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# PROJECT REPORT

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**Supervisor:** Adam Kamradt-Scott

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## Acronyms

CEO	Chief Executive Officer
COCP	Combined Oral Contraceptive Pill (the “pill”)
CPD	Continuing Professional Development
CYP	Couple Year of Protection
DFID	Department for International Development
DOH	Department of Health
HEE	Health Education England
NHS	National Health Service
IUD	Intrauterine device (“coil”)
KTHP	Kampong Touk Health Post
LETB	Local Education and Training Board
LSHTM	London School of Hygiene and Tropical Medicine
MDG	Millennium Development Goal
MJP	Maddox Jolie-Pitt Foundation
MOH	Ministry of Health
NGO	Non-Governmental Organisation
SHA	Strategic Health Authority
THET	Tropical Health Education Trust
UK	United Kingdom

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## **Executive summary**

### **Background**

In 2008 NHS South Central launched a new initiative entitled 'Improving Global Health through Leadership Development', aiming to provide both leadership development for NHS staff, and improve health in developing countries. This policy report both reviews the literature on the effectiveness and evaluation of similar 'health links', and evaluates the partnership with the Maddox-Jolie Pitt (MJP) Foundation in Cambodia with regards to its development aim; reviewing the schemes contribution towards improvement in health and healthcare, drawing examples from the family planning workstream.

### **Methods**

Literature was viewed on the effectiveness and evaluation of UK 'health links' with developing countries. A process and outcome orientated evaluation was conducted using qualitative research methods and a review of monitoring data. Interviews were conducted with Cambodian stakeholders with a focus on the family planning workstream. The evaluation did not specifically address cost-effectiveness, or issues of sustainability and equity.

### **Key findings and conclusions**

The findings from this evaluation suggest that 'Improving Global Health through Leadership Development' has contributed towards the improvement in health and healthcare within MJP's target area in Cambodia. There was evidence of changes in health services, and practices of Cambodian healthcare workers, attributable to the work of the scheme. The Cambodian experience of the process has been generally positive, but a number of challenges were identified, similar to those identified with other health links. The findings from this report add to the body of evidence on the effectiveness of health links, and their associated good practice.

### **Recommendations**

Recommendations are proposed around five themes:

1. Review and clarify the development objectives of the scheme
2. Improve alignment with Cambodian Ministry of Health policy
3. Enhance mutual learning by considering a minimum placement length of four months and reciprocal visits to the UK for developing country partner health workers
4. Promote local ownership of the workstreams that are led and driven by developing country partners
5. Consider further evaluation of links in order to contribute to the literature on best practice

## **1 Introduction**

National Health Service (NHS) South Central Strategic Health Authority (SHA) is responsible for the healthcare of around 4 million people in England.(1) In 2008 it launched a new initiative entitled 'Improving Global Health through Leadership Development', aiming to provide both leadership development for NHS staff, and improve health in developing countries. Partnerships have been formed in Cambodia, Tanzania and Kenya. This policy report evaluates the scheme (which will be referred to as 'Improving Global Health') in Cambodia with regards to its development aim, addressing the question; *"has 'Improving Global Health' contributed towards improvement in health and healthcare in Cambodia?"* Although NHS South Central does not explicitly refer to 'Improving Global health' as a 'policy', it is considered as such for this report, as considered consistent with Anderson's definition of policy as "a purposeful course of action followed by a set of actors dealing with a matter of concern".(2)

The report's introduction gives an overview of the background to the partnership in Cambodia, reviewing literature on the context, effectiveness, and evaluation of United Kingdom (UK) health links. The methods section outlines the reasons for choosing to use predominantly qualitative research methods to evaluate the family planning workstream, seeking the perspective of Cambodian stakeholders. The results and discussion then present the findings of the evaluation in the context of relevant literature, addressing the challenge of attributing change to NHS South Central, outlining possible policy implications. Finally, a number of recommendations are presented.

### **1.1 Background to the 'Improving Global Health' scheme**

The first partnership of the 'Improving Global Health' initiative was formed with the Maddox Jolie-Pitt (MJP) Foundation in Cambodia, one of the poorest countries in the world with a human development index rank of 124 out of 169 countries.(3) MJP, a non-governmental organisation (NGO) founded in 2003 by the philanthropist Angelina Jolie, implements an integrated development programme for a population of around 5000 people in an isolated rural community in northwestern Cambodia (Figure 1). Since September 2008, over 30 SHA health professionals (termed 'fellows') from various disciplines (including doctors, nurses, and midwives) have undertaken placements of between two and eight months working with MJP's health team. In addition there have been a number of shorter visits by senior NHS staff. The focus of the initiative has been on capacity building, with an emphasis on applying quality improvement methodology to improve services at two rural health facilities supported by MJP, staffed by health workers with no formal qualifications.(1)

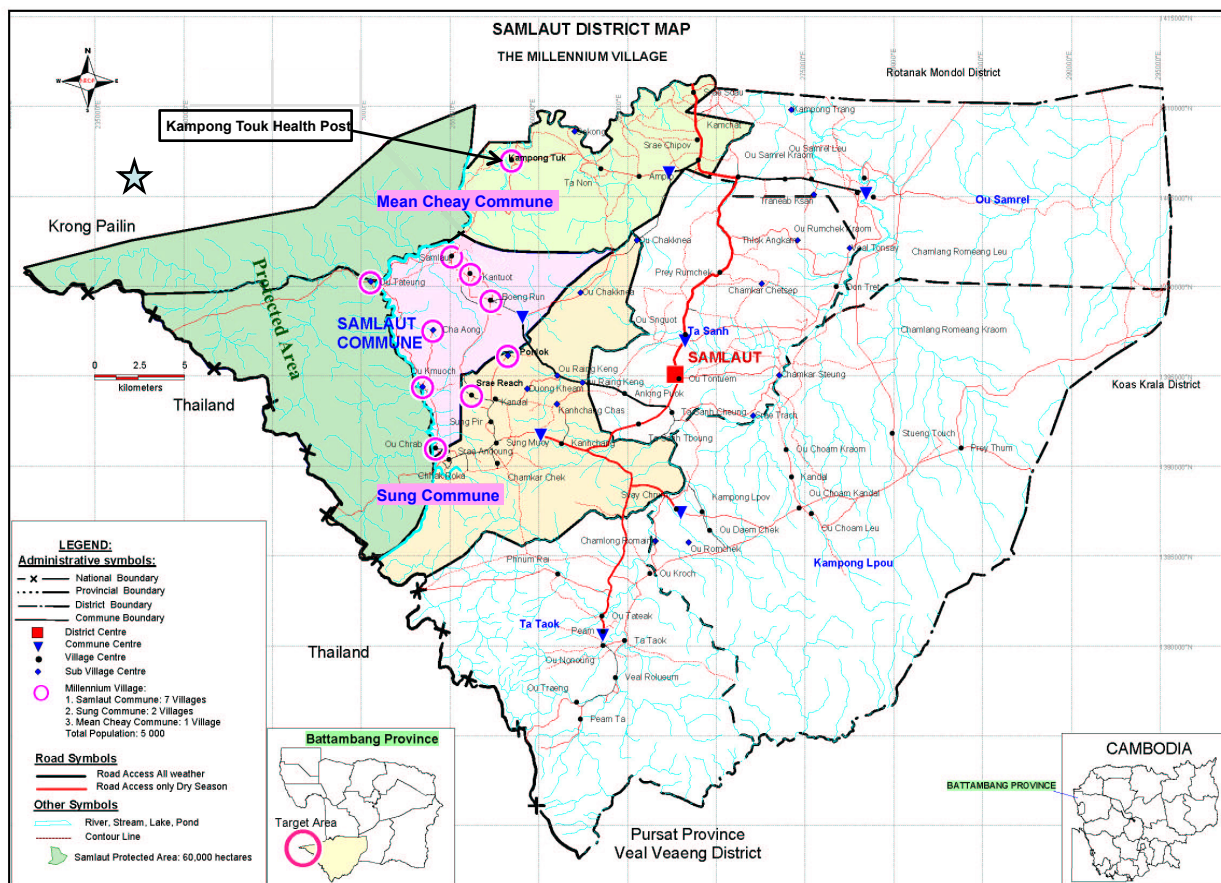


Figure 1: map of MJP target area (source: MJP)

A number of workstreams have been established by NHS fellows working with the MJP health team in Cambodia, focussing on Millennium Development Goals (MDGs) 4 & 5 concerning maternal and child health, including establishing a new family planning service. 'Improving Global Health' has articulated the following **six principles** that it is attempting to embed into its workstreams, which will be referred to throughout this report:(1)

- 1) The implementation of higher standards of clinical care with improved systems and processes
- 2) Appropriate service delivery and improved access to care – getting the right skills, equipment and people in the right place and encouraging patients to use them
- 3) The transference of technical, clinical and problem solving skills to MJP staff and other stakeholders.
- 4) The development of a culture of continuing professional development (CPD)
- 5) Supervision and support for Cambodian health workers
- 6) Data collection for the assessment of outcomes, knowledge and skills from the current baseline position



## 1.2 Health links in context

'Improving Global Health' is registered as what is termed a 'health link' with the Tropical Health Education Trust (THET), an NGO that has been advocating for and supporting health links for over 20 years. It defines health links as "long-term partnerships between UK health institutions and their counterparts in developing countries".(4) Common objectives of health links include health system strengthening, and improving health through training capacity building or clinical service delivery. Some links are set up as small charities whereas others, such as 'Improving Global Health', are funded directly by the NHS. In recent years the number of health links has expanded and it is estimated that there are currently more than 120 formal partnerships in the UK.(5)

At the same time, a number of documents have been published highlighting the potential role of the UK government and NHS in addressing global health issues, providing a favourable context for the formation of 'Improving Global Health'. Reports such as 'Health in Global: a UK Government strategy 2008-13', and the Department of Health's (DOH) 'International health, objectives and ways of working' paper have drawn attention to the potential benefits of "creative, joined up partnerships" in improving health globally, with the NHS as a key partner. (6)(7) In 2007, the Crisp report, 'Global health partnerships: the UK contribution to health in developing countries', highlighted the healthcare staffing crisis affecting many developing countries, and made a number of recommendations that the government accepted in its response document. (8)(9) Recommendations included partnerships based on the needs of developing countries and the creation of the 'NHS Framework for international development'. This document, produced by the DOH in 2010, set out key principles that NHS organisations should adopt when working in developing countries; the principles of ownership (that activities are driven by the needs of developing countries), alignment (of activities with country health plans), and harmonisation (co-ordination with other development partners)(10) (see appendix 1 for further details).

Health links can also be situated in the wider context of international development. Globally there has been a significant expansion in the number of global health initiatives that has led to an increasingly fragmented global health landscape.(11) This has led to concerns about co-ordination and accountability, leading to weakening of national health systems. At the same time there has been an increasing international focus on improving aid effectiveness, for example expressed in the 2005 'Paris Declaration on Aid effectiveness' and the 2008 'Accra Agenda for Action'.(12)(13) The principles of ownership, alignment, and harmonisation underpin the key partnership commitments outlined in these declarations, subsequently emphasised in the 'NHS Framework for International Development'.

### 1.3 Effectiveness of health links

Despite the expansion in the number of health links, there has been little published evidence about their effectiveness and impact, in particular regarding health outcomes. The Crisp report highlighted examples of well-intentioned initiatives that were misguided and ineffective, and there have been calls for stronger evidence on which types of interventions are effective, and the impact of health links on processes and outcomes of health care.(9)(14)

Literature identified on the effectiveness and impacts of health links in developing countries are generally of two forms. First, there is literature published by health links. Although most describe activities and experiences, some have reported patient health outcomes. For example, a public-health partnership between the UK and Swaziland, using a controlled before and after study, reported a reduction in Tuberculosis mortality as a result of an intervention initiated by the health link.(15) Other papers have reported case series where patient outcomes were considered to have improved after new services, such as telemedicine, were established by health links.(16)(17)

Second, a number of external evaluations of health links have been conducted in recent years, including 'International health links: an evaluation of partnerships between health-care organizations in the UK and developing countries', the THET commissioned 'Making an Impact?' and 'Review of Health Links in Ethiopia', and the Department for International Development's (DFID) 'Evaluation of links between North and South Healthcare Organisations'.(14)(18)(19)(20) Methodology included literature reviews and interviews with link co-ordinators. The Ethiopia review specifically reviewed experiences of health links from the Ethiopian perspective. Common findings included mutual benefits to both partners in fostering friendships, and sharing skills and experiences. However, challenges were also identified. The DFID evaluation reported variation in the effectiveness of links, with some that had failed to make a significant impact. Factors influencing effectiveness included degree of developing country ownership, alignment with country health plans, and length and number of one-off visits. A further challenge was finding evidence that health links activities resulted in changes in health-worker practices and health services. Furthermore, if change did occur, it was not always possible to attribute that change to the interventions of the health link (see appendix 2 for a table summarising evidence for the effectiveness of health links).

In order to assist health links with Monitoring and Evaluation, THET has produced a toolkit, 'What difference are we making'. It emphasises the importance of evaluation, highlighting the challenges of attribution; whether observed changes can be attributed to the intervention of the health link.(21) The issue of attribution is one that has also been addressed in the international development literature on programme evaluation, arguing that traditional approaches, such as the 'gold standard' randomised controlled trial, are not only expensive,

but may be inappropriate. Development practitioners have advocated for greater methodological pluralism, for example, observational studies with different levels of inference (adequacy, plausibility, or probability) providing evidence that the outcome was a result of the intervention.(22)(23)(24) The findings from this evaluation will be discussed in the context of literature outlined above, particularly addressing the challenge of attribution.

#### **1.4 Rationale for the report**

'Improving Global Health's' NHS staff leadership development aim was found to be largely met in a separate evaluation.(25) This will be the first evaluation for NHS South Central of the schemes development aim. It will also contribute to the literature on health links and their associated good practice, in particular contributing towards the gap in the knowledge by seeking evidence of changes in health services and practices attributable to the health link.

## **2 Aims and objectives**

The aim of the study is to evaluate the contribution of 'Improving Global Health' towards supporting the delivery of improvement in health and healthcare in Cambodia.

Specifically, the objectives are to:

1. Conduct a process and outcome focussed evaluation of attempts by the NHS to embed the six principles (outlined in section 1.1) into the family planning work stream, using qualitative methods and a review of relevant documentation and monitoring data
2. Review the literature on the effectiveness and evaluation of health links
3. Consider policy implications and make policy recommendations to NHS South Central

The study covers the first two years of the partnership between NHS South Central and MJP (September 2008 to September 2010).

## **3 Methods**

### **3.1 Choice of methods**

Several literature searches from different disciplines were conducted to inform various aspects of this report. Literature was reviewed on the following: patient health outcomes of health links,(26) evaluations of health links and family planning programmes, aid effectiveness and evaluation design theory. A number of biomedical and social sciences databases were accessed, in addition to citation searching and contacting experts in the field (see appendix 3 for a detailed literature review strategy).

The evaluation could be described as 'evaluation research'; "evaluation profiting from the kind of principled, systematic approach that characterises research".(27) It has formative and summative components; concentrating on the effects of the programme, with

recommendations intended to aid its development. The evaluation focuses on *process* (experiences of the health link from the Cambodian perspective; mainly NHS South Central principles 3-6) and *outcomes* (changes in health services and practice of Cambodian health care workers; mainly principles 1-2) rather than *impact*; terminology associated with logic models and frameworks commonly used in the international development field.(24) This is consistent with current guidance on health link evaluation and the notion that ultimately, good process will lead to good outcomes and impact.(21)(28) It was beyond the scope of this evaluation to measure impact; evidence of sustained significant change. Furthermore, it is difficult to attribute a particular organisational intervention to such ultimate impacts.(24)

The evaluation focused on the family planning service at Kampong Touk health post (KTHP), one of the first and longest running of the many workstreams initiated by NHS Fellows. Family planning is an evidenced-based intervention with good evidence for wide-ranging benefits on maternal and child health.(29)(30) Figure 2 demonstrates causal logic, adapted from Ebrahim and Rangan’s proposed model,(24) applied to the family planning workstream in Cambodia.

Process								
Inputs	→	Activities	→	Outputs	→	Outcomes	→	Impacts
<i>What goes in</i>		<i>What happens</i>		<i>Immediate results</i>		<i>Medium/long term results</i>		<i>Sustained significant change</i>
<ul style="list-style-type: none"> <li>• Funds</li> <li>• NHS fellows – knowledge and technical expertise</li> <li>• Length of contracts</li> </ul>		<ul style="list-style-type: none"> <li>• Training in family planning</li> <li>• Capacity building</li> </ul>		<ul style="list-style-type: none"> <li>• Cambodian health workers trained in family planning</li> <li>• Clients attending health post for contraception</li> </ul>		<ul style="list-style-type: none"> <li>• Increased contraceptive coverage in the target area</li> <li>• Improved health services</li> <li>• Changes in practice of health workers</li> </ul>		<ul style="list-style-type: none"> <li>• Progress towards MDGs</li> <li>• Reduced Total Fertility Rate</li> <li>• Sustained drop in poverty</li> </ul>

**Figure 2: Logic model applied to the family planning workstream**

Predominantly qualitative methods were used. Interviews were conducted with a range of key stakeholders in Cambodia, in order to gain an understanding of the perceived effect of the partnership. Evidence of change attributable to the health link was sought. Improvement was considered positive change within the logic model, for example change in practice by a Cambodian health worker reported by a service user. In addition, the following monitoring data and documentation relevant to the family planning workstream were reviewed: fellows’ project plans, end of placement reports, monthly reports including number of clients and amount of contraception administered.

Throughout the process, threats to reliability and validity were identified and addressed wherever possible. Concurrently, the principles of transparency and reflexivity were

considered; providing an honest account of methods and an awareness that the researcher is part of the process of research. Potential biases that could impact on data collection and analysis as a consequence of the researchers previous involvement in the scheme in 2008-9, including the family planning workstream, were considered.(31)

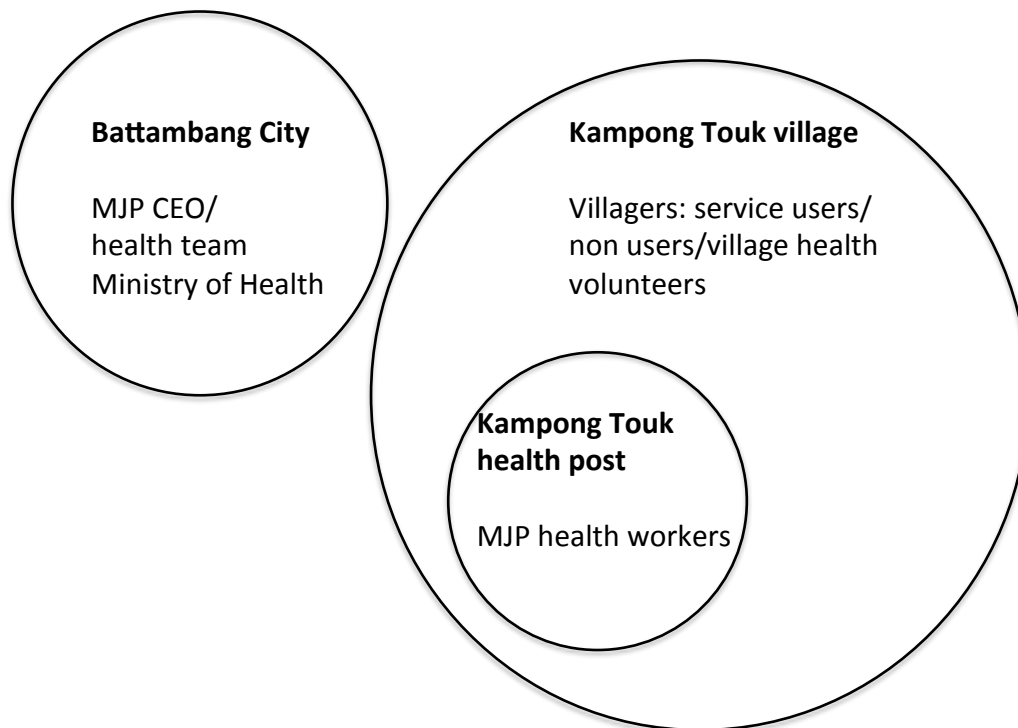
### **3.2 Key informant interviews**

Interview topic guides were designed exploring the six NHS principles, which were piloted, and modified during the process of data collection as new themes emerged (see appendix 4). Further clarification by NHS South Central of some of the six principles was obtained, but their interpretation remained subject to a degree of interpretation by both researcher and participants. Also, most NHS fellows were not aware of their existence. Aspects of additional evaluative frameworks were reviewed to aid development of, and incorporated into, the topic guide: The Bruce-Jain Framework, the most established framework for evaluating family planning programmes,(32)(33) along with the principles of ownership, alignment, and harmonisation outlined in the 'NHS Framework for International development' (see appendix 1).(10) Open questions were chosen to reduce response style bias; 'yes saying' to questions regardless of content.(31)

Data collection was conducted over a two-week period in September 2010. Semi-structured interviews were chosen to provide in-depth information on experiences of the health link. Focus group discussions could have provided additional insights into interaction between participants and the social construction of knowledge, but this was not possible due to logistic and resource constraints.(34) Interviews were conducted with 19 Cambodian stakeholders: 7 MJP health workers (unofficial health staff with no formal qualifications, midwives, nurses, a medical assistant and a doctor), villagers (5 service users, 6 non-users), an official from the Cambodian Ministry of Health (MOH), and the CEO of MJP as shown in figure 3. Specific questions asked would vary. For example, different questions would be directed to a Cambodian MOH official, compared to a service user depending on relevance and level of knowledge.

It is generally considered more appropriate to conduct reproductive health research with female investigators in order to minimise 'social distance' between researchers and subjects.(35) However, it was only possible to use a male Cambodian interpreter (hired independently via a different NGO) due to time limitations. Nevertheless, there were no refusals and most interviews lasted longer than anticipated, suggesting that the women were relaxed and happy to talk. It was possible to conduct three interviews in English. Interviews were conducted at villager's houses and at health facilities. Attempts were made to conduct interviews in private, although as has been noted in other studies, the expectation of a confidential interview was not always understood, and on occasions the interviews were

paused due to interruptions.(36)



**Figure 3: Cambodian stakeholders in the family planning workstream**

The interpreter's role, despite playing an important role in the research, is often not discussed in detail.(34) To address this issue, an interview was conducted with the interpreter at the end of the fieldwork to gain insights into his perspective on the research topic and areas of potential bias. A population sensitive to talking to NGOs could bias responses in order to influence funding or services. However, the opinion of the interpreter was that villagers gave honest responses. Conversely, he reported difficulty in judging the honesty of responses of the health workers, suggesting possible social desirability bias.(31) Given the small numbers involved with the family planning workstream, non-probability methods were used to identify key informants. Purposive (e.g. by consulting health workers), convenience sampling (those in the area who were available), and additional snowball sampling were used. Although small numbers of respondents were interviewed, few new ideas resulted from the later interviews, and a degree of 'saturation' was reached.(34) Notes of impressions and observations were made following each interview. To improve reliability, the interviews were recorded and transcribed verbatim into English, with sections also translated by a second independent Cambodian translator for comparison. This gave

valuable insights beyond that normally gained by verbal translation and note taking (see appendix 5 for a sample transcript).

### **3.4 Data analysis**

The framework method of analysis was chosen as it is considered particularly appropriate for studies orientated towards policy outcomes with clear aims at the outset.(37) This involved the following five steps: familiarisation, developing a thematic framework, indexing (also known as coding), charting, and mapping and interpretation. NVIVO software was used to organise the data.(38) First, the 19 transcripts were read and key recurrent themes listed. A thematic framework was developed around the six NHS objectives, which were considered the key themes (a priori themes), reflecting the original questions in the topic guide. For each of the key themes a number of emerging sub-themes were identified, and numbered in the thematic framework index (see appendix 6). The thematic framework was then applied to the whole data set: transcripts were annotated with numerical codes from the index, new themes identified and the thematic framework modified accordingly. The data were rearranged according to appropriate thematic references, allowing comparison of themes across and within cases.

To improve rigour in the analysis, efforts were made to maximise reliability by ensuring accurate and comprehensive coding. However, as an independent study it was not possible to use more than one coder. Attempts were made to maximise validity by extracting quotations for the report from the transcriptions, acknowledging diverse and deviant opinions, particularly if considered of relevance to NHS South Central. No quantitative analysis was carried out given the small number of interviews conducted. However, the following terms were used give some perspective on how common a particular opinion was as a percentage of those asked: all (100%), most (75-99%), many (50-74%), some (25-49%), few (1-24%), none (0%).(34)

### **3.5 Ethical considerations**

Ethical approval was granted by the London School of Hygiene and Tropical Medicine, in addition to written approval from MJP and NHS South Central. Ethical principles for conducting research in developing countries were considered, for example, the provision of culturally and linguistically appropriate information. Informed consent was obtained by all of those who agreed to participate (see appendix 7 for consent form).(39)

## 4. Results

### 4.1 Review of documents and monitoring data

The family planning workstream has been running since November 2008 with different UK project leads working with the MJP health team. Fellows' end of placement and monthly reports to NHS South Central described the activities, successes and challenges encountered. Initial work involved conducting a review of existing family planning provision. The district MOH officials were initially reluctant to allow a family planning service at the health post on the basis that the staff did not have the clinical capacity. However, following subsequent agreement, the district MOH and NHS fellows provided training to the four health post staff. A basic family planning service was started in February 2009 providing condoms and depot, with the addition of the combined oral contraceptive pill (COCP) in September. In January 2010 a review was conducted (fellow 2) to explore why some villagers were not using the service. Reasons identified included lack of awareness of the service and fear of side-effects. Subsequently, meetings were held in the community to raise awareness of the service. In March 2010, a community-based approach was added (fellows 3 and 4), aimed at promoting family planning (particularly condoms) to men. Also, links were made with other NGOs working in reproductive health, with support provided for women requesting long-acting methods of contraception, for example the Intrauterine device (IUD). Monitoring data included number of clients and contraception consumption. Figure 4 shows the timing of Fellows taking the lead for family planning from February 2009 to August 2010, together with number of clients for each contraceptive method. The increased condom consumption corresponds to the timing of community meetings launching the service.

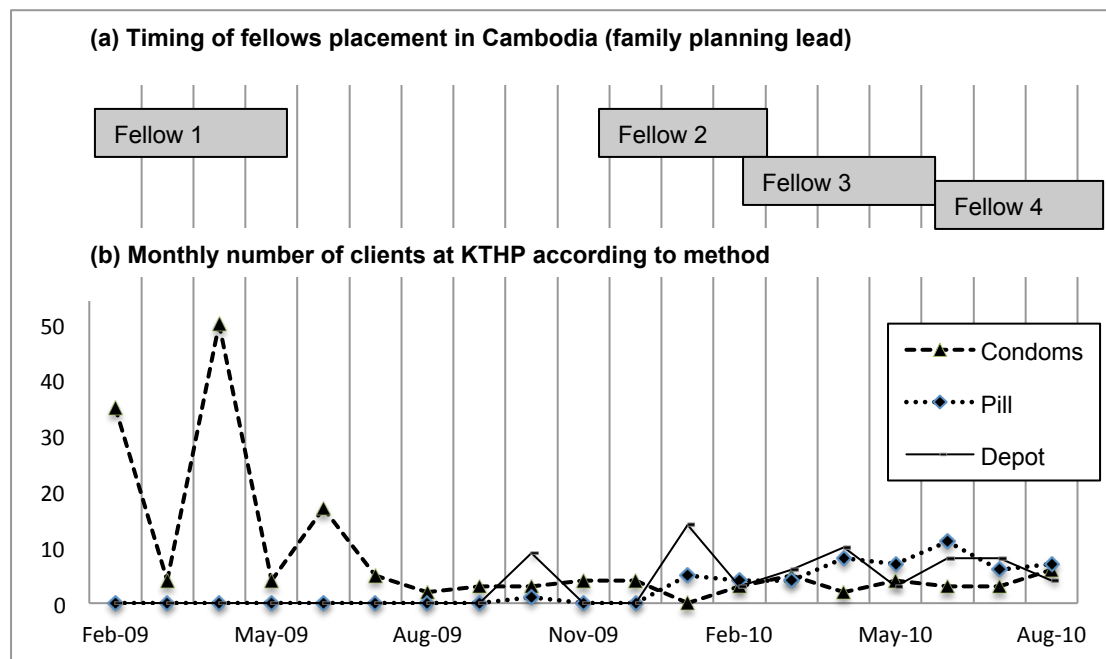


Figure 4: Timeline of the family planning programme at Kampong Touk Health Post between Feb 2009 and Aug 2010



The health post serves a village with a population of approximately 1000 people (MJP data), spread over a wide geographical area. Applying Demographic and Health survey data to this population it can be estimated that approximately 250 might be expected to be of childbearing age, with 119 wishing to postpone their next pregnancy by more than two years or have no further children (and therefore requiring contraception). (40)

Data on the amount of contraception administered by family planning services can be converted to Couple Year of Protection (CYP) and estimated 'unintended pregnancies averted', widely used indicators for family planning.(41) The 12-month period between February 2009 and February 2010 the service at KTHP resulted in an estimated 21 CYP, or 12 unintended pregnancies averted.(41) Based on the population estimates for Kampong Touk village, 119 CYP is required in order to meet the family planning requirements for the village. Therefore, during the above 12-month period the service at KTHP provided approximately 18% of the village's contraceptive requirements.

## **4.2 Interviews**

The results of the interviews are presented around the main topic of investigation: the six NHS principles. The themes from each topic are described and supported with quotations.

### **4.2.1 NHS principle 1: The implementation of higher standards of clinical care with improved systems and processes**

This topic focussed on outcomes; in particular, seeking evidence of change in practices of Cambodian health workers. Service users and health workers were asked questions regarding quality of clinical care provided at the health post, in particular; contraception method counselling, follow up and managing side-effects, interpersonal relations and contraception stock monitoring systems.

Of the respondents that reported being aware of the family planning service at the health post, all stated that the service was either good or improving. Most service users reported that the health post staff provided good **contraception method counselling**; information on available methods (condom, COCP, and depot), how to use them, potential side-effects and complications, and when to return for follow up. For example, a district MOH official stated:

*"I have seen it different because they did not clearly understand previously how to give the methods...but after the training they improved their understanding" (MOH)*

Most service users reported side-effects from using contraception, in keeping with other studies, highlighting the importance of **follow-up**.(42) However, most reported that the staff were able to manage these problems.

In terms of **interpersonal relations**, most service users reported that the staff had a good

attitude, although some stated that they were not friendly or that they treated rich and poor differently. Of these, some of them reported an improvement in recent times, for example:

*“Last year they did not take great care of patients, but this year they pay better attention to patients” (service user)*

Finally, regarding **systems and processes**, most clients and reported that contraception was available, but some said there were sometimes stock-outs of the depot. However, the staff reported that stock-outs never occurred.

#### **4.2.2 NHS principle 2: Appropriate service delivery and improved access to care: getting the right skills, equipment and people in the right place and encouraging patients to use them**

This topic considered both process and outcome aspects of the logic model, exploring the wider health system with regards to family planning service delivery. Respondents were asked about appropriate service delivery and access to care, exploring principles of ownership, alignment, and harmonisation.(10)

Regarding **appropriate service delivery**, all respondents stated that it was appropriate to have a family planning service in the area. All of the villagers interviewed already had children (between 2 and 6), and reported that they were not planning to have any more children. Reasons cited included *“I am getting older”, “because we are so poor”, and “I am busy just with the children and not having much time to make a living”*.

Some women were sexually active but not using any contraception, and there were reports of women having abortions in private clinics, indicating an unmet need for family planning.

Most people reported that the Cambodian MOH decides what services are provided at the health post whereas some were not aware. Most reported a good relationship with the MOH, although there were some reports of previous difficulties, for example, that NHS Fellows activities were not always in **alignment** with MOH strategy:

*“Barang<sup>i</sup> came to teach the staff at the health centre and I found that the training was good, in terms of skills and techniques, but some techniques and skills have not been allowed by the national level; but they had already done that.” (MOH)*

Furthermore, the district MOH reported working in collaboration with more than ten partner organisations, highlighting the challenge co-ordinating activities. There was evidence of **harmonisation**, for example, reports of strong relationships and networks built with other NGOs working in reproductive health; both Population Services International (for supply of commodities) and Marie Stopes (to provide a greater range of contraceptive methods).

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<sup>i</sup> ‘Barang’ is a Cambodian term for Westerner

Most villagers reported that an **appropriate range of contraceptive methods** were available (condoms, COCP and depot), fitting their health needs, although many were unaware of other methods. However, some of those interviewed reported that more methods should be available, particularly long-acting methods; e.g. sub-dermal implant and IUD.

**Service delivery system** preferences, and **access** to the service, varied according to geographical location. Those living in close proximity to the health post generally reported preferring to attend the health post for family planning, although a few stated a preference for community-based distribution. Local villagers and health post staff reported good **awareness** and use of the service, and increased use of contraception, with many clients returning several times, for example:

*“We have more clients if compared to two years ago. Clients are more aware of our service. More clients use the service now unlike the last two years” (MJP)*

Furthermore, there were some reports that suggested improved outcomes in terms of living conditions and health as a result of increased use of contraception, for example:

*“It is much better and progressive if compared to two years ago because some clients have reduced their reproductive activity and their living status is a bit improved. The last two years, they had a lot of difficulties in life and had more children and later on they reduced their reproduction due to the family planning service” (non-service user)*

However, there was less awareness of the service in the remote, poorer areas of the village, with some reports that the service had not been well promoted, for example:

*“The majority of these people have not accessed the service because the staffs of family planning have not promoted the service to a wide breadth. We don't know if the health post has family planning service” (non-service user)*

Other reported reasons why villagers were not accessing the service at the health post included distance and associated costs, being too busy, or side-effects from contraception leading to discontinuation.

#### **4.2.3 NHS principle 3: The transference of technical, clinical and problem solving skills to MJP staff and other stakeholders**

This topic focussed mainly on process (exploring NHS inputs, and factors affecting, and methods of, capacity building activities), but also outcomes of training. Responses were not only restricted to the family planning workstream.

Regarding **NHS inputs**, most stated that around three fellows on placement at a time was a good number. NHS fellows were reported as adding a systematic and analytical approach to the programmes, as well as providing technical knowledge and different ideas. Skills and

experience were considered more important than age. However, some respondents commented that some fellows had more knowledge than others, for example:

*“Some people, they do not have...good experience and then it’s difficult for them to work with us...example...we are assigned someone to work with the family planning then he or she does not understand what family planning is” (MJP staff)*

Most stated they thought longer contacts of more than four months were better, with most stating a preference for at least six months. This comment reflects potential problems with short contracts:

*“I think that it’s better at least six months. You know sometimes they just have only two months. Sometimes they just learn, just learn, only that, and then they have nothing to implement. And then is the time for them to finish the contract” (MJP)*

Many commented on the value of the continuous presence of NHS fellows working in the field, reporting that successive fellows were able to continue established projects. However, one MJP health worker commented that there might be some repetition of work. One comment was made regarding the short senior staff support visits:

*“I have less time to meet them because I’m always at the field. Yes they came to have a look what our activities... You know like [names omitted], but I have less time to meet them, you know because they always come and chatting or meeting with only UK people” (MJP staff)*

In terms of **factors affecting transference** of knowledge and skills, two themes were identified. First, many respondents reported challenges of working in a different language and working through translators. Some felt that this was problematic, for example:

*“Without the translator, it could be difficult because we use different languages. It is like taking a cow to see a movie. Sometimes I wanted to have a chat with Barang but difficult because I don’t speak English” (MJP)*

*“I think a bit difficult for NHS team that they cannot work directly with the health post staff. They have to work through the translators. This is a big problem for them. So...you see that they cannot work independently” (MJP)*

However others, particularly those of the receiving end of training, did not see this as a problem:

*“It was not a problem of a language because all handouts were translated in Khmer” (MJP)*

A second challenge identified for NHS fellows related more to the content of training delivered; adapting knowledge and skills to the Cambodian setting, and *“the need to break down information into bite sized pieces” (MJP)*, for example:

*“Some people, they have their skills, they have the experience and have knowledge but they cannot...do not know how to pass that knowledge to other people. This is a problem” (MJP)*

With regards to the **methods of transference**, several references were made to the weekly teaching sessions. There appeared to have been a shift from UK fellows delivering teaching, to Cambodians teaching Cambodians. Many said that they found on-the-job practical training by the UK fellows preferential to theoretical training, for example:

*“I really want to see the real practice with patients with my own eyes” (MJP staff)*

In addition to receiving training in Cambodia, some respondents (and all of those directly asked) expressed an interest in seeing how the UK health system works. A study trip to the UK was viewed as an incentive, an opportunity to gain new ideas, and a chance to see how the UK health system works, for example:

*“You sent...I think it’s maybe about ten people...to visit Cambodia to help us. And then we have never seen anyone from MJP...visit the activities in UK...I’m now in Cambodia and I have never seen UK. I do not know how well or how successful you’re implementing at your home.” (MJP staff)*

In terms of perceived **outcomes of training**, many Cambodian health workers reported increased theoretical knowledge, practical skills and confidence leading to changes in practice as a result of the training received by UK fellows, for example:

*“My knowledge and skills have been more developed...Before, I had no knowledge or skills in terms of the family planning and did not know how to educate people but after the trainings conducted by MJP I have been more knowledgeable and confident.” (MJP)*

These findings are supported by the reports of high standards of clinical care reported by family planning service users in section 4.2.1.

#### **4.2.4 NHS principle 4: Development of a culture of CPD**

This topic, building on principle 3, sought evidence of self-directed learning attributable to ‘Improving Global Health’ in two areas; examples of CPD, and plans for more learning. Responses were not restricted to family planning.

With regards to **examples of CPD**, many of the MJP staff made reference to the weekly teaching sessions initiated by NHS fellows. Different topics are covered and clinical cases are discussed. It was reported that the sessions take place regardless of whether NHS fellows are present.

*“Sometimes the training is conducted by Barang at Beung Run health centre and some other times by Khmer staff. It is very useful. We have shared experiences and*

*learnt from each other” (MJP)*

In terms of **plans for more learning**, many Cambodian health workers identified a need to keep up-to-date but apart from the weekly teaching sessions, there were few examples of plans for CPD, or that advice had been given in this regard, for example:

*“I have no plan but we should need more learning” (MJP)*

#### **4.2.5 NHS principle 5: Supervision and support for Cambodian health workers**

This process-focussed topic explored pastoral support for Cambodian health workers; interpersonal relationships between UK fellows and their Cambodian counterparts, and perceptions of the institutional relationship between MJP and the NHS.

With reference to **interpersonal relationships**, most stated that NHS fellows had a good attitude, with many reporting that they find it useful to share experience and knowledge, and ask questions. This was despite some initial reservations reported, for example:

*“I felt things would be difficult if Barang came to work here. I was afraid that Barang would come to see if we did something wrong but after sometime I felt normal like when working together” (MJP)*

Some commented on the differences in culture and traditions between Cambodians and UK fellows. The majority did not report this as a problem, for example:

*“We have different cultures and traditions or religion and we cannot change them but obviously the time they worked here they really had good attitude” (MJP)*

However, some challenges working with NHS fellows were encountered, for example:

*“To work with ten people, that have different characteristics, different ideas, different skills, experience...this is my problem...some people, whenever they come, it seems like they want to command me, or to order me to respect them, to follow them, just one or two that I met with...” (MJP)*

In terms of the **institutional relationship** between NHS Fellows and MJP, some commented that there was no separation between NHS and MJP, and that once the NHS teams arrived in Cambodia *“they became MJP employees” (MJP)*.

*“It’s been great that the NHS fellows have embraced...becoming part of the MJP family and are transferring their skills, and are taking responsibility for each other” (MJP)*

#### **4.2.6 NHS principle 6: Data collection for the assessment of outcomes, knowledge and skills from the current baseline position**

This topic explored both data on Cambodian health worker outcomes, and data collected on patient health outcomes from the health post. Responses were not limited to the family

planning workstream.

In terms of **Cambodian health worker outcomes**, reports of activities such as teaching sessions and workshops were recorded and included in the monthly reports for NHS South Central. A taskbook has been developed by one of the NHS fellows for Cambodian staff to record training received. This was reported to have been helpful and it was expected that this would continue to be used.

With regards to **patient health outcomes**, the health post staff reported recording all consultations in the standard record book supplied by the MOH. There was a dual reporting system where slightly different monthly reports are sent from the health post both to the MOH and MJP, but the staff did not report this as a problem. NHS fellows contribute to a monthly MJP health team report as well as a monthly report to the UK. One comment suggested that data collection from the health post could be more co-ordinated:

*“In the previous few months...we have a little bit difficulty with some of the NHS. Someone wants to know about the family planning like condom, injection and then they try to get the information. Sometimes they try to ask the other people to collect that information. And then we try to work together and then we try to find out what data that NHS needs and what data that MJP needs. And then we collect it together and then we ask at the same time” (MJP)*

It was reported that the NHS was providing useful input into a review of the MJP data collection system, aiming to develop one system that collects MJP indicators and Cambodian MDGs.

## **5. Discussion**

This study contributes to the existing body of knowledge on the effectiveness and impact of health links. It goes beyond previous evaluations by seeking the views of the local population served by the link, particularly with regards to outcomes; changes in health services and practices. (18) The findings will be discussed with reference to the logic model, introduced in section 3.1, as such terminology is commonly used in the field of international development; firstly with respect to process, and then outcomes. Subsequent implications for NHS South Central, health links in general, and evaluation of health links will be discussed.

### **5.1 Cambodian experiences of the process**

This section discusses aspects of the six principles concerned with the process components of the logic model (inputs, activities and outputs), considering the principles of aid effectiveness introduced in section 1.2, highlighting key successes and challenges. There is evidence that ‘Improving Global Health’ has made progress towards embedding all of the process-focussed principles (principles 2-6) into the workstreams.

### 5.1.1 Inputs

NHS fellows were perceived as bringing knowledge, technical expertise and experience to the Cambodian setting. However, a challenge was identified for UK fellows in customising and transferring information to Cambodians. Differences in culture, traditions, and language were perceived as problems by some, and not by others. Challenges arising from cultural differences and communication difficulties have been identified in previous evaluations.(14) However, the particular challenge for health links of working through translators does not appear to have been addressed in detail in the literature.

'Improving Global Health' offers a variety of placement lengths for fellows, ranging from two to six months. It is likely that the schemes policy of embedding UK staff into MJPs health team for placements of several months contributes towards the generally positive findings regarding interpersonal relationships, and the institutional relationship between both partners. In common with other evaluations, a preference was stated for longer contracts for NHS fellows and shorter visits were less valued.(20) Most respondents stated that six months was ideal, with four months being a minimum. The review of links in Ethiopia reported that all the Ethiopian partners requested that their UK partners undertake longer trips,(19) whilst the DFID evaluation highlighted the benefits of longer-term placements and challenges associated with shorter placements:

*“Working in a culturally different environment, understanding locally agreed protocols, meeting new clinical challenges, and overcoming language problems has posed difficulties for many UK staff, thereby reducing their effectiveness during the first few months of their placements” (20)*

In the same document, short visits were criticised as often involving those with limited experience of working in developing countries, spending considerable time gaining an overview, and with little opportunity to deliver contextualised training.(20) Problems with short-term workshops were also highlighted in a paper describing asymmetries of university partnerships in Botswana.(43) There was less evidence of benefit to Cambodian health workers from the short visits by senior NHS staff, but they likely play an important role in supporting UK fellows and maintaining the institutional relationship.

### 5.1.2 Activities

It is beyond the scope of this report to critique the theory behind, and evidence for, the principles of aid effectiveness, for example ownership, alignment, and harmonisation, articulated in documents such as the Paris Declaration. However, these principles underpin those outlined in the 'NHS framework for international development', which currently inform good practice for the activities of NHS links.

There was some evidence that progress was being made towards providing appropriate



service delivery and improving access to care (principle 2), and that principles of aid effectiveness were being considered. Firstly, there was evidence of demand from the community for a family planning service, as well as enthusiasm from MJP staff suggesting a degree of *ownership*. Second, there were positive findings regarding co-ordination between partner NGOs working in family planning, suggesting *harmonisation* of activities, although it has also been argued that some competition between providers, brands of contraceptives and different methods of delivery is healthy.(44)

However, some challenges were identified. The family planning workstream is one of many that have been initiated by NHS fellows. Since its inception a number of fellows have worked on the workstream in conjunction with the MJP health team. Successive fellows have taken different approaches (such as a community focus or promoting long-acting methods), and it is not clear from reviewing the project plans whether the plans of previous fellows were followed through. The phrase 're-inventing the wheel' is sometimes used when describing a programme that has different projects leads with different ideas, often with short contracts. The DFID evaluation reported that "many links changed their activities over time", which meant that evaluation proved very difficult. It also warned against northern partners driving the agenda and disempowering southern partners.(20) A workstream strategy that is driven by UK fellows may lack local ownership, *alignment* with local health plans, and sustainability over time. However, it could also be argued that with each new cohort of NHS fellows comes a fresh set of ideas that aids the development of a programme, and furthermore, the workstream is ultimately overseen by the MJP health co-ordinator. A challenge for all health links will be getting the right balance between capacity building, whilst facilitating local ownership of programmes.

Although the Cambodian governments health strategy considers family planning services an essential service for Reproductive and Sexual health,(45) difficulties were experienced with *alignment* at the district MOH level, with the perception that services were sometimes being developed without proper consultation and permission. Disagreement arose around what contraceptive methods should be available given the level of training of the health post staff. A desire for a wider range of methods, as requested by the community, consistent with qualitative research conducted in Cambodia, had to be balanced by what services were considered appropriate to provide from a small health post.(42) However, it is possible, given the large number of NGOs working in Cambodia, that the MOH finds co-ordination of activities difficult, and is disempowered. The DFID evaluation also reported that not all links were aware of the need to align, and that very few had made efforts to ensure that activities were in line with local and national priorities.

Another challenge identified for the family planning service was awareness of, and access to

the service in remote areas. This raises the question of equity, and whether the service is reaching the poorest and those in greatest need, as well as the broader question of whether health links are equitable, and “pro-poor” interventions. The addition of a community-based service delivery system may improve the situation. However, in common with other evaluations, an assessment of equity was not a principle objective.

It is not part of ‘Improving Global Health’ policy to support reciprocal visits for Cambodians to visit the UK. The review of links in Ethiopia reported some dissatisfaction amongst Ethiopian staff that reciprocal visits were not facilitated by some links. Although this sentiment was not expressed in Cambodia, the idea of reciprocal visits was viewed positively. The reasons cited were similar to those found by other evaluations, for example, “*making me think about how I could do things differently.*” (20) Although reported as generally effective, it was also reported that none of the links had effective evaluation of trips to the UK, so their impact was not fully known. Identified constraints to reciprocal visits included funding limitations, difficulty obtaining visas, and fear that staff might abscond.(19) Failure to address the issue of reciprocal visits could result in a perception that health links are unequal partnerships, with UK partners determining the nature of the link.(46)

With regards to training activities, a preference was expressed for on-the-job training rather than theoretical teaching. Sharing knowledge and experience, and developing friendships were particularly valued, as reported elsewhere.(14) The concept of CPD appeared less familiar to Cambodian health workers, and few examples of plans for CPD were offered. However, the self-directed learning sessions initiated by NHS fellows provided a good example of developing a culture of CPD (principle 4) that incorporates principles of ownership and sustainability.

Finally, the challenge of dual reporting of monitoring data on patient outcomes is common to health links. However, this was not reported as a significant problem, and moreover, steps are being taken to address this issue by simplifying and aligning data collection.

### **5.1.3 Outputs**

NHS fellows have contributed to organising and providing training that has resulted in a number of Cambodian health workers trained in family planning, in addition to a range of other topics. An NHS initiative, the taskbook for recording Cambodian health worker training, has been a success and links to CPD. Clients attending the new family planning service provide further evidence of outputs. However, during its first year the number of clients was modest, even considering that it is a small health post serving a population of around 1000. Unfortunately it was not possible to identify an equivalent service to compare this output data.

## 5.2 Changes in outcomes

Whereas outputs can be measured in terms of numbers of health workers trained, or clients attending a health facility, outcomes often relate to changes in practice or health services.(21) With regards to **changes in practice**, reports triangulated from a wide range of Cambodian stakeholders generally indicated a high standard of clinical care (principle 1), as evidenced by implementation of the fundamental elements of quality of care outlined in the Bruce-Jain framework, provision at the health post for family planning. However, on a few occasions, for example, when asked about contraception stock-outs, health staff gave different responses to service users, suggesting possible social desirability bias, as also observed by the interpreter. Furthermore, not all reports were positive indicating scope for improvement. However, the service needs to be evaluated in context; a rural isolated health post staffed by health workers with no formal qualifications.

A number of evaluations have reported the challenges of measuring impact of health links' activities such as training. For example, the THET report stated:

*"In common with most education and training activities, it seems reasonable to suggest that training workshops build the capacity of staff, but there is often very little evidence to suggest this is true, let alone that this knowledge is put into practice".(18)*

As introduced in section 1.3, it can be difficult to attribute changes in outcomes to particular interventions, in this case, the activities of 'Improving Global Health'. This evaluation provides some evidence of positive change in practice of Cambodian health workers and argues that, given that NHS fellows helped establish the family planning service, some of this change is attributable to the interventions of 'Improving Global Health'.

Reports, supplemented by monitoring data, of **changes in health services** provided further evidence of improved outcomes. There were reports that contraceptive use in the area has increased, particularly for those living near to the health post (improved access to care - principle 2). However it was beyond the scope of the study to formally estimate contraceptive prevalence in the area with a cross-sectional survey. The family planning service has provided approximately 18% of the estimated contraceptive requirements for Kampong Touk village, and averted an estimated 12 unintended pregnancies, some of which may have resulted in unsafe abortion. Although contraception is accessed through other private sector providers, the monitoring data, supported by information from the interviews, suggest remaining unmet need for family planning in the village. However, it should be considered that the workstream is still at an early stage.

Again addressing the issue of attribution, in order to assess the extent to which observed effects are in fact due to the project or intervention, evaluations with different levels of inference (adequacy, plausibility, or probability) have been proposed in the discourse on

large programme evaluation.(23) Adequacy evaluations assess how well the programme activities have met the expected objectives,(22) and perhaps could also be applied to health links evaluations. It could be argued that the outcome focussed aspects of this evaluation (using a combination of monitoring data and reports of increased contraceptive prevalence) provide an adequacy level of inference; that changes in the health services and practices of Cambodian health workers can be reasonably ascribed to the 'Improving Global Health' programme, given that the family planning service was initiated by NHS fellows. Furthermore, the argument could be extended to propose, applying the logic model (figure 2), that the findings provide evidence that 'Improving Global Health' is contributing towards overall impact (for example, achieving the MDGs for health) as there is evidence that family planning interventions improve maternal and child health. However, a plausibility or probability level of inference is not proposed, that the programme has an effect above and beyond other external influences, as it was beyond the scope of this evaluation to control for confounding factors with a control group. Nevertheless, it has been argued that adequacy evaluation, despite its ability to causally link programme activities to the observed changes, can provide assurance to funders that expected objectives are being met.(22)

### **5.3 Policy / organisational implications**

The findings of this evaluation could have policy implications for NHS South Central, but may be influenced by a number of other factors. First, this evaluation focussed on 'Improving Global Health's' development aim, from a Cambodian perspective, drawing examples from the family planning workstream. Some results may not be generalisable to other workstreams in Cambodia, and the partnerships in Tanzania and Kenya. However, it is likely that some of the key findings are likely to be relevant to the 'Improving Global Health' scheme as a whole. NHS South Central also commissioned the 'Independent Evaluation of South Central SHA's International Leadership Scheme' to review the schemes impact on the NHS and its leadership development aim.(25) The aims of the programme for the NHS, and budgetary factors identified in this report, will need to be balanced against those identified in Cambodia, for example regarding length of contracts. Second, NHS organisations are under pressure to cut budgets. The government's white paper 'Equity and Equality: Liberating the NHS' highlights the need for the NHS to achieve "unprecedented efficiency gains".(47) This evaluation may assist NHS South Central's assessment of 'Improving Global Health' in terms its cost-effectiveness. Finally, perhaps most significantly, the white paper outlines plans to replace SHAs with local commissioning groups made of general practitioners by 2012/13. It is likely that 'Improving Global Health' will be positioned within planned Local Education and Training Boards (LETB) that will be held accountable to Health Education England (HEE), due to be set up in 2012.(48) The managers of the scheme may wish to plan

for different possible scenarios and consider alternative sources of funding.

There may be implications in the wider policy context of health links. The evaluations findings contribute to the body of evidence on good practice and the role of health links as an efficient mechanism for international development, and may be of interest to other health links, THET, and DFID. The paucity of publications relative to the number of health links, suggests that health links may have unpublished monitoring data and evaluations that could be shared through THET, or published, to add to this literature. Health links activities vary greatly, and whereas some likely do contribute to improved health outcomes, there is still a danger that some have little impact, or do harm, even with the best intentions.

Health links remain the most obvious mechanism by which small NHS organisations can contribute to international development, and despite the current financial challenges and NHS re-structuring, their future looks positive. The government recently launched a new four-year 'Health Partnership Scheme', funded by DFID and managed by THET, to provide grants to health partnerships between UK and low-income countries. More evidence on their effectiveness may further aid their long-term success.

#### **5.4 Implications for future evaluations of health links**

Health links may wish to conduct evaluations for a number of reasons. This evaluation aimed to have both summative and formative components, both to provide accountability to funders, and to provide recommendations for improvement. A strength of this evaluation was the conscientious 'research evaluation' approach adopted, with attention to rigor in data analysis in order to account for bias. Health links may wish to commission external 'objective' evaluations depending on the evaluation's aims and intended audience. However, a potential limitation with such a rigorous approach is the length of time it can take from collecting data to completing analysis, resulting in findings already being out-dated. It specifically sought the Cambodian perspective, seeking to address the imbalance of evaluations from the UK perspective. This approach has cost implications, in terms of travel and the need for fieldwork assistance in the use of translators.

Health links often engage in a number of different activities that have different objectives, that often vary over time. This can lead to challenges in deciding on a focus for evaluation; how to measure (quantitative or qualitative data), and at what level on the logic chain. There has been a shift in recent years by NGOs to try to measure performance at all levels on this logic chain.(24) However, health links are generally small projects, and they may be advised to conduct process evaluations, focussing on areas where they have direct control.(28) The challenge of attribution is common, particularly with outcome and impact evaluation, and reasons for this have been well documented, for example: developing country link partners receiving support from multiple partners, lack of baseline surveys, and lack of expertise in

monitoring and evaluation.(5)(14)(21) To address the challenge of attribution, for this evaluation an *adequacy* level of inference was sought. The same principles of evaluation design could be considered for future evaluations of health links.(22) This evaluation focussed on a new service that had been developed by the health link, making attribution easier. However, if good baseline data exists for an existing service prior to the health links intervention, then evaluation with some level of attribution inference should be possible. A strength of this evaluation was its breadth, covering the 6 NHS principles that included process and outcome aspects. However, more in-depth information could have been obtained by focussing on only one or two issues. The broad scope of the NHS principles led to challenges in designing the topic guide, but did provide a framework for evaluation. The Ethiopian links evaluation found that many health links had difficulty in defining strategy,(19) which could result in difficulty with designing an evaluation. A number of possible areas for future study are outlined in section 6.5.

## **6. Recommendations**

Recommendations for the 'Improving Global Health' scheme at NHS South Central are proposed around five themes.

### **6.1 Clarify strategy**

- Review the development objectives of the scheme (the six principles). Consider revising them in line with the principles outlined in the NHS Framework for International Development, or specific MDG indicators, and ensure that objectives are communicated to fellows
- To enhance continuity between fellows, and give a strategic overview of each workstream, consider using an established framework, such as the DFID log-frame, for planning and monitoring the clinical workstreams

### **6.2 Improve alignment**

To ensure clinical workstreams are in closer alignment with country policy:

- Consider an observational placement for a fellow with the district Ministry of Health
- Ensure that an overview of the health system and governments health priorities are included as part of fellows pre-departure induction
- Where possible, ensure monitoring data is in alignment with MOH to avoid duplication and parallel systems

### **6.3 Enhance mutual learning**

- Consider a minimum placement length of four months (but ideally six), as recommended by Cambodian health workers, to allow fellows time to learn and make an impact, and review the number of one-off visits

- Consider reciprocal visits to the UK for developing country partner health workers
- Ensure that NHS fellows are made aware of challenges reported by developing country partners at pre-departure induction; a desire for on-the-job training, awareness of language and cultural differences, and the need to customise knowledge

#### **6.4 Promote ownership**

Reflect on getting a balance between a UK led 'capacity building' approach (supply driven) and one where workstreams are led and driven by developing country partners. The attitude of individual fellows will play an important role in getting this balance right, as will factors highlighted above such as reducing the number of new projects /workstreams being initiated by each successive new fellow.

#### **6.5 Further evaluation**

Consider further evaluation of health links to contribute to the literature on best practice. Resource implications could be mitigated by collaboration with THET, other health links, or academic institutions.

Future evaluations could focus on:

- Cost-effectiveness; to provide information regarding the cost per beneficiary for the interventions, allowing comparison against other programmes and development modalities
- Outcome or impact assessment seeking a plausibility or probability level of inference (the next logical step following adequacy evaluation) This would likely be a more costly and complex quantitative evaluation, for example in the case of the family planning workstream, a cross-sectional survey of contraceptive prevalence in the area
- Sustainability, for example, conducting an evaluation in a few years time, or after a link has completed its intervention
- Equity: are health links effective interventions for reaching the poorest, and therefore those in greatest need?

## **7. Conclusion**

The 'Improving Global Health through Leadership Development' scheme is a new area of work for NHS South Central. It is novel in that it has both NHS leadership development and international development aims. The findings from this evaluation provide evidence that 'Improving Global Health' has contributed towards the improvement in health and healthcare in Cambodia, and made progress towards embedding its six principles into the clinical

workstreams. The evaluation found evidence of improved family planning outcomes, as evidenced by changes in health services and practices, and argues that it is reasonable to attribute this to the scheme. The Cambodian experience of the process has been generally positive, but a number of challenges were identified, similar to those identified with other health links. The policy recommendations outlined may assist 'Improving Global Health' in addressing these challenges. The findings from this report add to the body of evidence on the effectiveness of health links, and their associated good practice.

The expansion in the number of UK health links reflects a proliferation of global health initiatives at the international level, potentially resulting in challenges for recipient governments, resulting in weakening of national health strategies and systems. The findings from this report suggest that health links will be most effective in mitigating these challenges if they embed the key principles of aid effectiveness, of ownership, alignment and harmonisation, into their approach.



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## **Appendix 1: Additional evaluative frameworks**

### **Bruce-Jain Framework:**

#### **a) Choice of contraceptive methods:**

Interview: facility has all (approved and appropriate) methods available; no stock outs, convenient days and times of services, (client receives method of choice)

Observation: adequate inventory of supplies/services, logistics pipeline, adequate equipment, appropriate medical waste disposal

#### **b) Information given to patients:**

Provider gives accurate information on the methods available / accepted (how to use, side effects, complications), methods of delivery, communicated by who, discuss dual method use

#### **c) Technical competence:**

Clinical guidelines, basic preparation, refresher training, universal precautions, adequate storage of contraceptives, on-going supervision and support (received a supervisory visit), basic items needed for delivery of methods available (gloves, blood pressure cuff, adequate lighting, water)

#### **d) Interpersonal relationships:**

Privacy, confidentiality, safety, respect/courtesy, appropriateness of staff, sensitivity of staff, waiting time acceptable

#### **e) Continuity and follow-up:**

Continuity of care, provider gives instructions on when to return, links between facility and community

#### **f) The appropriate constellation of services:**

Comprehensive reproductive health (safe motherhood, family planning, prevention and treatment of STD, RTI etc, gender based violence), (community vs. fixed clinic?)

Adapted from 'Fundamental Elements of the Quality of Care: A Simple Framework (32)

### **NHS Framework for International Development**

The NHS must therefore ensure that it is contributing to the delivery of effective international development assistance. And this means ensuring that any aid provided is:

- 1) Led and driven by the needs of developing countries, not by the enthusiasm and interests of UK participants. Interventions should be based on written agreements owned by the developing country partner and avoid 'supply-side driving' (**the principle of ownership**);

- 2) Aligned with the government in question's health plans as well as those at district and hospital level (**the principle of alignment**). This ensures that ownership is encouraged, not by-passed or undermined;
- 3) Adequately co-coordinated – with initiatives from other development partners (UK and others) working as one (**the principle of harmonisation**)
- 4) **Evidence-based** and subject to proper monitoring and evaluation. It is imperative to identify and (wherever possible) measure actual outcomes or **results**, because so much well intentioned activity in the past has either done harm or failed to achieve its stated aims;
- 5) **Sustainable**. This means that initiatives should be supported by long-term commitment from all parties involved. If the initiative is only undertaken by an individual, however motivated, with little institutional buy-in, the activities are likely to fall by the wayside when the individual moves on; and
- 6) **Mutually accountable**. This means that responsibility for the project or programme is shared.

Taken from The Framework for NHS Involvement in International Development (10)

## Appendix 2: Summary of evidence on the effectiveness of health links

### Literature published by health links

Study reference	Study characteristics / limitations	Summary of findings
Vassallo, D et al. <i>An evaluation of the first year's experience with a low-cost telemedicine link in Bangladesh</i> . Journal of Telemedicine and Telecare. 2000;7: 125-138	Non-controlled clinical case series. Evaluation of 27 telemedicine referrals between the UK and Bangladesh over a 12-month period.	Morbidity (various mainly orthopaedics and neurology). Referral was judged to be beneficial (e.g. change of management, diagnosis or reassurance) in 24 cases (89%)
Taylor, P et al. <i>Assessment of benefit in tele-ophthalmology using a consensus panel</i> . Journal of Telemedicine and Telecare. 2003;9:140-145	Non-controlled clinical case series. Consensus method assessment of benefit of 113 tele-consultations between the UK and South Africa over a 12-month period.	In 9 cases (10%) there was potential for definite improvement in visual health. In 48 cases (53%) there was potential for possible improvement of visual health
Wright, J et al. <i>Direct observation of treatment for tuberculosis: a randomized controlled trial of community health workers versus family members</i> . Tropical Medicine & International Health. 2004; 9: 559-565.	Before and after comparison of outcomes. Implementation of a community TB programme. (NB the RCT was comparing the subsections of DOTS by community health workers versus family members.)	Overall combined TB cure/completion 67% compared with 27% prior to implementation (40% improvement; 95% CI 34-46%). (Also described in the 'Research into practice' paper below)
Perera, N et al. <i>Establishing a breast clinic in a developing country: effect of a collaborative project</i> . EJSO. 2004;30: 229-232	Non-controlled clinical case series. Assessment of a new breast clinic (first 18 months) using clinic records	Improved pick up rate of breast cancer. 103/295 (35%) of breast masses were proved to be malignant of which 72% had early breast cancer. No data on outcomes after diagnosis.
Williams, J et al. <i>Establishing a cancer pain clinic in a developing country: effect of a collaborative link project with a UK cancer pain centre</i> . Journal of Pain and Symptom Management. 2001; 22:872-877	Non-controlled clinical series. Internal assessment of effectiveness of a new cancer pain clinic: audit of the first 100 patients treated.	Overall improvement in pain (Brief Pain Inventory) score and depression (HAD score) after treatment
Kingsnorth, A et al. <i>Operation Hernia to Ghana</i> . Hernia. 2006; 10 (5): 376-379	Descriptive account of a case series of surgical procedures performed over a six day period	Ninety interventions (hernia operations) performed on eighty patients
Wright, J et al. <i>Research into practice: 10 years of international public health partnership between the UK and Swaziland</i> . Journal of Public Health. 2010;32(2):277-282	Various before and after comparison of outcomes. (Also describes the Tuberculosis trial described above)	Epilepsy: Decrease in proportion of seizure free patients from 65 to 88% between 2003 and 2007

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## External evaluations of health links

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Study reference	Study characteristics / limitations	Summary of findings
<i>Review of Health Links in Ethiopia</i> 2009. Obtained from THET	Evaluation of four Health Links between Ethiopia and the UK, focusing on the Ethiopian perspective.  Methods: Literature review, observation, interviews (with health professionals, hospital managers, link coordinators and patients), case studies and narratives, focus group discussions, self-assessment tools	Some Links have recorded aspects of their work, undertaken internal reviews and implemented clinical audit as a means of assessing impact, whilst others have done little in this area. Example of motorbike service to assist with complicated deliveries. Other challenges identified included difficulty defining strategy, alignment, reciprocal visits, length of contracts
Baguley et al. <i>International health links: an evaluation of partnerships between health-care organizations in the UK and developing countries</i> . Tropical Doctor. 2006; 36(3): 149-154	Methods: Semi structured interviews with 22 link coordinators: 13 in the UK and nine in developing countries. The study was not designed to evaluate the impact of the health links on processes or outcomes of health	Links appear to offer mutual benefits to both partners in sharing skills, promoting global awareness, providing opportunities for personal and professional development of staff and promoting the development of friendships
<i>Making an Impact? A THET research report on the impact of Health Links on the capacity of both UK and developing countries' health institutions</i> . 2007. Obtained from THET	Document based study reviewing six UK-African health links. Evidence studied was from a UK perspective and hence at risk of bias. Only included Health Links where THET had acted as key facilitator. Lack of baseline data made attribution difficult	Changes identified in clinical practice, patient outcomes (a few examples e.g. new protocols and improved service design), teaching and learning. Issues identified re impact of health links, attribution, whether training results in change in practice
James, J et al. <i>Evaluation of links between North and South Healthcare Organisations</i> . DFID. 2008	Review of 12-links in Africa involving in-country meetings and semi-structured telephone interviews with southern partner local and national stakeholders (e.g. hospital/ district/ government/ local authority/ academic/ NGO).	Variation in effectiveness of health links, some that had failed to make significant impact. Issues raised re ownership, length of visits, links changing activities over time making evaluation difficult, reciprocal visits, harmonisation and alignment with country health plans
<i>Developing Global Health Link Partnerships to improve Health Capacity in Developing Countries. An end of programme evaluation report</i> . 2009. Obtained from THET	Mainly evaluating THET rather than health links. Methods: UK based. Briefings by THET and Link Partners; review of relevant documents; interviews, meetings and visits to UK Link Partners; interviews with DC Link Partners	Outcomes and impacts of links variable, and likely do have indirect contribution towards achieving MDGs. Links response to demands, promote awareness. Challenges identified include attribution, possible unequal partnership, links not always taking account of wider links learning
<i>International Health Links: an investigation into health partnerships between Wales and Africa</i> . 2011. Available from <a href="http://www.thet.org">www.thet.org</a>	Overview of activities and perceptions of links between Wales and Africa. Not evaluating impact. Methods included questionnaire and telephone interviews	Personal and professional benefits identified included problem solving, team working, developing friendships. Challenges included communication difficulties and visa problems.

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## Appendix 3: Literature searching strategies

Several literature searches of published and unpublished (grey) literature were conducted to inform various aspects of this report using a number of databases as well as citation searching and contacting experts in the field.

### Search 1: Patient outcomes of health links MEDLINE search strategy 13/3/2011

1. ((Link\* or (health or international)) adj3 (collaboration\* or partnership\* or link\*)).mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier]
2. (United Kingdom or UK or England or Scotland or Wales or N\* Ireland or NHS or National Health Service or Addenbrooke\* or Wessex or NHS South Central or South Central SHA or Sussex or Swansea or University of the West of England or Inverness or Aberdeen University or Guy\* or King\* or St Thomas\* or West Hertfordshire or Newcastle or Northampton or Hertfordshire or Plymouth or Hampshire Partnership NHS trust or Canterbury or Glan Clwyd or Nottingham or Leicester\* or Gwent or Sunderland or Yorkshire or Humber or NHS North West or Brighton or South West Strategic Health Authorit\* or Wales or Leeds or Birmingham or Glasgow or Liverpool or University of East Anglia or Blackpool or Coventry or Harrogate or Hay-On-Wye or University of London or Southampton or Stockport or Ashford or Bristol or Edge Hill University or Imperial College or Bro Morgannwa or Cheltenham or Cardiff or Velindre or Oxford or Bedford or Poole or Isle of Wight or Norfolk or Norwich or Northumbria or Cumbria or Somerset or London or Chester or Ulster or Hull or Exeter or Pont or Sheffield or Manchester or Lothian or THET or tropical health education trust).mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier]
3. exp Great Britain/
4. 2 or 3
5. ((((((Developing countr\* or low income countr\* or poor countr\* or third world or Africa\* or Asia or American Samoa\* or Malaysia\* or Samoa\* or Cambodia\* or Marshall Islands\* or Solomon Islands\* or China\* or Micronesia\* or Thailand\* or Fiji\* or Mongolia\* or Timor-Leste\* or Indonesia\* or Myanmar\* or Tuvalu\* or Kiribati\* or Palau\* or Tonga\* or Korea\* or Papua New Guinea\* or Vanuatu\* or Lao\* or Philippines\* or Vietnam\* or Albania\* or Kosovo\* or Serbia\* or Armenia\* or Tajikistan\* or Azerbaijan\* or Lithuania\* or Turkey\* or Belarus\* or Macedonia\* or Turkmenistan\* or Bosnia and Herzegovina\*).mp. or \*Moldova\*/ or Ukraine\*.mp. or Bulgaria\*.mp. or Montenegro\*.mp. or Uzbekistan\*.mp. or Georgia\*.mp. or Romania\*.mp. or Kazakhstan\*.mp. or Russian Federation\*.mp. or Antigua.mp.) and Barbuda\*.mp.) or Dominican Republic\*.mp. or Nicaragua\*.mp. or Argentina\*.mp. or Ecuador\*.mp. or Panama\*.mp. or Belize\*.mp. or El Salvador\*.mp. or Paraguay\*.mp. or Bolivia\*.mp. or Grenada\*.mp. or Peru\*.mp. or Brazil\*.mp. or Guatemala\*.mp. or Chile\*.mp. or Guyana\*.mp. or Colombia\*.mp. or Haiti\*.mp. or Costa Rica\*.mp. or Honduras\*.mp. or Suriname\*.mp. or Cuba\*.mp. or Jamaica\*.mp. or Uruguay\*.mp. or Dominica\*.mp. or Mexico\*.mp. or Venezuela\*.mp. or Algeria\*.mp. or Jordan\*.mp. or Tunisia\*.mp. or Djibouti\*.mp. or Lebanon\*.mp. or West Bank.mp.) and Gaza\*.mp.) or Egypt\*.mp. or Libya\*.mp. or Yemen\*.mp. or Iran\*.mp. or Morocco\*.mp. or Iraq\*.mp. or Syrian Arab Republic\*.mp. or Afghanistan\*.mp. or India\*.mp. or Pakistan\*.mp. or Bangladesh\*.mp. or Maldives\*.mp. or Sri Lanka\*.mp. or Bhutan\*.mp. or Nepal\*.mp. or Angola\*.mp. or Gambia\*.mp. or Nigeria\*.mp. or Benin\*.mp. or Ghana\*.mp. or Rwanda\*.mp. or Botswana\*.mp. or Guinea\*.mp. or Burkina Faso\*.mp. or Guinea-Bissau\*.mp. or Senegal\*.mp. or Burundi\*.mp. or Kenya\*.mp. or Seychelles\*.mp. or Cameroon\*.mp. or Lesotho\*.mp. or Sierra Leone\*.mp. or Cape Verde\*.mp. or Liberia\*.mp. or Somalia\*.mp. or Central African Republic\*.mp. or Madagascar\*.mp. or South Africa\*.mp. or Chad\*.mp. or Malawi\*.mp. or Sudan\*.mp. or Comoros\*.mp. or Mali\*.mp. or Swaziland\*.mp. or Congo\*.mp. or Mauritania\*.mp. or Tanzania\*.mp. or Mauritius\*.mp. or Togo\*.mp. or Mayotte\*.mp. or Uganda\*.mp. or Eritrea\*.mp. or Mozambique\*.mp. or Zambia\*.mp. or Ethiopia\*.mp. or Namibia\*.mp. or Zimbabwe\*.mp. or Gabon\*.mp. or Niger\*.mp. or Banjul.mp. or Bolgatanga.mp. or Korofidua.mp. or Kumasi.mp. or Nandom.mp. or Nkawkaw.mp. or Sekondi-Takoardi.mp. or Kintampo.mp. or Hossana.mp. or Jimma.mp. or Gondar.mp. or Khmu.mp. or Lucknow.mp. or Jan Swasthya Sahyog.mp. or Khandel.mp. or Rajasthan.mp. or Kolkata.mp. or Jakarta.mp. or Lesotho.mp. or Blantyre.mp. or Ekwendeni.mp. or Lilongwe.mp. or Nkhotakota.mp. or Zomba.mp. or Timbuktu.mp. or Edawu.mp. or Zaria.mp. or Port Harcourt.mp. or Kanu.mp. or Hashim.mp. or Dwu.mp. or Kambia.mp. or Cape Town.mp. or Hambantota.mp. or Juba.mp. or Gezira.mp. or Siteki.mp. or Eaco.mp. or Kilimanjaro.mp. or Mbeya.mp. or Zanzibar.mp. or Atatur.mp. or Butabika.mp. or Kisizi.mp. or Kiwoko.mp. or Mulago.mp. or Mbarara.mp. or Mengo.mp. or Mbale.mp. or Adujami.mp. or Gulu.mp. or Lusaka.mp. or Chainama.mp. or Chitambo.mp. or Lusaka.mp. or Ndola.mp. [mp=protocol supplementary concept, rare disease supplementary concept, title, original title, abstract, name of substance word, subject heading word, unique identifier]
6. Developing Countries/
7. 5 or 6
8. 1 and 4 and 7
9. limit 8 to (english language and humans)

## **Search 2: Evaluation of health links / family planning programmes**14/7/10

Key concepts (separated by AND):

- 1) Evaluation OR assessment OR qualitative
- 2) Health Link\* OR partnership\* OR collaboration\* OR (health OR international) adj3 (collaboration OR partnership OR links)
- 3) Developed or NHS or National Health Service OR high income OR high resource OR USA OR Europe
- 4) Developing OR Cambodia OR Vietnam OR Laos OR low income OR low resource
- 5) family planning OR contraception

## **Search 3: Aid effectiveness and evaluation design theory**

Material drawn on from MSc reading lists

### **Databases searched:**

OVID (each one separately):

Medline (via OVID)

Global Health (via OVID)

EMBASE (via OVID)

Popline

NHS Evidence

Web of Science

Google

ELDIS

Library catalogue for previous MSc projects

### **Limits:**

English only. Time period – last 25 years. Humans.

### **Expert sources contacted**

Tropical Health Education Trust (THET)

International Health Links Centre

Biku Ghosh (Ethiopia-Gwent health link)

John Wright (UK- Swaziland health partnership)

## **Appendix 4: Interview topic guide**

### **The implementation of higher standards of clinical care with improved systems and processes**

*MJP health workers:* What is your role within the family planning service at KTHP?

How would you describe the current situation with regards to family planning care at KTHP?

*Service users/non-users:* How many children do you have? How many pregnancies? Planning further pregnancies? Are you using a family planning method? Have you used the family planning service at KTHP?

Think about the last time you used the family planning service, how would you describe the standard of care that you received? What have you heard about the standard of family planning provision at KTHP?

### **Appropriate service delivery and improved access to care – getting the right skills, equipment and people in the right place and encouraging patients to use them**

*MJP health workers:* What could be improved regarding family planning provision in the Kampong Touk village area? How does this compare to the service 2 years ago? What has been the response of villagers to the family planning service? Who has the most influence regarding what services are provided at KTHP? It seemed like there were many clients to start with when the family planning service started at KTHP. Then the number of clients seemed to reduce. Can you think of any reasons why this happened?

*Service users/non-users:* Ideally, where would you go to get contraception? Ideally what method of contraception would you use?

### **The transference of technical, clinical and problem solving skills to MJP staff and other stakeholders**

*MJP health workers:* With regards to family planning (and in general), how do you think your skills/knowledge have developed?

*Service users/non-users:* With regards to family planning what do you think about the capability of the health post staff? Do you think the health post staff are able to deal with problems that arise? Example: if a client has side effects with contraception?

### **The development of a culture of continuing professional development**

How do you plan to keep up-to-date with family planning knowledge? How would you like to continue your learning? Do you have any log-book entries relating to family planning?

### **Supervision and support for Cambodian health workers**

Who would you ask if you were unsure about how to manage a client? What has been your experience of working with UK staff on the family planning project?

### **Data collection for the assessment of outcomes, knowledge and skills from the current baseline position**

In what way have the UK health workers contributed towards family planning data collection at KTHP?

### **Finally, in conclusion, to what degree do you agree or disagree with the following statement:**

Over the last two years, the UK has successfully supported a sustainable improvement in family planning provision in KT village

## Appendix 5: Sample transcript

Interview 6: September 2<sup>nd</sup> 2010

C: = Chris P: = Phally R: = Respondent

C:

P: What do you think about family planning service in general in Kampong Touk area?

R: The family planning service at Kampong Touk health post is much better than two years ago before. Many people have used the service here.

C:

P: Are there any other places to get family planning apart from the health post?

R: If the service were not provided at the health post, in the past, clients would buy pills or condoms from private pharmacy or other health centres

C,;

P: Where do the most people get their family planning contraception from now from this area, where do they go?

R: Most of them get their family planning contraception at the health post, because some contraceptives are available there and some clients buy it from pharmacy and some others who want to get implant or sterilization have to make contact to health centres such as RHAC or other health centres for coil, implant or sterilization. They can make contact to big health centres

C:

P: Why do some people use private clinics?

R: Because the family planning methods are not available here and some clients were afraid they would have babies, so they had to go to private clinic or the government one health centre.

C:

P: In general, are the staffs normally there at the health post or sometimes they're not?

R: The staff are normally available everyday. But only the midwife is there sometimes and she can cure the very simple diseases. They are not specialized or skilled in implant, coil or sterilization.

C:

P: What do you think about the methods of contraception available at Kampong Touk health post, condom, pill, depot, is that appropriate?

R: In my opinion, it is really appropriate. First, this does not mean that local clients have to use the service for years but they need sometime to look after their young children till they grow up and to improve the family status. They can have more children later if they want.

C:

P: Do you feel that they should be offered more methods of contraception at Kampong Touk such as coil, implant?

R: Yes, it is a good idea and more staffs should be added or expert staffs working on implant, coil, sterilization or other contraceptives should have real skills and speciality and they should be available here and promote this service and information to clients so that they will not feel afraid that it is safe to get it.

C:

P: Do you feel that for the basic contraception like condom, pill, do the villagers prefer the VHV system or they come to their house or they prefer to go to the fixed clinic like Kampong Touk?

R: In my opinion, clients should come directly to get it from the health post in order for them to more clearly understand the methods. But some villagers are afraid of using the contraceptives and some clients in the village are not aware of the contraception, and when they use it they have some side-effects.

C:

P: What could be improved for family planning in this area apart from the better, medical qualified staff?

R: For improvement areas, I think the expert staff must be available at the health post all time because clients can have some side-effects from using pill or depot, for example they have abnormal bleeding or dizziness and they would say this is caused by OK pill but of course they have bought this pill from private clinics with no clear consultation. So it is important to have an expert staff to give instruction and consultation in terms of methods to clients and they should come for medical check-up so that they will not feel afraid.

C:

P: Do you think all sections of community have been catered for like men, women (old women and young women), and military?

R: Of course the majority of these people have not accessed the service because the staffs of family planning have not promoted the service to a wide breadth. Some clients get aware of the service while some others are not aware of it. Like me, I have enough information about the service and I can deal with the staff for the service.

C:

P: Do you have any suggestions, how could we improve the information about the service?

R: In my opinion, the staff of the family planning should be available at the health post all the time every week and the staff or the village chief or TBA should help promote the service to villagers (in one gathering place) that now coil or implant are available at the health post, so they will not travel all the way to Battambang and they will not spend a lot of money as well because it is near by.

C:

P: Which people do not have information? Are they ones living in remote area or, which type of people?

R: Well, those who have never had any information about the service are sort of very poor people and they have never participated in the village meetings, because they sell their labour. This is why they are not aware of any information about the family planning. They know nothing about this.

C:

P: Are they not permanent people living in the village?

R: Yes, they are permanent villagers but they live in remote areas on their farm and some sell their labour because this village has a vast area.

C:

P: Do you think at the moment we are making effective use of local resource like TBA, VHV, are we using them effectively or could there be some improvement related to the information?

R: It is effective but most of villagers don't know all about the service provided in their community and some don't know who provides the family planning service in the village. They don't know who the VHV is. I think the staff of the family planning and contraceptives should be available at the health post so that villagers can come and get it if they want the service.

C:

P: How do you think of the family planning service in Kampong Touk is now compared to how it was two years ago?

R: It is much better and progressive if compared to two years ago because some clients have reduced their reproductive activity and their living status is a bit improved. The last two years, they had a lot of difficulties in life and had more children and later on they reduced their reproduction due to the family planning service.

C:

P: Have you yourself used the family planning service from Kampong Touk?

R: No, I have never used it at all because I don't know from whom I can get the service. I have never participated in any meetings with the staff but I have used it from private clinic.

C:

P: Why do you use the private clinic instead of the Kampong Touk health post?

R: (Laugh) because I have never known that all is available there. I have no information about it.

C:

P: Have you heard similar stories as from other villagers as well?

R: Even some villagers have never known this is available at the health post here. I know that some villagers who use the service everyday get pills from the health centre through VHV of RHAC. I think this service should be available at the health post and the village chief can help promote it to villagers.

C:

P: When clients have gone to the health post, have you heard what the quality of consultation is like when you meet someone at the health post?

R: The last few months, I saw MJP staff coming to have a meeting with the staff at the health post and people about the family planning but I did not participate in that meeting and some villagers here have never received any service. We don't know if the health post has family planning service but we know that medicine for malaria, and other types of diseases are available.

I have had no information because the staffs there have never disseminated the information villagers that all villagers don't need to go to any pharmacy because all contraceptives are available at the health post.

C:

P: Are you using contraceptive pill, OCP?

R: Yes, I do.

C:

P: Is it your first choice of contraception that you prefer to use?

R: Yes, it is my choice. I have used it for along time. It fits my health

C:

P: Regarding the services at Kampong Touk health post, how much does the local community have, be able to influence what services provided at the health post, do they feel they have any control as a community?

R: I think people in the community should access the service and be aware of the service of contraception and some of them have encountered a lot of difficulties such as being pregnant unexpectedly and they got it aborted and complained about their difficult situation because they did not know who they should have consultation with.

C:

P: When we first started the family planning service two years ago at Kampong Touk health post it seemed that there were many clients increased and then the number of clients seemed to reduce, do you have any reason why this happened?

R: The reason is that there is a health centre at Reh Dek. It promotes its service and drops contraceptives to VHV and clients have to pay for the service when they come to get it from VHV and VHV said this kind of contraceptive is not available at the health post but at her house. So some people keep coming to VHV because they think it is not available at the health post.

C:

P: Barang health workers have been working with over the last two years, what effects do you think it had in general?

R: As a result, since Barang health workers worked with Kampong Touk health staff, it was more progressive and villagers were pleased to see Barang staff and they have stronger belief in their capability and their speciality. Last month, I introduced some of villagers to use the coil at RHAC and if Barang health workers come to work at the health post on family planning, villagers will be more confident.

C:

P: Is it about the family planning service?

R: Yes

C:

P: How you think about Kampong Touk health post in general, has it changed over the last two years?

R: In short, it has changed a lot compared to the last two years because Barang staff educated villagers about the family planning, using coil, condom, implant, and some of villagers have followed the idea and they reduced having more children too.

C:

P: You have mentioned something about villagers who had abortion, where would they go for abortion?

R: They usually go to a private clinic in Sdao commune, Rottanak Mondal district. There is a midwife there who also works for government but he has a private business as well. Some villagers can have abortion there. He has skills.

(The laugh is here when I asked her to repeat a word, Sdao where a midwife work)

C:

P: Is it like surgical abortion or medical abortion?

R: It is kind of medical abortion

C:

P: Do you know are there many people who had abortion?

R: Yes, many. There are about 10-20 people. Some who are one month pregnant still keep using the pill but this did not work and they also had side-effects and then they decided to go to the midwife

C:

P: Do you have any experience of direct interaction with Barang and if so, what has been your experience?

R: Well, Barang workers were very good in their work and people had belief in them and they want to work with Barang in terms of family planning practice. They preferred Barang to come and work directly with them.

C:

P: Do you think MJP Barang were talking too much and no action?

R: MJP has done a large amount of work including: family planning service (but some people have not used it yet, though MJP promoted the service to them), agricultural seed, credit and techniques for poultry and agriculture

C:

P: Do you agree to this statement--over the last two years, the UK health workers have successfully supported the sustainable improvement of the family planning provision in Kampong Touk village area?

R: Yes, I strongly agree to the statement P: the last two years, Barang staff came to work here R: they gave support and people can access this service

R: I have a request that the family planning service promotion should be done more to villagers and there should be expert staffs in this area so that villagers will have belief or can trust their capacity because this can help reduce the poverty of people in my village as well.

C:

P: Do you think the staffs who are there now are capable of coordinating that?

R: Well, the staff has not done much promotion of the family planning service to people but some villagers come to the health post themselves to ask for some pills or depot and the staff sometimes said the pill or depot is not available. The health post staff have not done much promotion of the service to people.

C:



## Appendix 6: Thematic framework for data analysis

Key issues, concepts and themes

**To contribute towards sustainable improvement in health and healthcare in Cambodia**

### **1) The implementation of higher standards of clinical care with improved systems and processes (@KTHP – effect of MJP / NHS and MOH)**

- 1.1 Method counselling (information given to clients / what available and where if not available / how to use / potential side effects / complications / instructions on when to return / dual protection (condoms) offered / methods of delivering info / Bruce-Jain b)
- 1.2 Follow up / managing side-effects (information given)
- 1.3 Interpersonal relationships (consultation privacy/confidentiality / attitude of staff - respect/courtesy/partisan/discrimination/friendly/sensitive/any change / Bruce-Jain d)
- 1.4 Systems and processes (waiting time, supply of commodities / monitoring stock/ stock outs/requests/MJP versus MOH / client receives method of choice)
- 1.5 Standards of clinical care (in general, FP related. skills/knowledge of staff, change)
- 1.6 Standards of clinical care (not FP related)

### **2) Appropriate service delivery and improved access to care – getting the right skills, equipment and people in the right place and encouraging patients to use them (in the KT village area)**

*The appropriate constellation of services (Bruce-Jain f)*

- 2.1 Appropriateness of having a Family Planning service (need/desire for service / evidence of unmet need / unwanted pregnancy / abortion / number of children / fertility preferences - reason)
- 2.2 Decision/influence over services provided (ownership / community participation - whether opinions respected / MJP staff / NHS / MOH/OD alignment relationship / role / shared vision)
- 2.3 Relationships with other NGO's/service providers (harmonisation/links/service substitution/ activities including LARC / abortion)
- 2.4 Choice of methods available (approved - OD / appropriate – staff training / client preference of method – reason / LARC / Bruce-Jain a)
- 2.5 Appropriate service delivery system (preference for clinic and/or community / outreach, reason – cost/ transport/incentives / convenient days and times of services)
- 2.6 Use of service (awareness / information dissemination / links to community / promotion / service users / non-users / use of other services – reason, access / numbers / *evidence of clients returning / user fees / behaviour change / FP uptake*)
- 2.7 Family planning service (in general / change / improved / good / confidence / effect of Barang / *methods*) overlap with 1.6
- 2.8 Use / perception of KTHP in general (not FP related, change)
- 2.9 Ideas for improvement / requests (FP service)
- 2.10 Ideas for improvement & requests (not FP related)

### **Community Family Planning knowledge / experience**

- 2.11 Experience (past / current method use – reason afraid/husband influence, provider - community / clinic / private clinic), side-effect's / fear / examples)
- 2.12 Knowledge (of methods / information / advice given / examples)

### **3) The transference of technical, clinical and problem solving skills to MJP staff and other stakeholders (NHS training) and:**

### **4) The development of a culture of continuing professional development**

- 3.1 NHS inputs (before arriving in Cambodia: number of fellows, skills/qualification / age)
- 3.2 Factors affecting transference (challenges, language/culture, customising / teamwork with other departments / length of contract / continuation of training)
- 3.3 Methods of transference (training type: theoretical/group/real practice/refresher/ location: UK versus Cambodia, QI visits)
- 3.4 MJP staff & other stakeholder outcomes (respect / confidence / skills / knowledge - in alignment with MOH / understanding / problem solving / behaviour change)
  
- 4.1 Examples of learning & CPD (topics/sharing experience Wed PM teaching, whose idea, journal club, forgot)
- 4.2 Plan for more learning (keeping up-to-date)
- 4.3 Requests & ideas for improvement (identified need for more learning / strange diseases / trip to UK)

**5) Supervision and support for Cambodian health workers (mentoring / teamwork)**

- 5.1 Working with NHS & Barang (attitude of fellows / examples of supervision / support: approachable/ask questions if not sure / problems)
- 5.2 Relationship between MJP and NHS
  
- 5.3 External perception of MJP / NHS / Barang (community / MOH /aware of / interaction / afraid)

**6) Data collection for the assessment of outcomes, knowledge and skills from the current baseline position**

- 6.1 KTHP Family Planning Monitoring &Evaluation (examples, record keeping/number of clients / QI data / community data / NHS /MOH data)
- 6.2 Record of learning & outcomes (examples / log books)
  
- 6.3 Ideas for improvements & requests

## Appendix 7: Consent form & information for respondents

### CONSENT FORM:

**Evaluation of the family planning work stream of the NHS South Central  
International Fellowship Scheme in Cambodia**

I \_\_\_\_\_ have had the aims and objectives of the study described to me. You have explained what you are trying to find out and why you would like to talk to me.

**Please put a mark in the box to the right if you think the sentence is true:**

I have asked all the questions that I need to and I am happy with the answers you have given me.	
I allow you to write about what I have said during our talk and I understand that you won't be using my real name.	
I understand that I don't have to talk about things that I don't want to talk about. I know that I can stop our talk at any time and without giving a reason for this.	
I don't mind that you record our talk.	
I understand that I can take a look at the draft report for this study if I want to.	
<b>I would like to take part in the study. I can still change my mind at any time.</b>	

My questions have been answered by \_\_\_\_\_

**Participant (name in BLOCK CAPITALS)** \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_

**Researcher (name in BLOCK CAPITALS)** \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_

## Information for respondents:

### Evaluation of the family planning work stream of the NHS South Central International Fellowship Scheme in Cambodia

Thank you for your time.

I am [REDACTED], a medical doctor who has worked in Samlaut as part of the partnership between the UK NHS and MJP. I am also studying Public Health in London.

I am trying to learn about the first two years of the family planning service at Kampong Touk Health Post. The NHS, MJP, and the Cambodian MOH have worked together to develop this service.

The aim of this evaluation is to explore the contribution of the NHS within the partnership towards developing this service, exploring successes / challenges and making recommendations for improvement.

I will be talking to around 15 people who are involved in the family planning service at Kampong Touk health post. This will include health workers and members of the community.

I would like to talk with you because you are involved in the family planning project. It is very important to get the perspective of Cambodians. I would like to talk to you about this. I think that what you have to say about this is very important.

You do not have to talk to me. If you decide not to talk to me it will not affect any of the services that you receive.

If you decide to talk to you can change your mind at any time, and you don't have to give a reason for this.

You don't need to talk about things you don't want to talk about. Remember that you can always stop our talk or take a break if you want to.

Anything you tell us will only be seen by me. This means that whenever I write reports or summarize what you and others have told us, I will not use real names. However, given the small numbers involved it will not be possible to offer a full guarantee of confidentiality.

After the study is finished I will look in detail at what you and others have told us. I will then write reports about what I find out so that we can learn from it.

Would you like any more information or do you have any questions before you decide?

If you have any questions or opinions about this study, please ask Dr. [REDACTED] or email me:

[REDACTED]