Review of the Norwegian Esther Program (The FK Health Exchange program)

Final Report

Scanteam
Analysts and Advisers

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Review Team:

Karstein **Haarberg**, Senior Partner, Scanteam (Team Leader)

Elina M. **Dale**, Associate Partner, Scanteam (Team Member)

Erik **Whist,** Senior Partner, Scanteam (Quality Assurance)

Scanteam
Box 593 Sentrum, NO-0106 Oslo, Norway - Tel: +47 2335 7030 – Fax: +47 2335 7039
Web: www.scanteam.no – E-mail: scanteam@scanteam.no

Table of Contents

List of Acronyms

BMZ	German Federal Ministry for Economic Cooperation and Development
CHAM	Christian Health Association of Malawi
CMI	Christian Michelsen Institute
Esther	Ensemble pour une Solidarité Thérapeutique Hospitalière En Réseau
FK	Fredskorpset
GIZ/GTZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
HDS	Haraldsplass Diakonale Sykehus
HUH	Haukeland Universitets Hospital
ICT	Information and Communication Technology
KCH	Kamuzu Central Hospital
MDG	Millennium Development Goals
MHCS	Minister for Development and Ministry of Health and Care Services
NCA	Norwegian Churh Aid
NGO	Non-Governmental Organisation
NHU	Norsk Helsenettverk for Utvikling
NOK	Norwegian kroner
NONM	National Organization of Nurses of Malawi
SMO	Sophies Minde Ortopedi AS
SWOT	Strength Weakness Opportunity Threat
UDI	Norwegian Directorate of Immigration
UiB	University of Bergen
UK	United Kingdom
UNGASS	United Nations General Assembly 26th Special Session
WHO	World Health Organisation

Summary: Conclusions and Recommendations

Below are the conclusions and recommendations from the review.

Conclusions

This is the main conclusion structured according to SWOT (Strengths, Weaknesses, Opportunities and Threats). More discussion on the different SWOT elements is done in the main text of the report.

Strengths

- FK Esther fits its purpose and goals, and contributed to fill a perceived funding gap in Norwegian health assistance.
- The projects creates enthusiasm on all sides of the partnership
- Changed professional attitude and better motivation are some of the key benefits gained by Esther.
- Esther is strengthening the health sector in development.
- Reciprocity in exchanges is generally beneficial.
- Some of the Norwegian partners have used the learned skills to improve the work towards patients from different cultures in Norwegian hospitals.

Weaknesses

- Esther projects may in some cases be gap-filling.
- The project cycle is short, only one year.
- The Esther programme is a mix of projects, and lack a strategic direction
- Monitoring is improving, but still gaps need to be filled. Still indicators and data on performance are missing. Field visit should also be more targeted towards monitoring.

Opportunities

- FK Esther is flexible and has adapted and adjusted their practice to demands and request from applicants.
- Esther support equipment, which is a small but important and appreciated part of the programme.
- Esther has a long term perspective on the collaboration. The new FK strategy opens for until 12 years of collaboration with exchanges

Threats

- If Esther are scaled down or moved, may cause a widening of the funding gap for health projects as well as for the benefits that FK creates through their experience in exchanges.
- If the weaknesses in monitoring continue, and performance is not verified, then we believe that it will be challenging for FK to justify having the Esther programme.

Recommendations

These are the main recommendations based on the assessment above:

- Improve the strategic direction for the programme, through a process with FK Esther, North and South partners, Norad and MFA. FK Esther should find its own strategic

direction based on its own situation. Responsibility: Norad, FK Esther with participation of Norwegian hospitals (for example through NHU)

- Increase project cycle to two years. Responsibility: FK Esther
- Short term frequent visits within a continuous collaboration framework should be assessed as equal to one time longer stays. Allow Norwegian specialists that are on their 4 month leave. Responsibility: FK Esther
- Top up salaries where necessary, as it also gains the hospitals service in general. FK Esther and Norwegian hospital.
- Improve monitoring and reporting:
  - FK Esther:
    - Improve baseline and performance data
    - Make oversight reports, both for financial, output and outcome performance during the year
    - If projects are struggling with reporting performance, then use Questback survey tool to track performance on Esther programme. Make responding to survey a prerequisite in agreements.
  - Partners:
    - Track performance
    - Gain skills in Result Based Management.

1 Introduction

1.1 FK Esther programme

The FK Health Exchange Program supports institutional cooperation and capacity building, through exchange of personnel within institutional twinning arrangements between health institutions in Norway and in the South, primarily in Africa. The Norwegian program is affiliated to the ESTHER Europe network, an alliance of European countries that support development of health services in developing countries, where health personnel is the most important component.

The overall aim of the Norwegian program is to contribute to solving the health personnel crisis and reaching the Millennium Development Goals (MDG) in health, by strengthening the education of health personnel and delivery of quality health services in countries where Norway is engaged in long term development cooperation.

FK Norway has since 2001 supported exchange of personnel in the health sector. The FK Health Exchange program has been running since 2009 (Norway became a member of the Esther Europe Alliance in 2008).

As stated on its home page, the alliance of the ESTHER European partners is

> *a network of Governments, favouring the networking of health professionals and associations from the European region who decided to work in synergy for fighting HIV/AIDS and its disastrous consequences in developing and transitional countries through a high standard comprehensive treatment and care approach, aiming thus at contributing to the achievement of the Millennium Development Goals and to Universal Access to HIV/AIDS prevention, treatment and care.*

In the context of the Declaration of the United Nations General Assembly Special Session on HIV/Aids (UNGASS) of June 2001 (Global Crisis - Global Action), the conclusion of the G8 meeting of July 2001 and the setting up of the Global Funds to fight AIDS, Tuberculosis and Malaria in January 2002, a joint ministerial Declaration was signed on 11 April 2002 in Rome by France, Italy, Luxembourg and Spain, it was followed in Luxembourg by Austria, Belgium, Germany and Portugal in March 2004, and in September 2006 by Greece and in November 2008 by Norway. Norway had a broader focus than the other countries.

Esther's mission is supported by the 2006 World Health Report (WHO, 2006, p. xv), "at the heart of each and every health system, the workforce is central to advancing health". At the same time, there are currently 57 countries with critical staff shortages equivalent to a global deficit of 2.4 million doctors, nurses and midwives. According to WHO (2006), in Africa the ratio of total health workforce to the population is 2.3 per 1000 population. In Europe it is 18.9 per 1000 population. The shortage of health workers is compounded by lack of training opportunities and low job satisfaction among the existing staff. At the same time, movement of people across borders at unprecedented scale and rise of global epidemics make it important that health workforce learn about health systems in countries with different disease profile, and economic, social, and cultural context. To address these challenges the World Health Report calls for "global solidarity". International health exchange program can help address the human resource crisis in health and increase mutually beneficial global cooperation.

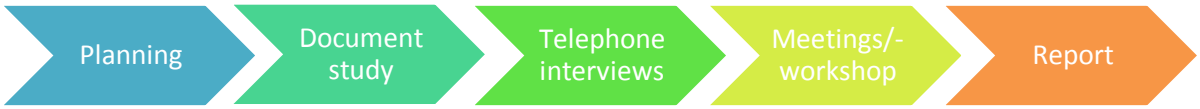
The FK Esther programme now consists of 11 main projects and one special project that originally was not an Esther project. A list of the FK Esther projects with budgets since the start up is included in Annex 1.

1.1.1 Purpose of the review

The aim of this review is to assess how well the program fits its stated overall aim, and to learn from the experience so far. The review report will give a summary of results (outputs and if possible outcomes) and highlight challenges. The report will also give recommendations for how the program can be improved in the future.

1.2 Methodology

The review has the following components:



Planning: After signing the contract a short period of planning, coordinating with FK which had to provide documentations, allocate time for FK interview; provide contact details for partners, etc.
Document study: After our review team had received the relevant documents from FK, and done a literature search (both Google and in Pubmed), the body of information was reviewed. A list of documents review is included as Annex 4.
Telephone interviews: Interviews were done by telephone and where applicable Skype, with Norwegian and South partners. A list of people interviewed is enclosed in Annex 5. Initially a questionnaire survey was planned. However, FK had recently done a survey that covered Esther participants and partners. It was concluded that it was likely that little was gained from undertaking an additional questionnaire survey. Therefore FK's own survey was used in this report. The interviews were semi-structured interviews based on the TOR as well as on special findings related to the different projects.
Meetings/workshop: The team leader had interviews with relevant staff in FK. He participated in a full day NHU seminar on the 30th November 2011 and made a few interviews there. A workshop focusing on success stories, vision and actions related to Esther (Norway) was done. FK, Norad and partners from the North were invited to this workshop. Unfortunately none of the partners could participate.
Report: A report was drafted and sent to Norad for comments. After addressing those comments, a final report was prepared.

The Esther programme consists of 11 main projects, and one recent larger project that was transferred from the Royal Norwegian Embassy, Malawi, see Annex 1.
This study was a desk study, without field visits to verify statements made against the reality on the ground. We only had the opportunity to talk to people that were part of the project one way or another, including FK staff, partners and participants. The report must be read and interpreted with this limitation in mind.

The terms of reference, as included as Annex 4, was used as guide for focus of the review. The issue "Carry out an analysis of costs in relation to the outputs and outcomes, and compare to other projects/programmes outside FK", however was not possible to do because lack of adequate data on costs, outputs and outcomes.

2 Findings

This chapter addresses the issues listed in TOR under "3 Scope of work".

2.1 Consistency between goal hierarchy and the overall goal

FKs mission is as described in chapter 1, to a) create change on the ground and b) creating change in our minds. FK Esther's overall goals are to "contribute to solving the health personnel crisis and reaching the Millennium Development Goals related to health". Documents also show that the Esther scheme was intended to address the two concerns:

> *"a) Ensure that existing health activities in the South provided a better funding opportunity and quality assurance than today, as a contribution to strengthening education and service delivery in Norway's partner countries as a means to resolve the healthcare crisis and contribute to MDGs for health*[1]*.*
> *b) Respond to the invitation of France's Foreign Minister to participate in hospital collaboration model Esther, along with other European countries and developing countries."*

(Translated from Norwegian)
All the above should be assessed when looking at consistency in the goal hierarchy.

There is consistency in the goals. Goals set by each project contribute to the overarching goals. All projects had some objectives related to increase staff capacity. This could be change in values, like the HDS Nkhoma project, or increase competence like the HUH Ocean Road partnership. Some had clear staffing objectives for South partners like the HUH Bwaila and KCH partnership that states "3 more midwives" as one of their objectives. A brief overview of each project with objectives is included in Annex 1.

2.2 Implementation of the projects

The implementation progress of the projects is mixed. Some projects appear to be implemented according to plans; others have delays or are struggling with implementation.
In projects which have been going on for some time, implementation has generally been going well and in a few cases even improved. Norwegian partners seem to struggle in the initial phase and first round of the exchange. This was also the case with the project on health staff exchanges prior to Esther. Also, gradually FK adapted its practice and applicants became more experienced with FK procedures.
It appears that this adjustment – basically adapting to applicants' requests – has been done without challenging other programme lines in FK, like the North-South, Youth and South-South. It has been feared that allowing one programme line – Esther – more attractive terms than others would create dissatisfaction in other programmes.
Frequent complaints from Norwegian partners to FK Esther have been:

a) Upper age limit for participants of 35 years does not fit health projects. Specialists are about 35 when they become specialists in Norway. Experienced personnel are therefore older. FK has allowed Esther partners to send older personnel. Average age in Esther is 38 (39 men, 37 women) while in the rest of the FK programmes it is 30 years.

[1] MDG 4: reduce child mortality; MDG 5: improve maternal health; MDG 6: combat HIV/AIDS, malaria and other diseases

b) Salaries are claimed to be too low for health staff from Norway. FK has a limit on level of salaries. As a result, the institutions have to top up these salaries in order to recruit staff for the program. Different Norwegian institutions have different approaches to topping up. Haukeland has set aside funds for topping up, based on its strategy for internationalisation. Haukeland has an interest in the Esther exchanges as it aims to improve its approach and services for the increasing immigrant population in Norway. No other partner institution has committed its own funds. This has been a major issue for Esther and partners. Meetings about topping up with FK, Norad, Minister for Development and Ministry of Health and Care Services (MHCS) have been held. FK claims that it cannot go higher. Even though Esther programme will benefit the participating hospitals, MHCS made it clear that this must be funded through the development assistance[2] and not through the general budgets of the hospitals and health institutions. Norwegian partner institutions, with the exception of Haukeland, find it hard to top up salaries and reasons for not topping up and their demands for salary levels differ. Haukeland has the most professional approach towards internationalisation, according to our view.
c) Length of stay (see discussion in 2.7),
d) Health competence in FK is useful as projects have technical aspects related to health: One staff in FK Esther, who has been in FK for one year only, has an appropriate background. FK finds this competence useful. When recruiting Esther staff, background in medicine or public health should be a requirement.
e) The FK Pre-course is claimed to be too long and not entirely appropriate for some of the more experienced participants: The Esther exchange personnel differ in age, professional and cultural experience, from the other FK programmes. Also positions and tasks differ compared to other programme lines. Other programme lines, like Young and North-South, does not necessarily have health specific or such defined tasks as FK Esther has. The review team understood that some participants resist pre-courses. Particularly Norwegian participants seem to have negative experiences with spending weeks with often much younger participants with none or very limited common basis. Southern participants seem to be generally more pleased with a general pre-course according to the review team's limited access to statements of the participants.
f) Some of the Norwegian partners claim that South-participants' salary (less than 5000 NOK per months, but with accommodations etc already paid) is too low to allow them to comply with FK's encouragement to have an active cultural life in Norway. Several Norwegian partners have forwarded the concern that South participants' salary per month is too low to have a decent life as well as doing what an FK exchange participants are expected to do. Although rent for accommodation, taxes etc are already paid, 5000

[2] This information is based on documents handed to the review team. We have not had meetings with the Norwegian Ministry of Health and Care Services (MHCS).

NOK per month is still too low, when food and other necessary expenses are taken into account.

g) Equipment is necessary and not comparable to other FK programme lines. Several partners, particularly South partners, have appreciated and pointed to the importance of having received equipments as a part of the collaboration. For partners like the SMO's prosthetic and orthotic educational project, equipment is important for doing the training. For Haukeland's collaboration with the blood transfusion centres in Zanzibar, the equipment was vital to start producing blood components and utilise effectively the skills and knowledge of the exchange staff.

FK has been increasingly adapting to the demands and needs presented by the projects. FK Esther team has gradually become more flexible and forthcoming. FK took on the Esther programme with the requirement that it was based on the same principles (like reciprocity, etc.) as the other programme lines. FK Esther had to balance the requests from Esther partners with the alignment to other programme lines and FK's general principles. The review team understands that this process has accommodated partners' needs and requests, without compromising other project lines.

North partners have explained that many of them struggled at the beginning with the rules and constraints set by FK. Administrative requirements in particular were time consuming. Several projects struggled with longer than expected time to get the proper visas and permits from the immigration authorities (mostly UDI).

The projects are only one year long. This seems like a short period, even though previous FK exchanges used to have a one year cycle. Given that there is an expectation of a long-term collaboration, a one year cycle seems unnecessarily short. Esther in Germany has a two year project cycle.

2.3 Results and outcomes

2.3.1 Successes

Improved motivation and changes in professional attitude among the participants, as well as in the institutions, were frequent outcomes mentioned by the interviewed partners as well as in documents. Also, a recent FK survey reported that generally, staff motivation and skills are seen as results from almost all types of cooperation. According to this, more than 50% of the respondents report results on staff motivation, skills and organizational development. Among FK funded institutions almost 50% also report results on service delivery. The review team assesses that improved motivation and change in professional attitude are likely to improve the way participants and their institutions do their work.

South partners also claim improved efficiency as the change in attitude and new improved ways of working improves the handling of patients, keeping records etc.

A recent questionnaire survey shows that Esther partners are generally more satisfied and claim more results (in terms of capacity building, motivation etc) than other programme lines.

The review team is particularly pleased with the findings that the collaborations (and exchanges) create a better motivation and improved professional attitude. As described extensively in the World Health Report (WHO, 2006), motivation is one of the key

determining factors in health worker performance and consequently, in quality of health services.
Esther programme filled a funding gap in the Norwegian development assistance for health. It is a home for ongoing health collaborations and upcoming initiatives, like the Special project that otherwise, would have struggled to find a donor.
For concrete examples of Esther's success stories, please see Annex 3.

2.3.2 Challenges

Based on the information available to the review team, the results (on both output and outcome level) are assessed as good. There is however an attribution problem. Some of the institutions that Esther partners collaborate with have other extensive collaborations. For example, the Kamuzu Hospital in Malawi participates in Norwegian as well as German Esther projects.
One of the possible negative results of increased qualifications is a "brain drain"[3] when skilled and trained staff leaves for better paid positions outside the partner institutions or countries. However, according to interviews, this is not a widespread problem. Most of the South partners report that only a few staff members who have participated in the Esther exchange have left their organization. For example in Haydom, 2 out of 10 exchanged staff has found jobs elsewhere, and in Zanzibar National Blood Transfusion Services none of the exchanged staff have left the organization. None of the interviewed partners report an increased loss of staff as a result of the exchange. However, given the short duration of the program so far, this is still a valid concern and should be reviewed in future assessments. The review team sees a risk of brain drain in instances where participants from the South may receive diplomas from highly recognized institutions during their exchange that would give them necessary accreditation to work elsewhere. The level of brain drain will depend on a particular country and organization, and as the German Esther review shows many of those trained through Esther were eventually recruited to other locations.
The Esther program is a mix of projects from different hospitals in Norway. It reflects the interest and ideas of Norwegian hospitals and health institutions where Esther is seen as a funding opportunity, not the strategic framework. Other countries have tried to focus their Esther efforts in certain areas, typically HIV/AIDS. There appears to be no effort to make a similar strategic direction for the Norwegian Esther programme. The review shows that this lack of strategic direction reduces the effect of the programme.

2.3.3 Monitoring and reporting

Monitoring and reporting has been improving. For about one year (18 months), the FK agreement (Annex 1) included a logical framework that is a table where each objective is supported by indicators, baselines, means and timing of verification. Unfortunately, as projects report only as project year ends, these reports had not been received by FK at the time of writing. The review team has therefore not had the opportunity to review the present reporting regime in practice.
When problems occur in projects, the Norwegian partners seem to discuss these with FK. However, there are cases where changes are made to original projects without prior

[3] Brain drain: Large-scale emigration of a large group of individuals with technical skills or knowledge; Human capital flight.

consultations and agreement with FK. Typically, it is the length of stay that changes (mostly reduced) because of requests by participants themselves or partners in the South or North. FK Esther have some means of stopping payment when deviations in number of participants through the payment system but no means of verification through the present reporting and monitoring system. Generally, reporting systems where projects report only as they are closing make it difficult to direct them and take corrective actions, at least within each application round. While in most cases corrective actions from FK Esther will not be necessary, this should be part of FK's role and responsibility.

FK staff also visit Esther projects; however this appears to be on an ad-hoc basis and is not based on a systematic approach with regular visits to each project. Germany has a system of visiting each project once a year. Interviews show that one visit at the end of the project from FK is not sufficient. The review team sees that better contact with FK Esther would be appreciated by South partners and participants.

Measuring capacity development and partnership is difficult and the Esther network is working on this. This is a process where FK Esther is involved and has made good contributions.

The new Annex 1 in FKs application process, with its logical framework and indicators, has caused some challenges for the partners. Some are clearly inexperienced with this type of management, and one northern partner said that, "We did not even know what an indicator was". Some northern partners have explained that they felt that they had to write in indicators that were either on a higher level and therefore out of reach, or measurable only in the long-term, i.e. long after their projects would end. This led to situations where participating organizations are unable to measure the set indicators, but on which they have to report.

Generally, the Esther programme lacked objective data to evaluate its projects. This may change as the new logical framework is implemented and reports from the field are submitted. At the time of conducting this review there were no data on project level reported to FK that was easily accessible to the team, although output data were available for some individual projects. Most of the outcome evidence was in the form of personal stories. During phone interviews the review team found that the partners (particularly in the South) had clear understanding of the project's performance. This knowledge could be utilized more effectively by Esther.

Scarcity of quantitative data, lack of baseline, and lack of benchmarks are key methodological constraints raised frequently in the literature, also a study of twinning of health organizations in UK (James et al, 2008). Such constraints make it difficult to evaluate the true impact of these programs. Thus, there is a need to improve current monitoring and reporting system, especially with regard to collection of baseline information and quantitative data on outputs and outcome.

2.4 Sustainability

The partners – both South and North – responded that sustainability was likely. Sustainability was defined by the interviewer as "the continuation of benefits ….after the development assistance has been completed[4]". Some projects had started recently so that

[4] OECD/DAC: "Glossary of Key Terms in Evaluation and Result Based Management".

issue of sustainability was not relevant. For those projects where support has been ongoing for some years, put forward the following supporting evidence that sustainability was likely:

a) South partner has other donors that will continue funding, and then supporting the continuation or at least maintaining the benefits.
b) The knowledge and capacity built will likely still be in the institution. Several thought that the capacity will still be developed as contact and communication will be going on even in a hypothetical situation that funding and the project collaboration came to an end. Several of the South partners reported that they have succeeded to maintain the trained exchanged staff within the institution.
c) Contact between South and North will continue even if the formal Esther project was closed down.

One example of sustainability mentioned by a South partner was that Norwegian partners departed a year ago from the Children's Emergency Unit. The results are still there, because things that were established have been transferred to local staff. Now, in a new phase, the two Norwegians are working in a different unit. So, the Children's Emergency unit is run by Malawians.
The review team assess the sustainability to be good.

2.5 Comparative study

The review team has been asked to compare FK Esther with other Norwegian funded health projects as well with other (international) projects experiences. This is done in two ways: (a) a literature review, and (b) a comparison of FK Esther model with models found in other health projects.

2.5.1 Literature review

The literature review showed that detailed case-studies of North-South partnerships remain limited. Most studies were not of direct relevance to our study, although many of them showed the need for programs such as those supported by FK. Below are highlights from this literature review. Please see the Annex 2 for details.
1. One of the very few English language studies found in PubMed on partnership between Norwegian institutions and partners in the South focuses exclusively on the increased "cultural competence" as the key outcome of the partnership (Hagen et al, 2009); although to its credit it describes the experiences and learning outcomes from both the Norwegian and the Malawian students. While the cultural competence is an important outcome of health personnel exchange, it seems that studies of these programs would benefit from focusing more on benefits to the population, i.e. users of health services in the country.
2. The study evaluating the partnerships developed between the London School of Hygiene and Tropical Medicine and three research partners in South Africa and Thailand **is one of the few studies, which combines qualitative and quantitative methods to assess the program impact** (Mayhew et al, 2008). The study draws the following conclusions:
a. Need to build-in mechanisms to enhance the institutional, rather than personal, aspects of the partnership as it seemed that success or failure of partnerships depended on links between individuals rather than organizations;
b. Importance of common language as it seemed to facilitate a more effective communication between partners;

c. Challenge of sustaining capacity in organizations in the South as trained staff with good research skills who then go to the private sector or more attractive government jobs; and

d. Regular joint negotiation of research priorities and funding issues were important in developing responsive mechanisms for governing these partnerships and making them sustainable.

3. One of the main conclusions of the study on scientific collaboration (Chandiwana & Ornbjerg, 2003) is that effective international cooperation requires "a holistic approach to institutional strengthening" ranging from provision of laboratory equipment and financial incentives in a form of fellowships to retain qualified staff to training in computerized accounting to meet the project's administrative needs.

4. An evaluation of neurosurgical capacity building in Uganda through twinning is particularly relevant (Haglund, 2011). The study shows positive impact of the twinning program on the capacity of the New Mulago Hospital. There was a significant increase in the number of complexity of neurosurgical cases performed. Utilization of the elective operating room days increased from 41% to 93% during the project period. The increase in capacity was maintained without the presence of the personnel from the North. **The results of this study are particularly relevant for our review of the FK Esther program.** It appears that health personnel exchange alone is not sufficient for significant improvements in capacity and should be combined with provision of essential equipment.

5. According to an evaluation report of UK health twinning programs (James et al, 2008), the impact of a particular link or exchange program depends on a number of factors, including the following:

a. Duration of placements or visits by northern partner staff matters as multiple "one off" visits of one to two weeks have little benefit to the southern partner and if anything, they are perceived to cause distraction and use up valuable resources such as time;

b. Visits to UK for southern partner staff appear to have benefits at individual level; however, the impact of such visits at organizational level in the South depends on rank of participating staff as more junior staff are less able to affect change in their organizations at home and may even face resistance;

c. There were instances when staff from the South has not returned to their home country or home organization after the exchange;

d. Donations of equipment should be based on the needs of the southern partner and ideally, should be part of a larger long-term program on capacity-building that includes training;

e. Access to information such as journals and databases such as PubMed is valuable;

f. Sustainability of a link depends on continuity of personnel and staff changes seem to impact negatively on the institutional commitment to the program;

g. The main "added value" of facilitating bodies seems to be financial support and it is unclear whether direct links between North and South healthcare organizations can work as well without such financial support;

h. At the same time, it appears that the role of facilitating bodies is important where partners on both sides are new or have little experience in international cooperation; and

i. Most relevantly for facilitating organizations such as FK, they can play a key role in ensuring that these exchange programs are "harmonized, complementary, in line with good governance, evidence based and cost effective" (James et al, 2008, p. 49).

2.5.2 Comparison with selected programmes

We have selected the German Esther programme as the Esther country with the most similar programme, but not the same, model as Norway. Two other Norwegian funded projects came up in our search and are also assessed below. These projects have been presented as potential models, however have no apparent similarities in terms of key aspects like south-south collaboration, staff exchanges (sending professionals from north is not enough to fall within the Norwegian Esther model), not to mention reciprocity.

The German Federal Ministry for Economic Cooperation and Development (BMZ), Esther Germany

BMZ joined the Alliance in 2004, only two years after its initiation. The GIZ sector project Strengthening the German contribution to global AIDS Response has been coordinating the German contribution to the European ESTHER Alliance since January 2007. For this purpose the ESTHER Germany Secretariat was set up. The aim of the German contribution is to improve the quality of services provided for people living with or affected by HIV and AIDS, in particular prevention, treatment and care. At the moment, the BMZ through GTZ supports 10 ESTHER partnerships. The exchanges North-South are several short (2-3 weeks) visits, South-North exchanges are three month visits. The programme also includes small-scale procurement of equipment, research and South-South exchange.

Norwegian Church Aid (NCA), Improved Health Training Education in Malawian Nursing Schools

The aim of NCA's project is to improve the quality of nursing education, increase and retain the number of nurses in the healthcare and delivery system in Malawi. This is through cooperation between Norwegian and Malawian nursing colleges which are as follows: In Malawi, all Christian Health Association of Malawi (CHAM) nursing colleges, Malawi College of Health Sciences (MCHS) Zomba and Blantyre campuses and Kamuzu College of Nursing (KCN). In Norway, Akershus, Diakonhjemmet, Østfold, Telemark, Vestfold and Stord/Haugesund. Norwegian Nurses‟ Organization Vestfold branch and National Organization of Nurses of Malawi (NONM) the Southern region are also part of the project. Stakeholders to the project are CHAM secretariat, Ministry of Health, NONM secretariat and Nurses and Midwives Council of Malawi. This cooperation is based on eight focus areas and these are staff development, curriculum development, attract and retain nurses, teaching and learning resources, research, networking, monitoring and evaluation and cross cultural issues.

Capacity Building and Improvement of Tertiary Maternal Health and Surgical Services in Central Region, Malawi (Spesialprosjektet)

This project was placed in FK by Norad/Embassy in Malawi. This is a project that has run since 2007. The Maternal Health Institutional Cooperation Project collaborates with the Bwaila Maternity Hospital. The goal of this Cooperation is to improve pregnant women's access to basic and comprehensive (safe, affordable and suitable) essential/emergency maternal and child health services and to contribute to reduce maternal and child mortality in Malawi. The objectives included increasing safety of pregnancy and delivery at Bwaila/KCH by improving interventions in the management of pregnant women at the

hospital; training of health workers and birth attendants; increasing the health personnel's access to training, cooperation, information and ICT/e-learning as well as establish a broadband connection for and between Bwaila and KCH.
The main activities in Phase 2 until 2010 was the rotation of four Norwegian staff (midwives and gynaecologists) through Bwaila /KCH Maternity Hospital, the supply of highly needed medical equipment (second hand equipment donated by the Norwegian Hospitals). The total budget allocated for the previous phase was NOK 5.9 million (83% allocated to cover the costs for Norwegian health personnel (midwives, gynaecologists- alternating at Bwaila /KCH Hospital)). The total budget allocated up to 2010 was NOK 7.9 million. The present budget 2011-2014 is NOK 15.4 in total.
This project is not a reciprocal exchange. It was rated as good related to performance in an evaluation in 2010.

2.5.3 Model assessment

All three models have got positive evaluations and the review team consider all of them successful models. We assess the three models relevance for FK Esther based on that FK will remain as it is to a large extent. We don't base on our model comparison that Esther will receive drastically more funds, or change function for example funding and monitoring construction projects etc.
Table 1 Model assessment table present an overview of the programmes. Our assessment is as follows:

a) NCA and Special have different demands for a donor. FK Esther handles exchanges well, but is not set up to handle projects which are larger and demand more and different capacity of Esther. NCA has until recently been also a construction project, building schools, and therefore have needed different capacity than an exchange project.
b) The Special Project is interesting. Officially it's not FK Esther project, but is placed in FK Esther programme to be managed there. It is more comprehensive and larger than other FK Esther projects. Given that FK Esther is to have a good quality and comprehensive support and monitoring for projects, we think that FK Esther should be strengthened to comply with higher demands for support and monitoring. The present set-up and monitoring are not adequate, see discussion on monitoring for details.
c) The Special Project gives an interesting experience in using specialist leave of 4 months for exchange. This has FK so far refused to accept, as it is below 6 months.
d) Both NCA and Special Projects miss the South-North exchange aspect, which we find to be useful and beneficial. It is also FK Esther's core competence and if the exchange part turns back to be the old model of sending North experts to South, we do not see a comparative advantage for FK.
e) Esther Germany is the one that the review team feels fits best with FK. It does allow for shorter exchanges, it does have South-North exchanges and it provides an

interesting example of model where shorter term exchanges are assessed as successful[5].

We believe that the best model for FK Esther is the Esther German model. We believe that Esther Germany is a programme that FK Esther can learn from. We do however see that Esther Germany should not be used as a blueprint.

[5] The review done of Esther Germany is taken as it is, and we have not assessed its weaknesses and therefore caution should be taken.

Table 1 Model assessment table

FK Esther model components	Esther German	NCA Malawian Nursing	Special project in FK
Strengthening primary health care institutions and hospitals	Yes	Yes	Yes
Contributing to the education of health personnel	Yes	Yes	Yes
Building up the capacity of technical medical personnel	Yes	yes	Yes
Establishing and strengthening quality systems.	Yes	In terms of educating yes	Yes
Strengthening the capacity of IT systems and telemedicine.	Yes	No telemedicine, some computer labs. Skills labs.	Yes
Capacity building within administration and management	Yes, particularly knowledge management	Partly yes. Phase 2 include management and administration (after 2008).	Yes
Exchange of personnel, with postings for of 6 months to 3 years. Exchange North-South, South-South or a combination.	Yes, but less than the time in FK	Only North-South, one meeting a year from South. Visits one to two months. Some of the same teachers returning.	North-South
Shorter visits by key personnel as a smaller component	Yes	No	Utilizing the 4 month leaves for specialists
Support with equipment (smaller part)	Yes	Up to recently this has been mainly a construction project, building school buildings. Books, skills labs, PCs.	Yes, but a very small part of total budget

2.6 Framework

2.6.1 Is the framework fit for purpose?

The Esther framework improves the Norwegian support to the health sector, as it is the only programme providing exchanges all ways (reciprocity). According to feedback from both this review and the evaluation of the German Esther programme, improved professional attitudes and motivation is beneficial, both for South partners, as well as North partners. FK has a unique experience and concept for exchange. The Esther programme utilized this. The original FK model, as used in other programme lines, had to be adapted and changed to fit the health/hospital projects. This has to a large extent already materialised, however some smaller adjustments are recommended, please see section 2.2 for details. We therefore see the FK Esther framework, with its adjustments, as fit for purpose.

We do not see that the mandate and guidelines limit the projects, when implemented in flexible way. Since there has been no significant negative impact on other FK programme lines, we believe that FK Esther can continue adapting to requests from applicants that will strengthen the projects.

2.6.2 FK Esther's added value

FK Esther's core competence is exchanges, and it is here that FK give value to its partners. FK Esther adds value to partners through FKs use of reciprocal exchanges. We have heard many success stories from South partners that find the exchange to Norway beneficial. We also see that Norwegian institutions can utilize the changed values and the skills of better dealing with patients from different cultures. In this respect FK is the right place and Esther is the right framework for the projects that now are within the programme.

The funds are small and exchanges have an important but limited role in health sector development collaboration. Therefore Esther improves the funding opportunities but does not fill the fund gap, in the health sector development assistance. Contributing to filling a perceived funding gap was one of the issues taken into account when deciding to establish FK Esther.

2.7 Short versus long stays

One of the complaints from applicants has been that the exchange duration requirement is too long and will not fit within the constraints faced by participants, particularly specialists. FK has solved this by maintaining a general rule of no less that 6 months (not including pre-course and after work), but allowed several exceptions as well as not punished violations if the length of the stay has been reduced compared to contract.

FK has allowed specialists on defined short term tasks, like training and teaching, to go for short periods.

Health staff from South, in particularly doctors and specialists, is not allowed to do operational work in Norway, but can only observe and work under supervision the Norwegian practice. This is useful; however one year with observation may be too long. We see many partners reduce it to less time. The German model uses only three months for South exchanges. Given their positive evaluation, it is likely that less exchange time may be optimal. The review team sees that the cultural aspect of the exchange will be reduced by shortening the period. This is for further study, as this review does not have conclusive data on this issue.

The general understanding is that long term involvement is a necessary condition for success. This also is the case for the individual exchanges – with some exceptions. South partners have explained to the team that short term visit from Norway has been useful as it is for defined short term task, like teaching a course.
Germany has had shorter visit but with several returns within the two year contract period. Also a recent evaluation of Esther Germany asserts that these shorter term exchanges were beneficial and successful.

2.8 Rejected applications

Six applications have been declined by FK of which one later was approved after changes and dialogue with the applicant. The table below shows the arguments forwarded for the five remaining rejected applications.

Table 2 Applications rejected by FK Esther up to October 2011

ID	Basis for rejections
1	The country was not a prioritised partner country in Africa. FK normally does not support student exchanges either.
2	The project was too country specific to be included in FK mechanism. Difficult to see Norway's comparative advantage that south can utilize. The applicant was already doing several other Esther projects.
3	The applicant was already doing another feasibility study. When this was ready FK indicated that they could take a new assessment of the project.
4	Based on a total assessment and existing funds. The applicant was already doing several other Esther projects.
5	Based on a total assessment and existing funds. This applicant was also too small (few employees) according to FK guidelines.

Only two of the five rejected applications (ID 1 and 5) are outside FKs rules and guidelines. For the other three applications the major argument was a too high activity level. Two applications (ID 2 and 4) came from a partner that already had a large share of the Esther budget and programmes, and FK wanted the Esther projects to be spread projects more evenly among the Norwegian hospital partners. There is no rules saying how large share a partner can have in Esther, this is a FK made decision as the review team understands. It may be a wise decision, but raises the question whether quality and productivity (in creating good projects) or "fair" distribution of the project among Norwegian partners should be the ruling principle.
One application for feasibility study funding was declined because the Norwegian partner already was doing another feasibility study for Esther (ID 3).

Annex 1: Project snapshotsBudgets figures

ProsjektID	Norsk partner	Partnere	Prosjektperiode	Runde	Budsjett
101005E	Haukeland University Hospital (HUH)	The National Blood Transfusion Serc(NBTS), Zanzibar Blood Transfusion Services (ZNBTS)	2009-2010	1	1530000
101007E	Haukeland University Hospital (HUH)	The National Blood Transfusion Serc(NBTS), Zanzibar Blood Transfusion Services (ZNBTS)	2010-2011	2	1930000
101012E	Haukeland University Hospital (HUH)	The National Blood Transfusion Serc(NBTS), Zanzibar Blood Transfusion Services (ZNBTS)	2011-2013	3	1346598
101003E	Haukeland University Hospital (HUH)	Kamuzu Central Hospital (KCHH), Bwaila Hospital	2008-2010	1	1578000
101011E	Haukeland University Hospital (HUH)	Kamuzu Central Hospital (KCHH), Bwaila Hospital	2011-2013	2	2399523
101009E	Haukeland University Hospital	Ocean Road Cancer Institute (ORCI)	2011-2012	3	1670310
101010E	Haukeland University Hospital (HUH)	Mnazi Mmoja Hospital (MMH)	2011-2012	1	2746841
111102E	Haraldsplass Diakonale Sykehus (HDS)	Nkhoma Hospital	2010-2011	1	1700000
111103E	Haraldsplass Diakonale Sykehus (HDS)	Nkhoma Hospital	2011-2012	2	1757855
102201E	Høgskolen i Bergen	Ahfad University for Women	2011-2012	3	1592580
112904E	Oslo University Hospital (OUS)	IPGME&R &SSKM Hospital, Kolkata and SNCU, Suri Sadar Hospital	2011-2012	1	1980000
112903E	Oslo University Hospital (OUS); Haukeland	Juba Teaching Hospital, South Sudan; University of Limpopo/ Medunsa Campus, South Africa	2010-2012	1	1700000

104906E	Sophies Minde Ortopedi AS (SMO)	TATCOT (Tanzania Training Centre for Orthopaedic Technologists), CSPO (Cambodian School of Prosthetics and Orthotics), Kamuzu Central Hospital (KCH), department of physical rehabilitation	2010-2011	1	3300000
104907E	Sophies Minde Ortopedi AS (SMO)	TATCOT (Tanzania Training Centre for Orthopaedic Technologists), CSPO (Cambodian School of Prosthetics and Orthotics), Kamuzu Central Hospital (KCH), department of physical rehabilitation	2011-2012	2	6 280 355
111601E	Sørlandet sykehus helseforetak (SSHF)	Haydom Lutheran Hospital (HLH)	2009-2011	2	2200000
111603E	Sørlandet sykehus helseforetak (SSHF)	Haydom Lutheran Hospital (HLH)	2011-2012	3	2195495
112002E	University of Bergen Centre, for International Health (UiB CIH), Haukeland University Hospital (HUH)	Addis Ababa University Medical Faculty (AAU MF), Myungsung Christian Medical Center (MCM)	2009-2010	1	1651000
112003E	University of Bergen Centre, for International Health (UiB CIH), Haukeland University Hospital (HUH)	Addis Ababa University Medical Faculty (AAU MF), Myungsung Christian Medical Center (MCM)	2010-2011	2	3250000

102703E	SPESIALPROSJEKTET: Haukeland University Hospital (HUH), Oslo University Hospital (OUS), The University Hospital of Northern Norway (UNN)	Kamuzu Central Hospital (KCH), Lilongwe, Malawi	2011-2014	A three year agreement. Previously an Embassy project.	15432120

Project snapshots

Project factsheets

Norwegian Partner

Haukeland University Hospita(HUH)

South Partners

The National Blood Transfusion Serc(NBTS),
Zanzibar Blood Transfusion Services (ZNBTS)

Staff exchange in the Field of Blood bank

Description NOR partner

HUH is the teaching hospital for the University of Bergen, and regional hospital for Western Norway, providing services to a population of approximately 1.2 million people. The Hospital has a capacity of 1400 beds, and approximately 8000 staff members. The hospital had the largest number of in-patient days in Norway in 2005.

Description of South partners

NBTS was formed in the year 2004 as a programme under the Ministry of Health and Social Welfare (MoHSW). It was established through a cooperative agreement entered into by the United States Centre for Disease Control and the MOHSW. NBTS is charged with the responsibility of facilitating availability of adequate and safe blood and blood products in the country ZNBTS was started in June 2005. It's a run under the Ministry of Health and Social Welfare Zanzibar which works in partnership with the Ministry of Health and Social Welfare Mainland Tanzania and Red Cross Society under Cooperative Agreement to Strengthen blood safety supported by PEFPAR (President Emergency Plan for AIDS Relief).Its overall goal is to ensure availability of adequate supply of safe blood and products from voluntary, non remunerated donors from low risk population. The Services has one Blood Transfusion Center for Zanzibar Islands which has a population of about 1.1million people. The Center is presently processing about 4,700 units of blood /year which supplies about 70%of hospitals performing blood transfusion in the Country.

Project description

The project is focusing on capacity building of NBTS and ZNBTS in order to improve the institutions' ability to deliver more and better blood products to the hospitals in Tanzania. This will be done by strengthening the technical services relating to blood bank activities and build the capacity of other parts of the institution. The project is also aiming at establishing new relevant research projects. HUH staff should also gain new experience in blood bank management and activities.

Project objectives

HUH

- Infected blood being handled more properly
- Increased commitment of staff members

NBTS/ZNBTS:

- Deliver more and better blood products to the hospitals of Tanzania/Zanzibar
- Modern and efficient technologies in the areas of blood screening and production of paediatric blood bags being used at NBTS/ZNBTS

Round number	Duration	Number of participants in total	Number of participants this round
3	November 2011 to December 2012	15	

Norwegian Partner	South Partners
Haraldsplass Diakonale Sykehus (HDS)	Nkhoma Hospital

Competence building and understanding – a collaboration project between Nkhoma hospital, Malawi and Haraldsplass Deaconess Hospital, Norway

Description NOR partner

HDS is a non-governmental hospital with a framework agreement supplying hospital services to the population in Bergen. Haraldsplass was founded in 1918 it has app. 780 employees and app. 560 man-labor year. It serves as first referral hospital with extensive co-operation with Haukeland University Hospital and University of Bergen.

Description of South partners

Nkhoma Hospital is a nonprofit health services provider in the Central Region of Malawi. The health department started at the end of the 19th century with the medical work of the Reformed church (South Africa). In 1915 Nkhoma Hospital was built. Currently, Nkhoma Hospital is a 220 bed hospital where, 3500 outpatients are seen monthly in the outpatient area, 200 women start antenatal care and 180 deliveries are performed. The hospital has an extensive primary health care program including safe motherhood, AIDS prevention, under five screening and indoor residual spraying for Malaria. The hospital also has a home based care program to visit terminally ill patients in the community. It serves as a referral hospital for12 surrounding health centers that send complicated deliveries, complicated malaria cases and other emergencies to Nkhoma. A formal agreement exists between Nkhoma and the Malawi government to provide these emergency services at no cost to the user with the Government providing the funding. This has greatly increased the number of referrals to Nkhoma but reduced the

Project description

The aim of the project is to improve the emergency care and to establish an emergency unit at Nkhoma Hospital. In addition the project is aiming at improving the quality of the high risk care provided in the maternity, surgical and general wards, and in this way reduces mortality among critical ill patients, mothers giving birth and children being born. The project should also promote internationalisation of HDS.

Project objectives

Exchange competence between Haraldsplass and Nkhoma hospital in order to fulfill the objectives for the two partners.

Haraldsplass:

An international perspective is integrated in the basic values of Haraldsplass Deaconess Hospital. The specific engagement in sharing of competence is regarded as a natural consequence of this international perspective.

Nkhoma hospital:

Objective 1: The quality of emergency care provided in casualty/out patients department has been improved.

Objective 2: The quality of high risk care provided in maternity, surgical as well as general wards has been

Round number	Duration	Number of participants in total	Number of participants this round
2	2010-2015		8

Norwegian Partner
Haukeland University Hospital

South Partners
Ocean Road Cancer Institute (ORCI)

Staff exchange in the Field of Oncology

Description NOR partner

HUH see elsewhere

Description of South partners

Ocean Road Cancer Institute is the only specialized centre for the treatment of cancer in Tanzania. Every year about 27,000 people die of cancer in the country, and of these about 6,000 die within a year of the diagnosis being confirmed. The amount of new types of cancer related to HIV/AIDS is increasing and the need for educated personnel is growing. Some forms of cancers, such as cancer of the cervix, breast, colorectal and most children cancers have a welcome improvement in survival especially when diagnosed in early stages.

Project description

Haukeland University Hospital and Ocean Road Cancer Institute have been cooperating for many years, and this third year of exchange will be the first with ESTHER programme. It will be focus on safe handling of chemotherapy in both institutions, along with creating an enabling environment where staff members can contribute in improving communication with cancer patients and their relatives.

Project objectives

Haukeland University Hospital

-Practical experience in communicating with cancer patients/relatives in a developing country, in order to provide cancer patients at HUH with multi-cultural background better follow-up of patients and their relatives

-Long- term partnership between ORCI and HUH have been developed

Ocean Road Cancer Institute

-Increased competence in administration and preparation of safe handling of chemotherapy/chemotherapeutic agents, in order to provide a more secure working environment for ORCI staff members

-Long- term partnership between ORCI and HUH have been develope

Round number	Duration	Number of participants in total	Number of participants this round
3	May 2011 to May 2012	8	

Norwegian Partner | **South Partners**

Haukeland University Hospital (HUH) | Mnazi Mmoja Hospital (MMH)

Exchange in the field of paediatrics, internal medicine and psychiatry between Norway and Zanzibar

Description NOR partner

HUH described elsewhere

Description of South partners

Mnazi Mmoja is the main referral Hospital in Zanzibar. It caters for tertiary services for the whole country, and primary and secondary care for Stone Town residents. It serves as a teaching hospital for the College of Health

Science and Zanzibar Medical University.

It has an estimation of 847 working staff and has a bed capacity of 544 spread over three campuses. The main campus, MMH, located in Stone Town, has 400 beds. Mwembeladu Maternity Home has 34 beds and Kidongo chekundu Mental Hospital 110 beds. Both the maternity and mental hospitals are located within the city limits of Stone Town but outside of the town area.

Project description

The project is between Haukeland University Hospital and Mnazi Mmoja Hospital, and will be the first round of exchange in the programme. The project will focus on competence building within the fields of paediatrics, internal medicine and psychiatry between the two institutions.

Project objectives

HUH:

Paediatrics: a) Extensive practical experience (volume training) in treatment of birth asphyxia in order to provide infants at HUH with asphyxia, improved treatment. B) Increased experience in clinical evaluation of infants with suspected pneumonia, in order to reduce number of supplemental examinations at Paediatric Unit, HUH.

Internal Medicine: Increased competence for HUH staff in diagnostic, treatment and prevention of tropical diseases focusing on internal medical conditions, with the aim of improving treatment of imported tropical conditions at HUH.

Psychiatry: a) Increase multicultural experience and understanding among the staff in the psychiatric division, b) Increase motivation and job satisfaction among staff members.

Hospital Management: a) Improve hospital management at Mnazi Mmoja Hospital within the collaborating fields of paediatrics, internal medicine and psychiatry

Medical Engineering: Improve medical engineering at Mnazi Mmoja Hospital in general, and specially in the fields of paediatrics, internal medicine and psychiatry

Mnazi Mmoja Hospital: Paediatrics: Modern clinical skills and simple modern technology introduced and adapted at MMH to increase survival and reduce complications in paediatrics

Internal Medicine: Reduced mortality and morbidity for patients at Dep. Of Internal Medicine at MMH with communicable and non-communicable diseases

Psychiatry: Develop competence on diagnostics and treatment of epilepsy in children and adults.

Number of participants in total | **Number of participants this round**

7

Norwegian Partner **South Partners**

HUH Bwaila and Kamuzu Central Hospital

Exchange of personnel in the supporting field of infantile and maternal care, radiology and pathology, between Malawi and Norway

Description NOR partner

HUH See elsewhere

Description of South partners

Bwaila Hospital is organised under the District Health Office, while KCH remains the Regional Hospital for central Malawi, under the MoH. Low risk births are now channelled to the new maternity clinic at Bwaila, who will mainly be run by midwives and clinical officers. Complicated and high risk births will be handled by the new maternity clinic at KCH. There will, however, remain a very close collaboration between the two institutions and the consultants and specialists at KCH will supervise and continue to follow up activities at Bwaila on a daily basis. This second exchange round of FK personnel will be anchored at KCH as the focal administrative south partner, but it is agreed that Bwaila will remain the key partner in the exchange programme, when it comes to the exchange of midwives.

Kamuzu Central Hospital (KCH) is the second largest state hospital in Malawi. The department of Obstetrics & Gynaecology (O&G) provides a district level service for the environs of Lilongwe. It is also referral centre for the central region of Malawi (estimated population over 4million). The department has a capacity for 12-13,000 deliveries per year and is running antenatal clinics, gynaecological clinics, elective operating lists, ward duties, providing 24 hour emergency cover. Alongside the departmental commitments, the staff is also involved in the training of student nurses, medical

Project description

The project is an exchange of personnel in the field of infantile and maternal care, radiology and pathology, between Kamuzu Central Hospital (KCH)/Bwaila Hospital, Malawi, and Haukeland University Hospital, Norway.

The project is focusing on capacity building of KCH and Bwaila in order to improve the institutions' ability to deliver more and better services in the above mentioned fields. HUH staff should also gain new experience in the collaborating clinical areas

Project objectives

Haukeland University Hospital

For maternal health:

- 3 more midwives – in addition to the first 3 who have been posting in Malawi through the main project and the exchange program - will have achieved increased competence at HUH in handling complicated births on their own as well as normal births
- Staff members at HUH are more motivated and there will be more applicants for the positions in Malawi further on.

For imaging:

- Carry out and read radiological examinations preformed with basic conventional x-ray equipment
- Develop skills in organizing, carrying out, and evaluate training of staff in computer technology (CT), including information technology support

For pathology: • be able to perform basic histopathological techniques with minimal technical support such as cut up of surgical specimens, processing, embedding, sectioning and staining.

- be able to develop, organise and manage a routine histopathology laboratory.

Bwaila Hospital and Kamuzu Central Hospital

For maternal health:

- Improved knowledge and skills of the staff in the earmarked areas of collaboration.

For imaging: • Take part in CT training, including developing protocols, quality control and optimization of examinations.

Round number		Duration
Number of participants in total		Number of participants this round
2	September 2011 to August 2012	11

students and student clinical officers.
- A routine histopathology laboratory using basic techniques including special stains is organised

Norwegian Partner

Høgskolen i Bergen

South Partners

Ahfad University for Women

NIBRAS; Rehabilitation and Physiotherapy Education in Norway and Sudan

Description NOR partner

HiB is a state run institution of higher education with 7000 students and 700 staff. Bergen University College offers high quality study programmes directed towards specific professions in society, and there is a great demand for graduates from our study programmes.

Description of South partners

AUW is a pioneer higher education institution in Sudan whose philosophy is women's education, development and empowerment. It was established in 1966 with the aim to train and equip women to become active change agents in the development of Sudan. The goal and philosophy of AUW are to prepare women to assume responsible roles in families, communities, and in the nation using a combination of well articulated academic courses, on-the-job training, individual research, and community extension activities. AUW vision is to create proactive women change agents and leaders from all parts of Sudan who can participate actively in the development of their families and communities.

Project description

The overall aim of the project is to contribute to physiotherapy teaching and supervision recourses to Ahfad University for Women, School of Health Sciences, during the first critical years of establishing and running a Bachelor Programme in Physiotherapy. The teaching and supervision recourses will partly be provided by North participants from Bergen University College and partly by South participants after posting at Bergen University College. The aim is to build competence in the area of physiotherapy education over time in order for Ahfad to be self sufficient in this area. The previous rounds of exchange have been within the framework of the North – South

Project objectives

HIB: a) Increased competence on teaching physiotherapy students at AUW and in tutoring placement supervisors

b) Increased competence on the process of developing and implementing a BSc in physiotherapy in Sudan

c) Develop a basis for student exchange between HiB and AUW

AUW: a) Implementation of an internationally recognized curriculum adapted to Sudan environment and conditions.

Round number	Duration	Number of participants in total	Number of participants this round
4	September 2011 to May 2012		9

Norwegian Partner	South Partners
Oslo University Hospital (OUS)	IPGME&R &SSKM Hospital, Kolkata, SNCU, Suri Sadar Hospital

Strengthening the area of newborn care: Institutional Cooperation and (technical) exchange of health personnel in north south collaboration

Description NOR partner

Oslo University Hospital (OUS) is government owned and includes the former Ullevål Hospital, Rikshospitalet and Aker Hospital. It is the biggest University hospital in Norway with approx. 20 000 staff members. OUS is the country's

Description of South partners

IPGMI: A level III city hospital with 2500 deliveries pr year and 2500 new born treated anually. 28 days mortality is 25/1000 live births. The hospital has a catchment area with 100.000 deliveveries pr year and 30% of the newborn treated at IPGMIR are delivered elsewhere, either at home or at one of the 10 private hospitals in the city.

SU:I. A level II district hospital with 7500 deliveries pr year and 400 newborn treated anually. 28 days mortality is 60/1000 live births. Also this hospital has a catchment area of 100.000 delliveries pr year. There are no private hospitals in this area. The two hospitals have separate administrations but the same medical pediatric leadership. They are both government owned and free of charge.

Project description

This project aims to improve the care of underprivileged newborns, in line with international standards, in a Government institute of West Bengal, India. The project also aims to give Norwegian health personnel experience in diagnosis and treatment of patients in the selected areas that will by far exceed the exposures they will get in Norway. With Norway having a large immigrant population, this would provide a platform for better understanding.

Project objectives

OUS: The health personnel in the Norwegian NICUs are confident in dealing with mothers and families with an immigrant background from South Asian countries (Nepal/India/Pakistan/Sri Lanka).

IPGM& SURI: Reduction of neonatal mortality at Department of Neonatology, IPGM&RSSKM Hospital, Kolkata and SNCU, Suri sadar Hospital, Birbhum District, West Benegal (DSNCU).

Duration	Number of participants in total	Number of participants this round
1February 2011 to September 2011		6

Norwegian Partner

Oslo University Hospital (OUS); Haukeland

South Partners

Juba Teaching Hospital, South Sudan; University of Limpopo/ Medunsa Campus, South Africa

Exchange of in the field of orthopaedics

Description NOR partner

Oslo University Hospital (OUS) includes the former Ullevål Hospital, Rikshospitalet and Aker Hospital and is the biggest University hospital with approx. 20 000 staff members. OUS is the country's biggest teaching hospital, also on the postgraduate level.

Description of South partners

The Juba Teaching (JTH) hospital was initially constructed in 1927 as army barracks before being converted into a hospital after the independence of Sudan (1956).The hospital is the biggest referral hospital in South Sudan with a total of 500 beds. It also serves as a Nursing Technical Secondary School, midwife training school, and a training facility for medical assistants. While the civil war in Sudan has ended, the hospital is still struggling to meet a rising demand for medical care among Juba residents and those residing in the surrounding areas. There is a lack of competence in orthopaedic surgery, affecting all parts of the treatment chain.

Faculty of Medicine, Medunsa Campus/University of Limpopo University of Limpopo /Medunsa Campus is the largest medical school in South Africa and trains predominantly black health professionals, including medical doctors, dentists, allied health professionals and nurses. Medunsa has the largest medical faculty in SA, and the majority of students are from disadvantaged groups.

Project description

After request from the Government of South Sudan (GOSS) health authorities the project for an improvement of orthopaedic care was started. A exchange program including all partners will be needed and specific requirements for equipment and implants should be met. The project is now (December 20119) cancelled.

Improving the health workers professional skills is pivotal for the quality of care. Implementing new treatment – orthopaedic surgery – implies that many personnel groups need training. The staff also needs to be reinforced by anaesthesiologist(s) and a radiologist. It is important to recognize that a successful treatment depends on much more that just the capabilities of the operating surgeon.

Exchange will be an important tool for the training of personnel. Health workers from Juba need to spend some time abroad, either in dedicated training programs, or with homologues (peers) at partner institution. The selected peers (homologues) will be both professional and social contacts. Legal regulations will restrict what work f. instance and operating room nurse can do in Norway, because their nurses' licence from Sudan will not be fully accepted in Norway. This must be dealt with on a practical level.

The core objective for the project is to establish a training program for orthopedic surgery and enable Juba Teaching Hospital to treat orthopedic trauma adequately.

Project objectives

OUS/Haukeland: a) Improved staff commitmet; b) Increased number of employees engaged in international projects; c) Reduced turnover for nurses; d) Long-term partnership between Oslo University Hospital HF, Ullevål /Haukeland University Hospital and Juba Teaching Hospital/ University of Limpopo/Medunsa Campus measured by: i) The number of staff members at Dep. Of Orthopaedics from OUS, Ullevål/HUH taking part in the exchange, ii) Number of international projects operated by our hospitals increased by 1. 22 participants planned for exchange, 2 ongoing December 2011.

Juba Teaching Hospital: a) Improved quality and capacity in orthopaedic care; b) Fewer days in hospital for the patient; c) More patients treated; d) Reduced number of infections; d) Reduced mortality rate; e) Strengthening the management of the orthopaedic department when it comes to training, maintenance, supplies, working schedules, budgeting and recruitment of personnel; f) Records, meeting international criteria in doctors' and nurses' reporting; g) Training, number of internal courses or lectures.

University of Limpopo/Medunsa Campus: a) Increased orthopaedic research collaboration; b)

Number of publications ; c) Increased SAPSE funding(student research funding); d) The network of international partnerships extended; e) Number of active international projects.

Round number	Duration	Number of participants in total	Number of participants this round
1	January 2010 to February 2012	2	

Norwegian Partner

Sophies Minde Ortopedi AS (SMO)

South Partners

TATCOT (Tanzania Training Centre for Orthopaedic Technologists), CSPO (Cambodian School of Prosthetics and Orthotics), Kamuzu Central Hospital

Capacity Building in Prosthetic and Orthotic Educational Centres and Services in Low Income Countries

Description NOR partner

SMO was established as a physical rehabilitation centre in 1912 and is Norway's largest physical rehabilitation centre owned today by Oslo university hospital. SMO has 90 employees, delivers all kinds of orthopaedic appliances and has a leading role in the Norwegian education for prosthetics and orthotics. SMO has a close

Description of South partners

TATCOT is located in Moshi in Northern Tanzania. It is a regional school for Prosthetic and Orthotic training and enrolls students from all English speaking African countries as well as other interested countries. As a result TATCOT has a determining role in the education of the P and O's delivering rehabilitation services to large parts of Africa. It was founded in 1981 with the material, financial and human resource support of the governments of Tanzania and the Federal Republic of Germany. The school was established in Cambodia in 1994. It is run by the Cambodia Trust, a UK registered charity as the only school of Prosthetics and Orthotics in the world with ISO 9001:2000 certification. The aim of CSPO is to create the foundation of sustainable physical rehabilitation services by producing qualified specialists with the skills and knowledge to provide support for people with disabilities. To achieve this, CSPO holds ISPO Category II accreditation. Graduates will be recognized internationally as professional Prosthetist - Orthotists and will be qualified to upgrade to a degree level in the future. (Source: http://www.cspo.org.kh/). CSPO enrols approximately 12 students per year per program. They currently have students from 13 different Asian nations. KCH is a government hospital in Lilongwe, Malawi. It is the major hospital in the central region. In relation with an ongoing development of the orthopaedic surgical department of the hospital a new Prosthetic and Orthotic centre has been built and opened April 2009. The P/O centre has seven employees and is in these days confronting a massive work related to organizing the physical rehabilitation service for the central region of the

Project description

The field of physical rehabilitation in low income countries is underdeveloped and is in grave need of educated professionals in order to meet the need of the disabled people. To achieve this, strengthening the schools giving training to prosthetists and orthotists is prerequisite. Both the educational institutions that we wish to collaborate with aims to hold an international standard in their education program, but find themselves geographically isolated from the field which in they are working. Through staff exchange and e-learning we wish to reduce this effect.

Project objectives

SMO: Objective 1: Staff is exposed to and holds elaborate competence in Prosthetic and Orthotic rehabilitation in low income countries. Objective 2: Become the WHO collaboration centre, recognised by the Norwegian government, with competence in prosthetic and orthotic education and rehabilitation services in low income countries. Objective 3: Work to put issues regarding physical rehabilitation on the agenda in forums associated with development work; bringing to interested partners attention (national and international stakeholders, Norwegian government) issues regarding physical rehabilitation and development work. TATCOT: Objective 1: A high academic and practical level in the P and O school sustained in regard to technology and components in relation to international standards. Objective 2: Students are taught by Tanzanian lecturers in upper limb prosthetics and orthotics, spinal orthotics and paediatric orthotics according to international standards and the gait lab is used for educational purpose. Objective 3: The staff is motivated and

committed. Objective 4: Collaboration between P&O School in Cambodia and Tanzania is established
CSPO: Objective 1: A high academic and practical level in the P and O school sustained with regard to technology and components in relation to international standards. Objective 2: Students taught by Cambodian lecturers in upper limb prosthetics and orthotics, spinal orthotics, pediatric orthotics and acute/trauma orthotic interventions according to international standards. Objective 3: Collaboration between P&O School in Cambodia and Tanzania is established.
KCH: Objective 1: A sustainable workshop at KCH delivering high quality services to physically disable in the central and northern regions of Malawi established. Objective 2: A Community Based Rehabilitation (CBR) programme established in the central region. Objective 3: Delivering appliances within lower and upper limb country prosthetics, lower and upper limb orthotics and spinal orthotics with high quality following international requirements.

Round number	Duration	Number of participants in total	Number of participants this round
2	January 2010 to January 2015	20	

Norwegian Partner
Sørlandet sykehus helseforetak (SSHF)

South Partners
Haydom Lutheran Hospital (HLH)

The Haydom – Sørlandet – Hospitals – Program (HSHP) Exchange for cross-cultural understanding in hospital care

Description NOR partner

The hospital now gives the overall hospital services to the two counties of Aust- and Vest Agder with a population of 250 000. It has all major departments including an active research department, which has a close collaboration in research with the University in Agder and others. The hospital offers a wide range of specialist health services

Description of South partners

Haydom Lutheran Hospital (HLH) is a hospital owned by Mbulu Diocese of the Evangelical Lutheran Church in Tanzania. HLH is situated in Manyara Region and trying to become a referral Hospital. The hospital was built in 1954 and is now a major health service delivery institution for a population of about half a million in Northern Tanzania. Additionally the hospital runs a number of community development projects in the area. For many years, the hospital has had extensive exchange of health personnel to European countries. The hospital has grown to provide health care through more than 400 inpatients beds, 122 086 patients in bed per year, 24 000 mother and children examined through Reproductive and Child Health Care Services in 2007. On the current exchange FK program 4 employees from Haydom have had one year stay at Sørlandet Hospital and vice versa. The 2 first participants now have department leader positions at Haydom. The hospital also has a long tradition of collaboration in research, with 7 PhD candidates (5 Norwegian and 2 Tanzanian) and several medical students from the Centre for International Health at the University of Bergen having done their field-work in the area. The hospital has received NORAD funding for many years through Norsk Misjonsråds Bistandsnemnd. Presently a new bilateral agreement between HLH and NORAD (with Sørlandet Sykehus, Centre for International Health in Bergen and Norwegian Lutheran Mission as co-partners) has placed Haydom under direct NORAD Landprogram support via the Norwegian Embassy in Dar-es-Salaam. A project for HIV/AIDS prevention is presently financed by NORAD. Linked to this researchers from SSHF and the Universities of Bergen and Oslo have established a research project for prevention of mother-to child transmission of HIV. As a part of this project the new drugs for treatment of

Project description

At SSHF the project was integrated as a part of a competence and capacity building programme in prioritised areas for staff in both hospitals. This includes resource building at the level of the Nursing, Medical, Technical and Administrative personnel. It will expose SSHF to African culture, its disease pattern and basic skills in simplified clinical diagnosis, treatment, nursing care and applied technology without advanced, modern medical solutions. This includes resource building at the level of the Technical, Nursing, Medical and Administrative personnel. In the project HLH will be integrated as a part of a competence and capacity building progamme in prioritised areas for staff in both hospitals. This includes resource building at the level of the Nursing, Doctors, Technical and Administrative personnel. HLH will have exposure to an European culture and disease pattern and advanced, modern medical technology and economic/administrative procedures. There is a special focus on building of competence and capacity at clinical level for diagnosis, treatment, nursing care, computerisation and administrative procedures with quality

Project objectives

To gain knowledge of each other's medical, nursing, technical and administrative practises to increase the relations between our two hospitals. So far 16 participants have participated in the current FK program. Our two hospitals have ambitions to prolong our collaboration to promote mutual learning, mutual competence building, professional competence building and to promote potential projects and research. A mutual cross-cultural understanding of international health problems and how they can be solved in resource-poor and resource – rich settings. Which inevitably will create arenas for both

partners to improve skills and HIV/AIDS are introduced at Haydom, and the effects on the HIV-situation are closely studied.

Duration	Number of participants in total	Number of participants this round
3	6 months	24

Norwegian Partner **South Partners**

University of Bergen Centre for International Health (UiB CIH), Haukeland University Hospital (HUH) Addis Ababa University Medical Faculty (AAU MF), Myungsung Christian Medical Center (MCM)

Addis Bergen Neurosurgery Programme

Description NOR partner

CIH) is one of eight departments at the Faculty of Medicine and Dentistry (MOF). CIH has a particular obligation to working inter-facultary at the UiB and together with other departments at MOF. CIH aims to address health in low-income countries. This is especially done through research, postgraduate teaching and advanced training in

Description of South partners

AAU is one of the largest higher learning institutions in Africa that was established at the end of the 1940s. Formerly known as Haile Selassie I University, AAU was established by Ministry of Education in 1949 as a Trinity College with 71 students and 9 academic staff. It was granted a charter in July 1950 as an autonomous higher learning institution under a different name of the University College of Addis Ababa (UCAA). This makes AAU one of the oldest, if not the oldest, modern African university. Faculty of Medicine was established in 1971-72 (1964 E.C.) in Addis Ababa. It grants medical Doctors diploma and postgraduate certificates as well as degrees. It has about 105 academic staff. MCM in Addis Ababa employs a staff of 328, including volunteers and administrative staff. They cooperate in medical service through seminars and by sharing their medical skills. The Neurosurgery unit performs brain surgery with the assistance of international neurosurgeons, coordinated by the UiB. MCM is affiliated to Addis Ababa University, which will help to increase the number of Ethiopian neurosurgery doctors.

Project description

The project aims to establish a sustainable Neurosurgery Service and Training Programme in Ethiopia. The overall long-term goal will be to establish a Centre of Excellence in Neurosurgery serving the entire Ethiopia and neighbouring countries. The health personnel from Norway will be exposed to and trained in neurosurgical cases that are common globally. They will also receive volume training on a scale that is unavailable in Norway.

Project objectives

Support the process of obtaining a self-sustainable Neurosurgery Service and Training Programme in Ethiopia through exchange of personnel between AAU/MCM and HUH. The overall long-term goal will be to establish a Centre of Excellence in Neurosurgery serving the entire Ethiopia and neighbouring countries. The health personnel from Norway will be exposed to and trained in neurosurgical cases that are common globally. They will also receive volume training on a scale that is unavailable in Norway.

Round number	Duration	Number of participants in total	Number of participants this round
2	September 2010 to September		18

Annex 2: Literature review

We conducted a systematic search of the English language literature in PubMed to find articles on capacity building through the exchange of personnel between North and South health care organizations, including universities. We included only English language studies published between January 2000 and November 2011. Our search algorithms combined the following Medical Subject Heading (MeSH) terms and text words: health exchange, North-South partnership, capacity-building and twinning, international educational exchange, international educational exchange and Africa. This resulted in 1,108 publications of which 39 were selected for abstract review on the basis of citation information. On the basis of abstract review, ten articles were selected for the full review. As one of the studies points, detailed case-studies of North-South partnerships remain limited.

In addition, the following phrases specifically related to projects supported by FK were used as search terms: neurosurgery services in Ethiopia, National Blood Transfusion Services and Tanzania, Haydom Lutheran Hospital, Kamuzu Central Hospital. This search resulted in 95 titles but only two titles were selected for abstract review because most of them were not of direct relevance to our study, although many showed the need for programs such as those supported by FK.

Articles could be broadly categorized as case-studies of specific institution experiences, general reviews, and personal accounts of former program participants. The review showed a strong focus in publications on cultural experiences and broadening of horizons of health workers and researchers from the North (for example, a study on Swedish nursing students in Tanzania by Sandin et al, 2004). There were very few articles on the impact of personnel exchange programs on quality of services, clinical skills, management and research capacity of local partners. Changes in health outcomes of local population as a result of these programs were also rarely studied. There were very few studies that presented quantitative results. Thus, the key findings described below are based mostly on qualitative studies and do not distinguish between case-studies of specific institutions and more general reviews.

Key findings:

1. As noted above, many of the studies on health personnel exchanges seem to focus on individual experiences of participants, particularly increased cultural awareness and recognition of the challenges of providing care in resource-poor settings (Hagen et al, 2009; Sandin et al, 2004; Smith-Miller et al, 2010). One of the very few English language studies found in PubMed on partnership between Norwegian institutions and partners in the South focuses on the increased "cultural competence" as the key outcome of the partnership (Hagen et al, 2009), although to its credit it describes the experiences and learning outcomes from both the Norwegian and the Malawian students. While the cultural competence is an important outcome of health personnel exchange it seems that studies of these programs would benefit from focusing more on benefits to the population, i.e. users of health services in the country.

2. There are certain health risks encountered in global health training programs for participants from the North mainly due to disease prevalence (e.g., multi- drug-resistant

tuberculosis), the availability of personal protective equipment, and the extent to which participants are prepared to work in a resource-poor setting with high prevalence of infectious diseases. Thus, organizations supporting and/or initiating health personnel exchange or volunteer programs need to carefully weight benefits and costs to the host community (DeCamp et al, 2011).

3. Strengthening research capacity is one of the key objectives of many twinning arrangements or partnerships. The study evaluating the partnerships developed between the London School of Hygiene and Tropical Medicine and three research partners in South Africa and Thailand is one of the few studies, which combines qualitative and quantitative methods to assess the program impact (Mayhew et al, 2008). Quantitative indicators of capacity development include number of staff trained in research through MSc/PhD programs, number of published articles in peer-reviewed journals related to the partnership, and number of new joint projects funded. These were collected over a period of five years and supplemented by qualitative data obtained from 25 in-depth interviews with program staff from South Africa, Thailand and London. The study draws several important conclusions, including:

a. Need to build in mechanisms to enhance the institutional, rather than personal, aspects of the partnership as it seemed that success or failure of partnerships depended on links between individuals rather than organizations;
b. Importance of common language as it seemed to facilitate a more effective communication between partners in South Africa and London as compared to Thailand;
c. Challenge of sustaining capacity in organizations in the South as trained staff with good research skills who then go to the private sector or more attractive government jobs; and
d. Regular joint negotiation of research priorities and funding issues were important in developing responsive mechanisms for governing these partnerships and making them sustainable.

4. Another study (Chandiwana & Ornbjerg, 2003) describes scientific cooperation between Zimbabwe's Blair Research Laboratory (BRL), Biomedical Research and Training Institute (BRTI), and the Danish Bilharziasis Laboratory (DBL). According to it, as a result of this cooperation, BRL and BRTI were able to provide good quality postgraduate training opportunity to their graduate students and retain their highly qualified senior scientists through research fellowships provided by DBL. Moreover, the training was reciprocal: the collaboration included joint supervision and training of Danish MSc and PhD students in tropical medicine using facilities at BRL. One of the main conclusions of the study is that for effective international cooperation, there is a need for "a holistic approach to institutional strengthening" ranging from provision of laboratory equipment and financial incentives in forms of fellowships to retain qualified staff to training in computerized accounting to meet the project's administrative needs (Chandiwana & Ornbjerg, 2003). Similar to the study by Mayhew et al (2008), joint setting of research agenda was also emphasized. Another successful example of North South partnership in building research and training capacity of partners on both sides is ICDDR-B based in Dhaka, Bangladesh (Khan, 2010).

5. As described in the study on international partnerships in child health and paediatric care (Nicoll, 2001), one of the key issues in health exchange programs is return of staff from

the South to their institution or country after their training in the North. Also, the study points out the difficulty of re-integration and ability to transfer the newly acquired skills to the colleagues who did not participate in the exchange, particularly if those who visited the linked hospitals are junior staff.

6. One of the FK supported projects aim at developing neurosurgery services in Ethiopia. Thus, the study evaluating neurosurgical capacity building in Uganda through twinning is particularly relevant (Haglund, 2011). As the study notes, neurosurgical capacity is extremely low in East African countries: For example, in Uganda five neurosurgeons serve 30 million people (1:6 million). Compare this to North America where 4,583 neurosurgeons serve around 370 million people (1:81,000). Given this need, the Duke University Medical Center used twinning to increase capacity of the New Mulago Hospital in Uganda. The Medical Center provided comprehensive surgical three training camps for the Hospital staff. This training was supplemented by provision of more than 21 tons of usable surplus equipment. This study, unlike most of the studies in this area, presents pre- and post-quantitative data on output and outcome indicators. The study shows positive impact of the twinning program on the capacity of the New Mulago Hospital. There was, a significant increase in the number of complexity of neurosurgical cases performed ($p<0.0001$). Utilization of the elective operating room days increased from 41% to 93% ($p<0.0001$) during the project period. The increase in capacity was maintained without the presence of the personnel from the North. The results of this study are particularly relevant for the current evaluation of the FK health exchange program. It appears that health personnel exchange alone is not sufficient for significant improvements in capacity and should be combined with provision of essential usable equipment.

In addition to search in peer-reviewed journals, reports from other ESTHER programs as well as other programs linking North and South health care organizations and focusing on personnel exchange were searched in public domains and, where unavailable, requested from relevant agencies. The UK institutions have been involved extensively in links between North and South, and what appears to be the most recent DFID evaluation report provides a rich analysis of programs' benefits to individual participants and organizations in North and South as well as populations being served by participating healthcare organizations in the South (James et al, 2008). Similar to findings in the peer-reviewed journals, cross-cultural awareness is reported to be one of the key benefits of the link programs to UK partners. At the same time, the report, unlike some of the publications in peer-reviewed journals, correctly points out that the results may be biased due to small sample size and response rate.

According to the evaluation report (James et al, 2008), the impact of a particular link or exchange program depends on a number of factors, including the following:

a. Duration of placements or visits by northern partner staff matters as multiple "one off" visits of one to two weeks have little benefit to the southern partner and if anything, they are perceived to cause distraction and use up valuable resources such as time;

b. Visits to UK for southern partner staff appear to have benefits at individual level; however, the impact of such visits at organizational level in the South depends on rank of participating staff as more junior staff are less able to affect change in their organizations at home and may even face resistance;

c. There were instances when staff from the South has not returned to their home country or home organization after the exchange;
d. Donations of equipment should be based on the needs of the southern partner and ideally, should be part of a larger long-term program on capacity-building that includes training;
e. Access to information such as journals and databases such as PubMed is valuable;
f. Sustainability of a link depends on continuity of personnel and staff changes seem to impact negatively the institutional commitment to the program;
g. The main "added value" of facilitating bodies seems to be financial support and it is unclear whether direct links between North and South healthcare organizations can work as well without such facilitation;
h. At the same time, it appears that the role of facilitating bodies is important where partners on both sides are new or have little experience in international cooperation; and
i. Most relevantly, for facilitating organizations such as FK, they can play a key role in ensuring that these exchange programs are "harmonized, complementary, in line with good governance, evidence based and cost effective" (James et al, 2008, p. 49).

Also, the report supports the earlier finding based on literature search that there is a dearth of objective data to evaluate these exchange programs. According to the evaluation report (James et al, 2008), general lack of baseline surveys and comparisons makes it difficult to evaluate the true impact of these programs.

Annex 4: Terms of reference

Terms of Reference
Review of the Norwegian Esther Program (The FK Health Exchange program)

1. Background

The FK Health Exchange Program supports institutional cooperation and capacity building, through exchange of personnel within institutional twinning arrangements between health institutions in Norway and in the South, primarily in Africa. The Norwegian program is affiliated to the ESTHER Europe network, an alliance of European countries that support development of health services in developing countries, and where health personnel is the most important component.
The overall aim of the Norwegian program is to contribute to solving the health personnel crisis and reaching the Millennium Development Goals related to health, by strengthening the education of health personnel and provision of quality health service delivery in countries where Norway is engaged in long term development cooperation.
FK Norway, as the institution responsible for the program, is a governmental institution that aims at creating change through global exchange of people and professionals. FK Norway facilitates exchange between partnering institutions in Norway, Africa, Asia and Latin-America. Individuals and institutions share competence and experience across cultures. FK's task is to facilitate reciprocal learning and development in organizations and communities. FK's vision states that FK promotes leadership for global justice in two ways; on the ground and in our minds:

Creating change on the ground: By facilitating the development of *technical capacity in institutions* which enables them to deliver better services and benefits to people and societies within which they operate.
Creating change in our minds: By promoting a set of *values and relationships* with individuals and institutions which are opposed to domination of some over others and discrimination of some by others.

FK Norway has since 2001 supported exchange of personnel in the area of health. The FK Health Exchange program has been running since 2009 (Norway became a member of the Esther Europe Alliance in 2008). It is still too early to conduct a comprehensive evaluation of the program and to make clear conclusions since few activities have been completed yet. However this review will capture experiences gained and lessons learned to date.
At the end of 2010/beginning of 2011 FK conducted a quest-back survey to map institutional cooperation within the health sector between Norway and the South. The aim of the exercise was to acquire a better understanding of the broader picture of health cooperation, beyond focusing on the FK funded programs. The survey was designed in two steps, firstly to map if Norwegian health institutions are involved in international work, and if so, the nature of this involvement. The institutions with an international engagement were then asked more specific questions. The survey was sent to 661 local, regional and national institutions/partners of varying size. Only 55 responded. Given the low response rate, it is difficult to draw and any clear findings and conclusions. Nevertheless, it shows some trends and raises some questions, but FK

Norway recommended that before any decisions are made about adjustments in the current program, one should have more information and knowledge. This review is a follow up to the FK survey.

2. Purpose and intended use

The aim of this review is to see whether the program fits the purpose and goal, and to learn from the experiences made so far. The review report shall give a summary of results seen so far (outputs and if possible outcomes), and also highlight challenges and problems. The report should also give recommendations for how the program can be improved in the future.

The review will assess the strengths and weaknesses, as well as potential opportunities and threats as it relates to:

- The existing 16 FK Esther projects
- The applications that have been rejected (To find out why they have been rejected, e.g. if the proposal is not good enough or if the projects do not fit within the program framework).
- Other Norwegian funded health projects, including the "special project" in Lilongwe, the capacity building project for the nursing colleges in Malawi (through Norwegian Church Aid) and other programs, if found relevant as comparison (to compare the models and to see if results more quickly can be achieved within the framework of the Esther program).The review will also include a comparison between different models, as well as final recommendations to FK and its partners as it relates to necessary adjustments and improvements of the projects and the program as a whole.

3. Scope of work

This review will:

- Assess consistency between the goal hierarchy in the different Esther projects and the overall goal for the program.
- Assess the implementation of the Esther projects.
- Assess results and outcome of the projects.
- Assess the sustainability of the projects.
- Compare with other projects involving sending of personnel outside FK (literature review)
- Carry out an analysis of costs in relation to the outputs and outcomes, and compare to other projects/programmes outside FK.

- Assess the framework for the Norwegian Esther program. Is the framework fit for purpose? Does FK as an institution give added value to the program (including the principle of reciprocity and the focus not only on technical capacity development, but also on changes also in values and relationships)? Does FKs mandate and guidelines limit the projects?

- Assess short visits vs. long stays in relation to results.

4. Implementation of the review

The study should be done as a desk study of documents in combination with interviews. Both Norwegian partners and South partners should be interviewed (telephone interviews and possibly electronic exchange with South partners), as well as staff in FK, MFA and Norad. FK shall make relevant documents available for the team (program documents, reports etc). FK will also provide the team with a list of partners to contact for interviews.
The review will be conducted by 1-2 external consultants (totally 20 to 25 working days). Norad, Global Health Section, will, in consultation with AMOR and EVAL, be responsible for facilitation of the review process. FK and MFA have provided input to the ToR, and the draft report from the review will be shared with FK and FMA for comments.

5. Reporting

- A draft report, maximum 15 pages, including a 1-2 page summary, should be submitted electronically to Norad no later than 5 weeks after the start of the study. One week will be given for comments. The final report to be submitted no later than 6 weeks after the start of the study.

- The report should include the assessment section delineated in the Scope of Work section as a sections on lessons learned and recommendations.

Annex 4: List of documents reviewed

Programme related documents:

Contracts from partnerships, all relevant years
Annex 1 (to contracts)
A selection of reports from participants
Final/mid-term narrative reports
Background documents for Esther
Meeting summaries where Esther has been discussed
Health Research for Action (Hera). Bwaila/*KCH Institutional Cooperation – End Review*. 2010
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16. Berland A, Richards J, Lund KD. A Canada-Bangladesh partnership for nurse education: case study. *International Nursing Review*, 2010, 57: 352–358.

Annex 5: List of people interviewed

Partner	Name
Sophies Minde Ortopedi AS	Rune Nilsen
Universitetssykehuset i Oslo	Kristin Hanche-Olsen
Universitetssykehuset i Oslo	Kristin Hanche-Olsen
Universitetet i Bergen, Senter for internasjonal helse	Ingvild Hope
Høgskolen i Bergen, fysioterapiutdanning	Mildrid Haugland
Haraldsplass diakonale sykehus	Solveig Ullaland
Haukeland University Hospital(HUH)	Grete Marie Eilertsen
Sørlandet sykehus	Sissel Ledang
Tanzanian Training Centre for Orthopedic Technologists (TATCOT), Cambodian School for Prosthetics and Orthotics (CSPO), Kamuzu Central Hospital (KCH)	Sisary Kheng
Haukeland universitetssykehus, Juba Teaching Hospital, University of Limpopo/Medunsa Campus	Jaap Metz
IPGME&SSKM Hospital; Kolkata and Suri Sadar Hospital, West Bengal	Dr Arun Kr Singh
Addis Ababa University	Dr. Be-eede Lemma
Ahfad Women University	Nafisa Bedri
Zanzibar Blood Transfusion Services (ZNBTS) and National Blood Transfusion Services (NBTS)	Mwanakheir Mahmoud
Kamuzu Central hospital	Lovemore Thom-Chisale
Kamuzu Central Hospital	Rachel Macleod Spring
The National Blood Transfusion Service (NBTS)	Mwanakheir Mahmoud
Haydom Lutheran Hospital	Olav Espegren
Haydom Lutheran Hospital	Emanuel Mighay
Fredskorpset	Ingunn Gihle
Fredskorpset	Tutu Jacobsen
Fredskorpset	Jan Olav Baarøy
Fredskorpset	Susanne Brovold Hvidsten
Norad	Ragnhild Seip
Kirkens Nødhjelp	Haldis Kårstad
GIZ	Yvonne Schoenemann
GIZ	Brigitte Jordan-Harder

Four exchange participants were interviewed as well.