Partnerships for global health: pathways to progress

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Foreword

‘Global health’ is a relatively new term, but health has always had a global dynamic. Take, for example, the movement of the plague epidemic across Europe in the 14th century, or the influenza outbreak of 1918 that killed more people than the First World War.

The new term reflects new challenges, mainly those of globalisation. As Nigel Crisp points out on page 16, there is now “an epidemic of noncommunicable diseases being spread globally by changing lifestyles”. In a world where the main causes of death and disease are chronic,1 we are challenged to find equitable uses of our limited resources to provide preventative, lifelong care.

This report features ways that the University of Cambridge and other Cambridge-based organisations are working with partners in developing countries to devise effective solutions to the global health challenges of today. For example, David Dunne and Pauline Essah’s work with the THRiVE and MUII Programme (page 35), Nick Wareham’s work with CEDAR and the Cambridge International Diabetes Seminar (pages 37–39), and Costello Medical Consulting’s Global Health Internship Scheme (page 24) are building capacity to undertake health research and design evidence-based public health interventions.

On page 18, Ndwapi Ndwapi of Botswana’s Ministry of Health writes about a partnership with Addenbrooke’s Abroad to develop the leadership and management skills needed to address the health challenges of today, and tomorrow.

Their work is paving the way to better health information and health services. And there are hundreds of similar projects around the world that are making a significant impact. However, the task ahead of us is momentous, and to build effective, preventative health care systems we need input from others still. Governments need to establish policies that mitigate our exposure to risk. Corporations need to act ethically and responsibly. And NGOs2 need to play their part in advocating for governments and corporations to fulfil their responsibilities. NGOs can also play a critical role in providing services to those who public and private initiatives cannot reach in the meantime.

The Humanitarian Centre has played an important role in convening all of these different actors for the Global Health Year, to advance dialogue and action for improved health for the world’s most vulnerable people. Insights from a range of contributors to the Global Health Year are offered in this report to help continue these conversations.

1 Noncommunicable diseases (NCDs) are diseases that are not infectious or ‘communicable’, that is, they are not transmitted from person to person. They are often chronic; lasting a long time, and sometimes a lifetime. (page 33).
2 ‘Non-governmental organisations’ (NGOs) are organisations that are independent of government. Traditionally (and in the context of this report) they are also ‘not-for-profit’ organisations. The term NGOs is generally synonymous with ‘charities’ and ‘civil society organisations’ (CSOs), though there are nuanced differences. Because NGOs are not-for-profit, they have traditionally operated on philanthropic and charitable models, rather than entrepreneurial or financial ones.
Seven key messages

No one organisation, nor any one sector, acting alone can tackle the many interrelated challenges of global health. Academia, industry, governments and civil society need to work in partnership. From grassroots initiatives to the United Nations, we need new spaces and new ways of working together that accommodate diverse perspectives and foster collaborations across sectors.

Partnership is an easy word to use, but a hard one to live up to. To ensure that our partnerships work for global health, we need to build good governance structures into them and be sensitive to different needs in different settings. Using techniques like social auditing, which hold all partners accountable to their commitments, can help to uphold transparency and trust.

Look to developing countries for global health innovation. We are all pursuing affordable solutions to health problems and can learn from developing countries how to innovate with limited resources. However, experience shows us that simply exporting ideas and technology from one place to another does not work. Global health problems need local expertise and local ownership to generate local solutions.

Better access to quality health research from developing countries means better health information for the whole world. We need more support for programmes that build the capacity of individuals and institutions in developing countries to undertake, use and publish health research.

Developing and delivering health services requires effective leadership, management and mentorship. Training for future global health workers, at every level, should expand beyond ‘hard’ science to encompass such ‘soft’ skills as leadership, negotiation and adaptability.

All over the world, disadvantaged people suffer from more disease than their affluent neighbours. We need to strive for global health targets that not only address health inequalities between countries, but also within countries, and communities.

We cannot tackle global health challenges without also addressing social, economic, and environmental challenges. Recognising this interdependence, we have an opportunity to shape policies and practices that are good for the health of the individual, and good for the health of society and the planet.
Introduction: why we need partnerships

Partnerships for global health: pathways to progress is a collection of pieces that capture lessons from the Humanitarian Centre’s Global Health Year. Why partnerships? Because the challenges of global health are interconnected to other challenges of social and environmental equity and sustainability – and they involve everyone. Partnerships – at least, good partnerships – provide a structure for collaborative work that recognises the value of each partner’s potential contribution.

As the subtitle to this report, quoted from Lord Nigel Crisp (page 17), says, ‘everyone has something to teach and everyone has something to learn’. This powerful, yet simple message sums up the approach we need to take towards working with one another to address global health challenges. It has helped focus the Humanitarian Centre’s approach to each event throughout the Global Health Year. It also encapsulates the foundations of the Humanitarian Centre’s work overall: that bringing people together in open dialogue leads to mutual learning, and to lasting change.

When Dr Peter Singer helped us launch the Global Health Year in October 2011, he concluded his speech with a challenge to us, and our focus on partnerships in global health:

> You have absolutely picked the right focus for the Global Health Year, in terms of partnerships across various sectors – academia, government, civil society, and the private sector – and also the importance of partnerships between southern and northern innovators and entities. These partnerships are critical to success. You know, the mark of a great community, and this certainly is one, is that you will rise to tackling global challenges. Take advantage of the Humanitarian Centre platform, prioritising partnerships, and tackle these challenges together.

Peter Singer, page 13

A great breadth of partners did take advantage of the Global Health Year platform, including student researchers, international NGOs, business leaders and parliamentarians – from the global north and south. We are grateful to participants, from across all sectors, who joined us over the course of the year, working with one another to address the most pressing global health issues. The ideas generated and the new partnerships kindled will contribute to future innovation in global health practice. We believe that we are already seeing the fruits of these new collaborations, as demonstrated on pages 24–25.

We are especially grateful to all of the speakers and special contributors to the Global Health Year, and we are delighted to have the opportunity to share the best of their contributions in this report. We would also particularly like to thank all of our sponsors (page 2). Their generous and thoughtful support has made the Global Health Year and this report possible.

Without further ado, we sincerely hope you enjoy, and are inspired by, this array of insights on ‘partnerships for global health.’

Anna-Joy Rickard
Director, The Humanitarian Centre

Steve Jones
Chair of Trustees, The Humanitarian Centre

Richard Howitt MEP joins the Humanitarian Centre and partners from academia, NGOs, and the private sector to address noncommunicable diseases and mental health issues in developing countries. Speakers from Uganda and Indonesia used Skype to join the discussion and Twitter helped to make the conversation accessible worldwide (page 48).

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*The terms ‘global north’ and ‘global south’ are often used in place of ‘developed’ and ‘developing’ countries to move beyond post-colonial connotations of ‘progress’. The ‘global north’ roughly maps on to the ‘high and middle income’ countries in North America and Europe. The ‘global south’ maps on to ‘low and middle income’ countries in Central and South America, Africa, Asia and the Pacific.*
Dr Fredros Okumu of Tanzania was the first southern innovator to be successful at the Grand Challenges Explorations $1 million scale-up level grant, for ‘smelly socks’ against malaria.

There are many different kinds of partnerships for global health, each with different goals. No one organisation, or even sector, can address the enormous challenge of tackling global health alone. Critically, all of these partnerships need to be focused on trust, mutual accountability and measurable achievements.

At the launch of the Cambridge Global Health Year, Peter Singer highlighted some of the successful global health partnerships that Grand Challenges Canada is involved with and inspired by. Dr Singer is well known around the world for his creative solutions to some of the most pressing global health problems, and particularly for looking towards the global south for the innovations that can “make tomorrow a better day than today”. What follows are excerpts from his keynote speech at the launch of the Cambridge Global Health Year.

I was privileged to be pulled into my own global health partnerships in late 2002, for the original Gates Grand Challenges in Global Health. This was designed to energise emerging science in global health, and relied very much on partnerships. The whole idea of the Grand Challenges approach was to bring people, who otherwise wouldn’t be doing global health, to global health, and also to have people working in communities around vexing scientific challenges.

Innovators partnering with funders

The original Grand Challenges were very large grants, on average $10 (£6.5) million. While they accelerated the development and deployment of some important ‘top-down’ innovations, like the genetically modified mosquito that doesn’t transmit dengue and malaria, they didn’t really allow for the ‘bottom up’ innovation of young people. And they didn’t really facilitate leadership on the part of innovators in low and middle income countries. That is what led to the ‘bottom up’ Grand Challenges Explorations programme, with $100,000 (£65,000) grants to test proof of concept, followed up by larger grants of $1 million (£650,000) to go to scale.

Dr Fredros Okumu, of Tanzania, was the first southern innovator who was successful at the $1 million scale-up level. He noticed that when children played football on the common, their stinky socks attracted mosquitoes. To complement antimalarial devices like bed nets, he isolated the scent in the stinky sock, and put it in boxes outside huts, combined with insecticide. Here it attracts and kills the mosquitoes before they can enter the hut.

This is a good example of a bold idea which could have a big impact, and is an excellent example of another kind of partnership, one which enables innovators, often young innovators, in low and middle income countries to solve their own problems.

Funders partnering with funders

Earlier this year Grand Challenges Canada launched a partnership called Saving Lives at Birth with the United States Agency for International Development (USAID), The Bill & Melinda Gates Foundation, Norwegian Agency for Development Cooperation (NORAD), and UK Aid from the Department for International Development (DFID). Saving Lives at Birth focuses on the critical 72 hours around the time of childbirth. It is during these
hours that most of the 350,000 women who die in childbirth every year die. And 1.6 of the 7.5 million children who die under the age of five also die in the first 72 hours of life. This type of partnership is a partnership amongst funders. Already, we have awarded 24 grants, from over 600 applications. We are seeing that different funders – private and public – from different countries can join in partnership to tackle global challenges together and, in so doing, support communities of innovators.

Communities partnering with scientists

Another type of partnership is the partnership that needs to happen between scientists and communities. Some of the technologies generated by the original Grand Challenges, for a genetically modified mosquito that does not transmit malaria or dengue, are approaching field trials, or had them already. In the community of Tapachula, Mexico, many children are dying of dengue. Grand Challenges investigators James Lavery and Anthony James engaged the community about the ethics of the genetically modified mosquito and the idea of something being done to insects for a particular end, and the community reached the conclusion that they wanted a field trial. Researchers, innovators and scientists must work hand-in-hand with the communities they intend to serve.

Partnerships with the private sector

Meningitis is a terrible disease that ravages the brains of children, kills them or leaves them disabled. There was no vaccine for the type of meningitis that affects children in West Africa, until a partnership developed between a Seattle NGO, PATH, the World Health Organization, and an Indian company, the Serum Institute of India, with funding from the Bill & Melinda Gates Foundation. This vaccine is expected to save around 130,000 lives over the next ten years and – here is the key point – it costs less than 50 cents per person. This example illustrates affordable innovation from a partnership between an NGO in Seattle, a multi-governmental organisation in Geneva, and a private company outside of Mumbai. Partnerships among the private and the public sector will be critical in tackling global health challenges. The participation of multinationals is also going to be needed, but it needs to come with a focus on trust. When Monsanto donated technology for water efficient maize for Africa, in partnership with African NGOs and CVMHIT (the seed organisation), my colleague Abdullah Daaz, working with our Nigerian colleague Obidimma Ezekia, developed a process of social auditing7 that ensured that the actors, in particular Monsanto, did what they said they would do. Social auditing builds trust between the participants in a partnership, and between those participants and the community. This sort of trust building, given the history we have had with multinationals in the area of global health, is definitely going to be needed, because the participation of multinationals is going to be needed.

Partnerships for the future of global health

But I think the future of global health is not actually the multinationals, but the small and medium enterprises (SMEs) those in India, China, Brazil, and other emerging economies today, and those in Africa and less-developed countries tomorrow. It is these enterprises that hold the key to future private sector engagement in global health.

For example, returning to innovation in malaria, bed nets are the front line of public health prevention. But where do you think the bed nets in Africa come from? A to Z Textile Mills in Arusha, Tanzania, is an up-and-coming SME; it makes 25 million bed nets a year and employs 6,000 people, many of them women. Imagine a world where 100 SMEs across Africa, like A to Z Textile Mills, are solving not only health problems, but also economic problems. A to Z Textile Mills got started in partnership with Sumitomo Chemical in Japan. This is a partnership between a large Japan-based multinational and an SME in East Africa, achieving global health and economic aims.

The Humanitarian Centre and Cambridge have absolutely picked the right focus for the Global Health Year, in terms of partnerships across various sectors – academia, government, civil society, and the private sector – and also the importance of partnerships between southern and northern innovators and entities. These partnerships are critical to success.

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Case study

Networks of excellence in sub-Saharan Africa

A young patient receives medication with an intravenous drip. She is a participant in a EDCTP-funded clinical trial for antimalarial drugs in Manhiça, Mozambique.

The European & Developing Countries Clinical Trials Partnership (EDCTP) was established in 2003 as a European response to the global health crisis in sub-Saharan Africa. Our goal is to accelerate the development of new or improved interventions to fight diseases through collaborative research. Our focus is on the diseases that are poverty-related, such as HIV/AIDS, malaria and tuberculosis.

The partnership began by engaging European national research programmes on poverty-related diseases and their African counterparts, as well as the pharmaceutical industry and like-minded product development organisations. All partners are actively involved in identifying needs, setting priorities and establishing a strategy for a joint research agenda. By integrating clinical trials, capacity development and networking, EDCTP contributes to addressing the current health and clinical research capacity needs of the African region.

EDCTP recognises that within sub-Saharan Africa, there is very limited south-south collaboration, and what exists is often not optimally utilized. Therefore, EDCTP developed a strategy to improve this situation: the establishment of four ‘networks of excellence’ for conducting clinical trials and promoting research in sub-Saharan Africa. The networks are organized at regional levels which reflect the African regional economic communities. Individual organisations are supported to pool their strengths in clinical trials research capacity and competencies such as data management, actual clinical trial implementation and management as well as laboratory support. More established institutions provide support to the upcoming institutions in the region.

**Improved research brings improved practice**

These four networks have brought together different research centres from eastern, western, southern and central Africa respectively, to improve capacity for clinical trials. They also foster south-south mentorship and the proliferation of knowledge and capacity beyond the lifespan of the clinical trials, thus enhancing sustainability. With improved knowledge and capacity comes improved quality of clinical research and practice in sub-Saharan Africa, allowing Europe and developing countries to tackle poverty-related diseases more effectively.

**Partnership – both conceptually and in practice – is generally seen as a good thing. It implies a shared contribution, shared accountability and also an equal share in whatever benefits the partnership produces. Sadly though, not all partnerships are created equal. Since the word has become commonly used within global health, it has too often been used to describe relationships that are not based on sharing and equality. When its use is so widespread, are we in danger of losing its real meaning?**

Bruce Mackay is a UK-based consultant who has worked for a number of donors and international agencies, mainly on reproductive health. He writes here in a personal capacity, about the dangers of unruly ‘partnership’.

**Take your partner for (yet another) dance**

International development generally, and health in particular, is awash with partnerships. I have an invitation here beside me to join ‘the UK government and the Bill and Melinda Gates Foundation, in partnership with UNFPA, national governments, donors, civil society, the private sector, the research and development community and’ (luckily for me) ‘others’.

Back in 1987 Dr Gro Harlem Brundtland told the UN that ‘partnership is what is needed in today’s world.’ Some partnerships seem to be just what the good doctor ordered, especially those designed by clever people to overcome market failures, or those where we can clearly see that the whole is greater than the sum of the parts – where two plus two really can equal five.

‘Partnerships’ muddy the water

But some seem to me to be a waste of time, or worse. The word itself reduces the clarity of role and responsibility which is characteristic of most successful ventures. I was recently asked to change both ‘donor’ and ‘recipient government’ – words which make explicit the relationship between the two – to ‘development partner’. This muddles what can anyway be murky relationships between unsophisticated donors, secretive corporations, unaccountable NGOs and international agencies who have no mechanism for saying ‘no’ to anyone knocking at their door.

More seriously, woolly governance arrangements obscure the fact that participants have different and possibly conflicting interests, and possess and exercise very different levels of power with which to pursue them. Those with money can use these partnerships to buy influence, while the less rich and less well-connected are marginalised.

Attending a meeting on ‘access to essential medicines’ chaired by an executive of Big Pharma, I wonder why there are no criteria by which a company found to be damaging children’s health might be excluded.

Six years ago Buse and Harmer felt that because ‘the concept of partnership is constructed through the dominant discourse … criticism of partnership per se is almost unthinkable’. I hope not. Challenged to put pen to paper on this topic, I was pleasantly surprised by the large and diverse literature I found.

We must not allow a situation where ‘cross-cutting and overlapping governance structures increasingly take private … forms thereby undercutting democracy’... 

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Partnership, co-development and leadership

The concepts of partnerships, mutuality and co-development are coming more and more to the fore as policy-makers, practitioners and politicians recognise how interdependent we are globally in terms of health and health systems.

This interdependence is not just with respect to our vulnerability to communicable diseases, although modern interconnectedness has accelerated their spread to an extraordinary extent: the Black Death took three winters to travel across Europe in the 14th Century whilst SARS crossed the world in three days at the start of this one. Alongside this, there is now, an epidemic of noncommunicable diseases being spread globally by changing lifestyles, growing affluence and the promotion of processed foods and tobacco by multinational companies. The impacts of climate change, environmental issues and migration all contribute to health becoming a global issue, whilst at the same time all the regions of the world are becoming increasingly dependent on the same health workers, drugs and technologies.

A challenge for us all

We are in this together, whether we like it or not. This interdependence is changing the way countries need to relate to each other. The richest countries now have a vital self-interest in knowing that there is adequate health surveillance in the poorest countries where new diseases may incubate and begin their spread. The world is vulnerable at its weakest part. Moreover, this interdependence reveals very clearly the current inequities in health and health resources. There are increasing demands to correct this imbalance as power shifts globally from West to East, North to South, the emerging economies of the BRICS’ rise, G8 gives way to G20,10 and global institutions come under increased stresses and demands for change.

Many different partnerships have been developed against this background: from the multinational Global Fund and GAVI,11 to regional and bilateral12 relationships and, at the most local level, hospital and service twinning, exchanges and links. As Bruce Maskell points out on page 15, the word ‘partnership’ has been used, sometimes obscurely, to refer to different structures that have very different aims and functions, and ones that are not always beneficial. However, I want to draw attention to the way in which mutual benefit, two-way learning and what we should be calling ‘co-development’ is becoming more prominent.

‘Co-development’: a new name

Many partnerships have been based on the richer and stronger partner doing things to or for the weaker – through charity, self-interest or a search for justice. And the concept of international development itself contains the assumption that developed countries are more advanced and can transfer knowledge and skills to developing ones. It is one way, top down and paternalistic. But not all partnerships have been like this, and I believe that in future we will increasingly see partnerships which are much more between equals, where both or all parties gain, and where they shape the partnership and set the terms of the relationship together.

I have argued elsewhere that we need mentally to ‘turn the world upside down’13 because those of us living in the richest countries have a great deal to learn about health and healthcare from people who, without our resources and, without our vested interests, are innovating and dealing with problems that we are unable to address adequately. There are examples throughout the world which range from clinical practice to service design and from product development to policy making. In other words, everyone has something to teach and everyone has something to learn. We should learn to think in terms of co-development, not international development.

The G8 (Group of 8) is a forum for the leaders of the countries that were the world’s largest economies in the latter part of the 20th century: Canada, France, Germany, Italy, Japan, Russia, UK, USA. The G20 (Group of 20) is a group of government finance leaders from 20 major economies. The G20 is replacing the G8 as the prominent world economic forum, denoting the increasing global importance of emerging and developing economies.

GAVI was formerly the Global Alliance for Vaccines and Immunisation. The Global Fund and GAVI are major private-public partnerships for global health.

Bilateral relationships are between one country and another – in the context of global health partnerships, usually one donor country and one recipient country.

Partnership, co-development and leadership: a response

In the past decade, the era of the US President’s Emergency Plan For AIDS Relief (PEPFAR) in Botswana, ‘development partner’ has become the politically correct way to refer to a Western donor or their agents (for example, a major US university). Moreover, the partnership model for funding HIV and AIDS programmes has evolved into one in which funding is disbursed through predetermined partners in a top-down approach to skills transfer and technical assistance. With this approach, a virtually one-way – and indeed, sometimes paternalistic – donor-recipient relationship has been consolidated in which the ‘development partner’ is burdened with ‘developing’ the host country. These false partnerships are not the result of donors’ deliberate attempts to undermine recipient governments, but more a consequence of PEPFAR’s beginning as an emergency or rescue initiative. Quick results demanded the enabling power of US Government funding and the superior technical skills of US-based universities and NGOs. There was, perhaps understandably so, an overriding and emergent need to save lives beyond any other efforts to build a sustainable approach to international development.

Missed opportunities and bad precedents
Notwithstanding its most honourable intentions, the advent of PEPFAR missed a historical opportunity to transform international aid in general, and global health in particular. Arrangements could have been made to ensure that both the donor and the recipient learn from each other in ways that could significantly benefit both sides. The agents of donor countries and organisations should not settle in the developing world for extended periods, only to live in the perpetual (and mostly incorrect) assumption that because of their financial and technical advantages, only their ‘advanced’ knowledge and skills are transferable. Nor should recipient governments and NGOs settle in these relationships with the intellectual inertia of donor aid dependency. All involved should ensure that the opportunities brought about by international aid, especially in health, are utilised to maximum effect for two-way learning and, as Nigel Crisp proposes, co-development.

A partnership of equals
Donors must position themselves in a way that is not only conducive to giving but also receiving. All development partners’ must be open to teaching, and also to learning. Ultimately, sustainability beyond the donor years depend not only on the self-reliance of the recipient, but also on the continued interest and interdependence of the donor country and its agents. When partnerships between donors and recipients are truly conceived of as equal, they encourage the recipient’s ingenuity and innovation. They also encourage humility in donors and their agents and, much to their benefit, drive them to learn to help other recipients better, and to derive lessons for health systems in their home countries.

Perhaps borne out of the many lessons of the past decade, the partnership between Botswana’s Ministry of Health and Addenbrooke’s Abroad is decidedly different from the traditional PEPFAR-funded initiative. In 2009 Botswana sought and gained approval to use PEPFAR funding to partner with an organisation of its choice to assist in leadership and management development in health. As a partner, Addenbrooke’s Abroad has not come with preconceived ideas of how this should be achieved. Instead, they have listened and deferred to our ideas, experience and opinions. This is very different to the programmes that are conceptualised and planned in the US long before they are even announced to the recipient governments. For the first time, a development partner from a ‘donor country’ is not just here to ‘aid’, but is also learning things that may well be applied to the NHS in the future.

Addenbrooke’s Abroad has had a steep learning curve in implementing the leadership and management strengthening framework in Botswana. Before they could even begin, they have needed to reflect on what their ideas and practices really mean in a setting outside Cambridge, in a different country and culture. These reflections have resulted in a palpable transformation in their perception of management and leadership strengthening.

From our perspective at the Ministry of Health, being in an equal partnership has also made us realise that the idiosyncrasies of our health system, so often viewed with shame as the blotches of underdevelopment, are actually respectable realities and opportunities for more equitable and effective health care in the future. Addenbrooke’s Abroad is witnessing firsthand how a health system with few opposing vested interests and a virtually unanimous national commitment to universal access can be immensely beneficial for advancing the wellbeing of the population.

These are the lessons of this partnership for universal access can be immensely beneficial for advancing the wellbeing of the population.

Exploring leadership together
It has been a significant hallmark of this relationship that Botswana chose Addenbrooke’s Abroad out of many possible development partners. In the future, perhaps a more deferential approach to disbursing donor funding, allowing recipient countries to lead in choosing partnerships and projects, will allow for more mutually beneficial associations. We are already seeing the beginnings of a far deeper relationship, based on mutual respect, that has all the hallmarks of one that will endure beyond the limits of the project’s funding. A body of knowledge is growing that will be immensely beneficial to how Botswana strengthens leadership and management in health. Cambridge University Hospitals is also acquiring the knowledge to engage in similar partnerships both within the UK and internationally. © Addenbrooke’s Abroad

Peggy Mooki Sebuyuyu and Pearl Mbulawa Kelope are running a screening programme for diabetic eye disease through the health partnership established between Addenbrooke’s Abroad and Botswana’s Ministry of Health, funded by Seeing is Believing.

© Addenbrooke’s Abroad
Albert Einstein once observed that “insanity is doing the same thing over and over again and expecting different results”. Unnervingly, we see hints of ‘insanity’ in global health work all around us. When we are faced with a reoccurring problem, if we don’t open our minds to new and different approaches, why should we be surprised when our efforts continue to fail?

Operation ASHA is a pragmatic NGO that adapts models that work, even ones drawn from the financial world, to fight tuberculosis. Its co-founder, Dr Shelly Batra, presented at the Global Health Commercialization & Funding Roundtable, run by Julia Fan Li of the University of Cambridge. The roundtable showed how business models are being applied to social problems, for affordable, market-driven health services for people at the ‘bottom of the pyramid’.

Using social innovation to get treatments to the people that need them

Not all global health innovations derive from scientific breakthroughs and technological improvements. There is a need for social innovation: taking existing biomedical interventions and finding ways to deliver them to all patients in need. At the bottom of the pyramid, where health needs are high but resources are low, there is potential for entrepreneurs to bridge ‘delivery gaps’, and deliver life-saving treatments to the people who are suffering. In India, a country that bears 20 per cent of the world’s tuberculosis (TB) disease burden, social innovations for treatment delivery are desperately needed.

Two entrepreneurs who took up this challenge founded Operation ASHA (OpASHA), an NGO working in partnership with the Indian government. It is funded in part by private foundations and donations, and run on a model adapted from the financial world to innovatively deliver TB medicines to the poorest patients, who live either in urban slums or hard-to-reach rural parts of India.

Medicines in temples and shops

OpASHA is based on a social franchising model. ‘Social franchising’ uses business franchising methods – replicating a successful operating model in new locations – to achieve social objectives as well as financial ones. OpASHA has created a network of TB medicine providers in strategically-recruited shops, homes, temples and even traditional medicine providers, which allows patients to easily access their antibiotics. For example, a TB medicines rack may be placed discretely at the local convenience shop, where patients take their medicine under direct observation of the OpASHA Provider (the recruited shopkeeper). This reduces the effort, time and money the patient invests in taking their medication, as well as encourages better compliance.

For every two TB medicine providers, an OpASHA counsellor is assigned to the area. The counsellor is involved in finding TB cases, sending samples to government labs for testing, and educating patients and their families on compliance. Once a TB patient has been diagnosed, the Indian government provides all TB medicines to OpASHA. If a patient misses a scheduled visit to the provider, an electronic medical records system (co-developed with Microsoft Research) can

> An Operation ASHA counsellor makes a home visit. This community-based approach has helped more TB patients to take the full course of their medication, lowering the risk of developing drug-resistant TB.
notify the responsible counsellor via SMS. The counsellor, who is also a resident within the slum, will make a house call to check on the patient and engage in re-counselling and re-medication. This is important because drug-sensitive TB is treated by a 6-month regimen of generic antibiotics. Compliance with long-term treatment plans is difficult, but when patients cannot access adequate medical care, the infection can become drug resistant, which is difficult to treat and is often fatal. Drug-resistant TB is best prevented by ensuring compliance to the ‘usual’ TB treatment. Treatment of drug-resistant TB is even more challenging because it lasts for 2 years, and the medicines have horrifying side effects.

**Bonus incentives**
Each counsellor is a full-time employee and is paid a bonus for helping their clients successfully complete a full course of treatment, and for actively finding people with untreated TB. OpASHA’s community-based model, which began over two years ago, has had excellent results in home treatment of drug-resistant TB.

In settings where resources are tight, this model allows for impressive cost-effective gains in global health. It generates economic incentives for individual providers (the micro-entrepreneurs), and the incentive for the government of better health outcomes motivates it to maintain the supply chain. In addition it is low cost: the cost of treating one TB patient through OpASHA is only £30 in India, and £55 in Cambodia, which is several times lower than other NGOs.

This social franchising model has achieved excellent results: increased case detection and decreased default report rates. In India OpASHA now serves an area of more than 7 million people in 1,352 slums in over 14 cities. In Cambodia, OpASHA serves 1 in 12 TB patients. For a disease like TB, where technologies for prevention and cure were pioneered years ago, one of the most significant areas for innovation is in getting the treatment to the people who need it.

> Getting basic medical and hygiene supplies to the people that need them can be a challenge. Here, Bimla, who works with Khandel Light in rural Rajasthan, delivers sanitary pads to girls who may otherwise have to stay home from school for several days each month.

>> There is a need for social innovation – taking proven biomedical interventions and finding ways to deliver them to all patients in need... At the bottom of the pyramid, where health needs are high but resources are low, there is potential for entrepreneurs to bridge delivery gaps.

© Khandel Light
What can happen at a 'hack day'

Bringing different kinds of people together in a common space can foster innovation. It can help disrupt closed patterns of thinking and introduce new perspectives and an element of serendipity. However, there are surprisingly few such opportunities in global health to step outside professional silos and try unfamiliar ideas.

Some exceptions to this are reported here: Miranda Swanson tells how two organisations, Medic Mobile and Costello Medical Consulting, used a space for ‘open innovation’ at the Global Health Hack Day and came away with inventive solutions. The Hack Day was organised by the Humanitarian Centre and Cambridge University Technology and Enterprise Club (CUTEC) to help people with different backgrounds into teams to work on ‘live’ global health challenges over the course of a week.

Costello Medical Consulting

Sophie Costello has a genuine interest in global health. As the founder of a consultancy that works in evidence-based medicine (using the best available research to inform medical decisions) and health economics, her potential contribution to this area is seemingly straightforward. There is an even greater need for evidence-based health policies and interventions in developing countries than there is in the UK – simply because there is a greater lack of skilled analysts to help collect and use this evidence.

However, although a UK-based consultancy could design these health policies and interventions for the developing world, a long-term solution requires training local practitioners to build their own evidence base.

Costello Medical Consulting associates Laura Hamerslag and Craig Brooks-Rooney took this problem to the Global Health Hack Day, where they connected with Ahmed Aboulghate (medical doctor), Katsiarjna Bichel (biobusiness scientist), Tina Lee (physician), and Veronika Mercks (intercultural communications specialist). Their multidisciplinary, international team brought a range of approaches to bear on this challenge, and arrived at an unconventional solution.

The team proposed an internship scheme, whereby Costello will recruit and train early-career health practitioners from developing countries, to work together on diseases in Costello’s portfolio and in the intern’s community. Costello and the intern will collaborate on a research project to control the spread of that disease.

The intern will be hosted by Costello in Cambridge for two months to be trained in the methods that Costello uses for clients, learning to use evidence as a tool for building public awareness of disease prevention. After the internship, with support from Costello, the practitioners will implement their newly acquired skills at home.

There are also benefits to Costello. Costello associates, often in the early stages of their careers, will gain experience in training colleagues. And the consultancy will benefit from the influx of new perspectives and from growing their portfolio with these collaborations.

The immediate goal is that the internship scheme will help reduce the spread of disease in communities where interns are based. In the longer term, Costello hopes that interns will train other local practitioners in evidence-based medicine, sparking a chain effect of increased impact in their areas, and throughout their careers.

Sim-Prints and Medic Mobile

In remote areas of developing countries, medical records can be inaccessible and immobile, locked away in filing cabinets, kilometres from the patients they correspond to. It can take weeks, or months, to receive a record, by which time it could be too late to treat a patient with a complex history, or vaccinate a migrant family’s children.

This cumbersome process is frustrating for health professionals and dangerous for patients. But what if information from a patient’s record could be delivered directly to a health worker’s mobile phone? A new mobile phone SIM card application developed by Medic Mobile, called Muvuku, can do exactly that.

The problem Medic Mobile now faces is how to ensure the right record gets to the right patient. This is especially hard in migrant communities, where people have common names, and birth dates are not always known. Enter laser physicist Shruti Badwar, protein biochemist Mariya Chaitriwala, and management scientist Toby Norman. These three joined Medic Mobile mentor Isaac Holeman to take on the challenge of creating a simple way to capture unique patient ID.

Their project, called ‘Sim-Prints’, is a system for storing and accessing medical records electronically. It’s cheap to produce, simple to operate and easy to transport. A health worker scans the patient’s fingerprint with a scanner connected to a mobile phone; a basic software programme converts the fingerprint into a unique digital code and sends it via text message to a central database. The code is matched to the patient’s records, and the information required is texted back to the health worker’s phone.

The original team has expanded to include an engineer, James Crosby, a business expert, Markos (Megan), and a programmer, Gail Mayher. Together this multitalented and multicultural team won first place at Idea Transform Start-Up Boot Camp, and has continued to develop the project with mentoring from Medic Mobile and other experts.

Mariya, Shruti and Toby are working to develop a prototype of the technology for what is hoped will be widespread application. Better availability of medical records will make it easier for health professionals to keep on track with vaccination programmes, and ensure that the right people get the right drugs. It could transform national health systems, reducing the time and costs for services, improving efficiency and encouraging more people to access care.
CBM developed an easy, low-cost cataract surgery that has allowed them to train hundreds of local staff to perform the high-quality surgery over the past 30 years, restoring vision to thousands of patients. These women are recovering from the surgery at Joseph Eye Hospital, Tiruchirapalli, India.

There are no simple solutions in global health. Achieving progress requires people, politics and processes, and we know all these things come with complications. Negotiation and leadership skills are as important for global health professionals as epidemiology and biostatistics, but are rarely taught in global health university programmes.

Dr Manpreet Singh is one of the founders of an initiative which began at the Harvard School of Public Health in 2010, out of awareness that global health education did not prepare students for the realities of modern day practice. It is called Aid for Health and it runs simulations of real life aid negotiations: immersive dramas which allow students to understand the politics and pressures surrounding global health realities and decision making. In March 2012, the Humanitarian Centre hosted the first Aid for Health in Europe following two simulations at Harvard. Later this year, the first African Aid for Health simulation will be held in Botswana.

Transformative education for global health

Global health education has gone through a recent boom. In the last 10 years, the UK has gone from having one full-time Bachelor of Science (BSc) degree in global health, to having eight. In America, from 2003 to 2009, global health programmes expanded from eight universities to 40. In theory, we can expect this new, growing generation of global health professionals to employ their training and skills to advance the health of people all over the world.

Of course, in reality, the picture is not so rosy. There have been a number of criticisms of the current state of global health education. A 2010 Lancet Commission on the education of health professionals, authored by luminaries such as Julio Frenk (Dean of the Harvard School of Public Health), Lincoln Chen (President of China Medical Board), and Lord Crisp (former NHS Chief Executive, featured in this report) claimed that “professional education has not kept pace with these challenges, largely because of fragmented, outdated, and static curricula that produce ill-equipped graduates”. They proposed a vision for the reform of health professional education: “a series of instructional and institutional reforms, which should be guided by two proposed outcomes: transformative learning and interdependence in education”.

To look at the future of global health education, we must first look into its origins. Global health started at the intersection of two academic disciplines. The first is tropical medicine, initially the study of diseases seen in the European colonies, and now dominated by doctors and clinicians working in infectious disease across the world. The second is public health, traditionally led by doctors and scientists, and focused on the skills of biostatistics and epidemiology. These are essential skills, and form the core toolkits of global health, but they are not sufficient for modern day practice.

As this report reflects, modern global health relies on many professional disciplines and sectors. Genuinely innovative practice requires an understanding of economics, international law, health systems, engineering, business models, politics, public relations and negotiation and leadership skills. There are no simple solutions in global health. Achieving progress requires people, politics and processes, and we know all these things come with complications. Negotiation and leadership skills are as important for global health professionals as epidemiology and biostatistics, but are rarely taught in global health university programmes.

Dr Manpreet Singh
Junior Doctor,
Member of the Aid for Health Global Organising Team


Whilst nobody will be an expert in all fields, an effective global health professional must be able to speak the language of other professional disciplines, to understand the value of a broad range of professional backgrounds, and to create a team that allows everyone to work to their strengths.

Meeting between bilateral and multilateral donors, governments and community organisations. The goal of the simulation is to arrive at an agreement to increase donor commitment for maternal and child health. But the real goal is to learn, through experiencing the process, the realities of negotiation, the interplay between donors and governments, and the real-life compromises required when forming partnerships between actors with different priorities. The simulation does not attempt to provide answers, but exposes participants to the messy realities of practice, as they learn that there are no easy solutions to global health problems. The simulation brings together students, faculty and professionals from different backgrounds, in an environment that encourages reflection.

The quality and creativity of programmes such as Aid for Health, which bring together future leaders to reflect on shared challenges from different perspectives, are transformative. Approaches such as these will create a generation of global health professionals who are equipped to work together and impact health worldwide.

An ‘International Network for Doctoral Training in Health Leadership’ has been established by the University of North Carolina at Chapel Hill, to address these issues. The network is dedicated to accelerating the pace and reach of urgently needed doctoral-level leadership training for senior health professionals around the world.

Anthropology, amongst others. Whilst nobody will be an expert in all those fields, an effective global health professional must be able to understand the value of a broad range of professional backgrounds, and to create a team that allows everyone to work to their strengths. As Lord Crisp and Dr Ndwapi discuss on pages 16–19, global health also requires leadership at the individual, organisational, national and international level.

Putting all this together, on top of the core toolkits of biostatistics and epidemiology, modern global health professionals must also be able to set up, work with, and lead, multidisciplinary, multisectoral and multicultural teams. To do this, they have to have a firm understanding of the context in which they work. This involves an awareness of the different roles played by government, multilateral organisations – like the UN, which brings together multiple actors – and private partners, and the interactions between them.

This sounds daunting: these so-called softer skills cannot easily be taught in the traditional educational spaces of lecture theatres and classrooms. They cannot be taught through textbooks, or setting exam questions. Transformative global health education requires innovative educational techniques.

In 2012, the Humanitarian Centre hosted the first Aid for Health simulation in the UK. They brought together over 50 students from 22 different countries, and more than 50 disciplinary backgrounds. The simulation allows participants to ‘play’ 14 different organisational roles, simulating a high-level meeting between bilateral and multilateral donors, governments and community organisations. The goal of the simulation is to arrive at an agreement to increase donor commitment for maternal and child health. But the real goal is to learn, through experiencing the process, the realities of negotiation, the interplay between donors and governments, and the real-life compromises required when forming partnerships between actors with different priorities. The simulation does not attempt to provide answers, but exposes participants to the messy realities of practice, as they learn that there are no easy solutions to global health problems. The simulation brings together students, faculty and professionals from different backgrounds, in an environment that encourages reflection.

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> Rameshwar Lal Verma, director of Nirman Sanstha, Khandel, partners with Khandel Light to engage local youths about health issues in their villages in Rajasthan.

>>> Whilst nobody will be an expert in all fields, an effective global health professional must be able to speak the language of other professional disciplines, to understand the value of a broad range of professional backgrounds, and to create a team that allows everyone to work to their strengths.
We have historically looked to the north for leadership. But when we “turn the world upside down”, to borrow the title of Lord Nigel Crisp’s book, and look to the south for health care innovation, we find many inspiring examples of projects and partnerships, that everyone can learn from.

**India and Cambodia:** Operation ASHA is using a ‘social franchising’ model to effectively and discreetly deliver essential treatments to people suffering from tuberculosis in the most disadvantaged areas of India and Cambodia (pages 20–23).

**Botswana, Malawi, Mozambique, South Africa, Zambia, Zimbabwe/France, Germany, Netherlands, Sweden, UK:** The Trials of Excellence for Southern Africa (TESA) Network is building capacity for clinical trials and research to tackle HIV, AIDS and Malaria (page 16). Their work strengthening management structures, improving labs and clinics and increasing trained staff is leading to better health for Southern Africa.

**Cameroon/UK:** CEDAR’s joint project with researchers in Cameroon has been the first project to objectively demonstrate the difference between rural and urban physical activity and energy expenditure. This is a stepping stone to understanding how to build an effective intervention to promote healthy physical activity in both settings (page 39).

**Brazil/UK:** Researchers from the Federal University of Rio Grande do Sul in Brazil worked with the Cambridge-based PHG Foundation to help create the Health Needs Assessment Tool Kit for Congenital Disorders. The Toolkit gives health professionals, policy makers and patient groups access to comprehensive data, information and a guide to developing strategies and services for the prevention and treatment of birth defects.

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**India (and 140 countries across the globe):** About half of all children in the world, in over 140 countries, are vaccinated with high-quality, low-cost vaccines from the Serum Institute of India. Pioneering private-public partnerships between the Serum Institute of India and international organisations, like the WHO, and NGOs, like PATH, are allowing for innovation in vaccine production for diseases such as meningitis (pages 12–13) and TB.

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Getting in the access loop

Marina Kukso is Publications Manager of the open access journal PLOS Neglected Tropical Diseases, the only open access journal devoted to the world’s most neglected diseases, which include elephantiasis, river blindness, leprosy, hookworm, schistosomiasis, and African sleeping sickness. PLOS aims to remove existing barriers that prevent scientists from sharing, finding, learning from, and building upon the shared scientific body of knowledge.

Fora for dialogue between journals and researchers

Achieving open access to research for all will not be complete without the ability of researchers from all countries to participate fully in the global scientific discourse. Journals play a key role in determining the ability of researchers from developing countries to participate in this global exchange by providing access to publication. PLOS is interested in exploring what open access journals can do to improve access to authorship and build capacity in our researcher community. What do researchers need from journals to support them in their work and strengthen submissions? What are the possibilities for collaborations that would best serve our community? There is a need for better dialogue between journals and researchers. Forums like HIFA2015, a global campaign to achieve Healthcare Information For All by 2015 can be good, neutral grounds for open, continuous dialogue.

David Carr is a Policy Adviser at the Wellcome Trust, a major funder of health research in Africa. The Wellcome Trust has a long-term commitment to enhancing research capacity for local healthcare priorities in a way that is sustainable. As a global foundation, it is dedicated to ensuring that the outputs of the research it supports are made widely available, so that they can be used in a way that maximises the health and societal benefits.

Support for open access

I am a passionate advocate of open access publishing, and believe it can play a major role in supporting the development of African science, through ensuring that researchers across the continent have free and unrestricted access to the latest research findings. But I recognise that the move to new publishing models also creates new challenges, and that the transition needs to be taken forward in a sustainable manner. It is vital that funders recognise the cost of publication as an integral research expense and provide the funds required to allow research to be published in open access form. There is also a critical need to raise institutional capacity and awareness of open access, and to advocate the benefits of open access to African science.

Pascal Mouhouelo is the Senior Librarian for the World Health Organisation (WHO) Regional Office for Africa. WHO has facilitated access to health research in Africa through HINARI, a partnership with major publishers that makes journals and books freely available in developing countries, and through support to the Forum for African Medical Editors (FAME), a network of editors and others interested in improving the quality of medical information globally, by improving the quality and visibility of African medical science and journals.

Improved visibility of health research from Africa

African medical researchers are scattered throughout the region — and the world. FAME needs to be revived and strengthened to help bring them together. Together, FAME, the WHO Regional Office, and other regional associations, like the Association for Health Information and Libraries in Africa (AHILA), could address important issues. These include training in the use of HINARI and integrating more journals into the African Index Medicus (which gives access to information published in, or related to, Africa and supports local publishing).

We also need to encourage African medical journals to join the open access movement, and support researchers. Researchers often need financial and technical assistance to publish. National or international sponsorship to publish open access will help their work to reach a broader audience.
Allan Mwesiga is an editor for the Pan African Medical Journal (PAMJ), an open access, ‘local’ African journal, based in Kampala, Uganda. PAMJ aims to be the leading medical journal in Africa and one of the best in the world.

Greater role for local journals

Local journals have an important and relevant role to play in helping African researchers get in the access loop. They have the opportunity to be the most immediate facilitators of scientific publishing. Only local journals are best positioned to provide the necessary capacity building and training for scientific writers through writing workshops. Though at times they are resource strained, local journals can, through the use of technology and institutional partnerships, support researchers to publish their work by providing mentoring opportunities and information about the publishing landscape.

However, this can only be done if local journal actors themselves have acquired the relevant skills to fulfil these tasks, and if researchers see local journals as an attractive means of disseminating their work. Authors often base their decision on where to submit a manuscript on journal-level metrics, which largely privilege international journals. These metrics are not perfect, and there is room for alternative article metrics that provide a more comprehensive picture of the impact of a journal’s content.

Dr Annettee Nakimuli is a MUII Fellow (Makerere University/UVRI Infection and Immunity Research Training Programme) at Makerere University and the University of Cambridge, and a practicing obstetrician and gynaecologist in Uganda. MUII was initiated to help East Africans pursue a research career in Infection and Immunity, focusing on endemic diseases of the region. As a MUII Fellow, she is mentored by Prof. Ashley Moffett of the University of Cambridge.

Support for health researchers

The formation of peer and mentoring networks are critical to effective publishing of African health research. Within Africa, researchers with common interests could jointly apply for grants and assist each other to publish. Outside of Africa, researchers at similar career stages could be twinned with counterparts within the continent, and connect through video conferencing, regular visits or exchange programmes. Academic institutions that work together could host regular meetings to disseminate work, and funders can support institutional collaborations.

Researchers also need to be aware of the value of mentors. Databases of mentors should be widely circulated inside and outside of Africa, and mentoring should be formalised when assessing career development.

African governments can support publishing by investing more in research, in compensation for scientists and health practitioners, and in institutional capacity. For example, better internet infrastructure would facilitate reading research articles, submitting work online and communicating with other researchers in the diaspora.

Dr Sonja Marjanovic is a senior analyst at RAND Europe. RAND Europe, together with Open University and the African Centre for Technology Studies, is involved in an evaluation and learning project for the Wellcome Trust’s African Institutions Initiative. This is an innovative and large-scale example of the growing number of networked research capacity-building initiatives that are emerging in response to the need for research capacity growth.

Evaluation and learning

Despite the importance of research capacity building for improving health outcomes, there is still a fragmented evidence base for understanding what works and what does not in African contexts, and how key policy issues unfold on the ground.

Our evaluation is helping identify how research capacity can be built at institutional and network levels. Consortia are establishing postdoctoral positions and research career pathways in African universities; they are also mobilising institutional support for research, for example advocating merit-based promotion and accreditation standards; they strengthen collaboration between African institutions and other global partners; and invest resources in institutional reform in research management, governance and administration practices.

Our experience to date emphasises that the success of multi-partner capacity-building networks strongly depends on supporting the development of institutional capacity of partners in the networks and of individuals as future research leaders.

Dr Pauline Essah and Professor David Dunne, are Coordinator and Director (respectively) for the THRiVE Programme at the University of Cambridge. The THRiVE (Training Health Researchers into Vocational Excellence) partnership, led by Makerere University in Uganda, aims to strengthen institutional research capacity in East Africa, and to support the next generation of East African researchers to become internationally competitive and self-sustaining scientific leaders, seeding a regional research community with the critical mass to address African health priorities.

Mentorship at all levels

Wherever you are in the world, a key enabler for young researchers to publish their work is good mentorship. This is needed in all aspects of research, from writing initial grant proposals through to publication of research findings. In this area specifically, young African researchers would benefit greatly from access to mentors with first-hand experience of routinely publishing in the best journals. Programmes like the Wellcome Trust-funded MUII and THRiVE, which link African researchers to mentors from Cambridge and London School of Hygiene and Tropical Medicine, are proving useful for delivering training and mentorship, including in key aspects of scientific publication.

Publishing success increases the global profile of African research, promoting a virtuous circle of enhanced competitiveness for international funds, enabling greater research output, and increasing the pool of world-class African mentors and role models for the next generation of African researchers.
There is an epidemic of noncommunicable diseases spreading all over the world – in rich countries and developing countries alike. But although bodies in the UK, Nigeria and Indonesia may be at similar risk of disease and diabetes, the way we address these risks and intervene to prevent them cannot be the same.

Nick Wareham has given his input on the control of diabetes on a national level to the National Institute for Health and Clinical Excellence (NICE) and on a global level to the International Diabetes Federation and the World Health Organisation (WHO). His work through the Centre for Diet and Activity Research (CEDAR) and the Cambridge International Diabetes Seminar helps develop research capacity to understand and implement appropriate local solutions to this global challenge.

Local solutions to global challenges: an interview with Prof. Nick Wareham

How did you first become interested in diabetes research?
As a junior doctor in London, working at Guy’s Hospital on a rotational programme in general internal medicine, I was allocated to work at the diabetes clinic for Harry Keen and John Jarrett. I became interested in diabetes principally because of its interface with clinical medicine and prevention. I was struck then by the failure of the system, even in a centre of excellence. I vividly remember a man in the ward who was blind through diabetic retinopathy, had bilateral amputations, had renal failure and was waiting for appropriate placement in a care home. Much of the burden he carried was avoidable. In medicine, you can either give your energy to amelioration of people’s symptoms or give your energy further upstream to the avoidance of complications in disease in the first place. My career has been combining clinical work and epidemiology for people who have got disease now, with public health and preventative work to lower the risk of people getting it in the future.

How did you first start thinking about public health and diabetes in an international context?
When I first came to Cambridge in 1993, I was the co-organiser of the Cambridge Diabetes Seminar, with Rhys Williams. The Cambridge Diabetes Seminar is an international seminar started in 1981, coincidentally by John Jarrett and Harry Keen, to provide training in the epidemiological aspects of diabetes and public health, for people all over the world. We have trained around a thousand people, and those thousand people have then gone around the world, many of them to be leading figures in this field. We try to focus the course on people from less developed countries, who are unlikely to have such training entrées into this field through other means. Once here, they live in a Cambridge college and work with the faculty – but probably the most important things that people learn are from the discussions that occur informally between participants and with the lecturers. It is really tremendous: the international lecturers who come and give their time in the spirit of trying to develop global capacity.
issues for which governments have the right levers, and that we also need to think about developing local solutions to some of these complex issues.

This is a very important research agenda that needs encouraging. We need to support the development of research into the identification of sustainable, low-cost public health research type solutions to noncommunicable diseases like diabetes. I think the UK has a lot to offer in terms of capacity building. I am not suggesting that we have a unique set of solutions, but what we can do is enable others to develop solutions locally by helping them to uncaps the great capacity of human ingenuity that all countries have.

Can you give us an example of research into local, sustainable public health solutions to these issues in developing countries?

A good model of this approach is CEDAR’s work in Cameroon, where we have helped to develop capacity to do public health research in an African context. Together with Professor Jean Claude Mbanya and the local lead researcher Dr Felix Assah we are partners in a project examining the relationship between population distributions of physical activity and metabolic risk.

It is actually a first to demonstrate objectively that there is a rural and urban difference in physical activity and energy expenditure. But this is also only a stepping stone to understanding how to intervene. In a Western setting, we might think about increasing recreational activity: encouraging people to make healthy choices with respect to transportation. However, that sort of aspirational goal is not so easy in an African context, unless you understand the specific drivers of behaviour in that context and the specific possibilities of what can be changed.

So this project is also increasing understanding of interventions and building research capacity in Cameroon, and in Cambridge?

Absolutely, that is our intention. Dr Felix Assah is a good example of that. Felix first came to Cambridge to attend the Cambridge Diabetes Seminar. We then supported him to do the (University of Cambridge) Masters in Epidemiology, and PhD work in his home country of Cameroon. As a consequence of that work, he got a Wellcome Trust Fund Clinical Fellowship to move from a more epidemiological paradigm for his work in Africa to a more public health orientated one, with his current attachment to CEDAR. He is now the project leader in Cameroon, training others in public health research.

How do all of these experiences influence your work with international coordination and advocacy bodies, like the World Health Organisation and the International Diabetes Federation?

The solutions to these issues lie at multiple levels. We have to put in place better, effective systems of care for people with disease and, where possible, to consider screening and individual prevention. But if we are to think about primary prevention, the issue of shifting whole populations, first of all we have to accept that diseases are related to people’s lifestyles and they go beyond a person’s individual choice. We have to accept that there are societal drivers to people’s behaviours, and therefore accept that there will need to be societal solutions. Sometimes that is a challenge to political ideology. Some people would prefer to say that lifestyles are a matter of individual choice, but the truth is, this is not a sufficient explanation. <

Why is it so important to build research capacity globally? I think that we have a choice. We could spend the next few years standing around saying that the global prevalence of diabetes is increasing and expecting politicians to do something. Or we can say that there needs to be government action on some of the societal problems. The problem is a global one... But the important point is that while the issues may be global, the solutions may differ by country. Although we have learning from Britain on how to address this type of issue and how to generate understanding about it, it would be a mistake to export our solutions, because they may be highly contextual.

The UK has a lot of offer in terms of capacity building. I am not suggesting that we have a unique set of solutions, but what we can do is enable others to develop solutions locally by helping them to uncaps the great capacity of human ingenuity that all countries have.
Translating research and practice into policy: the Humanitarian Centre’s recommendations to the UK Government for addressing non-communicable disease and mental health in developing countries

The UK Government should advocate for the inclusion of noncommunicable diseases (NCDs) and mental health in the post-Millennium Development Goals (MDG) framework, and it should play a leading role in implementing the recommendations in the United Nations’ declaration from the Summit on NCDs.

The UK Government should offer UK expertise and technical assistance to support national governments in low and middle income countries to develop national plans on NCDs and to implement the Framework Convention on Tobacco Control.

The UK Government should lead by example:

- Tackling NCDs requires an integrated approach: climate change, food security and sustainable development discussions must include consideration of NCDs. In general, urban design, agriculture, transport and trade policy should incorporate health considerations in their impact assessments and legislation processes.
- Tackling NCDs also requires a multisectoral approach. Governments at all levels must take responsibility for regulation, legislation and taxation for the prevention of NCDs; civil society organisations must be included in developing strategy and delivering programmes; and the private sector can also play an important role provided that the shared objective is public health and that there is transparency about competing interests. Calls have been made for the development of a ‘Code of Conduct’ that sets out a clear framework for interacting with the private sector and managing conflicts of interest in addressing NCDs.

Research needs to be funded and supported to identify effective NCD and mental health interventions which are tailored to suit developing country contexts. This includes increased quantitative and qualitative data collection for disease monitoring and evaluation of intervention outcomes. We need to work with national governments and develop local capacity to undertake adequate research and monitoring related to NCDs.

NCD prevention and control should be integrated into the UK’s international development policy. The Department for International Development (DFID) should continue to develop programmes for NCDs and mental health and devote funding to these issues.

The newly formed UK All Party Parliamentary Group (APPG) on Global Health should pay special attention to NCDs and mental health in its agenda.

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The Humanitarian Conference on Noncommunicable Diseases and Mental Health in Developing Countries’ was held in January 2012 as part of the Global Health Year. The conference was designed to carry on the momentum generated by the UN High Level Meeting on Noncommunicable Diseases (NCDs) in September 2011 – the second UN Summit ever to address a global health issue. The UN Summit brought the world’s attention to the fact that 60 per cent of deaths in the world are now due to noncommunicable diseases – 80 per cent of which occur in developing countries. These percentages are rising; it is estimated that in Africa by 2030 noncommunicable diseases will kill more people than maternal and child health problems, communicable (infectious) diseases and nutritional diseases combined.

In low-income countries, avoidable NCDs also pose a higher burden by significantly impacting economic productivity and health systems. In all countries, NCDs increasingly affect the poor, who are more exposed to the factors that cause NCDs. Moreover, people living with NCDs often lack access to affordable essential medicines and technology for care.

The Humanitarian Centre organised the ‘Cambridge Conference on Noncommunicable Diseases and Mental Health in Developing Countries’ with the belief that the UK has the potential to play a leading role in addressing these global health challenges. Mental health issues, also ‘noncommunicable’, were given a prominent place in the conference agenda, precisely because they were not featured at the UN Summit, though they are the third leading cause of disease burden today, predicted to be the leading disease burden by 2030. Two-thirds of people worldwide – and 90 per cent of people in developing countries – do not get the treatment they need for mental health issues. The fact that mental health issues are frequently hidden, ignored or stigmatised is all the more reason to take advantage of opportunities, such as the Cambridge Conference, to bring them to the fore. By drawing on the experiences of NGO member organisations, and working with the Cambridge Institute of Public Health and the Centre for Science and Policy (at the University of Cambridge), the Humanitarian Centre designed a conference programme that drew on UK expertise in NCD research, practice and policy. The ideas generated at the conference were translated into policy recommendations and shared at a reception in the House of Commons for policy-makers, private sector stakeholders, researchers and NGO advocates.

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NCDs are diseases that are not infectious or ‘communicable’; that is, they are not transmitted from person to person. Diabetes, heart disease, cancer, and lung disease are often referred to as the ‘four main’ NCDs, because they share behavioural drivers, and because they are responsible for most deaths and disability in the world. Many find that focusing on four NCDs is unhelpful, because it excludes other diseases that are not infectious – such as mental health issues and injuries – and medical advances that can be made with a more inclusive approach.


The Humanitarian would like to thank the following individuals and organisations for their comments on these policy recommendations: Anayaa Ali (Oxfam), Martin Anyaoku, Judith But (NCD Alliance), Richard Feetham (International initiative to combat disease diseases in the developing world), Mosh Mokhtar (National Heart Forum), Nicola Watt (London School of Hygiene and Tropical Medicine), Zara Tye (previously of the Centre for Science and Policy, University of Cambridge), Nita Wocan (CIEBAR) and Lord Nigel Crisp and Oliver Johnson of the All Party Parliamentary Group for Global Health.
Poverty, social inequality and environmental degradation have devastating consequences for health. Conversely, what is good for health is often good for society and the planet as well. For example, if city-dwellers in Nairobi had access to more locally grown fruits and vegetables, and were less inundated by processed foods, there would be reduced risk of developing certain diseases, promotion of crop diversification and stimulation of the economies of Kenyan farming communities.

Acknowledging this, the UN Systems Task Force Team, charged with planning new global development goals when the Millennium Development Goals (MDGs) expire in 2015, calls for a more holistic, less fragmented, approach to development. At the Rio+20 Earth Summit, held in June 2012, the UN also strongly acknowledged the interrelatedness of health to social, economic and environmental sustainability.

Liliana Marcos, Olga Golichenko and Julia Ravenscroft all work for organisations that are members of the Action for Global Health network, a broad European network of NGOs advocating for Europe to play a more proactive role in enabling developing countries to meet the health Millennium Development Goals by 2015. Below they write about the way forward for an interrelated agenda for health and sustainability.

Reflections on Rio +20: global health and sustainability

Disappointing, ‘missed opportunity’, ‘weak commitments’. These were just some of the reactions to June’s United Nations Conference on Sustainable Development, better known as Rio+20. With a lack of consensus between countries, the content of the final text did little to satisfy anyone and commitments by governments have been weak. Despite the ambitious title ‘The Future We Want’, the majority of conference participants were left underwhelmed.

However, those of us working on health have less to complain about. The global health relationship with sustainable development was firmly recognised and a whole ‘Health and Population’ section included the need to work towards Universal Health Coverage, strengthen health systems and support the leadership of the World Health Organisation. It also prioritised continuing to work to address major infectious diseases, reducing infant and maternal mortality, and reaching universal access to family planning and sexual and reproductive health.

The final statement of Rio+20, with no less than 286 articles, marks the messy consensus between countries, the content of the final text did little to satisfy anyone and commitments by governments have been weak. Despite the ambitious title ‘The Future We Want’, the majority of conference participants were left underwhelmed.

However, to have a truly sustainable future for health, universal health coverage must be included in the post-MDG framework. This is the only way to provide lasting and holistic protection for the poorest and most excluded of generations to come. It is the most profound stance against health inequality. In practice, universal health coverage means that all people (whether they live in developed or developing countries) have access to health services, including promotion, prevention, treatments and rehabilitation, without fear of falling into poverty. Health coverage should be determined not only by the direct cost of services to the patient, but by the funding mechanisms used to pay for it. It should use the most equitable funding system possible such as progressive public financing through a tax system. Transportation, geographical distribution of health care services, local culture, stigma and discrimination create the barriers for accessing healthcare. It is crucial to address these challenges to improve the access to health services. In the 2010 World Health Report on health financing, Margaret Chan, the Director General of the World Health Organisation, said “Continued reliance on direct payments, including user fees, is by far the greatest obstacle to progress (to universal coverage)”. Richer nations have the opportunity to support low-income, low-resourced countries to raise funds for health, reduce out-of-pocket payments and ease them for the poorest.

Developing countries too are leading movements for fairer access to healthcare. Models are already in place, such as in El Salvador, where user fees have been abolished, coupled with a huge national plan to increase health coverage. The plan aims to expand and strengthen primary healthcare at the rural level, increase health promotion and develop local health staff teams to avoid a lack of human resources. There are also efforts to make drugs cheaper with the approval of a national law.

Creating sustainable solutions is not possible without sufficient funding. There are viable ways to increase levels of funding for global health in addition to the traditional Official Development Assistance. For example, France has introduced a Financial Transaction Tax (FTT), known by some as the ‘Robin Hood Tax’, which is expected to raise €500 (€400 million next year alone. It will be imposed on share purchases involving publicly traded businesses with a market value over one billion euros. The French FTT is a precursor to a wider European FTT which will be introduced in the coming years by at least nine European countries. If even more European governments, like the UK, were to follow France’s example, the revenues could generate €6.7 (£5.7) billion to provide lifesaving treatment for people living with HIV, €7.5 (£6) billion for free healthcare for 227 million people in the world’s poorest countries and €25 (£18) billion to provide access to clean drinking water for all.

Right now, governments must continue to work towards achieving the current MDGs by 2015. However, to achieve a sustainable future for the poorest and most vulnerable beyond 2015, they also must realise the universal human right of access to healthcare. Everyone has a part to play in ensuring that access to health is a central part of sustainable development policy for future generations.

24 The targets set to reach the MDGs expire in 2015. There is great discussion about what should be done if the MDGs are not achieved by 2015, and what new global targets, a ‘post-MDG framework’, should supersede them.

25 The Sustainable Development Goals, like the Millennium Development Goals, would represent global, achievable targets for poverty eradication, environmental protection and sustainable consumption and production.
Lessons from the field of global health can and should be applied to other disciplines. Lord Crisp suggests ‘turning the world upside down’ for another vantage point to look for new approaches to global health challenges. If the idea of turning the world upside down helps us to see affordable innovations for health care delivery from the global south, can we use the same concept to make innovations visible in education, agriculture or conservation?

Similarly, if ‘getting in the access loop’ can enable scientists in Africa to more effectively undertake and publish vital health research, surely the recommendations being made by publishers, funders, mentors and librarians could also be applied to research on topics such as climate change, in low-resourced countries in Africa – or anywhere. In fact, the success of THRiVE and MUII, capacity-building programmes for African health researchers, has recently led to additional funding to expand the programme to a wider range of disciplines at the University of Cambridge.

And if a ‘Global Health Hack Day’ and ‘Aid for Health’ help future leaders in global health to approach challenges from different perspectives and work with multisectoral, multidisciplinary teams to find solutions to problems, then why not hold transformative learning events around energy security or human rights?

Operation ASHA’s entrepreneurial approach for delivering TB drugs to marginalised patients is inspirational. Perhaps this social franchising model could inspire entrepreneurs working to provide clean water and sanitation?

This report considers how valuable partnerships for global health can be, depending on the degree of transparency, equality and sustainability they entail. That is true of partnerships in every field (and, as Bruce Mackay points out, ‘partnerships’ are pervasive). As all kinds of stakeholders come together to decide what will replace the Millennium Development Goals in 2015, this kind of critical awareness can help to clarify the roles and responsibilities of different partners in setting and delivering that agenda.

Conclusion

> A partnership between the SEED Project and other NGOs provided health and hygiene education to volunteers during Zimbabwe’s cholera outbreak. In this way, with only two staff members, SEED managed to reach 72,993 families across 24 communities, including all of Harare’s densely populated suburbs: about 730,000 people.
Afterword: the importance of sustainability to global health

In June, world leaders at the UN Conference on Sustainable Development, Rio+20, emphasized the importance of health for sustainable development noting that: “We understand the goals of sustainable development can only be achieved in the absence of a high prevalence of debilitating communicable and non-communicable diseases, and where populations can reach a state of physical, mental and social well-being.”

But better human health is also related to the health of our planet. Degraded ecosystems take a heavy toll on human life and health status, contributing to higher rates of morbidity and mortality globally. The World Health Organisation estimates that 23 per cent of all deaths worldwide could be prevented through improvements in areas like water and sanitation and indoor and urban air quality. Preventable diseases directly linked to contaminated water and polluted air claim the lives of around three million children under five years of age each year, with these fatalities concentrated in Africa and South Asia. It is sobering to think that this number equates to the size of the entire under-five population of Austria, Belgium, the Netherlands, Portugal and Switzerland combined.

Recognizing that good health is both an outcome of, and a precondition for, sustainable development requires us to reassess how we pursue sustainable human development and tackle global health challenges. For me, as Administrator of the United Nations Development Programme, sustainable development is not about trading economic, social and environmental objectives off against each other. It is about seeing them as interconnected objectives best pursued together.

Effective approaches to tackle global health challenges must be based on cross-sectoral partnerships, the focus of this current report. As well, they must be based on the linked core values of human rights, equality and sustainability.

Disparities in health outcomes often mirror economic and social inequities, as demonstrated by the evidence collected by the Commission on Social Determinants of Health and work by academics and practitioners. Similarly, environmental threats, from climate change to natural disasters, have a disproportionate impact on the poor and marginalised in our communities, leading to higher rates of death, disease, and disability for those most disadvantaged. This is both unjust and unsustainable.

There is an opportunity now, as the international community moves towards defining a post-2015 development agenda, to recognize the importance of health to sustainable development, and vice-versa. The UN is helping to convene global and national discussions involving governments, civil society, the private sector and citizens, to inform consideration of a new post-2015 development framework. This report and next year’s one on sustainability are valuable contributions to this discussion.

For UNDP, the message is clear: when the environment is harmed, so too is the potential to lift human development. Conversely, to protect natural resources and reduce environmental stress, the world will need to reduce inequity and poverty. Discourse around global health needs to address these linkages between equity, sustainability and health outcomes explicitly.

Learning from the Global Health Year

The Global Health Year was the Humanitarian Centre's second themed year of events and activities. Over 600 people participated in the Global Health Year’s events in person and over 1,000 participated in activities virtually. On average, 75% of participants have said that the event they attended would affect their global health practice.

We hope learning from the year is helpful to other organisations that want to use their events for impact and influence, and produce lasting change in participants’ thinking and practice.

Participatory planning

Before designing the programme of events for the Global Health Year, we researched who was doing what and how in Cambridge – where our core activities were taking place. When a range of potential stakeholders had been identified, we held facilitated participatory planning sessions to ask how our events could realistically add value to (very busy) people’s work. These sessions also helped us to see who was missing from the discussion.

Different formats and different voices

Panel discussions have become the default format for presenting a variety of perspectives, but they are not always the most appropriate or engaging. We have certainly looked back at panel discussions we have held and regretted that the format was not as dynamic as the content our speakers had to offer. Even small changes to panel formats are stimulating, and can help to highlight key concepts. For example, the Global Health Life Raft Debate turned a panel discussion on the ways that different disciplines contribute to global health into a whimsical and humorous debate. Different and stimulating ideas in events also often come from ‘different voices’, for example, people from different sectors and from different countries.

Technology for inclusion

Including voices from colleagues in the global south is key for events that have a global dimension. However, travel is not always possible. ‘Getting in the Access Loop’, supported by PLOS and HIFA2015, used web conferencing software to hold a discussion between 50 people from over 10 countries in Africa and Europe. Even so, a significant portion of registered attendees were not able to access the internet at the time of the event. We had positive experiences using Skype to bring speakers in from the United States, Indonesia and Uganda, but have also learnt that it is crucial to practice using these technologies before the event, to have a dedicated moderator at the event, and to have a backup (e.g. a pre-recorded video) should any problems occur.

Investment in transformative learning

We ran two events that were unconventional in form and required significant commitment, trust and input from participants. Of all the events in the Cambridge Global Health Year, these were two of the most impactful, with the most potential to expand and improve participants’ working methods in the long-term.

The Cambridge Aid for Health Simulation (pages 27–29) allowed students to step into the role of a major player at an aid negotiation for improved health outcomes. The preparation and the simulation were intense, but they improved participants’ understanding of the real frustrations and complexities of competing aid agendas, and empathy for other actors’ positions.

The Global Health Hack Day (pages 24–25) gave teams of interdisciplinary students and professionals the opportunity to innovate for a live global health challenge. After one intensive week, teams presented their ideas to a public audience and a panel of entrepreneurs and development specialists. Two of the projects have since gone into the prototype stage of implementation, and participants reported improved confidence in working collaboratively with people from different backgrounds to find a novel approach to a problem.

These two events required a significant amount of preparation and administration, and relied on the support of many dedicated volunteers to deliver them; intensive, innovative events come at a cost to resources and capacity.

Translating conference outputs to impact

Conferences are also time- and resource-intensive to organise, so it is unfortunate when the ideas they generate are lost in reports circulated internally or to attendees only. By contrast, two conferences in the Global Health Year creatively transformed their outputs into influential media.

Ideas generated by the ‘Cambridge Conference on Noncommunicable Diseases and Mental Health Issues in Developing Countries’ (pages 40–41) were translated into policy recommendations for further impact. One week after the conference, the Humanitarian Centre held a Parliamentary reception in the UK House of Commons to share these key recommendations with Parliamentarians and policy makers.

The Global Health Commercialization & Funding Roundtable was initiated to bring together global health ecosystem participants to explore business models in discovery, development and delivery of global health innovations. The use of a live artistic rendering of panel discussions and live poetry, songs and videos helped participants to interact...
with the ideas in a new, creative way. Using social media – including podcasts and videos on YouTube – all helped to make the conference accessible to all those who could not attend.

**Using free and readily available technology**

There are some excellent, free tools for organising and promoting events, and some great resources for learning how to use them. Eventbrite and GroupSpaces have ready-made templates for managing events and mailing lists. Twitter and Facebook are indispensable for marketing and PR: on Twitter, if you can get your most followed follower to retweet your event, you can expect more people to register. Google Forms and Survey Monkey can also help under-resourced organisations to collect feedback to improve events in the future.

**Picking good partners**

We had some fantastic partners for events to share the organisational onus, bring contacts, ‘fill the seats’ and help disseminate learning from the event further afield. For example, for ‘Getting in the Access Loop’, we were able to continue the conversation after the event through our partners’ networks: the HIFA2015 Forum has over 5,000 active members, many of whom participate from developing countries, and PLOS was able to support a series of reflections on the topic on one of their blogs, “Speaking of Medicine”.

**Bringing in volunteers**

Bringing in a volunteer to help with an event eases some of the administrative pressures for the organisation, and also gives a volunteer the experience of contributing to a discrete project. We have been pleasantly surprised by the number of volunteers who have been keen to contribute to events in the Global Health Year; and delighted when their experiences working with us helped them to get paid roles down the line. Giving volunteers the right tasks that align with their skill-set and trusting their potential has been key to maximising this type of support.

**Integrating networking**

Allowing space and time for networking before, during or after every event can sometimes yield as much impact as the event itself. A stimulating event leads to stimulating conversations afterward (and refreshments help too). We have learned from the experience of other Cambridge networks that serendipity is sometimes the true mother of invention. But never forget that you can sometimes structure your events to give serendipity a little help!
The Global Health Year calendar of events

21 October 2011
Churchill College, University of Cambridge
Prioritising Partnerships for Global Health
Organiser: Dr Ahmed Aboulghate
Speakers: Dr Peter A Singer, Dr Jenny Dean, Dr Richard Smith

31 January 2012
Hughes Hall, University of Cambridge
House of Commons, Parliament
UK Action on Global Noncommunicable Diseases and Mental Health
Organiser: Professor Martin Bobrow
Speakers: Roberta Blackman-Woods MP, Rt Hon Sir Malcolm Bruce MP, Professor Nick Wareham

22 October 2011
Murray Edwards College
Workshop & Panel Discussion on Leadership for Global Health
Organiser: Dr Ellen Strahlman
Speakers: Dr Ellen Strahlman, Dr Kim Tan, Geetha Sena, Dr Adam Stoten, Lakshmi Sundaram, Rawal, Dr Bill Rodriguez, Counselor Davino Segobye

20 January 2012
Clare College, University of Cambridge
The Cambridge Conference on Noncommunicable Diseases and Mental Health in Developing Countries
Organiser: Dr Richard Smith
Speakers: Dr Ahmed Aboulghate, Dr Jenny Amery OBE, Professor Carol Bragin, Paul Chinnock, Mike Davies OBE, Dr Robert Doubleday, Dr Efrosyni Gkrania-Klotsas, Richard Howitt MEP, Felicity Jones, Dr Georgios Lyratzopoulos, Dr Andrew Mojanraj, Dr Maya Morris, Dr Amos Deogratius Mwaka, Mod Mwaasi, Dr David Stuckler, Professor Nick Wareham, Judith Watt, Dr Nicola Watt
Partners: Cambridge Institute of Public Health, Centre for Science and Policy

19 April 2012
Hughes Hall, University of Cambridge
Scars from the Front Lines of Technology Deploymnet in Africa
Organiser: Waigan Woza
Sponsor: ARM

21 March 2012
Hughes Hall, University of Cambridge
Scars from the Front Lines of Technology Deploymnet in Africa
Organiser: Waigan Woza
Sponsor: ARM

11 June 2012
Hughes Hall, University of Cambridge
Getting in the Access Loop
Organiser: Professor Bernard Bulkin, Dr David Cleeready, Polly Courtey LVO
Partners: Addenbrooke’s Abroad and Managing for Development

12 June 2012
Judge Business School, University of Cambridge
Workshop & Panel Discussion on Leadership for Global Health
Organiser: Dr Ellen Strahlman
Speakers: Dr Ellen Strahlman, Dr Kim Tan, Geetha Sena, Dr Adam Stoten, Lakshmi Sundaram, Rawal, Dr Bill Rodriguez, Counselor Davino Segobye
Partners: Addenbrooke’s Abroad and Managing for Development

9 March 2012
Centre for Mathematical Sciences, University of Cambridge
Global Health Partnerships
Organiser: Lord Nigel Crisp

9 March 2012
Centre for Mathematical Sciences, University of Cambridge
Cambridge Aid for Health Simulation & Centre for Mathematical Sciences, University of Cambridge
Global Health Partnerships Exhibition
Organiser: Julia Fan Li
Speakers: Professor Chris Abell, Dr Shelly Bhat, Dr Mark Bragin, Dr David Brown, Dr Geoff Coon, Dr Christopher Dye, Christopher Egerton-Warburton, Professor Elizabeth Garmsen, Patrick Ghan-Mulempa, Dr Ann Ginsberg, Dr Barry Purse, Dr Suresh Jadhav, Dr Zhengming Li, Dr Richard Jennings, Dr Marc Lipman, Dr Ruth Mcinemey, Dr Chandrasekhar Nair, Vinay Nair, Steven N Nelson, Michael Norman, Aaron Oxley, Professor Jaddeep Prabhu, Urvashi Prasad, Roman Prieur, Dr Bina Rawal, Dr Bill Rodriguez, Counselor Davino Segobye
Partners: Addenbrooke’s Abroad and Managing for Development

22 October 2012
Murray Edwards College
University of Cambridge
Linking Health & Sustainability
Organiser: Professor Bernard Bulkin, Dr David Cleeready, Polly Courtey LVO
Partners: Addenbrooke’s Abroad and Managing for Development

The Humanitarian Centre would like to heartily thank all of the wonderful volunteers, members, trustees and staff, without whom the Global Health Year would not have been possible.
Organisations that appear in this report

A to Z Textile Mills
www.atotextiles.net

Action for Global Health Network
www.actionforglobalhealth.eu

Addenbrooke’s Abroad
www.addenbrookesabroad.org.uk

African Centre for Technology and Libraries in Africa (ACTLIA)
www.acts.or.ke

African Index Medicus
www.indexmedicus.afro.who.int

Aid 4 Health
www.aid4health.org

All Party Parliamentary Group on Global Health
www.appg-globalhealth.org.uk

Anadach Group LLC
www.anadach.com

ARM
www.arm.com

Association for Health Information and Libraries in Africa
www.ahila.org

Cambridge Institute of Public Health
www.stream.ac.uk

Cambridge International Diabetes Seminar
www.cds2011.org

Cambridge University Hospitals
www.cuh.org.uk

Cambridge University Health Partnerships
www.cuhpartnerships.org

Cambridge University Institute of Public Health
www.ciphs.ac.uk

Cambridge University Press
www.cup.cam.ac.uk

Cambridge University Technology and Enterprise Club
www.cutec.org

CBA (UK)
www.cba.org.uk

Centre for Diet and Activity Research (CEDAR)
www.cedar.iph.cam.ac.uk

The Centre for Health Leadership and Enterprise
www.healthleadershipandenterprise.org.uk

Centre for Science and Policy
www.casp.cam.ac.uk

Costello Medical Consulting
www.costellomedical.com

Creative Warehouse
www.creative-warehouse.co.uk

Department for International Development
www.dfid.gov.uk

Emmanuel College
www.emma.cam.ac.uk

European & Developing Countries Clinical Trials Partnership (EDCTP)
www.edctp.org

Medic Sans Frontieres
www.msf.org.uk

The Bill and Melinda Gates Foundation
www.gatesfoundation.org

GAVI
www.gavi.org

The Global Fund
www.theglobalfund.org

Grand Challenges Canada
www.grandchallenges.ca

Health Partners International
www.healthpartners-int.co.uk

HIFAZO15 (Health Information for All by 2015)
www.hifazo15.org

HINARI
www.who.int/hinari

HoverAID
www.hoveraid.org

Hughes Hall
www.hughes.cam.ac.uk

Hughes Hall Biomedical Science in Society
www.hughes-hall-bss.org

Idea Transform
www.idealab.org

iideaSpace Enterprise Accelerator
www.ideaspacecam.org

Institute for Manufacturing
www.ife.cam.ac.uk

Institute of Metabolic Science
www.imms.cam.ac.uk

International Diabetes Federation
www.idf.org

International HIV/AIDS Alliance
www.aidsalliance.org

International Network for Doctoral Training in Health Leadership, Gilling School of Global Public Health, The University of North Carolina at Chapel Hill
www.sph.unc.edu/docglobal

Keg Travel
www.kegtravel.com

Khandel Light
www.khandel-light.co.uk

Langham Press
www.langhampress.co.uk

Makerere University/UVRI Infection and Immunity Research Training Programme (MUII)
www.muii.org

Managing for Development
www.managing4development.com

Medic Mobile
www.medimobile.org

Medsin
www.medsin.org

The Ministry of Health Botswana
www.moh.gov.bw

MRC Epidemiology Unit
www.mrc-epid.cam.ac.uk

Murray Edwards College
www.murrayedwards.cam.ac.uk

National Heart Forum
www.heartforum.co.uk

National Institute for Health and Clinical Excellence (NICE)
www.nice.org.uk

NCD Alliance
www.ncdalliance.org

Norwegian Agency for Development Cooperation (NORAD)
www.norad.no/en

The Open University
www.open.ac.uk

Operation ASHA
www.observ.org

Ovations Initiative to combat chronic disease in the developing world
www.ovations.org

Pan African Medical Journal
www.panafmedicaljournal.com

PATH
www.path.org

Patients Know Best
www.patientsknowbest.com

The Peanut Foundation
www.peanutfoundation.org

PLOS
www.plos.org

PLOS Medicine
www.plosmedicine.org

PLOS Neglected Tropical Diseases
www.plosntds.org

RAND, Europe
www.rand.org

The SEED Project
www.seed-project.org

The Serum Institute of India
www.sisinstitute.com

Spanish Federation of Family Planning
www.fsfe.org

Sumitomo Chemical
www.sumitomo-chem.co.jp

THRIVE (Training Health Researchers into Vocational Excellence in East Africa)
www.thrive.or.uk

The Trials of Excellence for Southern Africa (TESA) Network
http://www.tesafrica.org

United Nations
www.un.org

United Nations Development Programme
www.undp.org

United States Agency for International Development (USAID)
www.usaid.gov

The University of Cambridge
www.cam.ac.uk

The University of Iowa
www.uiowa.edu

Welcome Trust
www.wellcome.ac.uk

World Health Organisation
www.who.int
The Humanitarian Centre is an international development network that connects academia, industry, government and charities to find more effective ways of working together to address the root causes of global poverty and inequality. We also build the skills and capacity of charity members, positively impacting communities across the world. We are affiliated with the University of Cambridge and are a registered charity.

Organisations from the Cambridge area, and individuals from anywhere in the world, can join the Humanitarian Centre to become members of the network and benefit from a range of services. To find out more about membership, please visit www.humanitariancentre.org.
How to get involved with the Humanitarian Centre

- Join the Humanitarian Centre’s Cambridge Global Health Network on Linkedin to connect to others interested in global health in Cambridge and beyond.

- Become a member of the Humanitarian Centre. Join a dynamic network of individuals and organisations working to reduce global poverty and inequality, access our Resource Centre, and gain reduced entry to training, networking and learning events. For more information, please visit www.humanitariancentre.org.

- Sign up for regular updates on development-related events and activities in Cambridge, including the Humanitarian Centre’s training, networking and learning events. To subscribe to our mailing list, visit www.humanitariancentre.org.

- Volunteer or provide expertise. The Humanitarian Centre welcomes donations of time and expertise. If you would like to find out more about volunteering opportunities, or offer pro-bono services, please contact info@humanitariancentre.org.

- Donate or become a corporate sponsor. The Humanitarian Centre is a registered charity. Your donations help us to more effectively address the root cause of poverty and inequality through programmes like the Global Health Year and our member services. To make a donation, please go to www.humanitariancentre.org/support. For information about corporate sponsorship opportunities, please contact info@humanitariancentre.org.

- For 2013, the Humanitarian Centre is planning another exciting programme of activities and events around the theme of sustainability. If you or your organisation would like to become involved, please contact info@humanitariancentre.org.

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You can find an online version of this report and supplementary pieces at www.humanitariancentre.org/publications.

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Cover image:
Health worker training in Tete, Mozambique where there is a critical shortage of health workers.
“Everyone had something to teach. Everyone has something to learn.” - Lord Nigel Crisp,
© Institute for Healthcare Improvement.

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