The Royal Society of Medicine

Journal of the Royal Society of Medicine; 2017, Vol. 110(8) 316–319
DOI: 10.1177/0141076817712251

Shared learning in an interconnected world: the role of international health partnerships

H Issa, K Kulasabanathan, A Darzi and M Harris
Centre for Health Policy, Institute of Global Health Innovation, Imperial College, London, W2 1NY, UK
Corresponding author: Hamdi Issa. Email: hamdi.issa13@imperial.ac.uk

This is one of the articles in the Health policy series.

Background

For decades, governments within the 'global north' have mobilised themselves to channel significant funding and human resources to support fragile health systems, in response to the unique healthcare challenges experienced by low- and middle-income countries. Although much scepticism envelopes the global health spending paradigm,[1] the shift towards international health partnerships to strengthen health systems across the globe continues to gain momentum among academics and health professionals.

In the UK, international health partnerships are largely supported by the Tropical Health and Education Trust (THET) through the DfID-funded Health Partnership Scheme. This scheme supports project delivery in more than 80 health partnerships between UK academic and health institutions and their low- and middle-income country counterpart.[2] The primary goals for these partnerships are to enhance and strengthen health systems in low- and middle-income countries through skill transfer and capacity building, demonstrating the UK's commitment to global health.

In 2007, Lord Crisp's report 'Global Health Partnerships' reviewed the UKs role within these partnerships,[3] triggering greater support for international health partnerships at government level. The Health Partnership Scheme has been valuable in bringing significant improvements to healthcare in low- and middle-income countries, described as 'the most effective government action to support NHS overseas work in recent years'.[4] However, as the scheme draws to an end in 2017, conversations around the concept of 'mutual interest' are gaining more weight. In particular, how partnership models will continue to ensure positive changes not only in healthcare systems of resource poor countries but increasingly within the NHS as well. Even the NIHR recently launched a call for global health research proposals that benefit countries that have Official Development Assistance (ODA) need but also captures benefits to the UK.[5] Moreover, Lord Crisp's work on co-development highlights the necessity to reframe the UK health partnership model such that it is favourable to both partners and supports a global source of innovation. This increasing emphasis on developed country health systems challenges whether the current UK health partnership model is fit for purpose to bring beneficial learning to the UK system too.

The imperative to revise current health partnership models and learn from other countries saw THET's 2016 Annual Conference on '*Evidence*, *Effectiveness & Impact*' bring together academics, health professionals and students engaged in various health partnerships from the UK and elsewhere.[6] In evaluating the success of these partnerships in delivering transformative change in healthcare delivery, the conference showcased the striking difference in methodologies and approach in partnership models. The Norwegian governmental body, FK Norway, for example, stipulates a bi-directional flow of human capital between organisations in Norway and organisations in low- and middle-income countries[7] to support healthcare delivery in both regions, a contrast to the current UK partnership model, skewed towards supporting healthcare in low- and middle-income countries almost exclusively.

The Norwegian model speaks to the growing literature exploring 'reverse innovation', a term used to describe the flow of ideas from developing countries to developed countries. Reverse innovation, albeit a term some argue appears pejorative or contradictory,[8] has become the popular terminology to describe a movement that recognises useful innovations can be sourced from different settings. It is often used interchangeably with the term 'frugal innovation' which means 'doing more with less for many'.[9] Reverse innovations may be frugal, and perhaps are more likely to be so if from a low- and middle-income

© The Royal Society of Medicine 2017
Reprints and permissions: sagepub.co.uk/journalsPermissions.nav

Figure 1. Example of reverse innovation. Source: (12) Solar Ear. See http://solarear.com.br/ (last checked 13 May 2017).

Reverse Innovation: Solar Ear

Solar ear is a social business that was founded in Ramotswa, Botswana in 2003. It provides low cost, solar rechargeable and environment friendly hearing aids (12). It aims to lower hearing loss and the associated financial burden by means of innovative technologies. Solar ear hearing aid batteries are able to retain power for about a week before requiring sunlight exposure again. They have a life span ranging 2-3 years in contrast with the 7-10 days of a ordinary battery. The solar element of this device offers a huge advantage to those in developing countries where access to electricity can sometimes be scarce. Solar ear take pride in adopting a bottom-up approach with their innovation. Their first rechargeable hearing aid was invented in co-production with deaf workers. This digital hearing aid relies on two rechargeable AA batteries providing a cost-effective alternative to the hearing impaired globally. Solar Ear is now scaling to Canada, Brazil and India.

country.[9] The concept is beginning to expand beyond the business world and gain traction within healthcare, especially as a means to strengthen health systems across developed countries.[10] Central to the reverse innovation agenda is that our struggles are similar, and so therefore might be the solutions. Fundamentally, in the context of dwindling resources and growing demand both developed and developing countries are attempting to: move towards preventive medicine; connect different parts of healthcare system; empower patients in their own care; and maintain a system that is accessible and affordable.[11] These commonalities suggest that the solutions may also be inter-connected and it is necessary to identify a platform where acquiring knowledge and sharing learning happens globally. The vision for a global flow of innovation is not new – countries across the globe have been contributing to science and medicine for centuries. The current push, however, necessitates the removal of barriers to create a more seamless flow. The Global Diffusion of Healthcare Innovation study launched at the World Innovation Summit for Health, in Qatar, November 2016, shows that developed country frontline healthcare workers rarely consider emerging countries as a useful source of innovation.[12] The global health paradigm, as it is currently conceived can introduce preconceptions about low- and middle-income countries and their ability to offer learning to healthcare systems in developed countries[8] and in some instances may encourage high-income country actors to overlook innovations originating in low- and middle-income countries.[13]

Reverse innovation is ultimately connected to the learning dynamic that encourages learning across country borders and in both directions. While a universal model is yet to be acknowledged, health partnerships represent an important prospect for enabling learning across borders at a more global level. In the UK experience at least, this is only beginning to become recognised as an important additional purpose for the partnership activity.

We approached the policy recommendations by conducting a comprehensive review of several varied disciplines that discussed 'reciprocity', 'mutual benefit', 'shared learning' and 'bidirectional learning' for improving organisational outcomes. This paper draws from international health partnership, development, innovation, power, organisational learning, and strategic management literature.

Reciprocity in International Health Partnerships: – some policy recommendations

To a large extent, the type of learning that is captured in international health partnerships is personal and professional development of the volunteers involved in the partnership. However, a move towards co-development in health partnerships is concerned with learning that goes beyond personal and professional development to learning that has impact at the service or system level. Although the point of departure for THET-supported UK health partnerships is to '*improve health outcomes for poor people in DFID priority and other low income countries*',[14] THET is now encouraging health partnerships to shift their narrative towards 'collaboration', 'shared learning' and 'reciprocity'.[15]

Meaningful reciprocity, however, will require involvement of senior staff in partnership visits, well-delivered debriefing for volunteers and, simple though it may seem, appropriately conceived mission statements.

Senior staff involvement

Typically, health partnerships are constituted of members of different cadres within the health profession. However, because overseas placements are at times 'time consuming' and 'costly',[4] the cadres who are mainly involved in overseas volunteering are junior level professionals, mostly early career and/or student medics[16] rather than senior staff. Although there is value in this, it can result in senior staff from the UK not being exposed to valuable learning opportunities specifically innovative models of care that have been designed by the low- and middle-income country partners themselves. The theory of disruptive innovation indicates that the spread of ideas and innovation requires senior management as an essential channel for 'facilitating' or 'inhibiting' inter-organisational diffusion.[17] Knowledge and understanding of ideas originating elsewhere must also resonate with senior staff, often the cadre where power to make system level changes is concentrated.

Effective debriefing

In most organisations, debriefing is a regular exercise to reflect on and use learning experiences to advance practice. In the medical profession, debriefing sessions are used to integrate team experiences into the practical setting and across multinational companies debriefing is used to disseminate knowledge through company networks.[18] Evidently, exploiting knowledge opportunities is a key ingredient to an organisation's success. Within health partnerships, there is value in tapping into debriefing with volunteers who have been overseas. Structured debriefing sessions introduce an element of shared 'power, authority and responsibility for learning'.[19] Furthermore, volunteers made aware of the goal of debriefing sessions before they go overseas will have an 'expectation for value feedback'[20] to adhere to, perhaps encouraging volunteers to expose themselves to greater learning opportunities. Debriefing sessions tailored around the volunteers' experiences and learning not only allows volunteers to consolidate their thoughts and map their progress but it permits them to consider the validity of the ideas they witnessed abroad and extend the experiential learning experience to members who were not able to go overseas, allowing for open communication.

Meaningful mission statements

Finally, the use of words such as 'reciprocity' and 'shared learning' may be so generic that it invites individuals within different health partnerships to view these terms from their own personal perspectives. Generic mission statements can fail to have any real applicability.[21] To avoid such pitfalls, organisations coordinating health partnerships should clarify the desired definition, creating linearity in understanding and actionable mission statements. A well-structured mission statement will shape the culture of an organisation, and consequently its activities.[22] Although the strategic management literature frequently explores this within businesses, mission statements are overarching frameworks that provide strategic direction in all types of organisations including governmental, public sector and not-for-profit. The recent focus on 'reciprocity' and 'shared learning' requires revision of mission statements that drive a partnership in a particular direction. To encourage mutually beneficial learning spaces, a mission statement must clearly state vision for bidirectional learning at both personal and institutional level – else we risk this type of learning being missed in partnerships.

Conclusion

Although there is merit to be found in the current design of international health partnerships, much more needs to be done in facilitating the bidirectional flow of ideas and innovations. For valuable learning to take place, those who lead health partnerships have a responsibility to embed evaluation and reflection into volunteer experiences. Indeed, if health partnerships are to exercise transparent learning processes, while developed country actors continue to go abroad to share their skills and knowledge with developing countries, they too should be open to learning from their counterparts. As the NHS faces unprecedented challenges in the UK that are converging with those faced in low- and middle-income countries, now more than ever, we cannot afford to ignore the valuable ideas and innovations originating from the global south, a region home to more than half the world's human capital.

Declarations

Competing Interests: None declared.

Funding: None declared.

Ethics approval: Not applicable.

Guarantor: HI.

Contributorship: HI wrote the first draft of the manuscript and revised subsequent drafts for important intellectual content. KK wrote the first draft of the manuscript and revised subsequent drafts for important intellectual content. AD wrote the first draft of the manuscript and revised subsequent drafts for important intellectual content. MH wrote the first draft of the manuscript and revised subsequent drafts for important intellectual content.

Acknowledgement: We thank Yasser Bhatti for comments on an earlier draft of this paper.

Provenance: Not commissioned; peer-reviewed by Ophira Ginsburg.

References

1. Easterly W. *The White Man's Burden: Why the West's Efforts to Aid The Rest Have Done So Much Ill and so Little Good*. Oxford: Oxford University Press, 2006, p.380.
2. THET. *Support for Health Partnership Scheme extended beyond 2015*, 2016. See http://thet.org/health-partnership-scheme/news/support-for-health-partnership-scheme-extended-beyond-2015 (last checked 20 January 2017).
3. Crisp N. Global health partnership: The UK contribution to health in developing countries, Report to the UK government, 2007.
4. All Party Parliamentary Group on Global Health. *Improving Health at Home and Abroad. How Overseas Volunteering From the NHS Benefits the UK and the World*. London: Author, 2013.
5. NIHR Global Health Research Call, 2016. See http://www.nihr.ac.uk/funding-opportunities/global-health-research-call/4930 (last checked 19 January 2017).
6. THET. *Annual Conference 2016*, 2016. See http://thet.org/get-involved/annual-conference-2016 (last checked 20 January 2017).
7. fk Norway. Home page – Fredskorpset, 2016. See http://www.fredskorpset.no/en/ (last checked 20 January 2017).
8. Harris M, Weisberger E, Silver D, Dadwal V and Macinko J. That's not how the learning works – the paradox of Reverse Innovation: a qualitative study. *Global Health* 2016; 12: 36.
9. Bhatti YA. *Frugal innovation: social entrepreneurs' perceptions of innovation under institutional voids, resource scarcity and affordability constraints*. DPhil. University of Oxford, UK, 2014.
10. Snowdon AW, Bassi H, Scarffe AD and Smith AD. Reverse innovation: an opportunity for strengthening health systems. *Global Health* 2015; 11: 2.
11. Crisp N. Mutual learning and reverse innovation – where next? *Global Health* 2014; 10: 1–4.
12. Harris M, Bhatti Y, Prime M, Del Castillo J, Parston G and Darzi A. *Global Diffusion of Healthcare Innovation Making the Connections*. Doha: World Innovation Summit for Health, 2016.
13. Harris M, Weisberger E, Silver D and Macinko J. 'They hear ''Africa'' and they think that there can't be any good services' – perceived context in cross-national learning: a qualitative study of the barriers to Reverse Innovation. *Global Health* 2015; 11: 45.
14. Cochrane M, Chisholm G and Tomlinson N. Engaging in global health – the framework for voluntary engagement in global health by the UK Health Sector. Public Health Directorate, International Branch. See www.nationalarchives.gov.uk/doc/open-government-licence/ (2014, last checked 25 December 2016).
15. Chisholm G, Green E and Simms B. *In Our Mutual Interest — THET*. London. See www.thet.org/resource-library/in-our-mutual-interest (last checked 25 December 2016).
16. Chatwin J and Ackers L. Volunteering and overseas placements in the NHS: a survey of current activity. *BMJ Open* 2016; 6: e012160.
17. Keown OP, Parston G, Patel H, Rennie F, Saoud F, Al Kuwari H, et al. Lessons from eight countries on diffusing innovation in health care. *Health Aff (Millwood)* 2014; 33: 1516–1522.
18. Skyrme D. *Knowledge Networking: Creating the Collaborative Enterprise*. Oxford: Butterworth-Heinemann, 1999, p.311.
19. Keogh R, Walker D and Boud D. (eds) Debriefing in experience-based learning. In: *Reflection: Turning Experience Into Learning*. New York: Nichols Publishing, 1985, pp.69–84.
20. Warren K, Sakofs MS and Hunt JS. (eds) The student-directed classroom: A model for teaching experiential education theory. In: The Theory of Experiential Education. Dubuque, IA: Kendall/Hunt, 1995: 487.
21. Simpson D. Rethinking vision and mission. *Strateg Leadersh* 1994; 22: 9–11.
22. Mullane JV. The mission statement is a strategic tool: when used properly. *Manag Decis* 2002; 40: 448–455.