2021

POWER OF PARTNERSHIP

THET CONFERENCE ABSTRACT BOOKLET

SOLIDARITY IN THE SHADOW OF COVID

THET

STARK INEQUITIES IN THE AVAILABILITY OF COVID-19 VACCINES GLOBALLY AND DRACONIAN REDUCTIONS IN UK AID HAVE DEFINED THE FIRST HALF OF 2021. WHAT DOES THIS MEAN FOR A HEALTH PARTNERSHIP COMMUNITY INTENT ON WORKING IN SOLIDARITY ACROSS BORDERS?

Our 2021 Annual Conference will examine the myriad forms of solidarity across the Health Partnership community in this International Year of the Health and Care Worker and look to the future, as the UK hosts the UN Climate Change Conference in November and works to define itself on a global stage.

Bringing together leading voices from across the health, development, academic and government communities, conference participants will be invited to discuss how the Health Partnership approach has evolved in response to the pandemic, conflict and cuts over the past year; celebrate the continuing exchanges of expertise that have characterised this year; and consider how global solidarity can help to sustain the mental wellbeing of health professionals at a time of unprecedented strain.

ABSTRACT SUBMISSIONS

ROYAL COLLEGE OF GENERAL PRACTITIONERS AND MYANMAR GP SOCIETY QUALITY IMPROVEMENT TRAINING PROGRAMME FOR GPS IN MYANMAR- EVALUATING THE IMPACT AND RESPONSE TO COVID-19

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The Royal College of General Practitioners, in partnership with the Myanmar GP Society, have provided Quality Improvement Education to GPs in Myanmar since 2017. The training is provided by RCGP trainers, a third of which are Burmese speaking Myanmar diaspora. In 2020 this transitioned to remote teaching in light of the COVID-19 pandemic. This study seeks to evaluate the impact of this programme on the Myanmar GPs practice, and how it changed in response to COVID-19.

This study evaluates the programme using mixed-method thematic analysis of pre- and post-course confidence ratings, trainee written feedback and six semi-structured interviews with trainers.

The study demonstrated how Myanmar GPs developed skills equipping them to improve their practice with examples including improved infection control practices, communication skills, and setting up chronic disease registers. Qualitative comments suggested a key success of the programme was the formation of peer learning ‘quality circles’ which Myanmar GPs continued to use during the military coup to support each other emotionally and work together to set up emergency clinics. This built on their learning about quality improvement projects to develop system strengthening initiatives in response to the crisis. Another success was the training of Burmese ‘quality champions’ who facilitated small group sessions for the Basic QI trainees, which aided with language difficulties and aimed to improve the sustainability of the programme. The programme also helped to improve retention of Myanmar GPs, for example, one GP had been considering another career but after the programme choose to stay in the speciality and subsequently enrolled in further training.

In response to COVID-19 the training transitioned to remote teaching which increased accessibility and reach, decreased cost to both trainees and trainers, and increased frequency of sessions. Favoured remote teaching methods were small group discussions and role play. The major two limitations were internet connectivity and language difficulties. It was also commented that remote teaching impacted upon the rapport built between trainers and trainees compared to in-person teaching.

For future quality improvement programmes, it has been recommended to continue encouraging peer learning and creation of 'Quality circles'. In addition to continued involvement of Burmese 'Quality Champions' in curriculum planning and provision of teaching to ensure sustainability.

The trainers were all in agreement over the introduction of a blended programme once travel is safe, and to focus on small group discussions and role play. The value of developing an e-learning platform going forwards was also agreed.

TWINNING BETWEEN MIDWIVES' ASSOCIATIONS DRIVES INNOVATION, BUILDS RESILIENCE AND ENGENDERS SOLIDARITY: A CASE STUDY FROM THE UK AND BANGLADESH

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Background

Investing in midwives is essential for achieving the SDGs[1]; however, there is a global shortage of almost 1 million midwives[2]. Since 2017, the RCM and the Bangladesh Midwifery Society (BMS) have had a twinning partnership[3]. Twinning promotes solidarity, raises the profile of midwifery and provides a platform for advocacy, especially where midwives are new or marginalised[4, 5]. Twinning differs from other forms of partnership because of its explicit emphasis on the core value of reciprocity; critical success factors for midwifery twinning depend upon power-sharing and equity[6]. Partnerships between associations in female-dominated professions, such as midwifery, can lead to women's empowerment and leadership development[7].

In Bangladesh, midwives were introduced in 2018; however, many cannot yet perform their full scope of practice[9]. Meanwhile, in the UK, Asian women are twice more likely than white women to die from pregnancy complications[10]; ≥ 0.8% of the population identify as Bangaldeshi[11]; 2.8% of NHS staff are South Asian[12]; Black and Brown midwives experience more bullying at work, face more disciplinary processes and are less likely to advance in their careers[13].

Description of intervention

UK volunteer midwives and RCM staff are twinned with Bangladeshi counterparts for project management and workstreams such as development of online learning services, leadership development, quality improvement and advocacy. During the pandemic this partnership has continued remotely, has been strengthened and gained international recognition[14]. A new project has started, funded by THET, enabling midwives in rural areas most affected by COVID-19 to provide essential sexual and reproductive health services alongside other midwifery care.

Results to date

BMS' systems and structures have been transformed, creating a professional association able to engage and resource midwives across Bangladesh and developing a new generation of Young Midwife Leaders (YMLs). Reciprocally the RCM has developed digital resources inspired by BMS' innovations and improved member engagement, proactively involving diaspora midwives in the UK with the partnership. New remote and digital technologies enabled the partnership to respond to local needs grow and develop during COVID-19[15].

Conclusion

For this health partnership COVID-19 has driven innovation, built resilience and engendered solidarity, providing both partners opportunity for reputational growth and new ways of working.

Recommendations/next steps

Looking forward, BMS must become sustainable and capitalise on its enhanced esteem. The RCM will learn from YML development in Bangladesh to inform its work in the UK/Europe. The partnership is exploring new opportunities to strengthen midwifery in India and promote regional collaboration and learning.

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EVALUATING THE GARDEN ROUTE HOSPITALS INTERNSHIP CURRICULUM

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Medical internship training should be comprehensive and complementary to the healthcare system. In January 2020, The Health Professions Council of South Africa (HPCSA) modified South Africa's internship training programme to include a six-month family medicine rotation, emphasising the primary healthcare approach. This is in line with World Health Organisation's Sustainable Development Goals and South Africa's Healthcare 2030 Framework, which commits to the primary healthcare philosophy, strengthening the district health system and promoting equity. Internship training should meet the educational, physical and psychosocial needs of the interns. A competent, motivated and well-supported health workforce is a key building block for a desirable health system; therefore, it is vital to evaluate whether the curriculum is achieving its goals.

The COVID-19 pandemic brought disruption to work schedules, teaching and learning opportunities, mechanisms of feedback and had an impact on the wellbeing of interns. As Improving Global Health Fellows based in the UK, we worked virtually alongside local partners to design and deliver a sustainable feedback package to evaluate whether the intern curriculum and programme meet the needs of interns at four Garden Route Hospitals, Western Cape, South Africa.

Surveys were designed, piloted and distributed to interns and their supervisors, with questions mapped to HPCSA requirements to ensure validity. Four focus group interviews and two key-informant interviews were undertaken to triangulate results and expand on key themes. Thematic analysis identified seven key themes: meeting educational needs, teamwork & integration, supervision, pastoral support, communication, hours & rosters and COVID-19. These themes formed the basis of a 'SWOT' analysis. The results were reviewed in a semi-structured interview with the Intern Curator, and potential recommendations were presented to the programme's stakeholders.

Eighty-three percent of interns (40/48) took part. A snowball sampling method was used to survey supervisors, and nineteen took part. Responses have been used to expand on the strengths of the programme and address areas of improvement. Together, we have implemented a new, sustainable system to obtain annual feedback from interns and supervisors at the Garden Route Hospitals. This project is acting as a pilot for a larger research project that will evaluate the internship programme across the Western Cape province.

The HPCSA aims for ongoing improvement in the content and quality of the internship curriculum. We created sustainable channels to evaluate intern and supervisor experiences of the curriculum to ensure its goals are met, and to achieve the ultimate objective of strengthening South Africa's healthcare system.

JIELEZE MENTAL HEALTH SUPPORT

Author: Cecilia Ndungu, a registered Nurse in Kenya with a BSc Nursing and Diploma in Business Information and Technology

Introduction

Healthcare workers during this period of the COVID-19 pandemic have been facing various challenges over and above the usual demands at their place of work. Some of these challenges include fear of acquiring the fast-spreading coronavirus disease, fear of spreading it to family and patients, poor working conditions, and the potential risk of being placed in isolation once infected. These, among other challenges that arise during this unprecedented time, have been shown to increase psychological distress. There is a need to provide psychological support for the nurses and midwives and when needed, to mitigate the psychological distress.

How it works

'Jieleze' connects nurses via their mobile phones with quality mental health support. It shall get therapists who are certified by our nursing regulators. It's a supervision system that shall ensures consistent quality of therapy sessions, careful screening and digital training together with Identification and referral of high-risk clients by means of set questionnaire. These therapists shall communicate via messaging and calls.

This innovation shall provide a peer-to-peer mental health support network for nurses in Kenya. Nurses are to be trained to help other nurses to address their mental health needs using a proven and effective therapy method.

These therapists can come from various backgrounds and shall include experienced nurse psychologists, students in nursing and retired nurses.

The trained nurses shall be able to gain personal development skills in problem solving therapy and get a decent wage through paid clients. Nurses who coach their peers will be paid for their work too.

Thus, this idea shall be able to reach more than 80,000 nurses and positively impact their mental resilience and wellbeing and encourage more research and education in mental health.

*Jieleze is a Swahili word meaning 'Speak out'

ENHANCING THE CAPACITY OF COMMUNITY HEALTH WORKERS ON EPIDEMIC AND PANDEMIC PREPAREDNESS AND RESPONSE IN WAKISO DISTRICT, UGANDA

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Community Health Workers (CHWs) are a key human resource for health that support primary health care particularly in low- and middle-income countries. In Uganda, CHWs are the first contact of the community with the health system where they are involved in several activities including health promotion, mobilization for health interventions, treatment of childhood illnesses, disease surveillance, and referral of patients to health facilities.

The current COVID-19 pandemic has reaffirmed the importance of CHWs in responding to pandemics in LMICs where their roles have included health education, screening, contact tracing, and community management of cases. In addition, Uganda has faced several epidemics in the recent past including Ebola, yellow fever, anthrax, cholera, measles and meningitis. However, CHWs in the country have not received much training on epidemics and pandemics which we established during our recent study. Therefore, the aim of this project was to enhance the capacity of CHWs on epidemic and pandemic preparedness and response in Wakiso district, Uganda, with a focus on COVID-19.

This project was implemented as part of the 10-year partnership between Nottingham Trent University and Makerere University School of Public Health, Uganda. Our partnership has an established record of working with the CHWs in these communities hence we were able to quickly respond to this need of strengthening resilience in epidemics and pandemics. The project trained 766 CHWs in 2021 for 2 days, and the main topics of the training were: introduction to epidemics and pandemics including prevention and control of COVID-19; community engagement; contact tracing; risk communication; community sensitisation; and frontline protection. Pre and post training assessment was carried out to establish the level of improvement in knowledge of the CHWs on following the training. From this assessment, adequate knowledge on epidemics and pandemics improved from 7.5% to 92.8%; adequate knowledge and skills to communicate to the community during an epidemic / pandemic increased from 55.6% to 99.4%; and adequate knowledge and skills to carry out contact tracing in the community during an epidemic / pandemic increased from 30.0% to 97.9%. This project demonstrated improved knowledge among CHWs on epidemic / pandemic preparedness and response which is expected to lead to improved practices in their communities including during response to COVID-19. Such initiatives are important to strengthen health system resilience at community level particularly at such a time when COVID-19 continues to affect Uganda and other countries across the world.

HEALTH PARTNERSHIP SOLIDARITY AND ADAPTING TO CHALLENGES IN AMCGP MANAGEMENT OF DELAYED PRESENTING CLUBFOOT PROJECT

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Introduction

We describe how support provided between the partners on the Management of Delayed Presenting Clubfoot has adapted and evolved in the last 18 months, given the reduction in international travel and capacity across all partners.

Results

We have re-thought how we work together without meeting face to face and become a more compassionate and supportive partnership as colleagues in all partnership settings have faced increased clinical workload, and professional/personal pandemic impacts. We have adapted our activity timelines to be flexible for partners' reduced capacity and prepared more contingency plans. We have adapted to working online regularly e.g using video conferencing for planning and advisory group consultations, online surveys, and collaborating on online documents and medical teaching videos. It has been important to record and share these meetings carefully to mitigate poor audio/video/internet quality, and dictation software has helped. We have worked asynchronously sometimes, holding repeats of key meetings to enable more partners to engage. We have changed the format of our planned in-person pilot training courses due to restrictions in the local and international context. Beyond our partnership, we have joined Global Clubfoot Initiative's working group to share the challenges of implementing clubfoot training with the limits on face-to-face training and learned how other groups are developing hybrid formats and online formats and how to compare and assess their efficacy. Due to the reduction in international travel, the emphasis of the delivery of piloting the training course and mentoring follow-up has shifted more to the local surgeons and physiotherapists in Ethiopia, leading to stronger ownership of project outcomes.

Conclusion

We have adapted and used technology for training development and delivery and for partnership strengthening. We sought to learn from others, and this led to new elements of the course such as rehabilitation, patient perspectives, team communication and family-centred care. We recognise that the strength of the roots of the partnership from previous THET health partnership relationships has helped weather the storms of the pandemic so far. We have benefited from connection with Global Clubfoot Initiative with access to expertise from clubfoot trainers and learned how clubfoot programmes internationally are responding to the challenges of training during the pandemic.

Recommendations

We will expand on the lessons learned and report on the adapted hybrid format pilot course taking place early September 2021 led by Ethiopian faculty for local doctors and physiotherapists, with remote faculty joining via video conferencing.

PAUSE AND PROGRESS: REFLECTIONS ON DIGITAL PARTNERSHIPS, A CASE STUDY FROM MALUTI ADVENTIST HOSPITAL, LESOTHO

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Events that unfolded globally during the Covid-19 pandemic were rapid and unpredictable, necessitating decisive emergency plans for global partnerships around the world. One partnership was Health Education England's "Improving Global Health Fellowship", a 6-month programme linking National Health Service (NHS) staff to partner hospitals in resource poor settings, with projects focused on quality improvement (QI) and leadership. As borders closed in March 2020, the programme was suspended and fellows returned to the UK, many to frontline clinical roles.

A year later, in February 2021, a re-imagined fellowship was piloted to accommodate new limitations. A distance relationship was created with overseas partners, including Maluti Adventist Hospital (MAH) in Lesotho, and projects started in 2020 recommenced and led remotely via digital platforms. The fellowship was undertaken part-time over 6 months alongside clinical work in the UK.

This new framework posed many challenges for both fellows and partners; from the re-distribution of workload, to gaining a comprehensive intercultural understanding through digital mediums alone, all alongside changing governmental COVID-19 guidance often disrupting activities.

However, grander than the challenges, were the unforeseen successes of this arrangement. Despite limited time and digital resources, the ability and determination of local staff at MAH to establish an online partnership was remarkable. QI methodology had been novel to MAH in 2019 and staff engagement previously a significant barrier to project sustainability. Interestingly, remote leadership necessitated increased local staff involvement and hence ownership of QI concepts. In the case of MAH, what started as a crisis response could, despite its difficulties, be the stimulus for the future success and sustainability of the partnership.

From this partnership, the fellows gained a new and innovative leadership approach, through establishing working relationships with trust and shared purpose without ever visiting the hospital. Working on projects part-time provided a unique opportunity to directly apply timely learning from new health systems, QI methodology and leadership to NHS clinical work. For local partners, QI served not only to improve patient care but also to aid motivation and strength as a team, with one local staff member stating, "I have learned a lot in the QI office and you guys gave me superlative motivation and support throughout my internship program. You also gave me opportunities to recognize small things that are happening in our healthcare industry that can affect the quality of patient care." This demonstrates the unexpected opportunity that digital partnerships can represent, despite their challenges.

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT TRAINING TO HEALTH CENTRE STAFF IN GULU, NORTHERN UGANDA, IN A COVID-19 PANDEMIC

Authors: Kim Parker and Greg Harrison, Gulu Sheffield Mental Health Partnership

The Gulu Sheffield Mental Health Partnership (GSMHP) has been hosted since its inception in 2012, by the Sheffield Health and Social Care (SHSC) NHS Foundation Trust and Gulu Regional Referral Hospital (GRRH). Gulu is the main city in the north of Uganda and is a post -conflict area, having suffered 20 years of terror from the Lord's Resistance Army, led by the infamous Joseph Kony.

The partnership has received several grants from THET and works with Sheffield and Gulu University and service user groups. In 2019, GSMHP undertook a programme of Suicide Awareness and Prevention in Health Centres in Gulu, with the aid of a grant from THET through the Africa Grants Programme. Suicide was identified as a major health issue by Gulu partners, and the successful funding application followed a pilot training event held in a remote village in Gulu District in 2018.

Using a Training of Trainers (ToT) the project started training health centre staff in November 2019. GSMHP staff trained the ToT's in Gulu and employed local workers to manage and deliver the project. This ToT model has been used before in a previous THET grant for work in GRRH. Courses continued to be delivered until March 2020 when Uganda went in lockdown and for several weeks no activity was allowed. In May, it became possible to deliver courses, working within both Ugandan Ministry of Health and World Health Organisation guidelines. Ugandan partners reported that health staff were facing stigma and discrimination due to fear that they may carry Covid 19 from hospitals and health centres back to villages.

UNICEF and the Butabika National Mental Health Hospital in Kampala produced a training package on Mental Health and Psychosocial Support (MHPSS) which they trained staff in Regional Referral Hospitals to deliver in their area. However, no funding was available to deliver this training to health staff locally.

The GSMHP Suicide Awareness and Prevention project cancelled its planned trip to Gulu, due to Covid travel restrictions, resulting in an underspend. With THETs agreement this underspend was used to deliver the MHPSS training using staff trained by UNICEF and Butabika. Six courses were delivered by local ToTs to73 staff in health centres and GRRH.

This work was used to successfully apply for a dedicated Covid-19 grant from THET, which is currently delivering 15 two-day courses to 180 staff in health centres and GRRH in the Gulu District.

COVID-19 AS AN OPPORTUNITY: NEW WAYS OF WORKING, NEW POSSIBILITIES

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Over the past 18 months, King's Global Health Partnerships has worked with partners in Somaliland, Sierra Leone and DR Congo to support national and facility level responses to Covid-19. Each of these countries have experienced multiple waves of the pandemic and health workers have been placed under great pressure.

Drawing on the lived experience and expertise of clinicians in the NHS and our partner countries, we have provided support in new ways, including the collaborative development of training materials, the establishment of a clinical advisory group allowing for cross-partnership learning, online support & mentoring, as well as via volunteer placements. These modes of working have offered new avenues for engagement for KGHP and NHS volunteers and new expressions of international solidarity.

Together with our partners, we have also seen Covid-19 as an opportunity to support each other, strengthen infrastructure and embed strong practices and systems which will benefit patients beyond the pandemic. We will present 3 short case studies from Somaliland, DR Congo and Sierra Leone demonstrating some of the sustainable changes that have resulted from the pandemic. These will spotlight:

1. Development of Infection Prevention Control guidance and training in partnership with Hargeisa Group Hospital in Somaliland;
2. Work in Kongo Central Province of the Democratic Republic of Congo focused on the management of chronic diseases that are risk factors for severe COVID-19, with specific focus on a patient education programme for diabetes
3. Strengthening of triage and emergency care at Connaught Hospital in Freetown, Sierra Leone

DESIGNING A MASTER'S DEGREE IN NURSING LEADERSHIP THAT WILL CO-CREATE A RESILIENT COUNTRY, HEALTH SYSTEM, NURSING PROFESSION AND POPULATION. WHAT COULD SUCH DEGREES IN THE UK LEARN FROM THIS UBUNTU, ARTFUL AND POSITIVE DEVIANCE APPROACH?

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We are co-creating a Nurse Leadership master's degree and a culture of quality and ubuntu. It is universally agreed that we need more nurses everywhere and we need those nurses to do more influencing in policy and well as practice. The number of nurse leadership programmes and nurse leadership roles have grown, however, who their audiences are and how they are having an impact is not yet known. There remains a mismatch between the rhetoric of nurse leadership education and the reality of putting newfound learning into practice. Whilst across the world we have nurses in leadership posts they do not always have the influence to lead change. However, some do and work 'under the radar' to make things happen. Such invisibility means that the culture, competencies, courage, and compassion needed for such roles are not seen.

What if we could see where these nurses are, who they are, and what they do - and learn how to do it? What if we could develop the culture to make visible and therefore nurse leadership roles more valuable? What if nurses were seen to lead at all levels of health care and others learnt how to do this from them 'in situ'. What if instead of learning in and from the global north with global north resources such nurses learnt within global south systems and from colleagues in places where they will continue to work? What would be different? The same? Does it matter?

These questions have led to the commissioning of a new master's degree in nurse leadership. We are working with international peers and partners defining global south nurses' leadership education needs and designing the curricula content with those who will hopefully attend the programme and eventually employ the graduates. We are featuring and developing contextual and relatable resources so that participants build their knowledge upon evidence owned and authored within the Global South. We are building critical thinking skills that examine health as social justice, health as human capital and health as a right and responsibility. We are building leadership knowledge and competencies that improve quality and equity. We are building nursing skills that focus on a strengths-based approach and compassionate leadership and care. We are using arts-based approaches (forum theatre) to inform understanding of privilege, power and oppression. We are an African University. Is this a 'better' approach than UK Universities doing the same?

THE BI-DIRECTIONAL BENEFITS ASSOCIATED WITH A UROLOGY-THEMED WEBINAR PROGRAMME DURING THE COVID-19 PANDEMIC: A UK-ZAMBIAN EXPERIENCE

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Introduction

Urolink (part of the British Association of Urological Surgeons (BAUS)) has established health partnerships with urology centres in low- and middle-income countries (LMICs). Its key aims are to support link centres by promoting urological education and training, through visits and establishing educational courses. Consequent to the COVID-19 pandemic, restrictions have resulted in the temporary suspension of travel. Urology residents in link centres had previously requested access to ongoing web-based education. In partnership with the University Teaching Hospital (UTH), Lusaka, Zambia, an educational webinar programme was developed and delivered on a monthly basis via video teleconferencing software.

Methods

A series of 10 consecutive monthly webinars involving UK and Zambian residents was delivered by Urolink and the Urology department, UTH over the Zoom platform. The format involved case-based webinars of common urological conditions presented from both UK and Zambian perspectives. Moderated discussion was encouraged to highlight differences in case presentation and management, from each continent. Learning outcomes and satisfaction surveys were circulated post-webinar to evaluate participant's views of the educational benefit from this means of delivery (5-point Likert scale).

Results

Webinars were delivered between Oct 2020 and July 2021. Attendees included trainees (70%, n=23) and consultant urologists (30%, n=10). Post-webinar questionnaires were analysed with 37 total responses over the 10-month period. Participants rated webinars highly on measures such as content (mean 4.7/5), interaction/engagement (mean 4.5/5) and how interesting the session was (mean 4.6/5). All participants stated they would be likely to engage in future webinars (mean 5/5), with ease-of-access and convenience highly rated (mean 4.4/5).

Key benefits of the webinars were the bi-lateral learning of new concepts in patient management dependent upon the available healthcare environment, and the sharing of best-practice, evidence-based, guidelines. Participants were also able to consider new viewpoints/perspectives on common urological conditions and better understand healthcare delivery in differing healthcare economies. Specific benefits to trainees in UTH, Zambia included improved confidence which was transferrable to presentation of cases on ward round and when performing presentations.

Conclusions

In the presence of the travel constraints associated with the COVID-19 pandemic, we have been able to sustain Urolink's educative role and to demonstrate that webinars provided an effective way of engaging in educational activity with link centres in LMICs. This has had bi-directional benefit to trainees on each continent and has the potential to lead to improvements in outcomes and healthcare delivery in both Zambia and the UK.