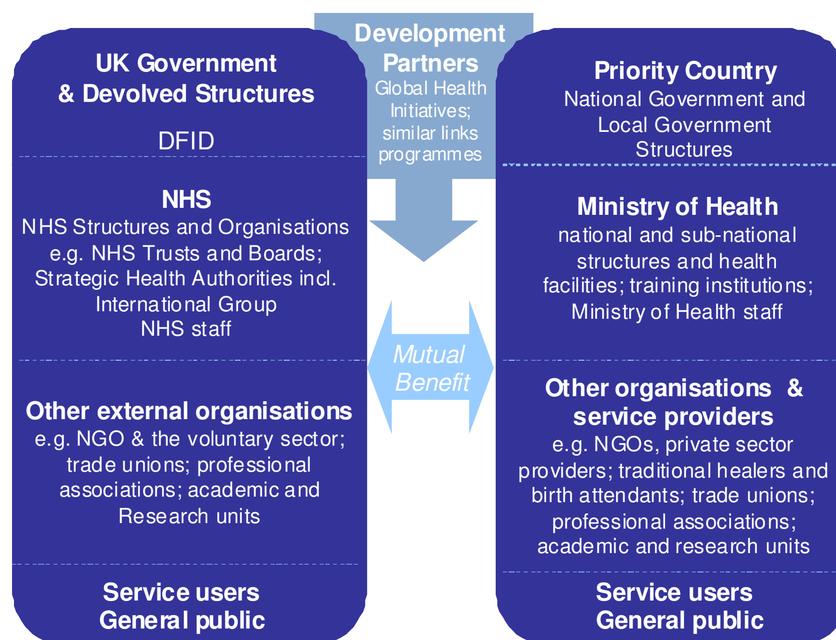
Social Appraisal (Draft 2)

This social appraisal will address the questions: a) does the programme reflect a robust understanding of poverty and the social context? (Part 1) and b) which groups of poor people will benefit and how? (Part 2).[1]

Part 1: Understanding of Poverty and Social Context

1. Figure 1 below provides an overview of the scope and scale of the HPS. The proposed programme will require facilitation of vertical and horizontal linkages that could touch multiple levels in this diagram. It will also require engagement with other International Development Partners and related international initiatives. Although the diagram does not attempt to provide a definitive list of institutions, structures and stakeholder groupings, it does provide an overview of the operational landscape. It also illustrates a key feature of this programme, namely the emphasis on mutual benefit for the UK public health sector and the health sector in partner countries.

Figure 1: Overview of the Scope of the HPS



Given the sizeable scale and scope of this programme, the contracted management agent will need to demonstrate capacity in working across all these horizontal and vertical levels.

2. The HPS intends to focus on DFID priority countries. The UK Government is committed to increasing aid spending to 0.7% of gross national income by 2013. Following an ongoing Bilateral Aid Review, the UK Government intends to direct these resources to priority countries where it can best achieve results through assistance for poverty reduction measures, as well as programmes to improve maternal health, women's right to family planning and protection against diseases

[1] DFID. 2005. *Essential Guide to Rules and Tools: The Blue Book.* Section B5:2. London:DFID

such as malaria.[2] Table 1 provides a list of DFID's priority countries at the time of this Appraisal; attention should be given to any published changes following the Review.

Table 1: DFID's Priority Countries[3]

Priority Countries: Africa		Priority Countries: Asia
Democratic Republic of Congo	Rwanda	Afghanistan
Ethiopia	Sierra Leone	Bangladesh
Ghana	Sudan	Cambodia
Kenya	Tanzania	India
Malawi	Uganda	Nepal
Mozambique	Zambia	Pakistan
Nigeria	Zimbabwe	Vietnam
		Yemen

The multi-country focus of the HPS is intended to ensure that the scheme reaches countries where there is a recognised social and economic need and where the scheme is likely to make the greatest impact in terms of healthcare priorities. It is evident from Table 1 that the HPS will be implemented in a variety of diverse and challenging settings, including some fragile states. It will, therefore, be necessary to balance equity of country participation against the safety of participants and the likelihood of achieving positive results. Systematic risk assessments and country-level appraisals using reliable key informants are, therefore, critical for establishing international health partnerships (IHP) under this scheme. There must also be appropriate orientation, training and debriefing programmes for staff placements, [4] with every effort made to ensure there is familiarity with the social and development context.[5]

3. Key UK strategies papers that are relevant to the HPS include:
    - Eliminating World Poverty: Building our Common Future (HMG, 2009a);
    - World Health Organisation: UK Institutional Strategy 2008-2013 (HMG, 2009b);
    - Health is Global: A UK Government strategy 2008-2013 (DH 2008);
    - Working together for better health (DFID, June 2007).

   All of these strategies emphasise the fundamental links between poverty and health and the mutual benefit of working together for a common future. There is also particular emphasis on the importance of strategic partnerships at institutional and operational levels, as well as improving access to services, especially for the poor and vulnerable (such as women and children). Other cross-cutting themes relate to efficient and coordinated use of resources, improving aid effectiveness, country ownership, demonstrating results and building evidence of what works. These themes are all addressed in the design of the HPS.

[2] http://www.dfid.gov.uk/Media-Room/News-Stories/2010/Aid-budget-to-be-refocused-to-deliver-better-results-/
[3] Source Department of Health. 2010. *Framework for NHS Involvement in International Development*. p.9. http://www.ihlc.org.uk/news/framework.htm
[4] See THET 2009. International Health Links Manual (Edition 2) http://www.thet.org/health-links/resources-for-links/. Particular attention needs to be given to risk management, personnel safety and issues of professional liability and indemnity.
[5] James J, Minett C and Ollier L. 2008. *Evaluation of links between North and South Healthcare Organisations.* London: DFID Health Resource Centre.

4. The HPS aims to address the poverty and social context through a focus on Millennium Development Goals (MDGs). The eight MDGs encompass a number of targets and indicators that aim to promote development by improving social and economic conditions in the world's poorest countries by 2015. Recently, there has been a growing body of literature on the interconnectedness of the MDGs, with a particular emphasis on the linkages between the health MDGs and those relating to poverty and hunger (MDG 1), primary education (MDG 2) and gender issues (MDG 3).[6] There has also been international recognition that progress in reaching targets on child mortality (MDG 4) and maternal health (MDG 5) has been unacceptably slow[7] and international consensus that interventions to address these goals need to be rapidly stepped up. The *Global Strategy for Women's and Children's Health* was launched at the United Nations MDG Summit (September 2010) to marshal international efforts to address these challenges.[8] The HPS is well-placed to make a timely contribution to this concerted effort. Notably, the MDGs do have their detractors[9] and, as 2015 approaches, consideration is being given to the period "beyond the MDGs".[10] HPS programme managers will need to monitor these debates in order to remain attuned to emerging priorities and approaches.

> *Investing in the health of women and children is not only the right thing to do; it also builds stable, peaceful and productive societies. It reduces poverty; stimulates economic growth; it's cost-effective, and it helps women and children realize their fundamental human rights.*[11]

5. The promotion of gender equity is a key theme in UK health and international development strategies, as well as being the focus of MDG 3. The emphasis of the HPS on maternal and child health is consistent with this development objective. The contracted management agent will, however, need to demonstrate a commitment to gender equity in all its operations.[12] Particular attention will need to be given to gender roles and sensitivities in diverse cultural settings, whilst ensuring that partnerships promote gender-based rights.

6. The *Framework for NHS Involvement in International Development*[13] explains how a focus on UK "diaspora" health workers from developing countries can be especially helpful in promoting the mutual benefits of health partnerships. There may also be particular benefits in promoting links between disadvantaged or

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[6] See for example, Grant K and Mundy J. 2008. *Strengthening linkages between the AIDS Response and the MDGs: A Discussion Paper for UNAIDS.* London: HLSP. www.hlsp.org
[7] United Nations. 2010. The Millennium Development Goals Report. New York:UNDESA
[8] See http://www.un.org/en/mdg/summit2010/
[9] Concerns largely relate to the unintended consequences of excessive focus on targets, and lack of attention to process, quality and sustainability.
[10] Institute of Development Studies. 2009. After 2015: Re-thinking Pro-Poor Policy. In Focus Policy Brief 9.1. June 2009. Brighton:IDS
[11] United Nations 2010. Launch of the Global Strategy for Women's and Children's Health . 22nd September 2010. http://www.un.org/sg/hf/global_strategy_release.pdf
[12] For example, there may be a need to promote equitable opportunities for "career breaks" (see the NHS Agenda for Change) and to provide guidance on childcare, or accompanying children. There will also be a need to consider gender in monitoring participation in the HPS, and in assessing health and development outcomes.
[13] Department of Health. 2010. *Framework for NHS Involvement in International Development*. http://www.ihlc.org.uk/news/framework.htm

vulnerable groups.[14] Consequently, where possible, the principles of *inclusiveness* and *diversity* should also be demonstrated in the implementation of this programme. Involvement of experienced non-governmental or voluntary sector organisations may be especially helpful in this regard.

7. The design of HPS makes explicit reference to the principles of aid effectiveness. These principles are derived from the 2005 Paris Declaration on Aid Effectiveness and emphasise the importance of country ownership, harmonisation and alignment of donor support, managing for results and mutual accountability. These principles were reiterated at the 2008 Accra High Level Forum and the Accra Agenda for Action emphasised the need for "building effective more inclusive partnerships". The HPS emphasis on coordinated programmes, as well as appropriate and effective activity is consistent with these principles. The DFID Resource Centre 2008 *Evaluation of links between North and South Healthcare Organisations* placed considerable emphasis on the need to increase the planning and decision-making role of Southern partners (at national and sub-national levels) in establishing IHP. Hence the focus of the HPS on country ownership and demand-led initiatives is of particular importance for ensuring relevance to social context and sustainability.[15]

8. Emphasis on country ownership and demand-led initiatives should also assist in ensuring links partnerships reach the poor and most in-need in partner countries. The emphasis of the HPS on rural settings is important. However, it is also necessary to consider that high rates of urbanisation in developing countries have led to concentrations of poor in urban and peri-urban areas.[16] Consequently, support for cross-cutting approaches, such as strengthening primary health care services, health systems[17] and human resource capacity[18], need to be considered as key themes in both large and small-scale IHP.

> *'The most pressing needs in developing countries are for balanced and integrated health systems with a particular emphasis on public health and primary care, not hospitals and tertiary care, although these have their place.'*[19]

9. The HPS aims to strengthen contributions to the poverty and social context by providing opportunities for longer-term volunteering. This principle is well supported by literature from the voluntary and non-governmental sector which emphasises the need to provide continuity of support and "long-term solutions" that move beyond short-term relief.[20]The 2008 DFID Resource Centre evaluation

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[14] See for example, VSO 2008. *VSO and Disability 2008-2013.* http://www.vsointernational.org/Images/VSO_and_Disability_2008-2013_tcm76-21048.pdf
[15] Demand-led approaches should also lead to opportunities for addressing local heathcare challenges, such as non-communicable diseases, within the context of the IHP.
[16] UN-Habitat 2010. *State of the World's Cities 2010-2011 –Cities for All: Bridging the Urban Divide.* New York: UN Habitat
[17] WHO. 2007. Everybody business : strengthening health systems to improve health outcomes : WHO's framework for action. Geneva: WHO.
[18] WHO 2006. *Working together for health: The World Health Report 2006* and WHO 2008. *Kampala Declaration and Agenda for Global Action*, Geneva: WHO.
[19] Dr Luis Sambo, World Health Organisation Regional Director for Africa, cited in Department of Health 2010:14, op. cit.

[20] See for example, CUSO-VSO 2009. *Volunteering as a Global Movement for Development. 2008/2009 Annual Report*. Ottawa:CUSO-VSO.

of health links[21] also suggests that longer term placements are of more value to Southern partners. Experience from the non-governmental and voluntary sectors suggests, however, that long-term volunteers need specialised support, especially when engaging with development issues in multi-country settings. The management agent will be expected to make provision for this support. The UK public health sector may also experience challenges in releasing staff for longer-term volunteer positions (see Institutional/Governance Appraisal). Again, the management agent will need to address these challenges. It is recommended that these factors are considerations in the procurement process.

10. The HPS is based on facilitation of mutually beneficial partnership between a range of stakeholders, institutions and structures. The concept that "development is not merely a moral cause, it is also a common cause" is now widely acknowledged and has been reinforced by global challenges relating to climate change, security, disease outbreaks and the economic downturn.[22] In 2005, the momentum created by Make Poverty History Campaign, the Live 8 concerts and the Gleneagles Agreement on aid and debt relief illustrated the value of raising public awareness, mobilising social networks and drawing on the energy, creativity and commitment of passionate individuals.

Case study: The Wales for Africa Programme

The Welsh Assembly Government is supporting activities in Wales that contribute to international sustainable development through its *Wales for Africa* programme. The Wales for Africa programme places strong emphasis on community development, leadership and community involvement, both in Wales and in partner countries. For example, the link between Rhondda Cynon Taf in Wales and the Mbale Region, Uganda is based on long-term intersectoral collaboration between NGOs, local communities, government healthcare providers and international partners to deliver improvements in health through training of volunteer community health workers.[23]

Part 2: Which groups of poor people will benefit and how?

11. Links are driven by a range of actors, from those responding to direct calls from a developing country government, through to links founded on personal experiences and relationships. Links have very different foci, ambitions, and results. There is, therefore need for caution in generalising about benefits and beneficiaries, given the potential number and diversity role players and structures.

12. The *Framework for NHS Involvement in International Development*[24] summarises a number of reports on the perceived benefits of international health partnerships. These are captured in Table 2 below:

[21] James et al. 2008. Op.cit.
[22] HMG 2009a. Op.cit.
[23] Source: Department of Health 2010:36 Op.cit; James et al 2008. Op. cit.
[24] Department of Health. 2010. Op. cit.

Table 2: Potential Benefits of International Health Partnerships

Benefits for NHS organisations and service users	Benefits for health sectors in partner countries and service users
• A better return on investment in training due to enhanced staff skills and ability to work in challenging environments, as well as increased staff satisfaction and motivation • Enhanced leadership and professional skills for NHS clinicians and managers • Enhanced reputation of the organisation among the public, staff and the media staff satisfaction • Development of culturally appropriate services based on increased understanding of social and ethnic diversity • Education and research opportunities that can benefit patients in both communities • Greater understanding of global health issues e.g. pandemics, and knowledge of diseases not routinely seen in the UK.	• Support for both public sector and non-governmental providers through: o improved education and training for health workers, managers and administrators o strengthening public health, health systems and institutions –covering all aspects of health from public health to health services, including their operational management and delivery o making knowledge, research evidence and best practice accessible to health workers, policy makers and the public alike.

13. In addition, the Framework suggests that IHP can help healthcare professionals (on both sides of the partnership) to consolidate and develop a range of hard and soft skills, such as clinical, managerial, leadership cultural and educational skills (see Part 2 of the Institutional Appraisal).[25] These skills can potentially contribute to the quality of services offered to healthcare users in both countries. The focus of the HPS on women and children and poor underserved communities means that these population groups could be particular beneficiaries.

14. The DFID Resource Centre evaluation of health links[26] highlighted the need for more reliable data on the impact of IHP. Reports on the value of IHP for the UK public health sector and partners in developing countries continue to depend largely on anecdotal and qualitative data. The design of the HPS makes clear reference to the need for robust monitoring and evaluation (M&E) frameworks and systems to support evidence-based decision-making, problem identification and demonstration of aid effectiveness in a variety of social contexts. Particular attention may need to be given to collection of data on the benefits and cost-effectiveness of IHP for the UK public health sector, especially at a time of increased resource constraints.

15. Figure 1 above provides an overview of the key stakeholder groupings that may be involved in or affected by the HPS. A more systematic stakeholder analysis suggests that there are a number of *potential* beneficiaries of a successful HPS at each structural level. For example, support for implementation of international

[25] Source Department of Health 2010: 13 Op.cit.
[26] James et al 2008. Op. cit.

health and development strategies is likely to enhance the reputation (nationally and internationally) of the UK government and devolved structures, as well as DFID. The HPS aims to benefit partner countries through support to the health sector. Increased access to information, data, resources and participation in larger-scale, coordinated IHP, based on effective and appropriate activity, is intended to benefit NHS structures and staff, as well as health structures and staff in partner countries. There may be similar 'spin-offs' for external organisations such as participating non-governmental structures, academic and research units, trade unions and professional associations in both the UK and partner countries; however, benefits for external organisations may be more uncertain or indirect and dependent on levels of involvement. There are also uncertain outcomes for existing International Health Links structures and staff (within THET and the International Health Links Centre) since their longer-term participation depends on the outcome of procurement processes. The role of other health care practitioners in developing countries (such as those in the private and traditional sectors) is also contextual and uncertain, and may be associated with perceptions of exclusion. Negative effects may be experienced by participating (direct) stakeholders in the UK and partner countries if the HPS is associated with increased management, administration, financial and/or M&E burdens, if there is inadequate management and mitigation of risk, or if there is failure to observe the principles of aid effectiveness.

Whether stakeholders have direct or indirect stake in the programme will depend on the nature and scale of IHP undertaken. However, given the potential range of stakeholders, ongoing processes of consultation should remain a key component of this programme.

Supplementary Stakeholder Analysis Tables

Table (i): Rapid Stakeholder Analysis of UK-based Stakeholder Groupings

Stakeholder Group	Interest/stake in programme	How programme affects interest	Comment
Government/Devolved Structures			
UK Government and Devolved Structures	Roll-out and implementation of government strategies on poverty and health in developing countries. Opportunity to address global health concerns and the health MDGs. Increased information and learning on health care delivery in priority countries. Increased reputation nationally and internationally.	+ + + +	Positive gains if HPS is well implemented.
DFID	As UK government above. Increased focus on aid effectiveness, strategic, coordinated more ambitious approach. Improved programme coordination under an umbrella framework through services of a management agent. Reduced management and administrative burden of supporting programme. Increased information on best practice.	+ + +/- +	Some staff may incur additional responsibilities in overseeing the management agent and monitoring the programme
NHS Structures & Staff			
NHS Trusts & Boards	Increased information on best practice, guidelines and protocols on planning, administering and managing partnerships. Increased information on how to maximise benefits and cost-effectiveness of IHP and minimise risks. Increased access to higher levels of funding for IHP. Increased access to brokerage support in identification, matching and facilitation of partnerships. Reduced costs in releasing staff for IHP opportunities. Reduced management, administrative & financial burden of supporting partnerships.	+ + + +/- +/-	Some staff may incur additional responsibilities and transaction costs in supporting larger scale IHP. The cost-effectiveness of releasing staff for IHP remains uncertain,
Strategic Health Authorities incl. International Group	Increased information on best practice for providing guidance to other NHS structures. Assistance in raising awareness on the role of NHS involvement Increased information and resource materials for promoting effective NHS involvement in international development. Reduced time burdens in supporting NHS involvement in IHP.	+ + + +/-	Some staff may incur additional responsibilities in monitoring and advising on IHP.
UK health care workers including clinical, non-clinical, managerial and 'diaspora'	Increased access information about opportunities for international development experience. Increased access to reliable guidance and advice from the *Healthbay*. Increased opportunities for participation in better coordinated, more effective initiatives. Increased opportunities for participation in on-line discussion forums and lessons learnt. Improved access to information on funding sources for IHP. Improved access to information on employment rights and implications for career development. Increased opportunities for longer term placements in partner countries.	+ + + + + + + +	Positive gains if the HPS is implemented well and there is adequate provision for absent staff.
External Organisations			
Independent providers Non-Governmental Organisations and voluntary sector	Increased access to information on the role and activities of the NHS re. IHP. Increased opportunities for higher levels of funding. Increased opportunities for partnerships with the NHS to improve the effectiveness and cost effectiveness of links.	+ + +	Positive gains for participating organisations if the HPS is implemented well. For non-participating

	Increased opportunities to deploy experienced, professional personnel. Increased participation in establishing best practice and technically sound approaches. Increased participation in more coordinated programmes with linkages to other international partners. Increased involvement in design, implementation, M&E of health partnership programmes.	+ + + +	organisations gains will be indirect or negligible. May be some perceptions of exclusion.
Academic/ research Units	Increased access to partnership and research opportunities relating to the health sector. Increased opportunities for making knowledge, research evidence and best practice accessible to health workers, policy makers and the public. (As NHS Trusts and Boards above)	+ +	Positive gains for participating units if the HPS is implemented well. Indirect of negligible gains for non-participating units.
Professional Associations	Increased access to relevant information for members. Increased opportunities to support professional development of members. Increased access to information on potential partnerships and practices of professional bodies in other countries. Increased opportunities to strengthen communication with professional bodies in other countries.	+ + + +	As above.
Trade Unions	As professional bodies above. Increased access to information on protecting the employment/pension rights of health staff and minimising risk. Increased access to information on potential partnership, practices and concerns of trade unions in other countries. Increased opportunities to strengthen communication with trade unions in other countries. Increased responsibilities in protecting rights of health sector staff.	+ + + -	Potential gains but likely to be increased workload in supporting and protecting rights of members working overseas.
UK General Public and Service Users			
UK General Public and Service Users	Increased awareness of global health issues through social networks. Improved quality of NHS services, with increased cultural sensitivity and understanding of diversity.	+ +	Positive gains if HPS is well implemented but gains may be indirect or delayed.
Other			
Existing Links structures (THET and International Links Centre)	Opportunity to participate in a more ambitious, coordinated links programmes. Opportunities to build on experience to date. Access to continued financing for links activities. Ability to undertake organisational planning and manage staff on basis of DFID contract and predictable funding.	+/- +/- +/- +/-	Role in HPS subject to procurement processes with an uncertain outcome.

With regards the stakeholder analysis of groupings in partner countries this is clearly a little hypothetical. Table (ii) below shows the kinds of interests that should be protected to ensure maximum buy-in. It also shows that interests may be negatively affected by increased management and administrative burdens, or increased marginalisation/exclusion.

Table 4: Rapid Stakeholder Analysis of Stakeholder Groupings in Partner Countries

Stakeholder Group	Interest/stake in programme	How programme affects interest	Comments
Partner Government			
National Government	Increased support for strengthening health sector based on principles of aid effectiveness. Enhanced reputation of government. Low management and administrative burden required for programme support (and associated partnerships).	+ + +/-	Positive gains if HPS is well implemented but some staff may incur additional responsibilities and transaction costs in supporting larger scale IHP
Ministry of Health	As government above. Greater participation in planning, decision making and selection of IHP inputs. Opportunity to establish relative roles and responsibilities re partnership initiatives.	+ +/-	As above.
Sub-national structures (health and local government)	As above.		As above
External Organisations and Service Providers			
Local NGOs, FBOs and CBOs and independent providers	Increased access to services of experienced, professional health sector personnel. Increased participation in establishing best practice and technically sound approaches. Increased participation in more coordinated programmes with linkages to other international partners. Increased opportunities to improve service delivery for minority and vulnerable groups. Increased involvement in design, implementation, M&E of partnership programmes. Low management and administrative burden re supporting links personnel, programme design and implementation and ensuring appropriateness of inputs (with limited resources for this role).	+/- + + + +/- -	Overall positive gains for participating organisations if the HPS is implemented well. Some staff may incur additional management and administrative burdens. Placement/ assimilation of staff in organisation associated with uncertainty.
Academic/ training and research Units	Increased access to partnership and research opportunities relating to the health sector. Increased opportunities for making knowledge, research evidence and best practice accessible to health workers, policy makers and the public.	+ +	Positive gains for participating organisations if the HPS is implemented well.
Professional Associations	As for UK professional bodies above		As above
Trade Unions	As for UK trade unions above		As above
Traditional leaders/healers	Opportunities for increased participation in the health system. Increased opportunities to share knowledge and receive professional skills development.	+/- +/-	Gains dependent on level of participation. May experience exclusion.
Private sector providers	Increased information on effective cross sector programmes Opportunities to benefits from links initiatives	+ -/+	Gains dependent on level of participation. May experience exclusion.
General Public and Service Users			
Local communities, health care users (especially women and children)	Improved health care services as part of more coordinated, integrated programmes	+	Positive gains if HPS well implemented.
Other			
International Development Partners	Increased opportunities to include UK healthcare personnel in coordinated programmes. Increased opportunities for shared learning and information exchange re experience of health sector personnel, innovation and more ambitious, coordinated approaches of HPS	+ +	Positive gains if HPS well implemented.