seven African respondents, all received visits from their Welsh partner and four said they visited Wales every few months. Again, most used email frequently to communicate with their Welsh partner.

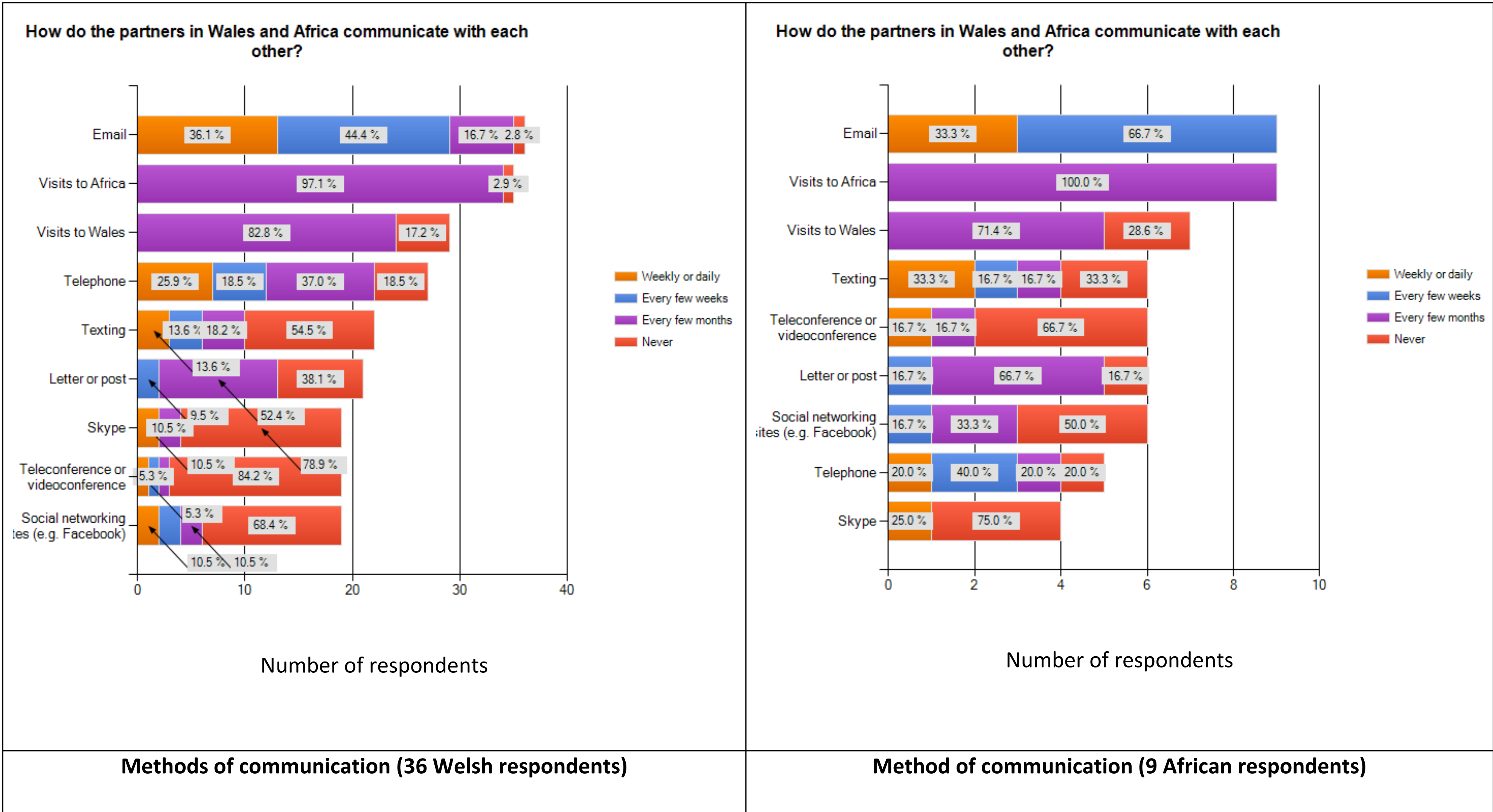


Figure 6 Methods of communication

The technical aspects of communication (such as poor internet connections and power cuts) were cited as difficulties by several interviewees. Some explained that it was less the technical problems but more a problem with perceptions of each other's communication needs, for example, some African partners were said to be very busy with little time for checking email and several also said that there was less of a culture of fast responses in African partner countries.

> *"Even when extremely busy here we still check emails and email to say I'm busy but that is not the way in ………., after waiting a couple of weeks when we prompt again , we get a reply saying 'I am the only surgeon at this hospital and have worked for 18 hours. Letters take couple of weeks"*

Welsh respondent

> *"It's improved with access through internet, its better. Have to wait for computer to be free, as so many people use it. 1 laptop and 3 computers would help if we had them now"*

African respondent

However, it appeared to be the respondents from the larger and/or older Links who had better and more frequent communication, maintained in spite of barriers.

> *"It's very easy to give up. It is hard for (partner)……… – when you ring home from there you realize that it's not easy with power cuts and internet not the best options. I call any day and any time frequently. (You can) overcome – treat it as a personal friendship"*

Welsh respondent

Personal relationship

Strong personal relationships were felt to be a very good facilitator of partnership working and effective achievement while the lack of them led to frustration and lack of action. Throughout the interviews, personal contact was said to be valued by both partners and considered fundamental to the working of a Link although some drawbacks were also reported in face to face contacts through visits from Wales to Africa:

> *"When you take people to see for themselves - in the past people became more engaged. But, you come to a point when it becomes not so useful, people who are not motivated can become a burden. Big parties can be negative, as some can be culturally insensitive. In the Health Link we are careful about who we take. Too visible, too big can be 'honey pot'*

Welsh respondent

"People who come here (to Wales) see the advantage of time keeping. Social cultural: OK as an organisation with wealth of knowledge. I keep asking questions; every time I visit I learn more."

Welsh respondent

Processes

Respondents were asked if they were aware if their Link had any of the following: 1. written Aims and Objectives; 2. a Memorandum of Understanding (MoU); 3. a documented needs assessment; 4. a documented monitoring process; 5. a documented evaluation or a published report. All African respondents were aware of written Aims and Objectives, as were the majority of Welsh respondents. Needs assessment, monitoring and evaluation processes and evaluations were less common however several commented that they were at an early stage and were still developing some of these. One respondent said they had tried to get a MOU signed "but the link at the other end didn't seem to want to take forward".

None of the interviewees mentioned processes for agreeing aims and objectives but two mentioned having agreements in places such as a Memorandum of Understanding. No one described an explicit process for assessing needs and agreeing priorities.

"Memorandum of Understanding does work – officials change. (It promotes) clear understanding and a structure of both sides is possible"

Welsh respondent

67% of Welsh respondents and 100% of African respondents were aware that their Link had a Memorandum of Understanding.

Welsh respondents said they did not know, or did not have, several other key processes, for example, 49% were not aware of a documented monitoring process, 39% were not aware of a documented needs assessment and 38% were not aware of a documented evaluation.

Welsh respondents were asked if they were aware of the Strategies and Priorities of the African partner's Ministry of Health. 22 (63%) replied 'yes' and 13 (37%) replied 'no' or that this didn't apply. African respondents were asked if the Link fitted with the Strategies and Priorities of their Ministry of Health and all nine (100%) agreed that it did.

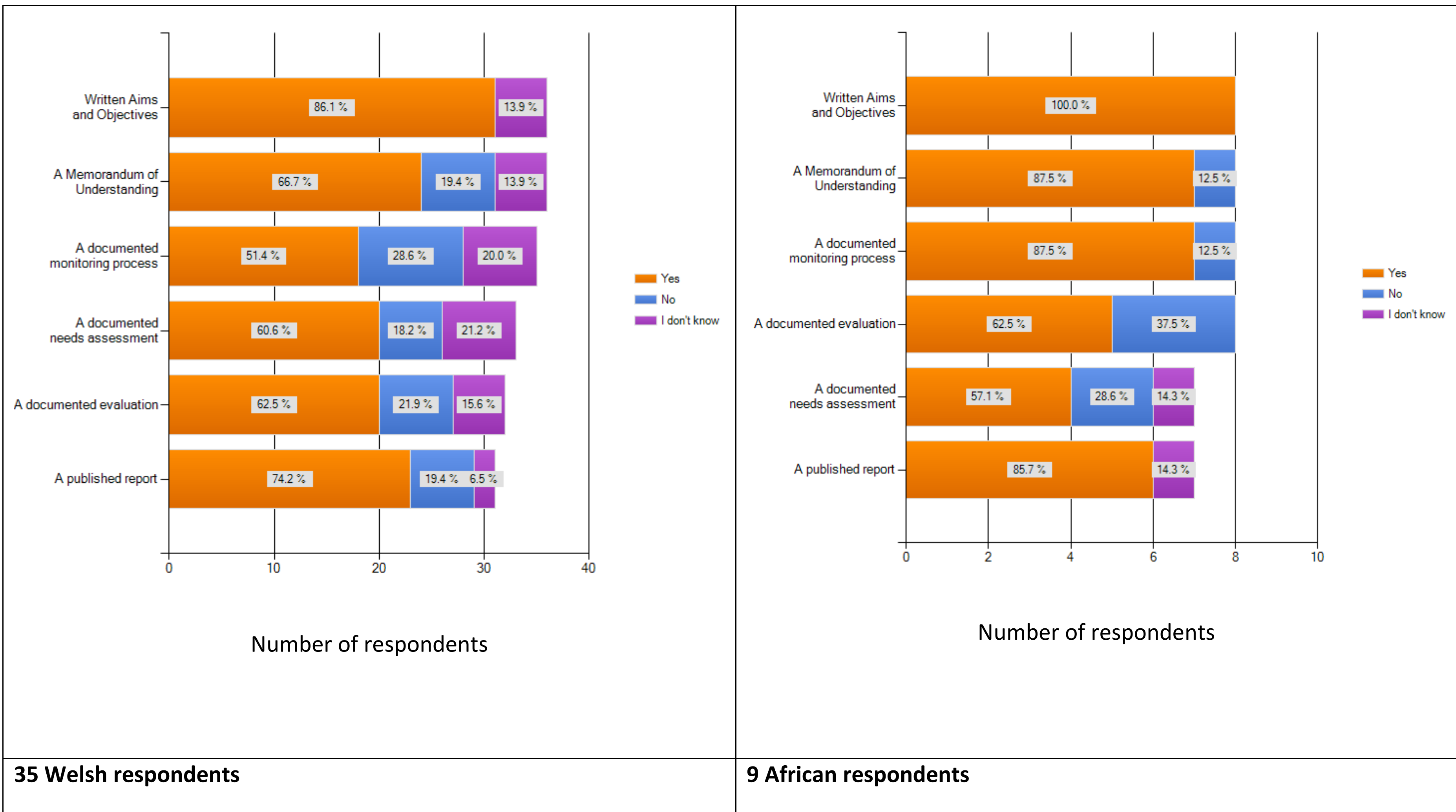


Figure 7 Processes in place

Most respondents talked about monitoring but used descriptions of various informal methods, few of which were described as being written down or undertaken at regular intervals. Several respondents said they were unaware of a monitoring process. Respondents talked about informal methods such as reports of visits, keeping records of costs and face to face conversations to monitor objectives.

The most often described subject of formal monitoring was that of a training intervention with questionnaires or surveys used afterwards and sometimes beforehand, to assess training needs.

Two respondents mentioned independent external evaluation.

The role of women

Many respondents brought up the fact that there was a relatively high participation of women in many Health Links, both in Wales and in Africa.

> *"(Our) Executive director is a woman. More women - women tend to volunteer more. One co-ordinator is a man. Participants 50:50 usually"*

African respondent

> *"At both ends there are more women. (For example), the Assistant co-ordinators in …….(and the) Health centre midwife lead. The Women's Association is involved in health centre. We listen to their views"*

Welsh respondent

Overcoming Challenges

When asked about challenges faced by their Link, *dependence on too few key individuals, communication difficulties* and *visa problems* were most commonly cited by Welsh respondents. However, there was a great variation in the perceptions of challenges faced in that a large number of respondents did not consider these issues to have been a challenge. Respondents related overcoming challenges as a main point of learning gained from their involvement in a Health Link.

The African respondents did not agree that most of the items on the list of potential challenges had been an issue for their Link. They identified visa problems and communication difficulties most commonly and in contrast to the Welsh respondents, only 2 identified dependence on too few key individuals as a challenge.

Welsh respondents spoke of several difficulties in partnership working such as maintaining relationships, gaining engagement, tackling corruption, providing equipment (customs problems and inappropriate equipment),providing training and education (not knowing if training given was making any difference), communication and cultural translation problems in delivery of training and of difficulties gaining practical support from their NHS employer. Neither the Welsh nor African respondents felt that the voice of the Welsh partner was too powerful but surprisingly, several African partners felt that the African voice was too strong.

Partnership working, with the emphasis on relationships, was a key concern. This was to be expected in that many people felt that it was the key factor in sustaining and delivering partnership aims.

> *"With the community health clinics, it is fine (But the) hospital has another agenda. It's difficult for them to engage with what we are about. Cultural differences, we need to be patient, we are very impatient in the West. Work Ethics: (they are) very committed. Training was didactic in ……..but very participatory now. First year was more formal*."

Welsh respondent

> *"We didn't understand what we were about, different expectations. We are still in the process of overcoming those. Frequent interactions and exchange visits and public awareness is helping. Getting there slowly. Concerns: Continuity, after government official leaves, what will happen? Is there enough commitment? Cultural differences, sometimes it's good to learn from each other. Dr (Welsh Link coordinator) lived (here) in ……. for 12 years."*

African respondent

Personal relationships fostered through visits were felt to be a major way of overcoming challenges such as cultural and communication barriers. Making more visits possible, in both directions, was a common

ambition including plans to gain financial support to enable staff on low incomes to join visits (both Welsh and African). Several respondents mentioned requesting employers in Wales to support staff to take leave for visits, or replacing staff while they were away.

Raising funds was frequently mentioned as an ongoing challenge and several respondents said they felt some staff in Africa should be reimbursed for their time, expenses and administrative support for Link activities.

Cultural differences and communication difficulties were often described together with solutions that the Link had tried.

> *"Cultural differences: always there, but we have worked on it and learnt right from the inception. We will be able to manage it by raising awareness, e.g. people smoking in front of other people is a big deal. People in the village do not smoke, e.g. white person on bicycle disrupted the children in the village school. People have traditional values. Corruption is there in government, you can't get rid of it, and we need to find ways to work with it. Need to know if individuals are corrupt, where the money is actually*."

African respondent

Equipment provision led to unexpected difficulties for several respondents:

> *"African partner tries to replicate what is happening here, ask for high tech equipment with low maintenance in place, unrealistic, instead of going 1 -2-3 , they go 1-3"*

Welsh respondent

> *"We sent second hand computers out, bad idea, 7/8 yrs old and are very slow"*

Welsh respondent

For Welsh partners, securing time for a visit for NHS employed staff was a barrier as several were unable to use study leave and then used their annual leave. Professional indemnity was also cited as a concern. There were practical barriers, such as time required for the practical organisation and preparation for visits, which were more difficult to carry out in Africa. Differences in culture, expectations and teaching methods were also cited.

> *"The trust I work for is very supportive of the link, however my manager struggles to see the value to the unit so it is often a bit of a battle to get time to travel to Africa as paid leave"*

Welsh Respondent

"Impossible to get leave - unable to return this year for follow up of the projects started last year as hospital not willing to authorize leave - even to approve standard leave using own annual leave instead of going on holiday"

Welsh Respondent

People described experiences that had led to learning and changing direction:

"*In the last 6 months our priorities have gone back to basics, our focus is on basics like running water and teaching: have moved over to equipping people with the skills rather than providing equipment: Long term rather than short term. Wasted time initially with putting a lift into hospital, took a lot of time, and had to take an engineer to Ethiopia. Unless there is a maintenance agreement—what will happen if it breaks?"*

Welsh respondent

"Library after ……… gave the money; we learnt that people in the village don't want to work in the library. We are on our 4th one. We need to have people on standby"

African respondent

Figure 8 Challenges

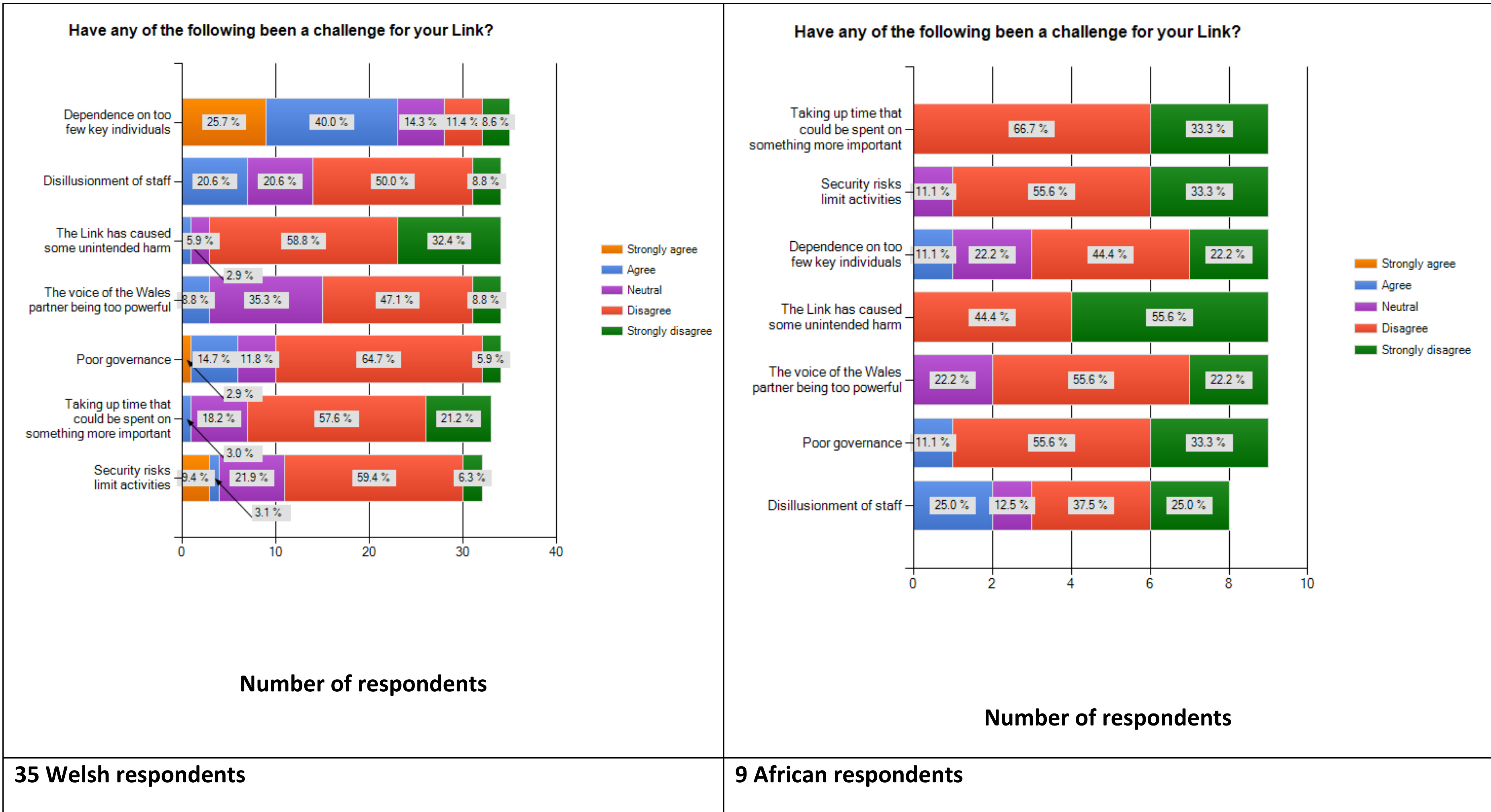


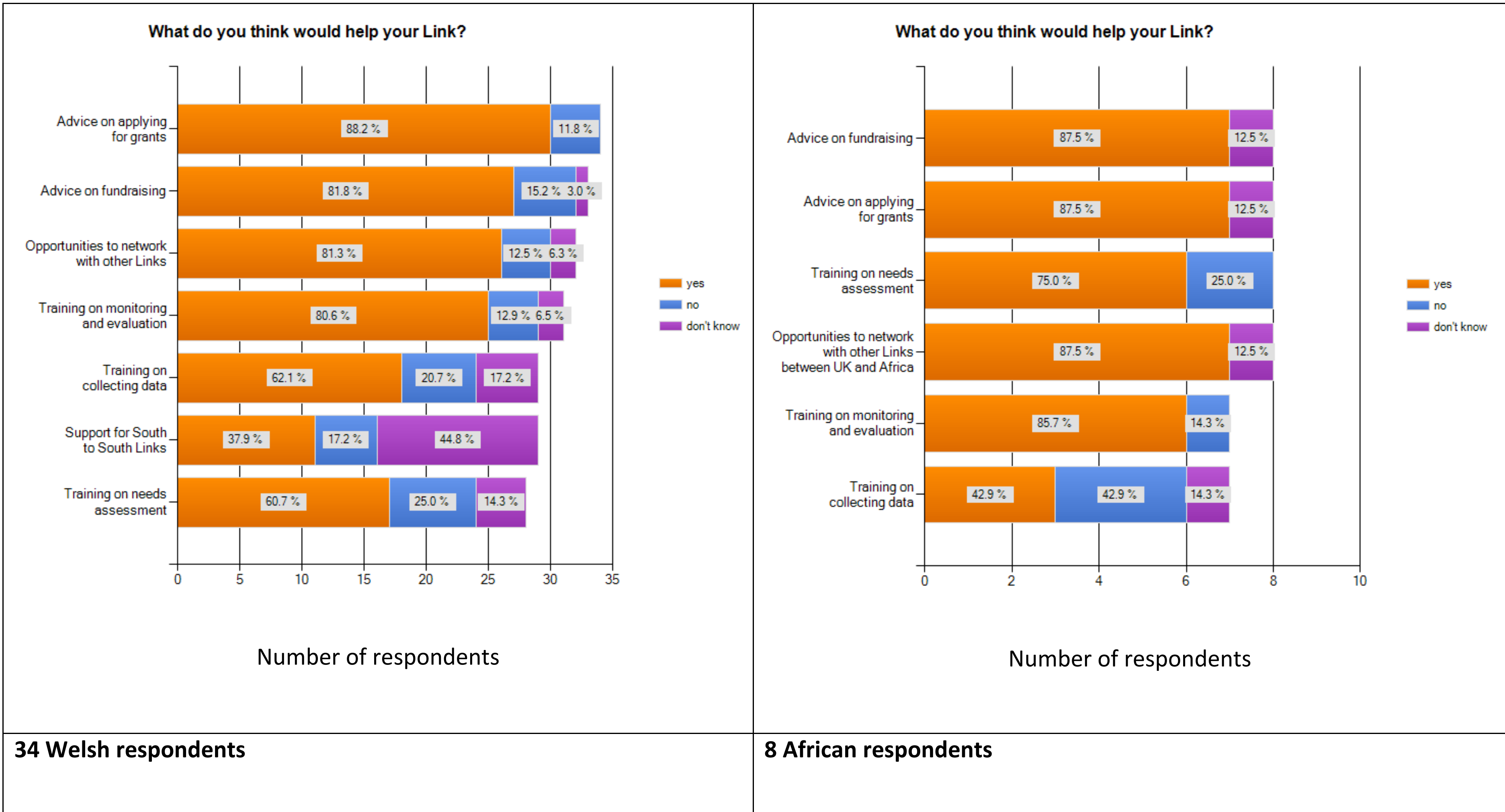
Figure 9 Challenges

Support Needs

In response to a list of options that might help a Health Link, most respondents expressed an interest in the majority with *advice on applying for grants*, *fundraising* and *opportunities to network with other Links* being the most popular. African respondents similarly replied 'yes' to most options, one commenting:

> *"Support to our continuous professional development program for nurses and midwives."*

African respondent



34 Welsh respondents	**8 African respondents**

Figure 10 What would help your Link?

Discussion

Strengths of the study

This was a broad ranging assessment method using a combination of quantitative and qualitative techniques to triangulate the information gained and thus to support robust conclusions. It was built on previous survey questions and learning gained from the piloting phase. The use of a web interface is likely to have reduced response bias in the questionnaire.

The study included a high proportion of people known to be active in Health Links between Wales and sub Saharan Africa and had a relatively high response rate. Previous research has largely focused on the coordinators of a Link but this investigation was successful in engaging a considerable number of people in Wales who were not Link leads and hence gained a better understanding of their perceptions rather than relying on second hand accounts from coordinators.

Limitations of the study

The sample was too small to identify many statistically significant associations. The sample of African partners in particular was very small and was less representative in that the sample selection depended on Welsh Links providing details, which in turn assumed reasonably active and trusting relationships. Non respondents cannot be assumed to be similar to the respondents. The individual respondents were likely to be unrepresentative, for instance many Links focused on midwifery training and yet there was only one midwife respondent.

The investigation was not able to differentiate sufficiently between larger scale and small scale Health Links and to take into account the heterogeneity of purpose, delivery methods and objectives of each Link.

Main findings

There is considerable involvement in International Health Links activity in Wales, certainly when compared to its relatively small population (4.9% of the UK population[xviii]). Over 70 individuals were seemingly actively involved in a Health Link and had joined the mailing list of the *Wales for Africa* Health Links Network; 20 separate Health Links were identified. The response rate to the survey questionnaire was higher than expected at 49%. Of the non-respondents, it seems likely that some individuals on the mailing list were not currently actively involved in a Health Link as the list is open to anyone with an interest, regardless of activity/involvement.

The majority of Health Links were very new and it remains to be seen whether this reflects an ongoing pattern of Links that do not become sustainable and cease after a few years and then new Links commence, or whether there has been a genuine increase in the number of sustainable Links. Only four Links were

more than six years old. There was a variety of types of partner, with many variations on the theme. There were also many different professionals involved but the majority of respondents were hospital specialists or nurses.

Mutual visits were very common. However, outside these visits, there appeared to be several "*active communicators*" who used multiple methods of communication. There was also a group of *"infrequent communicators"* who did not communicate much outside visits. The frequency of communication was significantly associated with well established Links and also with the perception of meeting educational needs. It is not clear whether these are cause or effect but it would be natural to presume that increasing the frequency of communication would lead to better relationships, which in turn are agreed to be the key to sustainability.

The value of personal relationships, friendship and mutuality came though strongly throughout the interviews and in responses to the survey questionnaire from both Welsh and African partners. For many, this aspect of "standing by our colleagues" and providing moral support was seen as an intangible but vital ingredient for improving the outcomes of partnership working.

Documented processes were not always in place, for instance a third of Welsh respondents were not aware that they had a Memorandum of Understanding with their partner and half did not know if there was a monitoring system. Only two thirds of Welsh respondents stated that they were aware of the Strategies and Priorities of their African partner's Ministry of Health, although all African respondents felt that their Welsh partners were aware.

Overall, respondents from Welsh and African halves of the International Health Links were very positive about their involvement in these activities. There are challenges and barriers and it is clear that these partnerships are not easy. However, overcoming the challenges was perceived to be a major personal and professional development experience. For both the Welsh and African respondents, two of the top three benefits brought by the Link were: *experience of different cultures* and *support and friendship with your overseas partner.* For the Welsh respondents the next top aspect was *putting UK problems in perspective*, while for African respondents the next top was s*ustainability of services.* The latter was particularly important to African partners through supporting them in just carrying on in difficult circumstances. Welsh partners appeared to realize the privileged circumstances they worked in at 'home' and were more motivated to make the most of this in their day jobs.

Many of the skills gained were the "soft skills" in leadership, management, communication and team working. The NHS invests a considerable amount in developing these in its workforce and involvement in international Health Links may be a more cost effective method of achieving the same outcomes as formal organisational development programs.

However, this investigation also demonstrated that not all Health Links have formal processes in place that could be regarded as the minimum for good practice in international development work, such as needs assessments, memoranda of understanding, or monitoring and evaluation processes. Many respondents did not comment on this and when asked about their support needs there was less interest in needs assessment training. This would suggest a lack of recognition in some Links of the importance of these fundamental processes of good health partnership working.

Few interviewees mentioned impact assessment or discussed how their Link's activity could be measured in terms of health outcomes. Respondents spoke of evaluation processes more in terms of individual training interventions. Although impact assessment is very difficult to do, it may be more of a requirement in future because many donors are now more interested in impact assessment thus monitoring and evaluation skills will be necessary. Impacts made by Health Links are not always easy to capture and quantify, so appropriate and innovative ways to evaluate and monitor need to be considered.

Benefits to Wales

There is strong evidence that Welsh staff who are involved in a Health Link believe that they gain personal and professional benefit from their involvement. Participants believed that their employing organization also benefitted, particularly in terms of development of an individual's problem solving, team working and organisational skills.

Every year the public sector in Wales, especially the NHS, makes a considerable investment in staff development in these areas. The Welsh Assembly Government also makes a very significant investment in this area, for example by funding schemes such as those run by the National Leadership and Innovation Agency for Healthcare (NLIAH)[xix], the Organizational Effectiveness Program for General Practitioners[xx] and the International Learning Opportunities[xxi] scheme, run by Public Service Management Wales (PSMW).

There is likely to be scope to capture and maximize the benefits of the involvement of Health Links to meet the aims of such existing programs and to meet the needs of different health professionals' mandatory Continuing Professional Development. There is also scope to more systematically capture and implement learning that may be useful in meeting the health needs of the Welsh population, especially in more resource-limited times ahead.

Conclusion

There is strong evidence that those who are involved in a Health Link, both in Wales and in Africa, believe that they gain personal and professional benefit from their involvement, particularly in terms of problem solving, team working and organisational skills. Investment by the Welsh Assembly Government in Health Links is believed by participants to be contributing to professional development and consequently providing benefit to the Welsh health organization by which participants are employed.

Recommendations

For Health Links

1. Increase good practice in partnership working and governance.

2. Invest in communication between partners, particularly in building personal relationships and increasing frequency and methods of communication

3. Ensure processes are in place, based on good practice guidance such as the THET *"International Health Links Manual"*, in particular:

    a. Establishing Aims and Objectives and including these in a Memorandum of Understanding.

    b. Ensuring processes are negotiated and established with both partners.

    c. Ensuring plans are based on needs assessments and have monitoring and evaluation built in from the beginning.

    d. Ensure major activities are supported by evidence-based good practice and effective delivery models.

4. Ensure plans are in place for sustainability, particularly where the Link perceives it is relying on too few individuals.

5. Make the most of available support to capture long term, quantitative and qualitative information for outcome evaluation and impact assessment.

6. Consider modern, distance based, sustainable methods of shared learning to reduce reliance on one-off short visits between partners for delivery of training.

For support organisations (for example the Wales for Africa Health Links Network, THET, SMIDOS, WACL and others)

7. Provide opportunities for networking and shared learning between members of Health Links, for both Welsh members and their African partners.

8. Support good practice and good governance in partnership working, for instance through guidance, facilitation of shared learning, training programs and toolkits.

9. Support good practice related to the most common major activities, particularly training and education delivery and provision of equipment.

10. Support the development of modern, distance based, sustainable methods of shared learning between partners to reduce reliance on one-off short visits for delivery of training.

11. Support Health Links in needs assessment, monitoring and evaluation.

12. Support research into how to measure the impact of Health Links' activity

13. Consider commissioning the development of standard templates for a range of documents that underpin best practice for *Wales for Africa* Health Links including Memoranda of Understanding and Monitoring and Evaluation Tools.

For Government, Health Boards and Universities

14. Ensure grant schemes include monitoring, evaluation and impact assessments with reports at the end and possibly mid-point, of the grant period.

15. Encourage the sustainability and scaling up of Health Links that have demonstrated success as much as supporting new Health Links.

16. Mainstream the learning opportunities of Health Links so that more public sector staff use the opportunities and the learning is effectively captured for the benefit of Wales.

17. Recognise the skills and experience gained by professionals involved in Health Links as integral to their continuing professional development.

18. Consider the cost effectiveness and value of the involvement of NHS and public sector staff in Health Links as an alternative to current spending on organisational development and leadership and management training.

19. Consider providing administrative support and logistic support to Health Links.

20. Develop a clear policy on study leave/ professional leave with national consistency

21. Consider how to integrate research that benefits African populations into Health Links' activity and that enables them to increase their impact.

22. A Charter Mark or Award should be developed that could be awarded to Health Links that met agreed standards.

Authors:

Kathrin Thomas and Jasmin Chowdhury designed the questionnaire and semi structured interview guide. Jasmin Chowdhury carried out the interviews. Kathrin Thomas and Hugo Van Woerden carried out the questionnaire analysis. Jasmin Chowdhury and Kathrin Thomas analyzed the interviews. Kathrin Thomas wrote the report, with comments from the other two authors.

Jasmin Chowdhury and Hugo Van Woerden declare that they have no conflicts of interest. Kathrin Thomas has been the coordinator of the Wales for Africa Health Links Network on a voluntary basis since May 2010 and is a member of the Wales Somaliland Community Links Health Committee

Appendix

Additional information from the study

Questions and answers

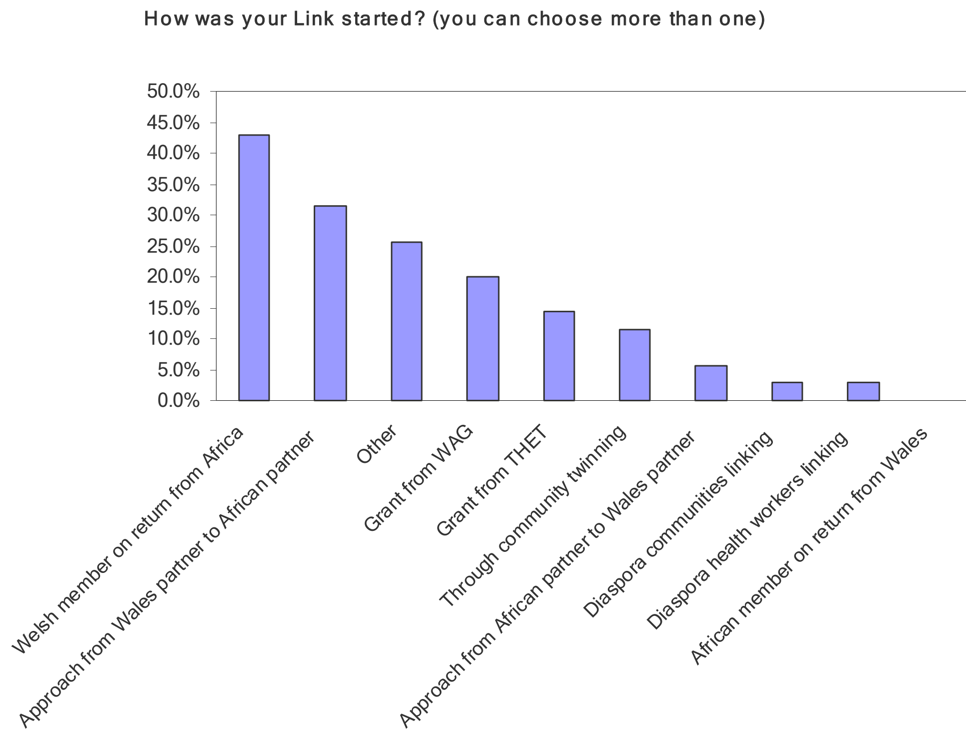


Figure 11 How was your Link started? (Welsh respondents: more than one answer could be given)

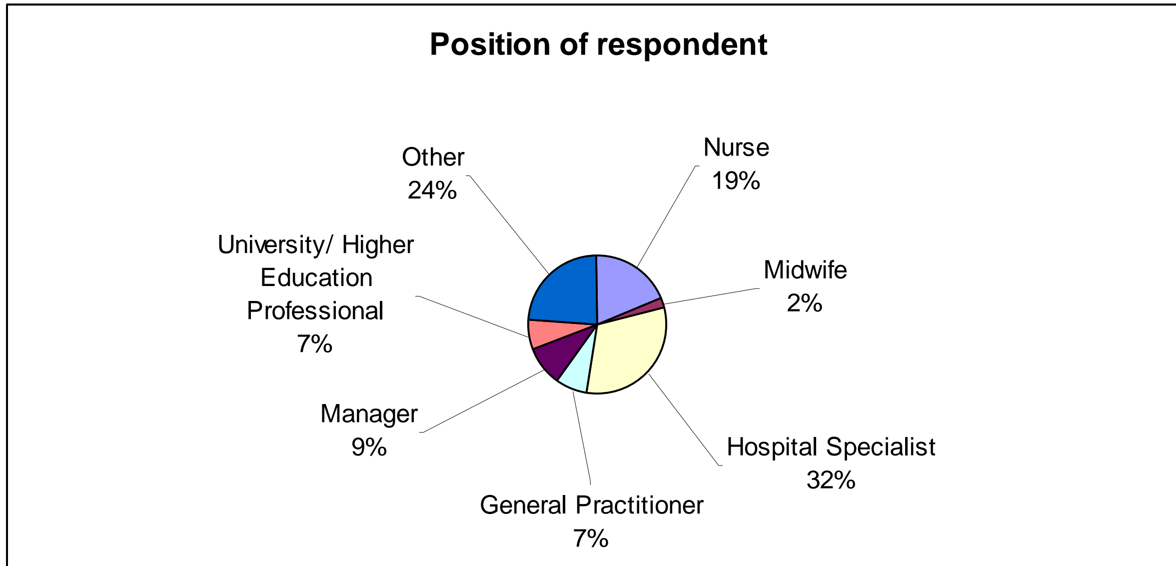


Figure 12 Position of respondent (Welsh respondents)

Example 1	Example 2	Example 3
Delegation and trust	Empowering others	Economy
Increased awareness of different values	Understanding of differing challenges	
creative thinking	persuasion	understanding
I have reorganised the way our practice rota works	I have helped develop the use of nurse practitioners in the practice.	I am far happier in my work
appreciation/rationalisation of resources	better team working	
Balanced evaluations techniques	Improved problem solving	Contextualisation of problems
Improved improvisation and problem solving	Improved MDT working	Better appreciation of system limitations
It has developed my leadership skills	I cope better with uncertainty	learnt how to apply for grants
Prioritising what is important in practice	Understanding restriction of resources	Development of educational skills
aware of the relative nature of problems here		
Problem solving	Awareness of working as a partnership	
more able to cope with emergencies involving failure in equipment in the UK because of experience in Africa		Teaching skills greatly developed
appreciation of resources	management tools	team working
None, apart from realising how well off we are in the UK!		
More patience regarding change	Importance of Public Health	
Understanding NHS problems in global context	Close bond with other disciplines in my own workplace through working as team in the link activities	Vastly improved resource and personnel management skills
encourage others to be less wasteful	involve colleagues to access network	
Better application of government policy at grass roots level	renewed awareness of clear written and verbal communication	
better perspective	more aware of funding issues	greater confidence
Appreciation of basic standards of living	Appreciation of different cultures	Humility
Increased knowledge of link process	Comparative problem solving	Involvement in link activity
More aware of the needs of developing countries		
Greater targeting of training appropriate to resources of recipient (as applicable in Wales as in Africa)	Much greater acceptance of fundamental importance of good health needs assessment	Greater understanding of challenges facing developing world
improved management skills	team building	
leadership skills	communication skills	collaborative working
Knowledge - midwifery complications	Using the experiences in my teaching	Confidence - to teach and present
my awareness of complex issues has informed practice		
More pragmatic approach to problems	Better communication skills	Understanding of other cultures
Research ideas on reproductive health in Africa	Research ideas on prevention of cervical cancer in Africa	Career break for 2 years to work in Africa

Table 14 Question 13 "In your opinion, what are the key changes in your own practice as a direct result of your Link involvement? (You can give up to three examples)"

References

[i] Welsh Assembly Government, Framework for Sustainable International Development 2006 http://new.wales.gov.uk/topics/sustainabledevelopment/intdevelopment/walesforafrica/frameworkafrica/?lang=en (accessed 11/1/11)
[ii] UN Millennium Development Goals http://www.un.org/millenniumgoals/ (accessed 11/1/11)
[iii] THET website http://www.thet.org/health-links/about-links/ accessed 15/10/10
[iv] Wales for Africa International Sustainable Development Framework http://wales.gov.uk/topics/sustainabledevelopment/intdevelopment/walesforafrica/?lang=en (accessed 11/12/10)
[v] Wales for Africa Health Links Network www.walesforafricahealthlinks.wales.nhs.uk
[vi] Wales Africa Community Links http://goldstarcommunities.webspring.org.uk/the-links
[vii] Sir Nigel Crisp "Global health partnerships: the UK contribution to health in developing countries"http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065374# (accessed 11/12/10)
[viii] Department for International Development (DfID) funding opportunities http://www.dfid.gov.uk/Working-with-DFID/Funding-opportunities/ (accessed 11/12/10)
[ix] *Framework for NHS Involvement in international development*, Department of Health England March 2009 http://www.ihlc.org.uk/Framework/benefits_organisations.htm (accessed 11/12/10)
[x] John James, Chris Minett, Liz Ollier *Evaluation of links between North and South Healthcare Organisations;* Department for International Development Health Resource Centre, May 2008
[xi] Datta, Ajoy and Katie Dimmer "*Making an impact? A THET research report on the impact of health links on the capacity of both UK and developing countries health institutions"* 2007
[xii] Andrew Furber *Survey of international health links of English NHS Trusts* Department of Health 2005
[xiii] Dave Baguley, Tim Killeen, John Wright *International health links: an evaluation of partnerships between health care organisations in the UK and developing countries* Tropical Doctor 2006;36:149-154
[xiv] John Wright, John Walley, Aby Philip, Hailemariam Petros, Helen Ford, *Research into practice: 10 years of international public health partnership between the UK and Swaziland"* Journal of Public Health Vol 32, No 2, pp 277-282 June 2010
[xv] THET *International Health Links Manual* 2009 *What difference are we making?* 2008 http://www.thet.org/health-links/resources-for-links/ (accessed 11/11/11)
[xvi] *The Framework for the NHS Involvement in International Development*, Department of Health England, 2009 http://www.ihlc.org.uk/Framework/framework.htm (accessed 11/11/11)
[xvii] The International Health Links Centre, Liverpool School of Tropical Medicine http://www.ihlc.org.uk/
[xviii] Office of National Statistics June 2009
[xix] National Leadership and Innovation Agency for Health Care http://www.nliah.wales.nhs.uk/
[xx] Organisational Effectiveness Program, Postgraduate Medical and Dental Education, Cardiff University http://www.cardiff.ac.uk/pgmde/sections/general/cpdwales/oep/index.html
[xxi] Public Service Management Wales, (PSMW) International Learning Opportunities Scheme http://wales.gov.uk/psmwsubsite/psmw/personaldev/international/?lang=en

governance Communication methods problems Consider challenges processes Wales participants support also needs clear asked majority African use activity evaluation example Support information sustainable skills every benefits agreed modern felt options relatively Ensuring Ensure new grants respondents problem lack next team staff particular organisational THET based partnership practice individuals public involved monitoring strongly work training development Africa resources members professional relationships partners Welsh reduce Assembly providing country gained answer working Saharan primarily research assessments questionnaire involvement delivery instance visits gave good including guidance developed reliance expressed improved particularly scale personal shared email believed plans continuing sub leadership reported education distance three solving examples made telephone interviewed Health Links mostly people short visa organisations opportunities Government learning investigation organization terms Understanding study partner method communicators aware communication effective one-off activities active management leave grant sustainability Link sector two question helped place impact health top Memorandum common used difficulties infrequent benefit major given