Executive Summary

Introduction

In February 2023, the UK Public Health Rapid Support Team (UK-PHRST) appointed Ipsos to undertake an exploratory evaluation of their approach to partnerships and capacity strengthening, covering UK-PHRST initiated activities conducted from 2021 to the end of 2023.

The evaluation sought to understand how UK-PHRST's approach to partnerships and capacity strengthening works in practice. To provide this assessment, the evaluation framework aimed to understand the following three components of both partnerships and capacity strengthening: 1) how both concepts are **understood and defined** across the partnership and also within the wider literature, 2) how they are **operationalised and experienced by partners** (both from UK-PHRST and partner perspectives), and 3) whether the way that they are understood, defined, and operationalised has led to **sustainable and beneficial outcomes** for partners.

The evaluation is grounded in participatory evaluation principles, including **participant-centred assessment** and **outcomes harvesting**. Both principles seek to place the views and experiences of UK-PHRST's partners at the forefront

Methodology

Evaluation fieldwork took place between April 2023 and January 2024. Findings from this report are based on the following strands of data collection and analysis:

- **A programme document review** of 138 internal programme documents.
- **A literature review** of 90 academic documents. The aim of the literature review was to develop a deeper understanding of how partnerships and capacity strengthening are defined and practiced, both globally, and specifically in the regions and fields in which UK-PHRST is active.
- **26 in-depth interviews and three focus group (FGD) discussions** with UK-PHRST partners and staff. Most of the in-depth interviews (IDIs) were conducted with partners in Overseas Development Assistance (ODA) eligible countries (n=20).
- **Three country case studies** in Brazil, Malawi, and Uganda were undertaken to assess the evaluation questions within the contextual and delivery features of the programme. The case studies consisted of an outcome harvesting workshop and follow-up interviews. Across the case studies, four workshops and 25 interviews were conducted.
- **A global partner survey,** which was developed and administered to UK-PHRST partners. Questions were developed around the evaluation questions and built on the learnings generated from the IDIs and FGDs.

There were some limitations to the study, including the fact that survey respondents were self-selected, potentially biasing responses. However, all objectives have been addressed.

Background to UK-PHRST

UK-PHRST is a **partnership between UKHSA and the LSHTM**. It is accountable to the Department of Health and Social Care (DHSC). A **UK-PHRST Project Board** helps to advise and provide

recommendations towards the overall strategy of the team, whilst a **Technical Steering Committee** provides independent advice.

The team itself is managed by the UK-PHRST **Senior Management Team (SMT)**, with different workstreams delivered by the **Core Deployable Team (CDT)**, **Research Management Team (RMT)** and **Capacity Strengthening Team (CST)**. Ethical assurances are delivered through ethics committees at UKHSA, LSHTM, and other academic partners.

UK-PHRST's current objectives are set out in the *Strategic Framework 2022 – 2025.* This includes supporting partners in Low and Middle-Income Countries (LMICs) to prepare for and respond to disease outbreaks, identify research questions with partners, and collaborate to support the development of in-country capacity. The strategy is underpinned by three principles, namely, to expand the teams **partnerships and networks,** focus on long-term sustainable **impact,** and establish a culture of ongoing **learning** and continuous improvement**.**

The UK-PHRST operates on a triple mandate, which includes the following pillars:

Deployment pillar

UK-PHRST aims to be ready to deploy to ODA-eligible countries as quickly as is required and on receipt of government authorisation. It predominantly deploys via **GOARN**, which is the WHO mechanisms for deployment; yet also responds to **bilateral deployments** via recipient country governments and to deployment requests from UK government entities, including the **UK Emergency Medical Team (EMT)** and **Foreign, Commonwealth and Development Office (FCDO)**.

While deployed, UK-PHRST undertakes various activities which are specific to the requirements of the mission. Deployment activities are documented via internal 'mission reports' as well as WHO reports where the team were deployed through GOARN. Under UK-PHRST current *Deployment Strategy for 2022-25,* it is aiming to improve the impact of deployments and diversify the mechanisms through which they are deployed.

Research pillar

UK-PHRST's approach to research has evolved since the inception of the programme. Initially, research projects tended to be short-term, small-scale pilot studies, but have since grown to become more long term and cut across multiple areas of health.

Research is grouped into thematic areas, which includes outbreak prevention and preparedness, outbreak detection, outbreak response, and impact and evaluation. Broadly, this includes two main components: **operational research** which organically takes place during or following outbreaks and **scheduled research** which is part of a research portfolio. Under UK-PHRST's current *Research Strategy for 2022-25*, scheduled research will include four strategic priorities, namely prevention, preparedness, detection and response, and impact and evaluation.

Capacity strengthening pillar

UK-PHRST's has recently enhanced their approach to capacity strengthening. Its current aim is to deliver activities with sustainable impact for outbreak preparedness and response; in FY 2023-24, the strategic themes the pillar is working towards include community protection, One Health, Emergency Coordination Leadership, Technical Specialist assistance, and Research Capacity Strengthening.

In terms of operationalising capacity strengthening, this is guided by two frameworks: 1) **UK-PHRST's Capacity Strengthening Spheres of Activities**, which outlines three interconnected spheres of the pillar (partnerships, global stage, and UK-PHRST workforce), and; 2) a **Content and Delivery consideration for activities**, which considers the context in which the activity is delivered, such as the organisational, national, and regional environment, and the broader political enabling environment.

Partnerships

The evaluation explored how UK-PHRST's partnerships are defined and operationalised, whether partners view them as equitable, and whether they are being sustained.

Understanding and Definition

The evaluation identified variation in how UK-PHRST, their partners and the literature define partnership, but some broad themes across stakeholders were identified. All partners and UK-PHRST staff stressed the importance of **shared priorities, interests and goals**. Other key themes included the importance of partnerships having a **mutual benefit** for all parties, the need for partnerships to be collaborative and based on trust.

In terms of the differences between groups, a key theme emphasised by ODA-eligible partners and reflected in some of the literature was that **shared priorities should be responsive to partners' actual needs** in the target population and community, with some stating that the focus in Global North-South partnerships should be on **the needs of the partner in the Global South**. ODA-eligible partners were also more likely to place emphasis on documentation, which was viewed to help ensure equity principles are embedded in partnerships, and supports accountability and transparency within partnerships. ODA-eligible partners also commonly highlighted the importance of **cooperation and co-creation in a non-hierarchical way.**

UK-PHRST's non-ODA-eligible partners emphasised the importance of equity in partnerships, framing this in a more socio-historical lens. For example, partners highlighted colonial and post-colonial legacies which continue to drive power imbalances within partnerships. Some of these partners also highlighted the importance for partnerships to address practical needs and avoid duplication, while still being flexible.

Amongst UK-PHRST staff, there was a range of conceptualisations, but staff tended to describe partnerships as a type of **relationship and** were also more likely to highlight the importance of **interpersonal factors** linked to partnerships.

Operationalisation

While UK-PHRST has changed its approach to building partnerships, moving from an '*ad-hoc'* approach to a more **purposeful and strategic approach,** the evaluation found that **partnerships are often established through pre-existing contacts and relationships with UK-PHRST staff**. Some staff wanted to broaden relationships beyond the focus on national public health institutions, and take a more active outreach approach to diversify their partner network. Conversely, other staff preferred a flexible, organic approach to partnership development.

The findings highlighted how UK-PHRST's partnerships can generally be categorised into the following typologies, although in reality there is significant overlap:

- The traditional approach where partnerships are developed through **individual networks and deployments**;
- **Research partnerships** which provide an opportunity for UK-PHRST to collaborate with a partner and strengthen their capacity to implement a project;
- **Multi-layered, institutional level partnerships**, for example with the Africa CDC, which are more long-term and provide more all-encompassing capacity strengthening activities.

Partnerships can also be categorised by mapping the mode of instigation (opportunistic vs strategic) against duration (shorter vs longer term). While longer term, strategic partnerships (such as with Africa CDC) can be seen as the most sustainable and useful in terms of reach and impact, shorter term opportunistic partnerships can also be valuable.

A small number of organisations and individuals who UK-PHRST had identified as partners did not consider it to be a partnership. This could be **linked to the lack of coherency in UK-PHRST's definition of partnerships as well as inconsistent documentation.**

Overall, partners were positive about UK-PHRST's approach to building, maintaining, and engaging the partnership, with few criticisms. In particular, partners described UK-PHRST as being **respectful, open, supportive, flexible, understanding of partners' contexts and responsive to their needs**. Partners also some areas for improvement within partnerships, including the need to **prioritise in-person collaboration and longer-term deployments**, and ensuring staff were **embedded** within partners' teams. Several **issues with the current deployment model** were identified, including delays arising from partnerships being insufficiently embedded, inadequate deployment length guidelines, and limited and confusing visibility of UK-PHRST in some cases.

Partners overall felt UK-PHRST's support to be **effective** in helping them to reach their goals. UK-PHRST was seen to support partners reach their strategic objectives through providing multidisciplinary **technical expertise**, increasing **capacity** of teams and providing **resources,** such as funding and other outputs.

Equity

When defining equity, partners highlighted the recurrent themes around **respect and mutual benefit, as well as transparency, accountability, collaboration and effective communications.** ODA-eligible partners felt equity relied on partners' understanding and responding to their needs and not imposing their own structures or priorities. Non-ODA-eligible partners emphasised shared, agreed upon goals and partners having an equal say, distribution and contribution.

Partners tended to conceive of their partnership with UK-PHRST as **equitable**, with interpersonal factors and the team's respectful and collaborative partnership approach driving this. **Inclusive policies** implemented by UK-PHRST were also seen as playing a vital role in facilitating equitability. The majority of partners felt UK-PHRST was effective at **mutually agreeing on goals** and objectives, which was seen as a key driver of equitability within their partnerships.

Nevertheless, a handful of partners described **elements of inequity** within their partnerships, although this was not always attributed to inequities or power imbalances. This included some partners who felt undervalued and under-consulted during **design**, with UK-PHRST focused on their own organisational priorities. There were also mixed views on whether UK-PHRST is effectively **co-creating** projects, with

some partners praising this and others wanting greater integration and involvement from UK-PHRST. Language skills were highlighted as a potential barrier to equitability within partnerships where English was not spoken by the majority of the team. There were also mixed views on whether UK-PHRST's partnerships were **bi-directional**, with evidence that staff were not clear on their organisational objectives in partnerships beyond the overarching objective of supporting partners.

Sustainability

In terms of sustainability, all partners wanted their partnerships with UK-PHRST to continue and grow. Some felt an increased focus on capacity building would support more sustainable outcomes. To support sustainability, **sufficient resources** are needed to build institutional level partnerships. In addition to building the **UK -PHRST team's capacity**, partners felt the team could conduct activities to **establish networks** between UK-PHRST's different partners, supporting collaboration and knowledge exchange.

Capacity strengthening

The evaluation sought to explore the understanding, implementation, and sustainability of capacity strengthening within UK-PHRST and its partnerships.

Understanding and Definition

Both UK-PHRST and its partners generally view capacity strengthening as a **continuous process** aimed at empowering individuals, institutions, and systems. They agree on its **crucial role in long-term pandemic preparedness**, **emphasising local empowerment** over temporary external interventions. UK-PHRST's definition has evolved over time, reflecting a comprehensive approach that considers individual, organisational, and broader contextual factors. This is embodied in the Capacity Strengthening Conceptual Framework. However, there's ongoing discussion about terminology, with preferences for terms like "capacity strengthening" and "mutual knowledge sharing and learning" over "capacity sharing". Overall, there is a need to prioritise partner needs and context through needs assessments, clearly defined outcomes, and sustained activities.

In terms of additional considerations, equity and power dynamics are crucial, emphasising collaboration, mutual learning, and respect for partners' autonomy and expertise. **Building on existing capacity** is also essential, recognising baseline capabilities and avoiding deficit-based approaches, and **bidirectional exchange** is important to ensure mutual learning and benefits for all involved.

Implementation

A **new capacity strengthening pillar has been established** to coordinate activities across the triple mandate and enable specialised capacity strengthening projects. Overall, the approach is iterative and has evolved from the Strategic Framework 2022-25, aligning with wider schools of thought emphasising multi-level capacity strengthening. Whilst acknowledging this, UK-PHRST's approach often focuses on individual-level partnerships, with the Africa CDC partnership as a notable exception. Strategic areas of focus have been identified, but **in practice UK-PHRST's activities are broad, cross-cutting, and have been directed mainly at emergency capacity strengthening**.

Partners engage with UK-PHRST through various mechanisms, including direct requests, deployments, and research activities. Collaborative training of UK-PHRST members, reservists, and partners emerges as the most well documented activity, with **partners valuing UK-PHRST's expertise and support**. Experiential learning, for instance through on-the-job training and mentoring during deployments is also highly appreciated. Additionally, partners benefit from technical assistance and knowledge sharing for instance encompassing human resources, platforms, documentation, and research support. Other

activities include embedding peer to peer learning, collaborating with global actors, and enabling governance through project management, process, structure and monitoring and feedback.

Alignment and Sustainability

Partners generally value UK-PHRST's capacity strengthening efforts and recognise their responsiveness to needs and priorities. However, a **disconnect exists between some delivered activities and partner expectations**, particularly regarding one-off trainings such as the R training delivered by UK-PHRST in 2022. **Partners desire greater involvement in designing and delivering activities**, ensuring alignment with local contexts and needs – this approach has since been incorporated into the UK-PHRST's current capacity strengthening activities. The need for consistent, long-term funding to support sustainable capacity strengthening is also emphasised.

Partners perceive that UK-PHRST's activities have contributed significantly to individual capacity growth and, to a lesser extent, institutional capacity. However, there's uncertainty about the long-term sustainability and resilience of these gains. The **focus on short-term activities raises questions about their contribution to lasting change**. Measuring sustainable growth and attributing it solely to UK-PHRST is complex, however. Evidence suggests contributions to primary outcomes like improved epidemic detection, prevention, and response, particularly through partnerships like Africa CDC, but further evidence is needed.

Bidirectional Exchange and UK-PHRST Capacity

Partners are hesitant to assess UK-PHRST's own capacity growth through these partnerships. However, limited evidence suggests potential gains in technical expertise, contextual understanding, and overall capacity. Partners acknowledge the possibility of UK-PHRST staff becoming more "culturally competent" through collaboration.

Overall, while UK-PHRST's capacity strengthening work is valued, there's **room for improvement in terms of partner participation, alignment with needs and priorities, and sustainable funding**. Further evaluation is needed to assess long-term sustainability, bidirectional exchange, and impact on UK-PHRST's own capacity.

How UK-PHRST contributes to their partners' outcomes

The evaluation sought to explore the extent to which the two evaluation concepts, and the way in which their defined and operationalised, are leading to sustainable outcomes for the partners.

Outcomes UK-PHRST partners are working towards

In line with UK-PHRST's diverse portfolio, partners are working towards a number of different objectives and outcomes. In aggregate however, partners are generally working towards the following thematic areas:

- **Outcomes developed through strengthened research capacity:** This is the area where most participants or organisations reported having strengthened, as per the partner survey. These were often specific to the research project, and examples include development of an Event-Based Surveillance application, slowing the spread of malaria through molecular research on pathogens, and developing a package of mental health interventions to support health workers in humanitarian settings.

- **Outcomes developed through strengthened epidemic preparedness and response:** This is another key area in which participants or organisations reported having strengthened, and includes activities linked to strengthening preparedness and response capabilities, and to a lesser extent, building outbreak readiness and engaging in post-response learning. Specific examples partners are working to strengthen include establishing mechanisms to coordinate the Ebola outbreak response in Uganda and addressing behavioural-linked barriers in communities during the Cholera outbreak in Malawi.

- **Outcomes developed through strengthened organisational capacity:** Relatively fewer participants who were surveyed had strengthened capacity in this area. Outcomes linked to this were often embedded across other outcomes and include activities like provision of equipment (e.g. lab-related equipment and small amounts of reagents for a response), upskilling staff, and improving institutional effectiveness.

UK-PHRST's contribution to partner outcomes

Overall, UK-PHRST is reported to be contributing to partner outcomes although there are some areas where they are contributing more than others. As per the partner survey, they are seen to be contributing the most to 'strengthening capacity of internal staff' (88%), and 'strengthening research capacity' (82%), and relatively less to 'capacity for post-response learning' (34%), and 'capacity in monitoring and evaluation' (33%). How UK-PHRST contributes to **research outcomes** and **pandemic preparedness and response outcomes** with their partners was explored by the evaluation team.

Regarding **research outcomes** partners overall viewed UK-PHRST as contributing towards strengthening their research capacity. It was reported that UK-PHRST **adds value** to research partnerships and **contributes to outcomes** through their approach to operationalising partnerships: this includes **providing technical and methodological expertise**, sourcing **the right staff and expertise** to the partnership, and using **open and collaborative approaches** to provide feedback and guidance. In addition to these strengths, partners felt that the team brought an **academic and global reputation** to research projects, which helped enable the achievement of research outputs and outcomes.

Some research partners felt there is scope for UK-PHRST to be **more embedded** in research projects, which may help the team contribute to outcomes. Research partners characterised UK-PHRST as an **enabling partner** rather than a primary partner, and there was appetite among partners for the team to play a **greater, more supportive role** – for example, by being more involved throughout all stages of the research project and delivering aspects of the work. To be more embedded in research partnerships, partners reported that UK-PHRST could develop more **multipronged relationships** within the partnership (as opposed to the partnership being held by one individual), **prioritise language skills**, and **provide greater clarity** to their partners on UK-PHRST team members roles and responsibilities.

Regarding **pandemic preparedness and response outcomes** partners viewed UK-PHRST as contributing to strengthening their capacity in most areas surveyed, particularly preparedness and response. Through deployments, the team contributes capacity to **help realise outcomes more efficiently** and address the **immediate needs** brought about by the outbreak. This is mostly achieved through the provision of **unique and useful expertise** (as characterised by partners) during deployments. This is further enabled by UK-PHRST's general **collaborative approach to partnerships**, which was especially well-received by partners who had directly engaged with the team via on the job learning and mentoring.

Partners felt that UK-PHRST could do **more outside of deployments** to help contribute to pandemic preparedness and response-related outcomes. Areas where partners felt the team could contribute more include engaging with partners before outbreaks take place, for example, by reviewing and inputting into preparedness plans; as well as after the outbreak takes place, for example, by delivering follow-up training with healthcare professionals. In addition, the **length of time** in which UK-PHRST is deployed was considered a key barrier to an effective response by some partners, particularly for protracted outbreaks.

Sustainability of outcomes

Stakeholders paint a mixed picture as to whether the outcomes UK-PHRST are working towards during deployments are sustainable. They noted that in some respect, the health outcomes achieved during deployments, which UK-PHRST was felt to have contributed to, were sustained, as the outbreaks are eventually contained. There is also evidence to suggest that interventions have led to sustained outcomes for healthcare staff, particularly in terms of embedding knowledge and skills at the individual-level. However, there is limited evidence to suggest that interventions initiated during deployments led to sustained outcomes for local health systems. Activities are often not embedded within the existing health system and not properly integrated within policies following containment of outbreaks. Furthermore, partners felt more work could be done post-outbreak to ensure the skills which they gained from the team are better embedded and absorbed by other healthcare professionals.

It should be noted that there is limited data to assess whether UK-PHRST is contributing towards long-term outcomes. The research partnerships included in this evaluation were not mature enough to document longer-term outcomes and impact; and the evaluation team notes that an absence of long-term M&E frameworks are a key barrier to understanding the sustainability of UK-PHRST's activities more generally.

Discussion

How does UK-PHRST's approach to partnership benefit their partners?

Partnerships in UK-PHRST have historically been initiated via 'organic' processes and are generally based on a previous relationship or connection with a person or institution. This approach has its strengths, including providing a secure relational backbone for the partnership, yet is overly-reliant on individuals to maintain and may bias UK-PHRST's overall portfolio. As UK-PHRST's move towards a more strategic outreach approach to partnerships, this has the potential to better-align with partners' needs and address larger inequities. Strategic partnerships will help to ensure roles are clear, are mutually beneficial, and be selective on who the team is partnering with, which could allow for UK-PHRST to partner with organisations which are typically overlooked.

The way in which UK-PHRST engages and supports their partners is well-received, and partners highlight clear strengths, including cooperation and trust and the technical expertise that is offered. Still, the activities which UK-PHRST contributes to do not generally appear to be contributing to wider outcomes or impacts, and there appears to be little consideration of this from both UK-PHRST and their partners.

There are two areas for UK-PHRST to consider in terms of how they operationalise partnerships. Firstly, the team could be **more visible during deployments**, which would both help trace UK-PHRST activities to outcomes and evidence impact, and help partners to understand who is providing what during deployments. Secondly, the evaluation noted **strengths and weaknesses of the deployment model**.

Where governments are sufficiently prepared, the model can be effective at responding to outbreaks and providing expertise; however, there are limitations in terms of rapidly responding to partners' needs, implementing capacity strengthening activities, and ensuring sustainability of outcomes.

How can UK-PHRST better strengthen their partners capacity?

Capacity strengthening is not a well-defined term, and there appears to be a disconnect between how UK-PHRST and their partners, and even amongst partners themselves, view capacity strengthening. Still, stakeholders tend to have a strong understanding of capacity strengthening personally and 'recognise it when they see it'.

The type of partnership influences the types of capacity strengthening activities UK-PHRST delivers. During **deployments,** capacity strengthening activities are largely determined by the immediate needs of the outbreak. **Research partnerships** and **wide-ranging partnerships** (such as those with the Africa CDC) provide more opportunities for UK-PHRST to engage in capacity strengthening activities and work towards longer-term outcomes.

Where UK-PHRST embeds their **relational approach** to partnerships in capacity strengthening activities, longer-term outcomes are better realised. The evaluation noted sustained outcomes among healthcare professionals resulting 'on-the-job' training and mentoring provided by UK-PHRST during deployments to Malawi and Uganda. Still, there is opportunity for UK-PHRST to **leverage capacity strengthening activities** to have a **larger impact.** For example, the learning conference in Cape Town was an activity identified by partners which effectively leveraged their global network to facilitate regional knowledge exchange.

There are two areas for UK-PHRST to consider in terms of how they operationalise capacity strengthening. Firstly, whilst **bidirectional capacity strengthening** is considered important for UK-PHRST staff, there was **limited evidence that this had been operationalised** and was often limited to 'knowledge exchange' opportunities where the team was able to better understand the context their partners are operating in. Second, the degree to which UK-PHRST contributes to **long-term, sustainable outcomes is unclear** as there is **minimal data** to back this up. UK-PHRST needs to better understand whether their activities are having an impact and are sustainable, whilst also minimising partnership burden as much as possible.

How might UK-PHRST better support partners?

Based on findings from this evaluation, we have suggested three approaches for UK-PHRST to consider. These are not recommendations (which are included further below), but instead aim to highlight the strengths and weaknesses of UK-PHRST's different approaches to partnerships and capacity strengthening, as well as the associated trade-offs:

1) **One option is for UK-PHRST to further expand the scope of research partnerships and focus more resource on this pillar.** Research partnerships offer a longer-term model for capacity strengthening activities and engagement in bidirectional knowledge exchange. However, focusing more efforts on this pillar would draw resources and associated away from other areas of UK-PHRST's mandate, notably the teams' capacity to rapidly support partners via deployments. This would have further implications for the team's ability to support partners during outbreaks.

2) **Another option is to move towards bilateral agreements to help ensure capacity strengthening activities better respond to the needs of their partners.** Bilateral agreements could enable UK-PHRST to engage in capacity strengthening activities outside of outbreaks more easily, whilst

also ensuring partners are supported during outbreaks. Furthermore, this could allow UK-PHRST to have a more direct channel of engagement with countries susceptible to outbreaks and therefore be more responsive. Still, by moving away from GOARN and towards bilateral agreements, UK-PHRST would inevitably be less agile in responding to global outbreaks. One way to address this limitation would be to continue to deploy through the GOARN mechanism and increase internal capacity to engage with bilateral partnerships.

3) **More radically, UK-PHRST could merge the research and deployment pillars of the triple mandate and instead initiate more all-encompassing partnerships with a select few organisations.** This could be operationalised in a few different ways: UK-PHRST could replicate their Africa CDC and Nigeria CDC partnerships and provide more multi-pronged support capacity strengthening to a specific subset of partners. Alternatively, UK-PHRST could develop a network of partners around a disease area in a specific region and enable South-South collaboration and capacity strengthening. While this would have notable limitations, including reducing UK-PHRST's global footprint and agility, this model offers more opportunities for long-term capacity strengthening activities and sustained impact.

Recommendations

Based on the findings, and in addition to the three scenarios set out above, UK-PHRST should consider the following specific recommendations:

1. **UK-PHRST could undertake stakeholder mapping to understand how their partnership portfolio sits alongside other organisations.** This would help UK-PHRST understand which organisations are overrepresented and underrepresented and where UK-PHRST could partner to provide additional support. This would contribute to improving equity across North South partnerships. (Insight 1)

2. **As UK-PHRST implements their partnership strategy, they should ensure the benefits of the previous relational process are embedded.** Partners consider UK-PHRST's interpersonal skills, including the team's ability to listen, collaborate, and build trust, to be a key strength of UK-PHRST, and are a key enabler to helping partners achieve outcomes. The team needs to ensure these values are embedded as the new approach to partnerships is implemented. (Insights 2)

3. **UK-PHRST should explore ways to provide longer-term support within the parameters of their mandate**. Partnerships and capacities can be strengthened during "peace time" and then reinforced during crises. A few ways in which UK-PHRST could do this include allowing staff to be seconded for capacity strengthening activities which could act as a parallel mechanism to deployments; leveraging digital approaches**,** remote-training post-outbreak which partners were not opposed to; and organising regional conferences or 'outbreak simulations' with partners. (Insight 6)

4. **UK-PHRST could consider ways to improve the visibility of the team during deployments whilst operating under GOARN.** There was some confusion among partners as to the identity of the team, especially during deployments. Partners expressed that it would be helpful for them to know the affiliation of deployed staff, so they can have better oversight of who is doing what and make it easier to follow-up with the team post-deployment. Additionally, this could help to better-evidence impact by ensuring UK-PHRST activities and outputs are more easily identifiable, thereby linking this to potential outcomes and impact.

5. **Operationalise bidirectional exchange by identifying areas where UK-PHRST can learn from partners and enhance its own capacity**. UK-PHRST's partners offer a rich reservoir of knowledge, skills, and expertise, which go beyond simply providing contextual learnings. The team could identify where they lack skills and experience and be supported to improve on these through their partners.

6. **Encourage staff to become "capacity strengthening practitioners" t**o **move from conceptual discussions to practical implementation**. The complexity associated with defining and conceptualising the concept of capacity strengthening may have contributed to the feelings of frustration and/or disappointment reported by some participants in relation to its implementation by UK-PHRST.

7. **UK-PHRST could consider clarifying the term capacity strengthening as "mutual knowledge and learning" or simply refer to the actual activities or targets when related to exchanging capacity.** For example, framing capacity strengthening activities as "x organisation will be able to do y activity by the end of the partnership, measured by z" could help to provide better direction and ensure activities are effectively monitored and measured.

8. **Activities related to capacity strengthening should be more accurately defined and distinguished including whether they are short-term, longer-term, or enabling activities.** This includes clarifying whether these activities are part of a broader strategy and how they relate to partnership activities.

9. **Training activities should pivot towards a 'Train the Trainer' approach, which promotes the development of future training capabilities.** Alternatively, it is suggested to adjust the balance between the 'Train the Trainer' approach and one-time training sessions, where feasible.

10. **Where possible, UK-PHRST should aim to engage in capacity strengthening activities which are embedded in relational approaches such as 'on-the-job learning', providing guidance and mentoring, and knowledge exchanges.** This is in contrast to one-off trainings and provision of resource, which, while addressing the needs of the project, tend to have a shorter-term impact.

11. **To achieve tangible results, there should be a greater emphasis on continued support and persistent mentoring following initial assessment and the first round of support or activity.** This approach would enable a consistent process of capacity strengthening, as opposed to focusing solely on "post capacity strengthening" activities.

12. **Evaluation should be carried out to provide evidence as to whether the work on capacity strengthening is cumulatively contributing to the long-term change and resilience that forms the core of UK-PHRST's definition of capacity strengthening.** This involves assessing the overall impact and effectiveness of the capacity strengthening efforts.

13. **Evaluation work should delve deeper into understanding whether the process of partnership and capacity strengthening has indeed bolstered UK-PHRST's capacities.** It is crucial to decipher whether this improvement forms an integral part of UK-PHRST's core work or if it is a result of their enhanced ability to be more effective partners and supporters of capacity building.

14. **UK-PHRST should engage in learning activities with their partners post-outbreak.** There are lessons to be learned from each outbreak, and these need to be embedded within the relevant

institutions. For example, the Malawi case study demonstrated the limitations of the GOARN mechanism in responding to sub-regional outbreaks, and UK-PHRST could play a role in amplifying the voices of sub-national partners in Malawi. More broadly, UK-PHRST could work with partners to help ensure learnings are taken-up and use evidence from deployments to advocate for change amongst the teams global network.

15. **Where possible, UK-PHRST should work with partners to ensure activities delivered during deployments are embedded and sustained within the wider health system.** This could be identified during 'peace time' and involve updating preparedness. This would be further enabled via rapid deployment.

16. **UK-PHRST should develop a MEL framework for measuring long-term impact and sustainability of their activities.** There is an opportunity here for regular, 'light-touch' follow-up over a longer period with the key partner contact. This could be similar to what UK-PHRST is doing now, but at regular touch-points – for example, asking two to three questions about capacity strengthening activities to a partner during informal communications. This can be formally documented and inputted into UK-PHRST's larger M&E framework.