2019

The Impact of Multidisciplinary Mobilities on the Effectiveness of Global Health and International Development Projects

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SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS OF THE DEGREE OF DOCTOR OF PHILOSOPHY (PHD), 2019

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Acknowledgements

I have encountered countless individuals over the last 10 years that have supported, encouraged, inspired and guided me through my research journey. There have been many highs (and a few lows) along the way and I am extremely fortunate to have been part of a such strong, positive and dedicated teams throughout.

I would like to thank all my colleagues within the 'Knowledge, Health and Place' research group at the University of Salford and the charity 'Knowledge for Change' for their ongoing encouragement and support. In particular, my supervisors Professor Anya Ahmed and Dr Mark Wilding and my various co-authors on the publications.

I would like also like to thank all my colleagues in Uganda, particularly Allan Ndawula, not only for your input and guidance to the research but also your friendship, humour and best efforts to make your country truly feel like a second home to me.

Finally, I would like to extend a special thank you to my longest standing colleague and mother, Louise. You have been an inspirational figure in my life and I could not have hoped for a better role model to guide me to becoming the project manager and researcher that I am today, and achieving all that I have over the years.

Declaration

This thesis includes a portfolio of publications that have been published as peer-reviewed books and within peer-reviewed journals. Full copies of the books and journal articles can be found in Appendix 2 and are also available as Open Access. The extent of the author's original contribution to each of the books and articles, verified by each of the collaborating authors, is listed in Appendix 3.

Date: 5th March 2019

Abbreviations & Key Words

Abbreviations	**Key Words**
AHP - Allied Health Professional	Aid
DFID - Department For International Development	Capacity Building
EEP - Ethical Elective Placement (Project)	Co-presence
GDP - Gross Domestic Product	Elective Placements
HEE - Health Education England	Globalisation
HIC - High-Income Country	Global Health
HRH - Human Resources for Health	Health Systems
K4C - Knowledge for Change	International Development
LMIC - Low- and Middle-Income Country	Knowledge Exchange
LMP - Liverpool-Mulago Partnership	Mobility
MOH - Ministry of Health	Professional Voluntarism/Volunteering
MOVE - Measuring the Outcomes of Volunteering on Education (Project)	Sustainability
NHS - National Health Service	
OECD - Organisation for Economic Co-operation and Development	
SDG - Sustainable Development Goals	
SVP - Sustainable Volunteering Project	
THET - Tropical Health Education Trust	
UoS - University of Salford	

Abstract

The mobility of healthcare professionals from high-income countries (HICs) to low- and middle-income countries (LMICs) has been growing rapidly over recent decades. The 'international elective placement', which was once a preserve of medical student curricula, has now become increasingly common amongst nursing, midwifery and allied health professional students. International volunteering for healthcare professionals has shifted from being mainly missionary or altruistically driven to being a critically important component of clinical experience, professional development and subsequent career progression. Furthermore, there has been a large growth in international aid expenditure since the end of the Second World War and a more recent increase in the desire and ability of populations to travel internationally. These have acted as stimuli for the implementation of a multitude of international development projects designed to build the capacity of healthcare workers in LMICs in order to strengthen local health systems.

However, despite the above, there is a distinct lack of research into the real benefits, costs and potential negative effects or externalities associated with such mobilities, or their ability to ethically and sustainably strengthen health systems in LMICs. Most existing literature is written by development actors themselves who often focus on the short-term and have a conflict of interest in proving that their interventions are positive and beneficial in order to justify current and future funding. This portfolio of six published works and eight supporting publications serves to bridge this gap in research and knowledge. Based on the author's 10+ years of action research experience in the fields of global health, professional volunteering and international development, it suggests that the desired outcomes can be achieved in an ethical and sustainable way but only if certain policies and procedures are adopted and implemented.

Combined, the publications generate a unique contribution to knowledge by offering tested, practical ways of enhancing the efficacy of international aid and professional and student voluntarism. For this reason, each publication is directed at key stakeholders and policy makers, providing clear conclusions and recommendations based on in-depth experience and concrete research findings.

Publications Included in the Portfolio of Published Works

The six core publications, upon which this portfolio is based, are listed below along with a brief description of their key aims and findings. The first three publications are books; the fourth, fifth and sixth are journal articles. Throughout the portfolio, these six publications will be cited in bold (e.g. **Ackers & Ackers-Johnson, 2017**) to help distinguish them from any other citations. Full versions of the books and journal articles listed below can be found in Appendix 2:

1. Ackers, H.L. & Ackers-Johnson, J. (2017) "Mobile Professional Voluntarism and International Development: Killing Me Softly?" Palgrave Macmillan. DOI: 10.1057/978-1-137-55833-6

This was the first of the three books to be written and formed a more general overview and critique of aid and global health interventions in LMICs. The book reported on the experience of managing and researching the deployment of professionals employed in the UK, primarily but not exclusively in the National Health Service (NHS), to public health facilities in Uganda through the Sustainable Volunteering Project (SVP). The SVP was funded in the first instance for 3 years, during which time it deployed around 60 long-term and many more short-term volunteers. The project was subject to intense on-going evaluation focused both on volunteer learning and the returns to the NHS and on the impact on hosting Ugandan healthcare facilities and health workers. This book focused primarily on the second dimension; capturing the impacts of these kinds of intervention on the receiving/hosting country or the 'development' perspective. The book concludes by providing a number of recommendations aimed at improving the efficacy of such professional voluntarism and international development initiatives.

2. Ahmed, A.; Ackers-Johnson, J. & Ackers, H.L. (2017) "The Ethics of Educational Healthcare Placements in Low & Middle Income Countries: First Do No Harm?" Palgrave Macmillan. DOI: 10.1007/978-3-319-48363-4

This book examined the impact of internationalisation on student mobilities, in particular the growing popularity of international elective placements. It reported on the Ethical Elective Placement (EEP) project which placed multidisciplinary groups of students in

Uganda and India (80 in total) to complete elective placements. The student learning outcomes were evaluated, along with the impact they had on the 'hosting' organisation and any costs and ethical considerations involved. The book concluded with a number of recommendations aimed at improving the ethics of such international elective placement programmes, maximising the learning outcomes for students and the positive impacts to the 'hosting' LMIC.

3. Ackers, H.L.; Ackers-Johnson, J.; Chatwin, J. & Tyler, N. (2017) "Healthcare, Frugal Innovation, and Professional Voluntarism: A Cost-Benefit Analysis", Palgrave Macmillan, DOI: 10.1007/978-3-319-48366-5

The third book was based on a combination of the SVP and supplementary data collected through the MOVE project. The research focused on measuring current levels of mobility within the NHS workforce, any barriers faced by NHS staff wishing to undertake an international placement, what staff learnt from spending time working in LMICs and how any learning could be of benefit to the NHS upon their return. The book concludes by proposing a model for sustainable and effective volunteering including recommendations for policy makers.

4. Ackers, H.L.; Ioannou, E. & Ackers-Johnson, J. (2016) "The Impact of Delays on Maternal and Neonatal Outcomes in Ugandan Public Health Facilities: the Role of Absenteeism", Oxford University Press: Health Policy and Planning, 31 (1152–1161) DOI: 10.1093/heapol/czw046

This article examines the issue of absenteeism within the Ugandan health system and how this impacts upon rates of maternal mortality. It was based on research conducted over the course of the SVP and a subsequent health facility audit of patient referrals, and focuses primarily on medical staff as opposed to nursing, midwifery or other backgrounds. The article concludes that high rates of absenteeism amongst doctors have strong direct and indirect negative impacts on rates of maternal morbidity and mortality.

5. Ackers, H.L.; Lewis, E. & Ackers-Johnson, J. (2014) "Identifying and Mitigating Risks in Medical Voluntarism: Promoting Sustainable Volunteering to support Maternal & Infant Well-Being in Uganda", IARMM JMS

This article examines the organisational and personal risks involved in managing or partaking in international professional volunteering programmes. It identifies and classifies various risks that exist and goes on to examine strategies that can mitigate such risks. It was written based on data collected during the SVP and supplemented by additional external risk assessment activities carried out over the course of the programme.

6. Ackers, H.L.; Ackers-Johnson, J.; Ahmed, A. & Tate, N (2019) "Optimising Student Learning on International Placements in Low Income Settings; the Contribution of Cultural Brokerage", Open Journal of Social Sciences, 7 https://doi.org/10.4236/jss.2019.73026

This article challenges the common assumption that student elective placements in LMICs inevitably promote the acquisition of 'cultural competence'. It examines concepts such as 'cultural learning' and provides examples of how exposures to LMIC environments can inadvertently lead to racial profiling or stereotyping as opposed to 'learning'. It concludes by providing recommendations as to what supporting mechanisms are required to maximise student learning and minimise occurrences of 'negative' learning.

Introduction

This Portfolio of Published Works focuses on the mobilities of highly skilled professional volunteers and students in relation to knowledge mobilisation processes. Specifically, it examines knowledge mobilisation processes and the impact that such mobilities can have on the effectiveness of global health and international development projects. The published works presented in this thesis have three core foci: the impact on the 'sending' country's health system, the impact on the 'hosting' country's health system and the impacts on the professional volunteers and students themselves having undertaken an international placement. It is important to note that, given the nature and style of the three primary publications as books rather than shorter journal articles, far greater detail on all of the topics raised in this thesis can be found within the books themselves. The remainder of this thesis is split into four chapters and a conclusion:

Chapter one provides an overview and background to the research area. It begins by discussing what is meant by international development, aid, global health and international voluntarism and how these fields have developed over time. It also examines some of the wider disciplinary perspectives and identifies gaps in the existing knowledge and literature.

Chapter two provides an overview of the various methodologies and methods utilised over the course of the various research projects. It also discusses ontological and epistemological viewpoints and the effect these have had on the selection of research methods.

Chapter three looks at the interrelationship between the publications included within the portfolio, their combined contribution to knowledge and how this fills some of the gaps highlighted in chapter one. Three key linkages are analysed in greater detail; globalisation and the liquidity of human resource for health, the critical role of co-presence in effective knowledge exchange and the importance of professionalising voluntarism.

Chapter 4 offers a critique of the presented publications in terms of their methodologies, limitations, some ethical considerations and contextual variances. In particular, it looks in

more detail at the evidence base within global health policy, the classification of the research as ‘action research’ and the effects of positionality.

The conclusion summarises the impacts of the portfolio of publications and contains some implications for practice and policy, along with recommendations for future research. It is followed by a number of appendices which contain more information on the individual research projects conducted over the course of the research, full versions of each of the publications and statements of candidate’s independent work and individual contribution to each of the publications based on the ICMJE guidelines.

Chapter 1: Overview, Background & Wider Disciplinary Perspectives

The first chapter of this thesis provides an overview and background to the research area. It also discusses some of the wider disciplinary perspectives published by prominent scholars working in the same or similar fields. The chapter analyses international development, aid, global health and international voluntarism and mobility separately, however in reality all of these areas have blurred boundaries and very often intersect one another, particularly international development and aid.

International Development

Countries are often described either as 'developing' (as opposed to 'developed') or more recently as lower- and middle-income countries' (LMICs) in contrast to high-income or resource-rich economies (HICs). However, these classifications are crude and can often be misleading as judging countries based on their per-capita income (usually GDP) or status of development does not necessarily correlate with their populations' standard of living. Key examples would be countries such as the USA and Singapore which, despite on paper having high GDP per capita, have a huge divide between the rich and the poor and their relative access to systems such as education and health and their resultant health, wealth, quality of life and life expectancy. Similarly, countries such as Kuwait and Venezuela which have high levels of natural resources such as oil and minerals are not necessarily highly developed in economic or social terms.

To avoid the problems of using GDP or resource levels as measures of development, O'Sullivan & Sheffrin (2003) describe LMICs as having "a less developed industrial base and a low Human Development Index (HDI) relative to other countries" (p.471). Kofi Annan (former Secretary General of the United Nations) took a more broad and socially focused approach, referring to how developing countries allow their citizens to enjoy free and healthy lives in safe environments (UN, 2000). What is clear is that there is no globally accepted definition of what constitutes an LMIC and that all definitions carry a level of contextual variance and subjectivity. However what all of these characterisations do suggest is that binaries exist: the 'haves' and 'have nots' or at least that countries sit somewhere along a continuum between two sides of a scale.

Most LMICs share certain common characteristics including high levels of poverty, lacking human resources (resulting from poor education and weak health systems) and economic vulnerability. In many instances, these problems can be caused and/or compounded by political instability and high levels of corruption. Challenges frequently faced by LMICs include: public health issues such as illnesses/disease, malnutrition, road traffic accidents and pollution; lower levels of women's empowerment and a higher prevalence of sexual harassment and domestic violence; poor access to water, sanitation and hygiene; and the growth of urban slums or 'slum cities' (World Bank, 2014) which typically harbour higher levels of crime and poor living conditions.

Aid

International aid can take many forms and often provides a key element of LMIC development financing. For many LMICs, official development assistance (ODA) represents the largest source of external financing and is critical in supporting education, health, public infrastructure, agricultural and rural development (GPF, 2018). A target was set by the United Nations in 1970 for all HICs to commit a minimum of 0.7% of their GDP to ODA, however very little progress was made towards this goal over the following 30 years. In 2005, the 15 EU member states at the time again agreed to meet this target by 2015 however, as of 2017, the UK was one of only six countries to achieve this (OECD, 2018).

Furthermore, aid has become ever more complex and intertwined with governments' international agendas, soft diplomacy and building trade links over time. There has been an increasing trend for donor countries to 'tie' aid by, for example, requiring that it be spent on exports from the donor country or for military support aligned to the donor's international agenda. There may also be political strings attached, aimed at promoting the local business interests of the donor rather than the real development needs of the recipient.

In the UK, aid expenditure is governed by the Department for International Development (DFID). DFID's core objective is to "[work] with international organisations and the governments of poorer countries to help end poverty" […] "building a safer, healthier, more prosperous world for people in developing countries and in the UK" (DFID, 2018). DFID's key areas of focus include poverty, disease, mass migration, insecurity and conflict.

In 2016, the UK spent £13.4 billion on international aid. Figure 1 provides a breakdown of how this was distributed.

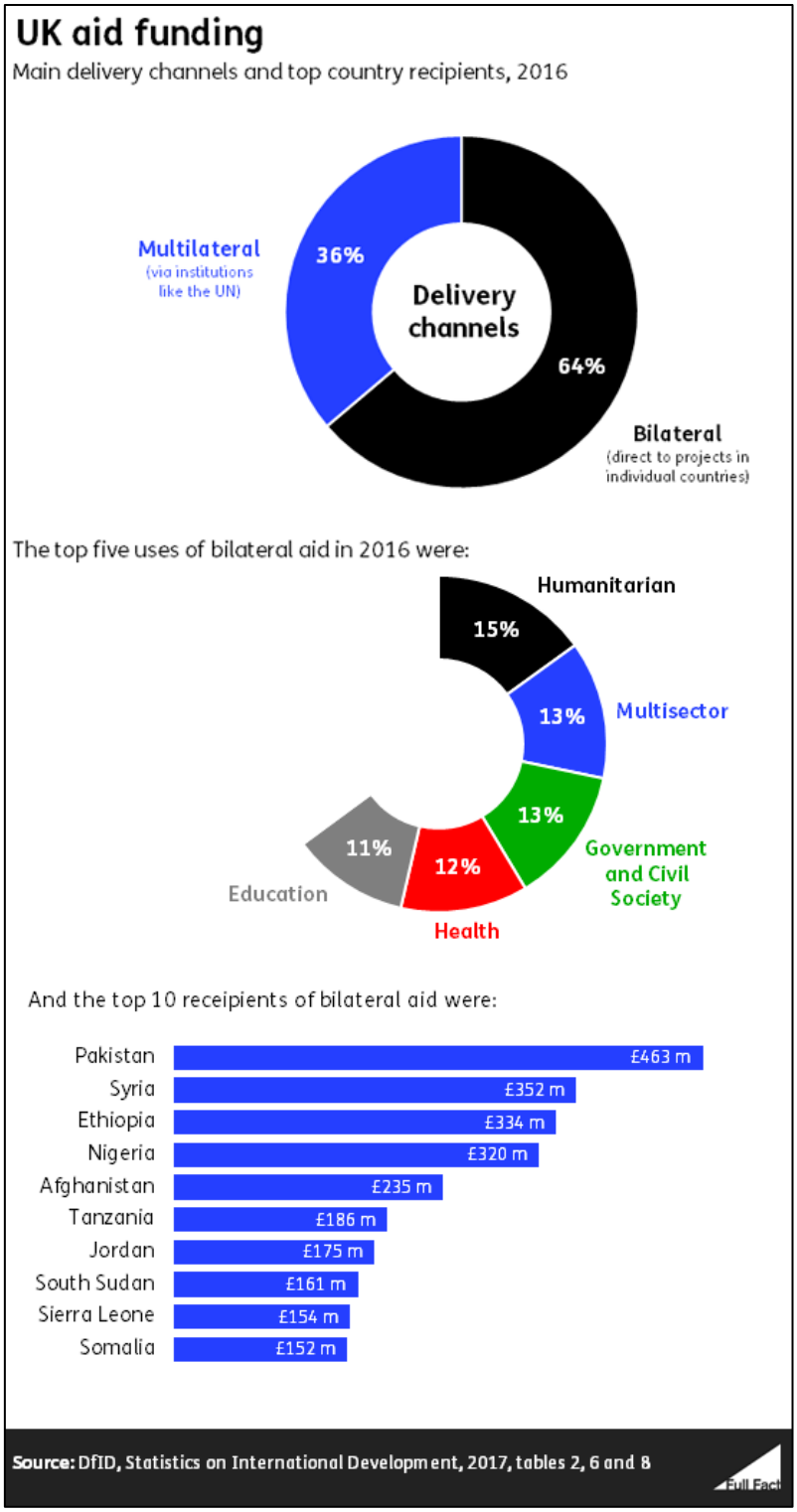

Figure 1 - Distribution of UK aid Expenditure in 2016 (Source: Fullfact, 2018)

To put the aid received by Uganda into perspective, the Ugandan Ministry of Health published figures indicating an annual spend of 1281.14 billion shillings (about £256.5 million). Of this, 68% (£150 million) is provided by the Ugandan government and 32% (£106.5 million) by 'donors'. The growth in donor share is quite alarming, almost doubling from 13.7% in 2011 (Ministry of Health, Uganda, 2015). DFID's figures for 2015 indicate a spend of over £26 million in 2014/2015 on health in Uganda; the majority of which (63%) goes on reproductive, maternal and newborn health (DFID, 2011). These figures are indicative only and most certainly under-estimate the monetary value of aid, reflecting only the direct inter-governmental funding that travels down through the Ministry. However health partnerships, for example, are largely funded as local charities and whilst the amount of money involved may be quite high, this can be dwarfed by the real costs of in-kind contributions through volunteer labour (Handy & Mook, 2011, p. 414).

Bolton (2007, p.75) suggests that 'broadly speaking, aid can have two aims. It either provides humanitarian relief in response to emergencies or it tries to stimulate longer-term development'. Humanitarian or emergency aid seeks to provide an immediate response to catastrophic events such as famine, earthquakes or wars. In such situations, immediate service intervention is easier to justify and concerns around unintended consequences or collateral damage less pressing. This type of activity could, in theory and out of necessity, be achieved by foreign volunteers in the absence of local staff. The deployment of 'Mercy Ships,' for example, is designed to 'fill the gaps in health care systems' through service delivery. Emergency aid can be (and has been) provided in many contexts without in-depth analysis of a country's economic status or political decision making (Bolton, 2007, p.76).

Bolton (2007) calculates that around 95% of aid falls into the alternative category of 'Development Aid' – a form of investment which is both 'much better value' (in terms of promoting resilience) and 'harder to get right' (p.76). This aid comes from a diversity of sources including, as Bolton indicates, charitable donations and philanthropy (of which a sizeable component are linked to religious organisations pursuing their own agendas); national aid provided by governments and international aid provided by organisations such as the World Bank and the United Nations. Bolton (2007) argues that the boundaries between these forms of aid are fuzzy and the political imperatives (underlying national

and international aid and its links with diplomacy and trade) combined with the marketing functions of charitable fund-raisers together result in an opaqueness and lack of honesty about impacts.

Dambisa Moyo's book with its stark and (as described by the Daily Mail) 'incendiary' title, "Dead Aid: Why AID is not working and how there is another way for Africa" had a major impact on the design of all of the research upon which the portfolio of publications are based. Moyo (2009) argues that the culture of aid derives from 'the liberal sensibility that the rich should help the poor and that the form of this help should be aid' (p.xix). With reference to its impact on 'systemic poverty' (as opposed to humanitarian crises), Moyo concludes that aid has been and continues to be 'an unmitigated political, economic and humanitarian disaster for most parts of the developing world' (p.xix). She goes beyond many other writers who express similar concern at the efficacy of aid to contend that aid is not only ineffectual but, of far greater concern, it also generates externality effects (unintended, indirect or secondary effects) that can actually cause damage.

Moyo describes how aid is often seen as an 'industry' by actors in high-income (donor) settings; it is also seen very much as an industry in low-resource settings. Indeed, poverty is a magnet for aid and the more overtly poor and destitute the case, the greater the prospect of attracting investment. Sadly, in some situations, this creates a vested interest for local leaders in the deliberate preservation and presentation of impoverishment and chaos in order to suck in cash and create opportunities for embezzlement. In that sense, poverty can be both functional and profitable.

Global Health

The above mentioned anxieties about the effectiveness of aid, fuelled by political correctness about the use of the term 'development' have led to new concepts to capture the investment dimension and focus on longer-term systemic change. The Tropical Health and Education Trust (THET) is one of a growing number of intermediaries funded by DFID and focusing on 'capacity building' and 'sustainability'. Locating itself within the 'global health' agenda, THET describes its mission as building long-term resilient health systems to promote improved access to essential health care as a basic human right (THET, 2015). At the centre of this strategy is the concept of 'human resources for health' or 'HRH'.

The global health agenda has usefully shifted attention from the haves–have nots and donor–recipient binaries referred to before, talking instead, somewhat hopefully, of partnerships and 'win–win' relationships. Lord Nigel Crisp has pushed this agenda forward arguing quite forcefully that the UK's National Health Service has as much to learn from low-resource settings as vice versa. Focusing again on health systems (rather than poor people per se), Crisp suggests that the concept of global health 'embraces everything that we share in health terms globally' (2010, p.9). Crisp's approach rests on two ideas. Firstly; health systems in high-resource settings are facing growing challenges in terms of resources and sustainability. Secondly; globalisation is itself creating complex mobilities (both human and microbial) and interdependencies that effectively challenge the autonomy and resilience of nation states: we are all increasingly connected, whether we like it or not. The growing mobility of health workers or the spread of Ebola are prime examples.

In the context of global health, the growing emphasis on human resources has usefully shifted the debate from one about providing 'top-down' cash injections in the form of national or international financial support to (sometimes corrupt) governments to supporting forms of knowledge exchange through grounded partnerships. THET describes its focus on reducing health inequalities in LMICs with a particular emphasis on improving access to essential health care (as a basic human right). Achieving this requires significant improvement in health systems and this in turn places the emphasis on human resources:

> *"The lack of human resources for health is a critical constraint to sustainable development in many lower- and middle-income countries"* (THET 2015, p.10)

This leads naturally on to what they describe as 'a unique partnership approach that harnesses the skills, knowledge and technical expertise of health professionals to meet the training and education needs identified in low-resource settings'. And 'international volunteering' is one of the key mechanisms it supports to achieve this skills harnessing process.

International Voluntarism & Mobility

Internationalisation has become a feature of many, if not most, careers (Smetherham, C.; Fenton, S. & Modood, T., 2010, p. 412). It can be achieved through a variety of mechanisms including, perhaps most obviously, the recruitment of staff from other countries. Certainly, international mobility has come to play an important role both in terms of attracting the 'brightest and best' across global labour markets (Iredale, 2001; Mahroum, 2000; Smetherham et al., 2010) and in terms of fostering mechanisms to provide international exposure to locally recruited staff. Mobilities of various forms involving shorter or longer stays at different stages in careers and to diverse locations are widely acknowledged to play an important role in the generation and exploitation of knowledge and innovation. Whilst the 'mobility imperative' (Ackers, 2010; Cox, 2008) has received greatest attention in those careers specifically associated with knowledge generation (such as research), there is increasing recognition that all professionals are inherently engaged in knowledge creation and mobilisation (Baruch & Hall, 2004; Baruch & Reis, 2015; DeFillippi & Arthur, 1994).

Healthcare professionals are not simply the consumers or users of knowledge but through their daily lives actively engage in its co-creation (DeFillippi, R.J. & Arthur, M.B., 1994, p. 128). The concept of 'lifelong learning' bridges archaic boundaries by distinguishing early career phases of intense knowledge acquisition (through formal 'learning') with subsequent knowledge utilisation (through professional practice or 'doing') (Baruch & Reis, 2016, p. 24). Set within this wider context, the growth in professional mobilities involving healthcare professionals will come as no surprise. In some cases, these mobilities may themselves represent 'migrations' as healthcare professionals identify opportunities

for longer term relocation abroad (Buchan, 2001). Recent years have seen a growing interest amongst British healthcare professionals in Australia and New Zealand contributing to what is often referred to, somewhat simplistically, as the 'brain drain' (Lumley, 2011). In many other cases, mobilities take the form of shorter stays to gain exposure, respite or adventure in foreign climes (Hudson & Inkson, 2006).

The portfolio of publications presented in this thesis focus on one component of these complex mobility flows, namely temporary stays undertaken by health workers from High-Income Countries (HICs) in Low- and Middle-Income Countries (LMICs). The mobility of highly skilled health care professionals from HICs to LMICs is certainly not a new phenomenon. Ever since the initial colonisation of African and South-East Asian countries by the various European empires; medics, nurses, midwives and Allied Health Professionals (AHPs) have travelled to all corners of the globe to impart their knowledge on those deemed less well-resourced or educated and those battling with unforeseen environmental or politically aggravated emergencies (Tilley, 2016). However, as mentioned above, what was once a largely missionary style movement has now, since the end of the Second World War, become ever more complex and intertwined with governments' international agendas, soft diplomacy and building trade links (Bolton, 2007). At the same time, many LMICs have become more accessible for travel and this, combined with the growing desire (or in some instances imperative) for individuals to gain international experience (Iredale, 2001), has led to rapidly expanding professional volunteering, general volunteering and (the more negatively perceived) 'voluntourism' industries (Gillett, 2016).

Despite this area of growth, only a limited but growing body of research has been conducted in to the effects of volunteering in terms of the impact is has on the volunteers themselves, the countries which 'host' them or the 'sending' country once they return home (Tiessen & Heron, 2012, p. 49). Additionally, very little is known about the real costs of such volunteering activities (Handy & Mook, 2011). According to DFID (2017, p.4), the UK spent £13.4 billion on aid in 2016 but this is highly unlikely to capture most of the direct costs of volunteering, let alone the indirect costs such as those required to provide backfill for travelling staff, loss of staff earnings whilst abroad and the costs incurred directly by volunteers in funding their travel and other requirements.

The Gap in Knowledge

Numerous critics of International Aid have questioned why so many LMICs are continuing to struggle to improve health outcomes despite huge international investments and argue that new and innovative projects and strategies should be considered as alternatives (see Moyo 2009, Bolton 2007, Crisp 2007). The authors agree that there is a relative lack of reliable evidence and literature about what works and what does not. Moyo (2009, p.44) explains how 'short term aid evaluations give the erroneous impression of aid's success whilst failing to assess long-term sustainability' and that 'study after study after study have shown that aid has no appreciable impact' (p.46). Bolton (2017, p.79) argues that there is little honest public debate about the quality of aid and is critical of the fact that most of the information we get about aid is from charities that have a clear conflict of interest: they need to convince the public that aid is effective in order to justify their expenditure and maximise the future funding they receive. This leads to 'compelling simplicity' and exaggerations of how effective aid can be. The same could also be said for higher levels in the international development sector; even government bodies such as DFID and political parties have the impetus to convince taxpayers that their taxes have been well spent, or else risk losing voters' support (Liang & Mirelman, 2014). This huge pressure to raise and justify funding results in a tendency to simplify and exaggerate the effectiveness of aid and 'the outcome is probably the most unaccountable multibillion dollar industry in the world' (Bolton, 2017, p.79).

In his comprehensive report on Global Health Partnerships, Lord Crisp assessed how expertise in health could be used to best effect to help improve health in developing countries. In his summary of the wider picture of development activities over recent years, he noted:

> *'I have been told and seen evidence of any number of well-intentioned initiatives that foundered after a few years – or had their funding withdrawn – or that were simply misguided and ineffective and where all their gains evaporated quickly. There have been many earlier efforts to reform and improve.*
>
> *This can lead to cynicism and a counsel of despair that "despite all the effort over the years, nothing has really changed and nothing will really change"'*

(Crisp, 2007, p. 5)

This is a clear acknowledgement that much development aid simply has not been effective in achieving its desired positive and sustainable changes in LMICs. Crisp is referring here not only to the health sectors but also education, women's empowerment and wider economic development. He goes on to ask the question, frequently cited by other critics of aid and echoed within this thesis, "what will we do differently this time to ensure that we don't just get the same results as we have always got?" (p.6). This resonates a growing sentiment in the international development sector that the same mistakes are being made over and over again due to 'very little systematic application of knowledge and learning from successful - and failed - projects' (p.9).

The Academy of Medical Royal Colleges' (AOMRC, 2013) 'Statement on Volunteering' maintains a slightly more positive stance, however essentially points to the same conclusion that the monitoring and evaluation of volunteering activities does exist but at present is very limited. It also includes research in to the long-term impacts of volunteering under the same bracket, affirming 'there is a pressing need to develop consistent approaches to robust monitoring and evaluation' (p.2).

Simply put, what the above authors highlight is a severe lack of reliable, credible and accurate literature on what works and what does not in terms of positive, sustainable and cost-effective international development projects. Crisp (2007) calls for more international studies that, 'show what impact they can make and how they should best be used' (p.14); Moyo (2009, p.154) emphasises the need for 'a generous dose of honesty about what works and what does not' and AOMRC (2013, p.3) conclude that 'there is also a need to invest in research on the subject to better understand how volunteering activities can best improve health in developing countries, increase global health capacity, as well as how volunteering activities can improve healthcare delivery in the UK'.

Despite the huge recent growth of international voluntarism (Tiessen & Heron, 2012, p. 49) as one key element of many global health and international development projects, only a relatively small (but growing) body of research has been conducted in to the effects of volunteering in terms of the impact is has on the volunteers themselves, the countries which 'host' them or the 'sending' country once they return home (Sherraden & Lough,

2008, p. 395). Additionally, as discussed previously, less is known about the real direct and indirect costs associated with volunteering such as providing backfill for travelling staff, loss of staff earnings whilst abroad and costs incurred directly by volunteers in funding their travel, subsistence and other requirements (Yeomans, 2017, p. 4).

In addition to the gaps noted above, more generally this portfolio of publications debates the positive and negative impacts that aid (with a focus on human mobility as opposed to direct financial aid) can have on HICs and LMICs and how activities can be conducted in a more effective and ethical manner in order to achieve positive sustainable outcomes. It provides an evaluation of the learning outcomes and costs associated with professional volunteering and student placements in LMICs and how the efficacy of placements can be improved. It also establishes the resultant short, medium and long-term impacts on the health systems within the volunteer or student's 'sending' and 'hosting' countries, including ways in which any negative externalities can be reduced and any positive outcomes can be maximised and, most importantly, sustained in both settings. One of the main aims of the portfolio, which to a great extent dictated the style and tone of the publications, is to provide clear and concise policy recommendations to a variety of stakeholders involved in international development, aid and global health, ranging from a high level for government bodies such as DFID to lower level development organisations, charities and individual volunteers.

Key topics that are recurrent throughout each of the publications include sustainability, ethics, capacity building, reciprocity and professional volunteering. This work is of particular importance in the current global environment as many high-income countries face slowing economic growth (FocusEconomics, 2019). In many cases, this has resulted in worsening living standards and tightening austerity measures especially since the 2009 financial crash (Coppola, 2017) (Legido-Quigley, et al., 2016). Increasing pressure has been put on countries and governments to justify their expenditure on international aid and to achieve higher levels of cost effectiveness and value for money for taxpayers (Willem te Velde & Massa, 2009). All of the books and articles debate this in great detail and provide evidence backed evaluation to inform future policy.

In response to the Crisp (2007), Bolton (2007), Moyo (2009) and AOMRC (2013) criticisms and recommendations, this portfolio generates a body of knowledge, based on a wealth of experience 'in the field', on what works, what does not and reasons as to why this might be the case. It has deliberately been written in a simple, direct and pragmatic way that makes it relevant and accessible for the target audience of stakeholders and policy makers working in the fields of voluntarism, international development and global health. The portfolio has been written in an honest, meaningful and, as far as possible, objective way using concrete real-world examples, based on the authors' research experience, to support all findings and recommendations.

Chapter 2: Methodology

Ontology and Epistemology

Young & Temple (2014) discuss how epistemology, ontology, methodology and methods are inextricably linked, with one impacting upon the other and vice versa. The choices of methodologies within this portfolio of publications was influenced by my epistemological and ontological positions as a researcher. Likewise, the study design, evaluation plans and research objectives will have influenced the choice of methodology. Carter & Little (2007) explain how the methods utilised within health research projects tend to arise from, and are shaped by, epistemological positions and methodological choices. As a researcher, it was important for me to be aware of my epistemological and ontological values and any impact these may have had on the research design, findings and interpretation of results. It is also important that appropriate and compatible methods and methodologies were selected to optimise robustness and rigour.

The personal beliefs and background of a researcher tends to form their epistemological and ontological positioning (Carter & Little, 2007). This chapter will discuss issues such as positionality and personal motivations; the critical roles these played in shaping my epistemological and ontological views; how these, in turn, may have affected the methodologies and resulting methods selected and the overall impact on the publications presented within this portfolio. It is important to note that the process is symbiotic; the research process and findings will have also influenced my personal, epistemological and ontological views and motivations.

Ontology relates to 'the study of being' and is generally depicted as a continuum with realism on one side and relativism on the other. Simply put, a realist position holds that one single reality exists which can be objectively measured and is independent of the human mind. Conversely, relativists believe that reality is constructed and only exists within the human mind so that reality is a subjective experience, relative according to each individual who experiences it at a given time and place (Moon & Blackman, 2014). I posit that the research in this portfolio follows a relativist ontology and that at least some classes of things have the properties they have but only relative to a given framework of assessment, such as local cultural norms or individual standards of practice, and congruently, that the truth of claims attributing these properties holds only once the

relevant framework of assessment is specified or supplied (Baghramian & Carter, 2019). The radical differences observed between cultures and the complexities of an individual's 'cultural learning' described in **Ackers, Ackers-Johnson, Ahmed & Tate (2019)** support the view that everything is relative and depends on the individual's perspective or point of view. Following a relativistic ontology tends to lend itself to qualitative rather than quantitative data collection methods, as was the case within this portfolio of publications.

Epistemology relates to how people acquire knowledge, make meaningful sense of the world, and how 'we can know what we know' (Moon & Blackman, 2014). Similar to ontological perspectives, epistemology tends to be depicted as a continuum with objectivism/empiricism on one side and subjectivism/interpretivism on the other (Danermark, et al., 2002). Objectivists would tend to collect quantitative data and utilise quantitative data analysis techniques and metrics with the belief that there is an objective truth 'out there', waiting to be discovered with appropriate methods to bring accurate and certain knowledge of that truth. Subjectivists, however, believe that 'all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, developed and transmitted within an essentially social context' (Crotty, 1998, p. 42).

There are several different branches or schools of thought relating to epistemology. Tekin & Kotaman (2013, p.86) argue that there are traces of both positivism and post-positivism in action research, but that it should ultimately be classified as a post-positivist mode of inquiry due to its conditional nature. However, in the case of this portfolio and its comprising research, I struggle to justify a positivist or post-positivist viewpoint given my position that all research participants are complex individuals as opposed to generic, identical entities that will react the same way if subjected to the same 'force'. The ethnographic research conducted supports this contention, for example two staff with ostensibly identical backgrounds, education and roles have been observed to show patients greatly different levels of compassion and empathy. On a number of occasions throughout the research, staff/volunteer 'behaviour' has been extremely difficult to predict and change, largely due to complex individualistic factors which cannot be realistically or accurately attributed and measured.

An alternative epistemology more suited to the research conducted within this portfolio of publications is that of pragmatism. Pragmatism is a theory of meaning that has application in the real world and views the problem as being more important than the method (Murphy, 1990). A pragmatic researcher should choose data collection and analysis of methods that provide insights into the research question and should use pluralistic approaches to understand problems and search for meaningful solutions (Cherryholmes, 1992). Mertens (2005) also argues that pragmatism rejects the scientific notion that 'truth' about real world issues can be understood by scientific methods alone. This compliments the complex mixed-methods approach followed throughout the research process, with the selection of methods being based on their ability to solve a real-world problem, such as improving a placement learning outcome or improving a referral pathway within a healthcare system. As an action researcher, I necessarily had to remain dynamic and frequently had to change the research methods being used within a project in the face of new problems or challenges presenting or new interesting research areas being identified.

In adopting a pragmatic epistemological viewpoint, it is necessary that I acknowledge myself and my experiences as an active and influential force in the research process. I have been inextricably linked to all stages of the research including the design, implementation and evaluation of projects and the dissemination of findings. Additionally, my interactions with the research participants (be they local staff, professional volunteers, students or wider stakeholders) will have shaped the findings of this study. It is imperative that I locate myself in my research and be transparent about my position in order to verify and justify these findings. Central to this is understanding positionality which is discussed further in chapter 4.

Methodology

As concluded in chapter 1, relatively little is currently known about the real impact of aid, international development and global health initiatives. A useful way to separate and summarise these impacts, as posited in Ackers & Ackers-Johnson (2017), is to look at the impact on the 'sending' institution, the impact on the 'hosting' institution and the impact on the mobile individual (member of staff, volunteer or student) as a vector of knowledge. There are a range of methodological approaches that can be followed which are aligned with a pragmatic epistemological approach. Holloway & Wheeler (2010) promote the use

of grounded theory to generate theory from data in cases where researchers have little pre-existing theory or expectations of findings. In reality, true grounded theory as a methodological approach is hard to achieve as the availability of existing literature, along with my predetermined opinions, motivations and life experience will inevitably have led to some preconceptions and therefore disturbance to the data collection and interpretive process.

A potential solution was found to combine grounded theory (or as close as possible) with ethnographic research. Ethnographic research supports the comprehensive "description and interpretation of the culture and social structure of a social group" (Robson & McCartan, 2016, p. 156). It often requires a researcher to immerse themselves within a particular group or culture for an extended period of time. Classical ethnographic researchers have the primary objective of understanding rather than changing the group being studied (Barab, et al., 2004). This contrasts with the principles of action research which necessarily involves change processes. It is therefore not possible to claim that this research followed a classical ethnographic approach, however one might describe it as being strongly ethnographically influenced. Establishing the portfolio of research as action research is analysed more closely in chapter 4.

Despite not having completed a single extended stay in an LMIC, I have spent almost 18 months in Uganda and over 3 months in India, split over several separate visits. Some authors may argue that this time is insufficient to complete an accurate ethnography, however from my experience I have identified some benefits to conducting multiple, repeat visits as opposed to one long stay. The fact that I keep travelling back to these countries builds a level of respect and trust with local stakeholders, perhaps more so than, for example, a volunteer who stays for 12 months and then never returns. It demonstrates the long-term nature of my commitment to the project work and the research which is acknowledged by local colleagues. As a result, I have built up close life-long friendships which can prove extremely fruitful both socially and in terms of clarifying research findings. I believe this also partially remedies one of the main criticisms of ethnography, specifically that the intense presence of an individual in a particular group has the potential to disturb and distort the natural setting, thereby calling into question the quality and reliability of research findings generated in this manner (Robson and

McCartan, 2016). Travelling to a country for a short period of time, implementing an intervention and then leaving to observe at a distance (or evaluate during a later visit) removed me, as a researcher, from the situation and provided improved insight, particularly into the sustainability of the intervention.

Research Methods

The publications included in this portfolio of published works comprise multiple individual action research projects; I have listed these in Appendix 1. The majority of projects were subject to their own bespoke evaluation and methodological approach; these were often designed with the requirements of the funding body in mind. In general, my research team and I judged the following elements to be of critical importance during the design of all research and evaluation activities:

- A focus on understanding process (as much as outcomes)
- Achieving triangulation by following a multi-methods approach
- Longitudinal data collection to capture change over time
- Contextualised research and evaluation
- Independence
- Reflexive and rigorous analysis
- Engagement with trained researchers
- Honesty and humility to ensure the research is ethical and reduce the impact of researcher positionality
- Effective and timely dissemination/publication of results

The emphasis on change processes, particularly within the Sustainable Volunteering Project (SVP) and Ethical Elective Placement Project (EEP), coupled with the paucity of reliable secondary data, demanded innovative and iterative multi-method approaches. Building on many years' experience of research on highly skilled mobilities and knowledge transfer processes, the evaluation strategies embraced a range of methods complementing and balancing each other through the process of triangulation (Iyer et al. 2013).

As researchers, we were acutely aware at the outset of the limitations of the facility-generated secondary data mentioned above. Accurate, reliable data on maternal and

newborn health (for example) do not exist in Uganda. During the research, we conducted a major benchmarking exercise across all project sites including health centres and hospitals. This was an interactive process in itself and was as much about improving data collection and record keeping as it was about data capture; indeed, the process included training of record keeping staff. These data should be regarded with caution; as Gilson et al. (2011) note, even in this 'hard data' context there is no single reality, no simple set of undisturbed facts and the data that we do see are essentially socially constructs.

We have also used simple before-and-after testing schemes, for example using Likert scales to assess learning and skills enhancement during formal training programmes. Capturing the impacts of volunteer or student engagement on health workers (and more specifically on behaviour and systems change) is far more complex. A range of measures have been utilised including qualitative interviewing of volunteers and students, structured monthly reporting and bi-annual workshops. Wherever possible, we interviewed volunteers and students at least three times depending on their length of stay (with interviews prior to, during and post-return). Over 200 verbatim transcripts have been drawn over the course of the research from across all project sites; most have been conducted face to face in Uganda or the UK with some taking place via Skype. Where appropriate, email has also been used to discuss issues.

The research has also involved interviews and focus groups with over 100 Ugandan health workers, line managers and policy makers. Throughout the research, I have also spent many months in Ugandan health facilities and working with Uganda health workers in the UK. I have made regular visits (around four per year) ranging from 2 weeks to 5 months in duration. The SVP also deployed two social scientists as long-term volunteers to support the project evaluation process. This intense ethnographic work is recorded in project notes and diaries and is perhaps the most insightful of all of the methods deployed. As mentioned above, all of the qualitative material has been coded into a software package for qualitative analysis (NVIVO10) and subjected to inductive thematic analysis.

In addition to this, volunteers and students have been encouraged, where appropriate, to develop specific audits to support contextualisation and highly focused interventions. This has included audits on, for example, maternal deaths, triage and early warning scoring

systems, antibiotic use and C-section rates. These audits are small scale and necessarily inherit the same problems with the accuracy of data and of medical records as the wider study.

The three main projects undertaken over the course of the research were the Sustainable Volunteering Project (SVP) which ran from 2012-2015, Measuring the Outcomes of Volunteering on Education (MOVE) which ran from 2014-2016 and the Ethical Elective Placement project (EEP) which ran from 2015-2018. A brief description of the research methods utilised within each these projects is provided below.

The Sustainable Volunteering Project (SVP)

The SVP was initially funded for 3 years, beginning in April 2012, and aimed to leverage the knowledge and expertise of UK health professionals in order to achieve the following objectives:

1. Support evidence-based, holistic and sustainable health systems change through improved knowledge transfer, translation and impact.
2. Promote a more effective, sustainable and mutually beneficial approach to international professional volunteering (as the key vector of change)

These linked aims and objectives were formulated as a research question framing the wider intervention:

"To what extent, and under what circumstances, can mobile professional voluntarism promote the kinds of knowledge exchange and translation capable of improving the effectiveness of public health systems?"

The ultimate goal of 'improving health systems' was broken down at an early stage to define more specific medium term aims. These included, for example, improvements in the areas of patient safety (infection control, patient management systems etc.), reductions in caesarean section rates and attention to referral systems to reduce maternal delays. At a lower level, these medium-term aims were further broken down in to shorter-term aims and objectives and formed the basis of many individual professional volunteers' projects and subsequent follow-up grant applications.

The SVP evaluation included the following elements:

- On-going research and policy review (broader than systematic review)
- Facility benchmarking (aligned to local data management systems and linked to capacity-building)
- Professional Volunteers (n > 44):
    - Holistic data capture from initial enquiry through to post-placement interviews
    - Documents such as application forms and monthly reports (following set templates)
    - Interviews (qualitative, semi-structured, face-to-face/Skype)
    - Active ethnographic (participatory) research during workshops
    - Individual reports on training interventions
    - Tracking email communications
- Ugandan Actors/Health Workers (n > 35):
    - Interviews (qualitative, semi-structured, face-to-face)
    - Active ethnographic (participatory) research during workshops
    - Focus Groups
    - Tracking email communications.
- Collecting longitudinal data collection over a 3-year period (imported to an expansive Nvivo 10 database and coded thematically)
- Linked PhDs (x3) running simultaneously to examine specific research areas in greater detail
- Regular reporting to funding body and other stakeholders which contribute to further iterative and reflexive dialogue
- Proactive dissemination across disciplines and with non-academic audiences, for example presenting at international conferences and writing peer reviewed publications

Measuring the Outcomes of Volunteering for Education (MOVE)

The MOVE study was initially funded for 2 years, beginning in November 2014, and built on extensive previous action-research on professional voluntarism within the frame of the SVP. The aim of the project was to evaluate the outcomes of Professional Volunteers

completing placements in LMICs but focusing on the individual and the UK National Health Service (as opposed to the 'hosting' health system in the LMIC as researched during the SVP). The evaluation strategy included a range of methods complementing and balancing each other through a process of triangulation. The study adopted a multi-method approach designed to capture as accurately as possible the complexity of learning that takes place during international placements. The primary data sources are listed below:

- A review of available research and literature on professional volunteering
- A face-to-face electronic survey of staff in a selection of NHS facilities in the North West of England (n = 1000).
- Semi-structured interviews with key informants (key actors, policy-makers, NHS employers/line managers) and returned professional volunteers both within the frame of the SVP (n = 150) and drawing on the survey population (n = 51)
- Analysis of documentary evidence collated as part of the SVP including volunteers' monthly reports
- Ethnographic observation and fieldwork with professional volunteers deployed via the SVP to Uganda.
- Delphi Process incorporating a Systematic Review

The Ethical Elective Placement Project (EEP)

The EEP was initially funded for 2 years, beginning in April 2015, but also built on the research conducted during the SVP but with a specific focus on international student placements, as opposed to Professional Volunteering, in LMICs. The project involved the placement of over 120 Nursing, Midwifery and Allied Health Professional students in Uganda (n>101) and India (n=19). The EEP evaluation utilised a complex multi-method approach, combining qualitative and quantitative methods. All of the data was collected, coded and analysed using Nvivo10 software. A grounded approach was followed in generating a node framework, into which all qualitative data was imported and coded. The main sources of data collected during the EEP evaluation are summarised below:

- Weekly reports during placements (n > 150).
- Comprehensive end of placement reports (n > 80).
- Pre-, mid- and post-placement interviews (n > 80).

- Quantitative post-placement survey (n = 67).
- Interviews with UK HEI programme leaders, Professional Volunteers (Uganda only) and staff in hosting LMIC facilities (n > 30).
- Reports from staff in hosting LMIC facilities (n = 10).
- Observations by UK and LMIC project management, evaluation staff and post-doctoral researchers over the course of multiple site visits (n > 15).
- Transcribed focus groups, meetings and workshops with students, LMIC hosts, PVs and project management (n = 12).
- Email communications between project management and Professional Volunteers, students and hosting LMIC staff (n > 100).

A critique of the above-mentioned research methods is provided in chapter 4. The next chapter will examine the interrelationship between the publications and their combined contribution to knowledge.

Chapter 3: The Interrelationship between the Publications and their Combined Contribution to Knowledge

The first chapter of this thesis provided an overview and background to the research included in this portfolio. It also examined wider disciplinary perspectives and some gaps in the existing knowledge and literature. This chapter of the thesis will look at the interrelationship between the publications included within the portfolio, their combined contribution to knowledge and how this fills some of the gaps highlighted in chapter one. As the research areas covered by the publications are extremely broad, it is impossible to include all of the linkages between them. Therefore, three of the more key 'inductive themes' have been selected and analysed in greater detail:

1. Globalisation and the liquidity of human resource for health
2. The critical role of co-presence in effective knowledge exchange
3. The importance of professionalising voluntarism

Globalisation and the Liquidity of Human Resource for Health

The first interrelationship between the publications concerns the effect that globalisation and the increasing mobility of populations can have on the human resources requirements of health systems. There is growing consensus that health systems across the world are in crisis (Sánchez-Serrano, 2011); countless articles in the British media would argue that this is as true of the UK's NHS as it is of health systems in LMICs. A major factor contributing to these crises concerns what has become known as 'Human Resources for Health' (HRH). The impact of human mobilities on the ability to engage effectively and ethically in workforce planning lies at the heart of the problem and those health systems committed to providing high quality, universal coverage (equity and access) are particularly affected. Put simply, one might ask, 'How can a high quality universal healthcare system such as the NHS maintain its reputation and continue to meet ever-changing health care challenges in the face of unfettered global mobility?' And, if one of the world's best universal healthcare systems (the NHS) faces such challenges, 'how can universal healthcare, as envisaged under the Sustainable Development Goals (SDGs), become a reality for citizens in LMICs'?

Until recently, global health agendas have been informed by quite a narrow disciplinary base; with an emphasis on clinical and international development concepts and theories. In parallel with this, social science (and socio-legal studies) have developed more sophisticated analyses of contemporary mobilities. 'What is the Future?', published by John Urry in 2016, reflects on earlier optimistic, utopian even, perspectives on globalisation to posit an alternative prognosis of 'catastrophic futures' (p.32). This work is the culmination of extensive research which increasingly characterises mobilities as 'fluid' or 'liquid' and globalisation forces as contributing to the removal of boundaries; a 'borderless' world. In this environment, 'settlement migration' (conceptualised as a one-time permanent re-location and total loss or gain in 'embodied' knowledge) becomes only a small component of the mobility-knowledge mobilisation / service innovation story. Increasing recognition of the role of diaspora in scientific mobilities; 'the scientific diaspora' and in human mobilities in global health is an important case in point.

Mobility can be seen as both a potential threat and a solution (Ackers, H. L. & Gill, B., 2008). On one hand, it creates new spatial patterns of dependency and health needs as families are dislocated internationally and it creates ever-growing opportunities for health workers to market their valuable labour across the globe. Mobility can also disrupt traditional relationships balancing 'contributions and claims' or, in training terms, 'investments and returns'. These relationships underpin the fiscal mechanisms sustaining bounded universal welfare systems. It is therefore becoming increasingly challenging to predict health needs and plan health workforces accordingly **(Ackers et. al, 2017)**. The impact on 'sending' countries, especially LMICs and less developed regions of the EU, have been captured by the rather caricatured concept of international 'Brain Drain' with an emphasis on numbers (volume) and settlement (permanent) migrations (Ackers & Gill, 2008). In LMIC settings, the outcome has been a fixation with the volume of permanent emigrations (especially of doctors) and the impacts of this on patient-health worker ratios. Little, if any, attention has been paid to human resource productivity; how existing human resource is deployed and the relationships between that and emigration 'risk'. In such settings, internal (within-country) 'brain drain' or 'brain stagnations' may significantly outweigh losses via emigration. These issues are rarely raised in political and policy agenda but have been experienced regularly throughout the research; the causes,

implications and potential solutions have been reflected upon within the portfolio of publications, particularly **Ackers, Ioannou & Ackers-Johnson (2016)** and **Ackers & Ackers-Johnson (2017)**.

On the other hand, workforce managers in the NHS recognise the contribution that certain forms of human mobility can make. Exposure to international placements in LMICs (and HICs) has been shown to play an important role in up-skilling the NHS workforce through both student and professional mobilities **(Ahmed, Ackers-Johnson & Ackers, 2017)**. Increasingly, such mobilities are recognised as playing an important role in recruitment and retention strategies. The ability to attract foreign staff to the NHS also plays a critical role in filling vacancies and enriching / diversifying the NHS workforce. More recently, and reflecting the commitment in UK aid policy to reciprocity or 'Mutual Interest', the potential for 'frugal' or 'reverse innovation' has emerged **(Ackers et. al, 2017)** suggesting substantive potential innovation returns to 'sending' countries. The 'reverse innovation' agenda (Bhatti et. al., 2017) marks a paradigmatic shift from traditional, uni-directional, 'donor-recipient' Aid interventions, placing more focus on multi-lateral knowledge mobilisation processes. This generates an important need for a broader evidence-base to underpin global health strategy; one that is less focused on clinical medicine and traditional international development theory **(Ackers & Ackers-Johnson, 2017)**.

At the same time, concerns about Aid efficacy and the success of the Tropical Health and Education Trust's (THET's) Health Partnership Scheme have evidenced the role that human mobilities (professional voluntarism) can play in knowledge mobilisation and human resource capacity-building in LMICs. Mobility, in this context, becomes an important vector for health systems change. It is a prime example of what are often conceptualised as 'cross-border spill-overs' that inextricably connect global health systems **(Ackers & Ackers-Johnson, 2017)**. The health workforce is not only made up of service delivery cadres. Organisations such as Health Education England embrace a wider variety of functions including service delivery but also education and training and research. These diverse functions are associated with different forms of knowledge and different forms of mobility. Whilst service delivery to a large extent relies on longer term physical 'co-presence'; education and training and research may be achieved and maybe improved

through a combination of corporeal co-presence (perhaps involving short term, bi-lateral 'shuttle' visits) and forms of virtual mobilities **(Ackers et. al, 2017)**.

Finally, the mobilities to be considered during workforce planning are not only those of health workers. Citizens themselves are becoming increasingly mobile, not only as tourists, retirees or workers but also as patients in order to access global health resources. The demographic profile of recent mobility flows in to the UK have created specific and often quite localised challenges for the NHS whilst at the same time making a major contribution to the social care workforce. Of perhaps greater impact, the consequences of mobilities on the distortion of informal care networks as families are spread across international space will have an increasing impact on universal health and social care systems with the exponential rise in long-term conditions and effects of ageing **(Ackers et. al, 2017)**. This area of research is being further pursued within the 'Knowledge, Health and Place' research group at the University of Salford.

The Critical Role of Co-presence

The second interrelationship between the publications is a recognition of the importance of strong positive interpersonal relationships and the vital role that 'co-presence' plays in shaping these relationships to lead to ethical and sustainable health systems strengthening and international development projects. The link between co-presence and relationships has been noted previously by authors such as Hudson & Inkson (2006) and Williams (2006). Put simply, in the context of this body of works, co-presence means working together to share knowledge and ideas. It acknowledges that skills transfer is not a one-way process and that different types of knowledge and skills can move between different health workers in different ways. In practical terms, it means that HIC professionals/students should always be working alongside LMIC professionals/students in an environment that promotes skills transfer. **(Ackers et. al, 2017)** concludes that professional volunteers should not be seen as replacements for local staff or fill-in for them in their absence: they are not 'locums'. Co-presence does not imply that professional volunteers do not engage in clinical work, however they should ensure that when they do they will be appropriately mentored and/or mentoring (according to their needs).

Co-presence and Relationships

Ackers, Lewis & Ackers-Johnson (2014) note that assumptions about the role of professional volunteers and the nature of mutual obligations often leave volunteers working in isolation which can lead to increased risk and undermines the building of relationships conducive to knowledge transfer and shared learning. **Ackers & Ackers-Johnson (2017)** explains how professional volunteers may take on the role of substitute labour or 'service providers' which can bring benefits to the patients they immediately 'serve' but can also cause damage to the health system in the longer term. Both of these findings are echoed by other scholars including Bauer (2017), Bezruchka (2000) and Guttentag (2009). Hudson and Inkson (2006, p.312) cite a respondent in their study who experienced this situation: *'A bad day is filled with frustrations and lack of understanding... all staff will have mysteriously disappeared'*. Unfortunately, similar experiences were all too common during the research conducted within this portfolio of publications, some far worse involving cynical manipulation and deception of volunteers **(Ackers & Ackers-Johnson, 2017)**. In relation to student placements, the potential consequences of such situations were found to be more severe due to their relatively low levels of skills and experience **(Ahmed, Ackers-Johnson & Ackers, 2017)**. Radstone (2005, p.109) highlights how (medical) students often find themselves under pressure to exceed their role whilst on an international elective placement.

Co-presence generates the potential for relationships but ultimately it is the quality of the relationships that matters (Williams, 2006, p. 592). An understanding of 'positionalities' in the widest possible sense improves our understanding of why professional voluntarism is largely failing to generate sustainable systems change. The concept of 'positionality' has the potential to expose key dimensions of the knowledge transfer-impact dynamic. Put simply, the concept of positionality recognises the fact that individuals (be they doctors, midwives or cleaners, volunteers or employees) are social actors working in and responding to a very particular environment. Factors such as their age, specialism, seniority, nationality, ethnicity, wealth, mobility capital, organisational context etc. will all shape in quite powerful ways the way they experience and interact with other individuals.

Williams (2006, p.598) identifies the relevance of factors mediating the potential for 'intercultural communication' suggesting that: 'Stereotyping – over-generalised expectations and beliefs about the attributes of group membership – increases the likelihood that the voices of strangers will not be heard within an organisation'. Williams identifies a range of referents shaping positionality including gender, nationality, ethnicity, migration status, professional affiliation and more complex 'orientations' such as cosmopolitanism and positioning along a 'stranger-friend' continuum. Failure to counter stereotypes and 'foster empathy, trust and openness in identities' will, as Williams postulates, 'debase the organisation's potential for knowledge creation and transfer'. This becomes more of an issue when we move away from a narrow concern with technical skills to challenge the 'legitimacy of practices within organisations'. As Williams (p.599) indicates, migrants have great potential in this area but the translation of the more tacit forms of systemic and strategic knowledge 'are far more identity sensitive'.

The portfolio of publications presented in this thesis stress the importance of these categories. The following, non-exhaustive, list begins to map the dynamics of 'positionality' that have emerged in the course of the research as key dynamics shaping the quality of relationships in Health Partnerships and their resulting effectiveness. These include: gender, professional discipline (specialism), employment/volunteer status, seniority, age, ethnicity, nationality, religion, 'culture' and corruption.

Co-presence and Knowledge Transfer

Ackers & Ackers-Johnson (2017) describe Health Partnerships (HPs) as 'knowledge networks with various forms of physical and virtual mobility playing a critical role in network-generation, evolution and impact' emphasising the role that co-presence plays in building effective knowledge transfer relationships. Relationships lie at the heart of knowledge transfer; this is evident at a more theoretical level as the research on highly skilled mobility has been increasingly influenced by network theory. Knowledge does not travel or 'engage' in a vacuum. Meyer's metaphor of 'sticky branches' (2003) captures the process perfectly.

Williams (2006) distinguishes various types of knowledge suggesting that some forms (such as more technical skills) require less co-presence (or face-to-face interaction) and

may indeed be transferred via text or virtual means. He contrasts this with 'embodied' knowledge where learning takes place through doing, is highly context-bound and requires greater co-presence and stronger relationships. Meusburger (2009, p.30) similarly identifies a 'missing distinction' in debates around the spatial mobility of knowledge, between knowledge and 'routine information' suggesting that, 'Codified routine knowledge that can be stored in databases has to be distinguished from intuition, foresight and competence based on years of experience and learning'. Jöns (2007) also argues that different forms of (scientific) knowledge display different levels of 'convertibility' depending on the degree of 'spatial embeddedness'. Breinbauer (2009) explains the empirical focus on mathematicians in his work on scientific mobility on the grounds that, 'Mathematics conveys qualifications largely independent from cultural contexts and apparatus [and] qualifications can be transferred comparatively easily worldwide (via 'paper and pencil')'. This type of knowledge can be contrasted with the kinds of knowledge involved in more anthropological or policy oriented research where knowledge is far more embedded in 'place' (Ackers, 2013).

As active participants in the HP community, **Ackers & Ackers-Johnson (2017)** were very aware of the emphasis placed on the transfer of explicit knowledge, skills or 'capabilities' (Michie et al, 2011). In many cases, HP outcomes are framed in terms of the number of clinicians trained in a particular 'skill' such as infant resuscitation. Assessing the implementation of that skill and the extent to which recipients will understand, accept and apply that knowledge is much more difficult. A simple example can be seen in the emphasis on improving patient monitoring (triage) in most HPs. It is one thing to train clinicians to use a thermometer or pulse oximeter (a clinical skill) and complete a Maternal Early Warning Score (MEWS) template but quite another to embed it in clinical practice through behaviour change. Although triage has been identified as a target for intervention by UK and Ugandan colleagues, considerable investment in training has failed to embed in practice **(Ackers & Ackers-Johnson, 2017; Ackers, Ioannou, & Ackers-Johnson, 2016**; Lewis and Muyingo, 2012; Van de Velde et al (eds.) 2013). Similarly, **Ackers, Ackers-Johnson, Ahmed & Tate (2019, p.10)** found that exposing students to different cultures whilst completing an international placement does not necessarily lead to increased levels of cultural awareness as many would claim. On the contrary, a very high level of co-

presence is required, in the form of a 'more knowledgeable other', to avoid the tendency for essentialising or stereotyping. To put it simply, a student might assume they are gaining knowledge and skills in cultural awareness but, without the input from the more knowledgeable other, they could potentially be generating 'flawed' knowledge **(Ahmed, Ackers-Johnson & Ackers, 2017)**.

Whilst it is useful to identify explicit and tacit knowledge as opposite poles along a continuum, in practice the categories are fluid (Meusberger, 2009, p.31). And the distinction begins to lose its significance when it comes to the application of knowledge. The capacity-building and systems change objectives of HPs demand highly complex forms of knowledge transfer combining technical skills with mechanisms for their translation into socially relevant outcomes. In that sense, even very standardised forms of knowledge (clinical skills) need to be complemented with highly contextualised knowledge to support effective implementation **(Ackers & Ackers-Johnson, 2017)**. Highly contextualised knowledge may include experience as a practitioner within a particular, for example low-resource, context where different techniques may be required to perform a treatment. For example, an anaesthetist may choose to use a different method of sedation as a result of knowing there is no resuscitation equipment within the hospital. As Williams (2006, p.592) notes, while it is important to distinguish different types of knowledge, 'one of the keys to their valorisation is how they are combined'.

Williams and Balatz's (2008) paper on knowledge transfer in the case of returning Slovakian doctors opens with the assertion that, whilst healthworker migration is an 'inescapable feature of the health sector ... there has been relatively little research on mobility as a conduit for learning and knowledge transfer' (p.1924). The paper identifies a range of knowledge acquired by doctors including technical skills, academic knowledge, cultural knowledge, management know-how and administrative skills' (p.1925). They suggest that whilst some knowledge may be transferred electronically perhaps through reading and published protocols, other forms of 'embodied knowledge' are 'rooted in specific contexts, physical presence and sensory information and may include participation in clinical practice'. And these forms of knowledge are 'grounded in relationships between individuals' and in socialisation processes.

Coming from a rather different disciplinary perspective (health psychology) the 'COM-B framework' (Cane et al, 2012; Michie et al, 2011) is based on a theoretical proposition that behavioural change necessitates a combination of capabilities, opportunities and motivations. The acquisition of 'capabilities' is a necessary but not sufficient condition of behaviour change. Along with the example of neonatal resuscitation mentioned previously, this view is reflected powerfully by **Ackers, Ioannou & Ackers-Johnson (2016)** who argue that the main cause of maternal mortality in Uganda is not a lack of skills (capabilities), which is assumed by many HIC clinicians that volunteer in the country, but rather a fault of human resource management systems and low staff motivation which lead to high levels of absenteeism (and therefore the inability to put the capabilities in to practice). Similarly, **Ackers et. al (2017)** found that professional UK volunteers, particularly more junior staff, were often unable to implement new skills in areas such as management learnt whilst abroad once they return to work in the NHS due to the hierarchical organisational culture and a broad culture of resistance to change, meaning the volunteers did not have the opportunity. High levels of resistance to change have existed more generally across multiple areas and functions of the NHS for many years (Plamping, 1998) (Lumbers, 2018), suggesting that this problem is not specific to international volunteering placements but more widespread and deep rooted.

Co-presence and Risk

Co-presence is not only a requirement for learning and knowledge transfer as discussed above, but is also extremely important in relation to risk mitigation. In practice, various assumptions about the role and motivations of professional volunteers and the nature of mutual obligations often leave UK professional volunteers working in isolation **(Ackers & Ackers-Johnson, 2017)**. In this context, both students and professional volunteers may take on the role of substitute labour or 'service providers' **(Ackers, Lewis & Ackers-Johnson, 2014)**. This will typically bring benefits to the patients they 'serve' but contributes very little to sustainable systems change and may, indeed, reduce the impetus for change by propping up broken systems **(Ackers & Ackers-Johnson, 2017)**. The consequence of this risk is a reduction in the effectiveness of aid and results in lower impacts, a lack of sustainability and generally poorer long-term cost-efficiency for organisations and taxpayers.

Of perhaps greater risk is the increased personal risk faced by students and volunteers as a result of ineffective co-presence **(Ackers & Ackers-Johnson, 2017)**. The issue of personal risk gained focus within the research following the completion of a comprehensive risk assessment process (conducted at the beginning of the Sustainable Volunteering Project in July 2012). This highlighted 'lone working' as a very serious risk to volunteers and formed the basis of **Ackers, Lewis & Ackers-Johnson's (2014)** article which researched certain aspects, such as the emotional and legal consequences of accusations of medical malpractice, in greater depth. For example, during the research, one volunteer experienced this situation when left to provide anaesthetic care for a patient on her own. The patient fell off their bed and later died which lead to a series of traumatic accusations against the volunteer which were difficult to disprove. **Ahmed, Ackers-Johnson & Ackers (2017)** highlight other occasions where students have been observed working alone and carrying out clinical procedures well above their level of training and competency. As above, this not only puts them at risk of emotional and legal consequences but also puts patients' lives at risk should any mistakes be made.

Professionalising Voluntarism

The third key interrelationship between the publications is the requirement to professionalise and streamline voluntarism. The volunteers and students deployed in Uganda and the many Ugandans who have spent time in the UK throughout the research are first and foremost highly skilled migrants or, if the language of migration is off-putting for some, people exercising forms of professional mobility. The label 'volunteer' (defined simply by the absence of a formal employment relationship or remuneration) does little to capture the motivations of the diverse groups of people involved and has an unfortunate tendency to characterise them, within the donor–recipient model, as 'helpers' or occasionally 'missionaries' **(Ackers et. al, 2017)**. Over time, the drivers for voluntarism have evolved and the activities and stakeholders have changed. The individuals and groups now involved in international volunteering or mobility are by no means homogenous, either in terms of personal characteristics or motivations (Bussell & Forbes 2002; Lewis 2006; Strachan 2009). The nature of their deployment, their roles in the receiving country and the objectives and quality of the placement organisation all vary enormously. Collectively, these forms of mobility are historically associated with

voluntarism largely because the periods of time spent in the low-resource setting are not remunerated by the hosting organisation. However this does not mean that the individuals involved receive no financial support. The (quite contentious) concept of 'compensation' has been utilised to distinguish contributions to accommodation, subsistence, travel and so on, from remuneration (as pay). In many respects, this tells us little about the motivations or roles of those involved and more about attempts to negotiate legal parameters on the part of deploying organisations **(Ackers & Ackers-Johnson, 2017)**. The main point to consider is what added value such volunteers and students bring to the host society and its public health or education systems. A recent boom in the 'voluntourism' industry has driven the need to better understand what voluntarism is, what the impacts are both in the 'sending' and 'hosting' countries and how any positive impacts can be maximised and any negative impacts be minimised.

Within this thesis and the portfolio of publications, the term 'professional volunteer' has been coined to overcome some of the concerns about the (value-laden) concept of volunteer and emphasise the fact that, first and foremost, the people referred to are highly skilled (mobile) professionals. Professional volunteers are fully qualified individuals with the required skills, level of education and/or experience to be able to practise professionally, in for example the UK NHS or education system, and volunteering in the same/similar field. It is important to note that professional volunteers (and students) may not be from health backgrounds; they could be qualified teachers, construction workers, managers or from other backgrounds. Characterising them as professionals and students who are engaging in Uganda with fellow professionals and students (many of whom are also involved in various forms of international mobility) helps to situate the project within the frame of both international knowledge mobilisation and human resource management. This is the frame within which international teams have been engaged with previously, as research collaborators rather than donors. The words 'professional' and 'student' also hint at motivational dynamics and the fact that, for the majority of volunteers and students, motivation is a complex concept combining altruistic, touristic and career progression components (amongst others). The students referred to are those currently studying professional qualifications and whose volunteering activities are aligned with their curricula. Other people who do not engage in the ways discussed above and do

not possess the required skills or competencies to perform their assigned role whilst volunteering are far more likely to fall under the category of 'voluntourism' (**Ahmed, Ackers-Johnson & Ackers, 2017)**. This would include people who travel internationally and participate in teaching or building projects without being qualified, for example during a holiday or gap year, and would typically result in the person gaining far more from their experience than they are able to contribute and are therefore more likely to be unethical **(Ackers & Ackers-Johnson, 2017)**.

Professional voluntarism is an umbrella term not only relating to an individual's characteristics but also to the organisational context within which they are volunteering. Voluntarism is only professional if the processes and outcomes are sustainable and ethical **(Ackers & Ackers-Johnson, 2017)**. This would usually require them to be conducted through a respectable intermediary organisation, such as a Health Partnership or charity, which has an ethical ethos and is able to mitigate risks, coordinate activities and monitor individual and organisational impacts over time.

One of the main drivers to professionalise voluntarism is cited by **Ackers & Ackers-Johnson (2017)** and **Ahmed, Ackers-Johnson & Ackers (2017)** and relates to the perception of volunteers by local staff in the 'hosting' country and stakeholders in the 'sending' country. Examples of volunteers and students turning up for placements late, disappearing without providing reasons, being too focused on taking photos for their social media and not engaging effectively with local staff often led to a breakdown of relationships and resulted in ineffective partnership working with local colleagues. Students and volunteers that behave in this way also create a negative perception of voluntarism in 'sending' countries as the placements become viewed more as holidays than learning experiences **(Ackers et. al, 2017)**. Similarly, **Ackers, Ackers-Johnson, Ahmed & Tate (2019)** found that students often perceive themselves to possess superior clinical knowledge to local staff which inevitably causes disputes and disrupts relationships and learning. It goes on to promote the critical need for detailed pre-placement induction programmes and post-placement debriefing.

As discussed previously, there is a common assumption that international experience is beneficial for learning and career progression. However, this is certainly not the case in all

circumstances and there is currently little way of recognising or accrediting good international placement experiences. Professionalising voluntarism on a larger scale provides greater standardisation of experiences and resultant learning outcomes and enables educational institutions and employers to better appreciate their relative value **(Ahmed, Ackers-Johnson & Ackers, 2017)**. It also promotes the value of professional voluntarism to LMIC stakeholders which can improve their levels of buy-in, engagement and support **(Ackers & Ackers-Johnson, 2017)**.

Professionalising voluntarism can also lead to increased and better sustained impacts. **Ackers & Ackers-Johnson (2017)** found that the relative short-term nature of international placements meant that many new initiatives often failed once the volunteer returned to their HIC. However initiatives started within the frame of an organisation which has access to any funding and networks required combined previous knowledge and experience with a longer-term strategic plan and feedback mechanisms were much more likely to be successful and for their impact to be sustained in the longer-term. Such organisations were also more likely to have access to any funding and networks required to support promising initiatives.

Finally, as touched on previously in this thesis, professionalising voluntarism reduces the risks involved in volunteering both for the volunteers themselves and the patients they encounter during their placements. Organisations with experience of working in a particular area can advise regarding travel, health and safety issues **(Ackers, Lewis, & Ackers-Johnson, 2014)**. They should be aware of the legal requirements involved, relating to issues such as visas/work permits, clinical registrations and insurance which can protect volunteers whilst on placement **(Ackers & Ackers-Johnson, 2017)**. They can also play a role in supporting student and volunteer wellbeing in terms of providing pastoral care and advice on social activities **(Ahmed, Ackers-Johnson & Ackers, 2017)**.

Chapter 4: A Critique of the Presented Publications

This portfolio of published works serves to bridge the gap in research and knowledge highlighted in chapter 1. It is based on 10+ years of intense action research experience in the fields of global health, professional volunteering and international development, formally through the Liverpool-Mulago Health Partnership and more recently through Knowledge for Change (a Health Partnership registered with the Charity Commission in England and Wales) and the University of Salford. A table detailing all of the projects undertaken throughout the research has been included in Appendix 1. It is important to point out that the ultimate goals of all of the projects have been to promote the standard of healthcare received by patients in both LMICs and the UK NHS in a sustainable way through capacity-building and the mutually beneficial exchange of knowledge; the primary end goal is positive, effective impact in terms of health systems change. A secondary goal was to extend global health learning opportunities to hitherto neglected groups of students, for example those with lower levels of mobility capital **(Ahmed, Ackers-Johnson & Ackers, 2017)**.

This chapter of the thesis forms a critique of the portfolio of publications, looking initially at the more general criticisms of generating evidence-based policy in global health and the context within which the research was carried out. It then reflects upon the action research approach followed, the importance of ethics and understanding context and the implications that these factors had on the design and implementation of the projects. Finally, the chapter moves on to critique the methodological, epistemological and ontological approaches followed within the three main projects undertaken during the research:

1. Sustainable Volunteering Project (SVP)
2. Measuring the Outcomes of Volunteering on Education (MOVE)
3. Ethical Elective Placement project (EEP)

These three projects, amongst a number of others, formed the comprehensive dataset upon which the portfolio of publications is based. Each publication drew upon data from multiple projects spanning over 8 years of experience in the field.

Evidence Based Policy in Global Health

As outlined in chapter 1 of this thesis, one of the main criticisms of aid is the lack of reliable, credible and accurate literature on what works and what does not in terms of positive, sustainable and cost-effective international development projects. Short-termism and conflicts of interest are inevitable and commonplace in the sector with individuals, organisations and government bodies all under pressure to demonstrate immediate positive and cost-effective impacts in order to justify past and future donations or the use of taxpayers' money. These pressures have been felt whilst conducting the research projects included within this portfolio of publications, the largest of which were indeed funded by taxpayers through the UK Department for International Development and Health Education England. This chapter of the thesis will examine how these pressures manifested throughout the research and critique any impact they may have had on any findings and the resulting publications.

The Reliability of Metrics

Ackers & Ackers-Johnson (2017) criticises the 'fetishism with metrics' (quantifiable indicators) which is common within the international development sector. There are a number of reasons why organisations use metrics and there is a common perception that they create an impression of objectivity (Cochrane & Thornton, 2016, p. 58). Organisations such as DFID may use metrics as they can be more simply relayed and 'understood' by the general public; the main contention here lies in the inference of 'understanding'. Metrics can also provide simplified comparability when conducting benchmarking activities (Cochrane & Thornton, 2016, p. 62); pre- and post- training session testing for example or the movement of mortality figures over time within a particular health facility. There's no arguing that there is a time and place for the use of metrics, however **Ackers & Ackers-Johnson (2017)** argues that many metrics are based on the belief that there are 'facts', divorced from social context, that can 'speak for themselves'. This may be true with randomised controlled trials involving inanimate 'objects' but is more unreliable when looking at, for example, social interactions between individuals from different backgrounds and working in differing and unpredictable environments. Put simply, just because one training session in one facility leads to an improved level of knowledge does not necessarily mean it will have the same effect in another facility, and says even less

about whether this knowledge would be implemented by the staff and lead to a sustainable improved outcome.

Ackers & Ackers-Johnson (2017) refer to an 'empiricist myth' and warn of the risks of measuring the measurable rather than the meaningful. Of greater concern is the question of whether 'the tail is wagging the dog' in regards to the initial design of projects; are only the activities whose impacts can be easily quantified being prioritised over others that might yield greater impact but are more difficult to measure? This would not only lead to inefficiencies but also carries ethical ramifications for both the 'donor' and 'recipient' countries.

The dangers of empiricism are compounded by the assumption that metrics are created from accurate and reliable data in the first instance (Cochrane & Thornton, 2016, p. 68). Over the course of the research, some of the main challenges faced were due to the poor quality of record systems in LMICs, a lack of appreciation of the importance of data collection and a resulting lack of training and skills for staff working in these areas, political pressures to massage data to make it appear more positive or negative and falsification of medical records (which only became apparent due to the high level of in-depth engagement and ethnographic research over time). Figure 2 shows an example of a typical patient records book in a Ugandan Health facility:

Figure 2 - a typical patient record book in a Ugandan health facility

The research included within the portfolio of publications has long grappled with the issues of poor-quality data and a pressure from funding bodies to collect data in the form of quantifiable metrics. Indeed, the publications do include some metrics of this type, based on potentially unreliable data, although care has been taken to ensure all findings

are critically analysed and are backed by the authors' expansive ethnographic experience. Conversely, there is a risk that some metrics that have been excluded from the publications may have been more relevant, useful or more easily interpreted by certain groups of stakeholders accessing them.

Evaluation versus Research

The difference between what constitutes evaluation and what constitutes research has been the centre of on-going debates since the beginning of the research. This is partly due to differing understanding of the meanings of each of the terms which can occasionally be confused or blurred. Within this portfolio of publications, the distinction between the two activities and how they compare can best be illustrated by means of an evidence-base 'continuum' as depicted in figure 3, (below):

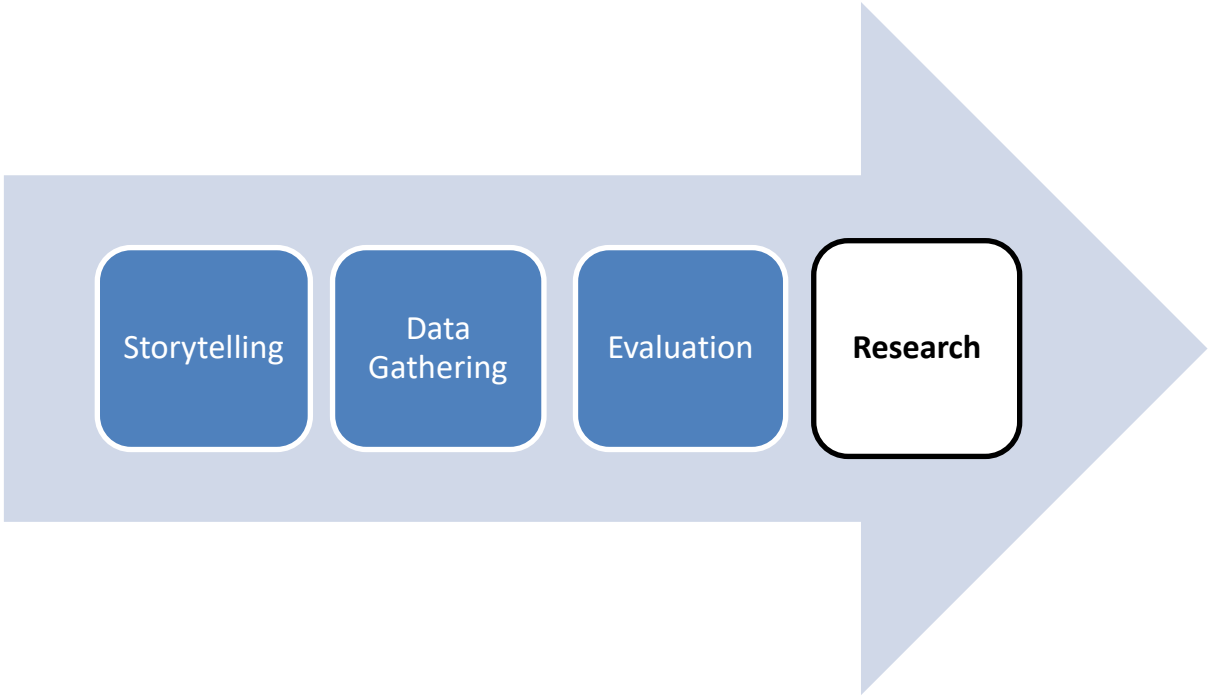

Figure 3 - The Evidence-Base 'Continuum'

The first stage of the continuum 'storytelling' is commonplace within international development and aid, and particularly so within voluntarism. This is largely due to the short-term nature of many volunteering placements and the desire for individuals to self-account for their actions and resultant impacts over this short, finite timeframe regardless

of whether their placement is two weeks or two years in duration. Authors such as Lewis (2011, p.505) highlight the advantages of storytelling as a form of research, such as its ability to add identity and self to a narrative. These self-assessments are often subject to report bias for a number of reasons, ranging from the volunteer not understanding what a proper measurement is to them wanting to 'look good' to others (Rosenman, et al., 2011, p. 321). Additionally, given the time, effort and often financial investment into such activities, it is natural for a volunteer to seek (and report) a positive level of achievement (Lough, 2010, p. 454). Despite perhaps being desirable and/or interesting for the individual and their close peers, such stories are often at best anecdotal due to the high level of subjectivity and narrow contextual relevance. They are predominantly descriptive and left to 'speak for themselves' in a random and decontextualized manner rather than being subjected to rigorous analysis.

The second stage of the continuum involves strategically collecting and gathering these stories together to form a body of data or experiences which share some level of contextual similarity, for example a series of volunteers' end of placement reports that are involved in the same placement programme. Gathering these stories together does reduce contextual variance, although this alone is not enough to make them useful for a wider audience.

The third stage 'evaluation' or 'analysis' is the first stage at which a rigorous level of evaluation is involved. Through more systematic collection and thematic analysis of such qualitative data and by obtaining a robust data sample, the level of subjectivity is reduced and contextual variance can be controlled (Braun & Clarke, 2006, p. 78). This enables a level of meaningful analysis and the ability to find recurring themes. Many international development projects stop at this point and do not proceed to the final stage of the continuum; research. There are a number of reasons for this; firstly, as discussed previously, the issue of short-termism means that many individual volunteer's engagements, or indeed entire projects, have ended by this point and funding bodies assert pressure to find out the results of their investment. Even the largest of entities, such as DFID, are bound by 5-year political cycles so the maximum length of projects tends to be just 3 years which in many cases is too short in terms of measuring longitudinal change. Short-termism also has ethical implications in relation to empiricist 'data

grabbing' and contributes little to knowledge of the processes of sustainability; most traditional evaluation methods are based on simplistic attempts to measure outcomes quantitatively using metrics such as 'the number of people attending a training session' rather than high-quality qualitative analysis (Cochrane & Thornton, 2016, p. 64).

Secondly, evaluation in these contexts can often comprise a proliferation of disparate, poorly designed audits conducted using only basic qualitative and quantitative skills (Cochrane & Thornton, 2016, p. 67). Research, however, requires higher level skills in areas such as data interpretation, causation, attribution and publication. As the majority of evaluation activities are not carried out by academics, these areas which have the greater potential to contribute to knowledge and longer-term sustainability can be missed. The projects conducted and the resulting publications included within this portfolio are perhaps somewhat distinct in this respect to the extent that the authors and research teams are experienced researchers occupying established academic posts, embedded within an active research team, and as such not personally reliant upon the demonstration of project 'success'. Whilst this distance supported a degree of independence and objectivity, the fact that the authors were simultaneously designing, implementing and evaluating the intervention distinguishes the project from classical research. They were not seeking to 'measure' controlled static phenomenon and reduce 'contamination' to a minimum (MRC, 2008), but rather to institute change processes and capture their impacts longitudinally.

There are other requirements aside from time and skills that differentiate evaluation and research. Conflicts of interest can influence even the most experienced researcher's ability to remain independent (Romain, 2015, p. 123). By way of an example, Romain argues that projects or organisations which deliver unfavourable or underwhelming results are naturally less likely to receive continuation or future funding. One might argue that decision would be justified and represent an ethical outcome, however if a researcher receives their salary from this funding then presenting such results could jeopardise their employment which can lead to a conscious or subconscious dilemmas. Similar dilemmas do not only affect the researcher but also the quality of their data (Romain, 2015, p. 124). Examples within the body of research may include students overstating their learning on placement in order to justify their financial investment or to promote themselves on their

CV. Conflicts of interest can also act as a strait-jacket, reducing the independence of research by controlling for example the topic, who is involved, the type of data collected or how this is presented. In order to be research, projects must be iterative and reflexive (Gilbert, 1976, p. 283). They must also be conducted in line with appropriate research governance and ethical procedures and be able to be contextualised in systematic research reviews and theorised in order to be embedded in to knowledge (P.294).

Impact on the Publications

The portfolio of publications presented in this thesis has inevitably been affected by the above dilemmas of short-termism, conflict of interest and research independence. The portfolio of publications builds on over 10 years' worth of intense experience of working in these areas. One way to view them would be as an emerging longitudinal ethnography with shifting priorities in response to funded projects and real-world experience; such research is very rare yet essential in this context. However, many would argue that this timeframe is still too short to be able to understand such complex scenarios. This, compounded by the fact that the research area itself is constantly evolving in line with various political, economic, social, technological, legal and environmental factors, must be born in to consideration when interpreting the findings.

The extent to which the research has been conducted independently and whether conflicts of interest existed can also be questioned. It is certainly impossible to argue that the research was truly grounded as, similar to much research conducted by academic institutions, the research topics were largely dictated by where sources of funding were available. The largest source of funding for the research projects was the Tropical Health Education Trust (THET), an arm of DFID which has a strong focus on the promotion of Health Partnerships. Interestingly, THET's objectives are not research focused but rather the implementation of health projects and the monitoring and evaluation of their impact. Their main stakeholders are DFID and the British taxpayers which has immediate implications on both the type and duration of projects they are willing to support and the forms of data (evaluation) they require. The research has indeed evolved in response to these factors, however despite some obvious differences between the branches of project activity (e.g. cervical cancer screening, family planning, antimicrobial resistance,

biomedical engineering, student learning outcomes), the core research focus on health systems change has remained consistent throughout and the same 'golden threads' mentioned in chapter 2 are clearly noticeable across all project activities.

As a result of the above, some academics may argue that the publications presented in this portfolio are not actually 'true' research, instead lying somewhere along the continuum as a form of 'evaluation research'. Conversely, the author would argue that this form of action research does constitute true research given the context of understanding of change processes. The significance of action research is considered in more detail in the following chapter. Regardless of this classification, the activities and resulting publications were found to play a critical 'boundary spanning' role mediating true academic research and policy making; not only providing any feedback required by the funding body but also providing the depth, rigour and robustness required to reliably inform policy. In this way, researchers can act as effective 'knowledge brokers', translating research into more accessible forms of knowledge that has the ability to support high impact.

Action Research & the Critical Importance of Context

All of the individual projects included within this portfolio of publications can be described as action-research. It is necessarily iterative and there was no desire to achieve a specific sample size or end point but continue to spend time in Uganda interviewing and observing work in public health facilities and facilitating active workshops to encourage discussion around key issues. Indeed, it is through this iterative process that challenges have been identified that are central to understanding both resistances to change in Ugandan health systems and the efficacy of professional voluntarism and student mobility.

McCormack (2015, p.310) concludes his chapter on action-research with the reflection that 'context is a constant tussle between conflicting priorities where everyday practice is challenging, often stressful, sometimes chaotic and largely unpredictable'. Understanding context is a labour-intensive longitudinal process that unfolds to inform and respond to interventions over time. For the action-researcher, there is no convenient chronological start and end point. Somekh (2006, p.7) echoes this sentiment, suggesting that action-research is cyclical and evolves until the point at which, 'a decision is taken to intervene in

this process in order to publish its outcomes to date' and 'it is unlikely to stop when the research is written up'. Tekin & Kotaman (2013, p.86) argue that 'theoretically, there is no end for action research because social issues are dynamic and in that dynamic structure problems arise all the time. Therefore, the intervention that is applied may solve some problems, but new ones will appear, and new interventions will be needed'. This phenomenon was experienced on several occasions throughout the research process; for example, one particular intervention at Kasangati Health Centre (Kampala) resolved a human resource issue but in doing so uncovered a new issue relating to the procurement of consumables. Often, what at first appeared to be one simple problem turned out to be a chain of separate complex problems, each requiring its own research in order to find a solution. Only once solutions to all problems in the chain were found could the original problem be solved.

Lewin (1946) highlighted the important role that social scientists can play in using their expertise and skills in problem solving to bring about social change, pushing the view that research should be conducted 'with' people (and for the benefit of people) rather than being conducted 'on' people. 'The subject of research should not be scientists' individual curiosities but problems that practitioners encounter when applying curricula. Thus, science can contribute to the betterment of society' (Tekin & Kotaman, 2013, p. 86). This principle is particularly important in the context of international development as it links strongly to ethical concerns regarding the beneficiaries of any aid and research projects. Following an action research approach throughout the research process has enabled dynamism and flexibility, ensuring that the maximum benefit is received by the people (and systems) involved whilst retaining academic transparency and rigour. It would be unethical (and entirely pointless) to continue a failing project until the end of its planned lifespan if small but attributable changes can be made that improve its outcomes. In this way, the projects and publications have been able to make a "simultaneous contribution to social science and social change" which is one of the leading principles of action research (Carr & Kremmis, 1986, p.164).

I would argue that I am necessarily both a practitioner and an academic researcher. I not only research static phenomena from an objective distance but also implement interventions subjectively, based on the research, in order to achieve improved outcomes.

Tekin & Kotaman (2013) discuss how academic research and practice are not isolated poles and that having experience as a practitioner can be beneficial for research as it can provide a significant and better-informed knowledge base. An example of this would be having experience of the translation of research findings into real world interventions and some of the issues that can occur such as costs, logistics and other indirect barriers. An interesting example of this, as experienced over the course of the research, involved the issue of corruption in hospital facilities in Uganda. Simple interventions aimed at improving patient triage systems would often fail for no apparent reason. It would often conspire that the reason was due to corruption, however this knowledge is not easily accessible to most researchers as local staff would rarely discuss it in, for example, an interview in order to protect themselves or colleagues or to avoid embarrassment. Gaining experience of corruption in the workplace and how it manifests itself as a practitioner helps to understand and predict the effect that it might have on an intervention.

A further advantage of following an action research approach relates to the complexity of the change processes being researched. The MRC (2006, p. 17) promotes the value of following a 'causal modelling approach', including elements of action research, when evaluating complex interventions as it "makes explicit the choice of intervention points and associated measures along the causal pathway". Such an approach enables researchers to not only analyse an intervention's effectiveness, or why it might have succeeded or failed, but also better model whether or not any shorter-term changes in behaviour may lead to desired longer-term outcomes. Moore et. al. (2014, p. 101) argue similarly that evaluating complex interventions requires researchers to "move beyond a 'does it work' focus, towards combining outcomes and process evaluation" taking context into consideration in order to learn why they are or are not successful. They go on to explain how impacts can often differ when the same intervention is implemented in a different context. This phenomenon has been experienced on multiple occasions within the research whereby an intervention has worked well in one health facility but not in another, despite them appearing very similar. The often subtle and indistinct differences usually relate to the complex behaviours of individuals.

Robson and McCartan (2016) describe how extensive ethnographic research has the ability to describe and interpret the culture and social structure of a social group. In turn, this can lead to an understanding of the differences between complex individuals, their behaviour and the change processes required to achieve a desired outcome. A true ethnographic approach is difficult to achieve in this context as it can be argued that the presence of the researcher and their intervention will disturb the natural environment and this could potentially affect the reliability of any outcomes (Robson & McCartan, 2016). Building strong relationships, often to the extent of close friendships, over a long period of time with local staff and stakeholders helped to mitigate this risk.

Furthermore, action research takes this process one step further by implementing a change process (action) and constantly monitoring the impacts of the intervention. Once an intervention had been designed and implemented, the research team would withdraw and 'observe from a distance' to assess its level of success and sustainability. A second phase of 'action' would only occur once this period of review and reflection had taken place. Over the course of the research process, the combination of extensive ethnographic and action research has worked extremely well. A deep ethnographic understanding has informed interventions (actions) and the action research has further improved the understanding of ethnography. For example, action research identified that staff absenteeism often led to increased maternal referrals and mortality. Ethnographic research helped understand the reasons as to why staff were absent, and this informed further action research to find solutions to these problems.

Many authors (see for example Moore et. al. (2014), MRC (2006), Bates et. al. (2014)) highlight the need for more knowledge and guidance on evaluating complex interventions. This portfolio of publications helps to close this knowledge gap in the context of complex Health Partnership Interventions in LMICs. On that note, it is important to clarify that all the publications in this portfolio have been written at various points of a learning process and that, perhaps more importantly, this learning process is still on-going. Throughout the journey, each step taken to better understand one behaviour, activity or problem has opened another door for further research and evaluation. "Thus, knowledge derived from practice and practice is informed by knowledge in an ongoing process" (West, 2011, p. 91). This is inevitable within most action research projects and particularly within health

and social sciences due to the fact that societies (and their health needs) across the globe are always changing and evolving as a result of various political, economic, social, technological, legal and environmental pressures. This is what made the research extremely interesting on one hand but also rather frustrating on the other.

Positionality

As discussed in the earlier section on epistemology, all research is to some extent effected by the researcher's own background, personality and motivations. This can influence a research project, perhaps pushing it in a certain direction. Being aware of and reporting these influences is important in ensuring the transparency and rigour of the research findings. As a project manager with educational backgrounds in business economics and management, I view myself as a practical person with an interest in finding practical solutions to real life problems. Working in the field of global health within a University environment for several years has taught me the importance of health workers providing evidence-based care to patients and the improved patient outcomes this can lead to (along with the negative patient outcomes that can occur when evidence-based care is lacking). As discussed previously, practitioners are often in a strong position to contribute to the evidence base due to their real-world experience in the field (Tekin & Kotaman, 2013).

Over the last 10 years I have attended countless global health and international development conferences and workshops, both in the UK and abroad. Whilst typically being very interesting, I find it frustrating that many of the research projects presented tend to have been done 'on' stakeholders in low-income countries rather than 'with' or 'for' them. I believe this has huge ethical implications and feeds into the common perception of 'data grabbing' from people in LMICs by researchers in HICs purely for their own benefit. Very few research projects demonstrate efforts to improve a situation, solve a problem or actively inform practice or policy change to the benefit of the LMIC stakeholders. Furthermore, it is noticeable that many of the conference attendees already work in the same or similar projects or partnerships and are already aware of the challenges or trends being presented. To this effect, it feels that too much time (and money) is being spent preaching to the converted, relative to the amount being spent actively implementing change initiatives. This sentiment acted as a driver for me to focus on projects with the potential to achieve real positive change as opposed to arguably selfish research portfolio building or career enhancement. Having said this, I do acknowledge that my own career and research portfolio has, and continues to be, built on this albeit arguably less directly than many other practitioners or researchers. As noted

previously, the drive to bring in new projects in order to support my salary from time to time will have influenced the nature of projects undertaken and, in some cases, the evaluation and research methods deployed as a requirement of the relevant funding bodies.

Perhaps the strongest effect that positionality can have on research, particularly qualitative action research, is the effect of the personal and physical attributes of the researcher on the research participants. In the case of this portfolio of publications, this includes not only myself but also my research team and the staff, volunteers and students involved in the research. Interesting examples noted over the course of the research included being male, early career, mixed race, non-medical, British, English speaking, from a middle-class background, relatively educated, in fulltime employment and not religious. Examples of how some of these features could have potentially affected the research are provided in the brief, non-exhaustive table below:

Table 1: Potential Impacts of Positionality

Attribute	**Potential Advantages**	**Potential Disadvantages**
Male	Slightly greater levels of access to and respect from higher levels of management in Uganda and India due to generally patriarchal societies. No effect noted in the UK.	Female research participants sometimes less willing to engage and provide honest feedback, particularly relating to 'female' health issues.
Early career	Early career medical volunteers tended to build relationships with similar level Ugandan doctors and integrate into local teams more easily than more experienced consultants were able to.	Reduced access to funding streams and less well respected in some academic circles. Perception of youth or inexperience can reduce access to some research participants, particularly higher-level stakeholders.
Mixed race	Generally improved access to research participants in Uganda; often became a topic of interest.	Less of an effect noted in India and no effect noted in the UK.

	Sometimes assumed to be mixed race Ugandan and British which reduced barriers in Uganda.	
Non-medical	Arguably the ability to remain 'one step removed' due to being less patient focused. Sometimes easier to build relationships with non-medical stakeholders due to lower perceived power distance.	Less well respected within medical circles and health systems (and in Global Health more generally) as these sectors are still largely dominated by doctors. More difficult to understand complexities of some medical conditions.

The attributes noted in table 1 affected not only how research participants related to myself, my research team and the volunteers and students involved but also how they related to one another within focus groups, workshops or meetings etc. For example, a senior male doctor would likely be more vocal within a focus group and tend to have more of his opinions heard than a young female cleaner. Using ethnographic research methods such as observations, over a long period of time, was beneficial in balancing, validating and positing some of the less obvious interview and focus group data. However, it is also important to avoid essentialising or stereotyping these characteristics as sometimes they will be relevant, and sometimes they will not be.

Positionality also has links to aspects of culture and 'racial' stereotyping. It is common for British staff and volunteers to be referred to as 'muzungus' in Uganda. Although translated strictly to mean 'traveller' the concept of 'muzungu' in Uganda refers in more complex ways to 'wealthy' foreigners. In the context of professional voluntarism, it is also linked to a historic association with missionary-style, 'do-gooder' voluntarism. An example of this can be seen in the nick-name given to a volunteer obstetrician as 'Dr Donor'. In many instances, volunteers are viewed as 'cash cows' rather than co-workers. This perception of volunteer roles reinforces the expectation that volunteers travel to Uganda as locums and donors, challenging their commitment to knowledge exchange and co-presence. The corollary of this 'binary' is the caricature of the Ugandan clinician as the

passive recipient of training at the opposite pole on a linear knowledge gradient; the individual lacking capabilities and collectively, the system lacking experienced personnel. These myths continue to shape development interventions, damaging relationships and limiting impact. They create obstacles to the achievement of the kinds of balanced professional relationships experienced in other international contexts, based on more democratic concepts of collegiality.

Conclusion

Host, Sender and Individual Impacts

The main theme running through all the publications is the impact that multidisciplinary mobilities can have on the effectiveness of global health and international development. Key topics that are recurrent throughout each of the publications include sustainability, ethics, capacity building, reciprocity and professional volunteering. As noted in the methodology section, one useful way of summarising this body of research areas is to split it up in to three separate areas: the impact on the hosting (usually LMIC) institution; the impact on the sending (usually HIC) institution, for example the NHS and the impact on the mobile individual who could be from either the LMIC or HIC and could be a member of staff, a professional volunteer or a student. Chapter 3 explained the relationship between the publications included within the portfolio and drew out three key themes induced from the data; increasing globalisation and the liquidity of human resources for health, the critical role of co-presence in sustainable knowledge transfer and the requirement to and benefits of professionalising voluntarism. Table 2 provides a matrix to highlight the links between the three areas of impact and the three inductive themes.

Table 2 - Matrix of Impacts vs. Inductive Themes

	Impact on Hosting (usually LMIC) Institution	**Impact on Sending (usually HIC) Institution**	**Impact on Mobile Individual (Staff/Volunteer/Student)**
Globalisation and the liquidity of Human Resource for Health	• Increasing supply of both high- and low-quality volunteers (requires control) • Changing nature of international mobility (e.g. duration, aims, background, funding) • Increased potential for 'brain drain' of highly skilled staff to relocate to other countries • Increased 'Internal brain-drain' of staff within the LMIC (e.g. from public	• Greater demand from staff to undertake international volunteering activities • Increased mobility of staff to migrate to other HICs (staff retention/backfill) • Greater demand for part-time/flexible working hours • Requirement for reverse innovation (cost saving measures) • Changing demographics of populations (more skills	• Increased pressures and drivers for mobility (for personal, career or other reasons) • Increased opportunities for volunteering/migration both nationally and internationally • Greater ability to be mobile, either through short- or long-term volunteering/migration • Increased diversity of workforce and patients

	health sector to private health sector or international NGO) • Increased demand from staff to travel internationally (e.g. staff exchanges, conferences) • Increased funding opportunities for local/international research collaboration	required to deal with consequences) • Global spread of health conditions as a result of mobility/immigration (more skills required to deal with consequences) • Increased strain on (and requirement for) welfare systems to remain dynamic and responsive	• Increased flexibility within careers (and ability to change career) • Increased pressure on academics to build international links and research collaborations
The Critical Role of Co-presence	• Improved learning outcomes from co-working • Improved relationships with HIC partners • Reduced risk of 'maverick' volunteers • Improved sustainability of interventions • Increased likelihood of reciprocal visits and future joint research projects	• Improved learning of volunteers which can be implemented upon return, particularly leadership, systems thinking etc. • Increased likelihood of reciprocal visits and future joint research projects • Improved learning of staff during visits by staff from LMICs • Improved corporate social responsibility and ability to market activities (e.g. University advertisement)	• Improved learning outcomes • Reduced risk from traumatic experiences, medical malpractice, litigation etc. • Improved wellbeing and level of satisfaction • Improved ability to integrate into local teams • Improved efficacy of volunteer activities • Increased ability for coordination of activities and handover/sharing experiences between subsequent volunteers (improved efficiency and sustainability)
Professionalising Voluntarism	• Improved reliability of volunteers (e.g. skills, punctuality) • Increased efficacy of activity due to improved relationships between local staff and volunteers • Improved expectation management (e.g. competencies, working	• Greater recognition and appreciation of benefits of voluntarism • Greater willingness to enable volunteers to volunteer in LMICs • Provision of funding streams to enable staff mobility	• Improved recognition of achievements whilst volunteering • Greater benefits for career enhancement/CV building • Improved 'conduct' of volunteers whilst on placement • Improved satisfaction as a result of positive and

	hours, financial commitments) • Improved safeguarding of staff and patients (from un/under-qualified or inappropriate volunteers) • Less time wasted by already under-resourced local staff having to provide pastoral support for volunteers	• Increased staff motivation as a result of productive international placements • Greater willingness to enable volunteers to utilise new skills upon return • Movement away from damaging stereotypes of volunteers (e.g. missionaries, saviours, do-gooders, 'voluntourists')	productive volunteering experiences • Reduced individual risk (e.g. theft or injury) • Improved placement structure and timetabling to provide clarity and improve efficiency • Improved ability to volunteer due to improved recognition of benefits

Practice and Policy Impacts

The research presented within this portfolio of publications is of particular importance in the current global environment as many high-income countries face slowing economic growth and rising populism (Moffitt, 2016). Many taxpayers are now experiencing worsening living standards as a result of government austerity policies (Coppola, 2017) (Legido-Quigley, et al., 2016). This inevitably puts increasing pressure on countries and governments to justify their expenditure on International aid and to achieve higher levels of cost effectiveness and value for money (Willem te Velde & Massa, 2009). All six of the publications debate this in great detail and provide evidence backed evaluation to inform future policy. Drawing on in-depth contextual and ethnographic experience, the portfolio forms an honest, detailed and transparent reflection of the author's journey through the various research projects over time in the pursuit of achieving sustainable health systems change. The knowledge and recommendations provided are of particular interest and use to policy makers and stakeholders working in global health, international development and professional volunteering in LMICs. This view was echoed by the Chief Executive of the Tropical Health Education Trust (fund managers for DFID) in his review of **Ackers & Ackers-Johnson (2017):**

> *"Its frankness and willingness to take on big issues and suggest possible solutions is refreshing […] This is to be not only applauded but also acted upon for, as the book quite rightly argues, this way leads towards evidence-based incremental systems change"* (Simms, 2017)

Collectively, the portfolio of publications provides a unique body of knowledge which suggest that Aid can be effective, and outcomes can be sustainable, if managed correctly. Each of the publications contain case studies of both highly successful and failed international development projects and activities and examines the reasons as to why the outcomes may have been more or less positive than expected. In particular, it looks at what learning can be achieved to avoid any mistakes being repeated in the future. In order to achieve the above, the portfolio acknowledges the benefits of following an action research approach and the importance of retaining flexibility, dynamism and reflexivity within this process.

In relation to the exchange of knowledge within vehicles such as Health Partnerships; understanding the complexity of the knowledge end of the knowledge-transfer process is only part of the challenge. The 'transfer' component rests on relationships and these are often taken for granted. It is not enough for international development grant holders to establish relationships with senior policy makers or managers alone; effective knowledge transfer demands engagement at all levels and across disciplines. The portfolio concludes that insufficient attention has been paid to the quality of these critical peer relationships in Health Partnerships to the mechanism of knowledge transfer, translation and impact. It places 'co-presence' and understanding of positionality centre stage. Health Partnerships have, perhaps unwittingly, encouraged an unbalanced and ineffective model in which knowledge flows from professionals in the 'North' to recipients in the 'South' to generate a free floating 'training' premium. Strong and effective relationships grounded in co-presence and mutual respect are necessary to harness relational knowledge in support of behavioural change. Achieving this requires recognition of the role that positionalities play in relationship-building. Rather than accentuating and essentialising differences we need to understand them and being aware of these elements of 'difference' should reveal the commonality of experience which Harvey (1996, p.360) argues forms 'the basis for alliance formation between seemingly disparate groups'.

Well managed professional voluntarism and student mobility programmes have the potential to play an important role in this process and in ensuring that knowledge transfer is mutually beneficial for both the 'donor' and 'recipient' health facilities and wider health systems. Many projects involve the transmission of complex forms of knowledge including

technical (e.g. clinical) skills but also more embedded forms of strategic knowledge. To be effective in this context, knowledge needs not only to be transferred but also to be translated before it can begin to be implemented. Implementation is a highly political and contested process that demands engagement with other forms of expertise and actors.

Many critics of international aid have questioned why many LMICs are continuing to struggle to improve health outcomes despite huge international investments and argue that new and innovative projects and strategies should be considered as alternatives. I share this view and many of the recommendations provided within the publications reflect this. There is already evidence that major high-level stakeholders, such as the UK Department for International Development (DFID) and the Tropical Health Education Trust (THET), are embracing and adopting some of the authors' key recommendations. A key example is the 'Co-Presence Principle' which my research team developed in 2012 and is now commonplace within DFID, THET and other development organisations' literature and operational plans. Furthermore, many organisations have replicated the models provided in the 'recommendations' sections of **Ackers & Ackers-Johnson (2017)** and **Ahmed, Ackers-Johnson & Ackers (2017)** as examples of best practice. These examples illustrate the high research impact of the publications; harnessing the relationship between highly skilled migration and knowledge transfer processes to influence research policy at national and international level and promoting professional voluntarism in international development. The research has led to invitations on to expert panels, speaking at international conferences and operating in an advisory capacity for other Health Partnerships and high-level stakeholders.

In terms of academic impact, and aside from the impact of publications themselves, aspects of the research presented within this portfolio have been selected by the University of Salford as a case study for the Research Excellence Framework. This marks recognition that the body of research presents potential benefits to the UK economy, society, culture, public policy and services, health, the environment and quality of life and impacts in these sectors beyond the UK (REF, 2014). My research team have also been awarded two grants from the Higher Education Innovation Fund (HEIF) to expand areas of the research such as student mobility. More generally, recognition of the quality and importance of the research has opened the doors to new funding opportunities. Since

completion of this portfolio, further grants have been received from DFID to expand the cervical screening research project, from THET to begin new research in to anti-microbial stewardship and from the Engineering and Physical Sciences Research Council (EPSRC) to design, test and locally manufacture a low-cost body powered prosthesis system for upper limb amputees in Uganda and Jordan.

Future Research

As noted previously, the learning process and all of the individual research projects which have contributed to the knowledge conveyed within the portfolio of publications have been necessarily iterative in nature. The learning is by no means complete and I plan to conduct further research in line with the ever-changing context and resulting challenges within Health Systems in LMICs. My current research continues to focus on improving the efficacy of professional and student volunteering programmes, as well as the impact and sustainability of global health and international development interventions. Ongoing projects include an expansion of the cervical screening project, as well as professional volunteering and student elective placement projects currently running through Knowledge for Change. I am also working on the Antimicrobial Stewardship Project running through the University of Salford.

Moving forwards, I plan to continue the work I am doing but also expand the research focus to include other LMICs in other areas of the world. I recently conducted a scoping visit to the Indian Himalayas to assess the potential for similar models of intervention there. I have also built networks in Tanzania, Cambodia and Vietnam which I will explore in similar vein. The research continues to be some of the most challenging I have ever conducted and I know that there will never be any simple solutions. The publications so far mark an important milestone along the research journey; further research and the resultant dissemination of findings and recommendations will continue to add value to the knowledge base and policy within this subject area and hopefully towards ever more effective, sustainable and ethical models of development and volunteering in the future.

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Appendices

Appendix 1: Summary of the Main Funded Projects Conducted during the Research

The table below details the main funded projects that have been conducted over the course of the research period in chronological order. The three main projects that contributed to the portfolio of published works are written in bold. It is important to note that many other small-scale or unfunded research activities have been also been conducted but are not included below.

Project Name	**Timeframe**	**Funding Received**	**Objectives**
Eleanor Bradley Fellowships	2008-2013	£90,000 (The Eleanor Bradley Trust)	The placement of 6 Obstetric fellows in Mulago Hospital (Uganda) on 12-month placements for capacity building and knowledge exchange
British Commonwealth Fellowships	2008 onwards	Ongoing (British Commonwealth Fellowship Scheme)	Hosting of over 30 British Commonwealth Fellowship funded Ugandan staff (medical, nursing, midwifery and engineering) in the UK on 3-6 month capacity building placements.
The Ugandan Maternal & Newborn HUB	2011	£20,000 (Tropical Health Education Trust)	Setting up of the Ugandan Maternal & Newborn HUB which linked together 8 established UK-Uganda Health Partnerships for coordination and joint project working.

Mulago Hospital High Dependency Unit Renovation	2012	£25,000 (Tropical Health Education Trust)	Renovation of the High Dependency Unit at Mulago Hospital (Uganda) and staff training in emergency care.
The Biomedical Engineering Project (phase 1)	2012-2014	£30,000 (Tropical Health Education Trust)	Improving the impact of knowledge transfer in Health Partnerships through infrastructural investment and capacity building in Biomedical Engineering
The Sustainable Volunteering Project (SVP)	**2012-2015**	**£495,000 (Tropical Health Education Trust)**	**The placement of 44 British doctors, midwives, nurses and biomedical engineers on long-term (6+ month) placements across 9 Ugandan health facilities for capacity building and knowledge exchange**
Hoima Staff Accommodation Construction	2014-2015	£27,000 (private donor funded)	The construction of new accommodation block for a local obstetrician and British volunteer obstetrician to reside in at Hoima Regional Referral Hospital (Uganda)
Measuring the Outcome of Volunteering on Education (MOVE)	**2014-2016**	**£335,000 (Health Education England)**	**Research into the impact on the UK NHS from healthcare professionals taking time out of their training/employment to complete long-term voluntary placements in LMICs (survey of over 1000 staff and interviews with over 50 volunteers and NHS managers)**

Hand Hygiene Project	2015-2017	£17,650 (Tropical Health Education Trust)	Reducing Infection through Improvements in Hand Hygiene. Involved capacity building, knowledge exchange and minor infrastructural developments
The Biomedical Engineering Project (phase 2)	2015-2017	£197,120 (Tropical Health Education Trust)	Scaling up of phase 1 (above) to include additional health facilities and professional volunteers and to develop a new biomedical engineering undergraduate degree at Kyambogo University, Kampala.
The Ethical Elective Placement Project (EEP)	**2015-2017**	**£250,000 (Health Education England)**	**Research into the impacts of nursing, midwifery and AHP students completing elective placements in LMICs in terms of their learning and the impact on the 'hosting' health system. Involved piloting 60 student elective placements in Uganda and 20 in India (4-week durations).**
UoS HEIF Funding	2017	£37,500 (University of Salford)	Evaluation of a multidisciplinary student placement programme in Uganda (piloting the placement of 30 students on 4-week placements)
WeCare Research Project	2017-2018	£20,000 (Wellbeing of Women Foundation)	Research into patient and health worker perceptions of respectful maternity care in Uganda and the barriers faced in providing appropriate care.

Agder University Student Placement Programme Evaluation	2018	£17,000 (University of Agder)	Piloting and evaluation of 25 undergraduate International Development student placements in Uganda (4-week duration).
Cervical Cancer Screening Project	2018-2020	£50,000 (Department for International Development)	Setting up a cervical cancer 'see and treat' service at 3 health facilities in Uganda. Involves the placement of professional volunteers for capacity building and infrastructural investment.
Antimicrobial Surveillance Project	2019-2020	£60,000 (Commonwealth Pharmacist Association and the Tropical Health Education Trust)	Research into antimicrobial surveillance in Uganda and capacity building to reduce the inappropriate distribution of antibiotics to patients in order to reduce antibiotic resistance.

Appendix 2: Publications Included in the Portfolio of Published Works

Mobile Professional Voluntarism and International Development: Killing Me Softly

palgrave pivot

MOBILE PROFESSIONAL VOLUNTARISM AND INTERNATIONAL DEVELOPMENT

Killing Me Softly?

Helen Louise Ackers and
James Ackers-Johnson

Mobile Professional Voluntarism and International Development

Helen Louise Ackers • James Ackers-Johnson

Mobile Professional Voluntarism and International Development

Killing Me Softly?

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ISBN 978-1-137-55832-9
ISBN 978-1-137-55833-6 (eBook)
DOI 10.1057/978-1-137-55833-6

Library of Congress Control Number: 2016955040

Printed on acid-free paper

This Palgrave Pivot imprint is published by Springer Nature
The registered company is Nature America Inc.
The registered company address is: 1 New York Plaza, New York, NY 10004, U.S.A.

We dedicate our book to the mothers and mothers-to-be of Uganda

Foreword

I believe we are entering a time when traditional approaches to overseas aid are giving way to new forms of development, involving new sources of finance and new partnerships. In this context, the health partnership model is increasingly relevant. It enables countries to work more collaboratively and at scale. It is an approach that is grounded in the powerful transformative concepts of mutual benefit of co-development and co-learning, themes central to this book – and to the Sustainable Development Goals which now shape our work.

The Health Partnership Scheme, funded by Department for International Development (DFID) and managed by Tropical Health and Education Trust (THET), has provided 50,000 training courses or other educational opportunities to developing-country health workers with over 60,000 UK health professional days spent volunteering. And so my interest was suitably piqued by the title of Chapter 3 of this book, 'Fetishising and commodifying "training?"'. I couldn't resist and neither should you.

I expect readers, especially those with experience in health partnerships, will find this book challenging and important. Its frankness and willingness to take on big issues and suggest possible solutions is refreshing, and while I wouldn't agree with all of its arguments or recommendations – and knowing the authors they would be frankly disappointed if I were to do so – this is a book to be engaged with.

We are not convinced, for example, that the authors are right in generalising from their experiences in the Sustainable Volunteering Project (SVP) to draw conclusions about the health partnership model. From our perspective, the SVP is one (albeit, very interesting) project amongst 200 that

were funded by DFID. Some of the challenges encountered in the SVP have been fully addressed by other projects, such as the management of trainees' expectations of per diem payments. We also have more sympathy, as you might expect, with the need for DFID ministers to communicate clearly with the UK public. This necessitates a simplification of messages, with some implications for evaluation. This is amply balanced in our experience, with an appetite for nuance and learning at DFID.

The case studies in Chapter 5 are to be savoured. Based on the notion that you've got to fail in order to learn – an idea, incidentally, highly valued by THET as well – they provide a wonderfully detailed and valuable portrait of the challenges encountered by practitioners on the ground.

This book pulls no punches, and with a style both academic and personal the authors challenge us all to put our collective shoulder to the wheel to develop a more structured approach to professional volunteer deployment within health partnerships based on principles of negotiated conditionality. This is to be not only applauded but also acted upon for, as the book quite rightly argues, this way leads towards evidence-based incremental systems change.

The wide-ranging critique of aid, based on the authors' years of experience of managing programmes of work in Uganda, covers a great deal of ground examining the nature of development interventions, ethical standards in volunteer deployment as well as the efficacy of donations or the meaningfulness of prevailing evaluation methodologies. It also has a lot to say about the tough issues faced on the ground by health professionals working in development, such as corruption and labour substitution.

The challenges thrown down by this book, based on first-hand experience, are vital in helping us understand better the nature of the solutions. As we join together to co-create a better world I warmly welcome this book's important contribution.

Tropical Health and Education Trust

Ben Simms
Chief Executive

Acknowledgements

We would like to acknowledge the support, both financial and personal, that we have received from the Tropical Health and Education Trust, which made the Sustainable Volunteering Project (SVP) possible.[1] As volunteer manager, Graeme Chisholm has remained a close colleague always willing to discuss ideas. We are also very grateful to our fellow trustees in the Liverpool-Mulago Partnership, particularly the Chair, Mrs Vanessa Harris, who have extended their commitment, support and trust. Our colleagues in the Ugandan Maternal and Newborn Hub, especially Sarah Hoyle, Robert Bates and Helen Allott, have provided ongoing support and advice and we have learnt a huge amount from them.

We would also like to acknowledge the vision and support of our current employer and colleagues at the University of Salford, UK. Whilst many of us find the title of our School something of a mouthful, the multi-disciplinary and multi-professional character of the School of Nursing, Midwifery, Social Work and Social Science has created a fertile and supportive environment for this highly complex and time-consuming action-oriented intervention.

The past 8 years have been challenging and, at times, extremely frustrating, but ultimately very exciting. We have been working at the boundaries and intersections of knowledge. We have gained significantly, both intellectually and personally, from our relationships with the SVP volunteers. The UK and the NHS in particular should feel extremely proud of the professionals it has nurtured and the high levels of professionalism, compassion, innovation and commitment they demonstrate. They have

played a key role not only within the frame of their own disciplines but also as critical knowledge brokers, action-researchers and team players.

Finally, and most importantly, we would like to extend our sincere thanks to those Ugandan health workers who have become our colleagues and friends over the years. The context within which they are attempting to exercise professional responsibility and clinical excellence is punishing to say the least, and their ability to imagine a better reality, in which public services can be improved and mothers' and babies' lives saved, is challenged on a daily basis. Our conclusion, that development aid through professional voluntarism is largely failing to translate into sustainable systems change, in no way reflects on their capabilities or individual commitment. We would like to be able to name those of you who have played such a critical role in supporting the Sustainable Volunteering Project and ongoing work but we are aware that doing so may have damaging personal repercussions. You know who you are and we thank you. We hope that the honesty and trust that you have shown, and we have presented here, will generate new evidence-based opportunities for international professional relationships focused on systems change in the Ugandan Public Health Sector.

Note

1. The Sustainable Volunteering Project (SVP) is funded by the Tropical Health and Education Trust (THET) as part of the Health Partnership Scheme, which is supported by the UK Department for International Development (DFID). The views expressed are those of the authors and do not necessarily reflect the views of THET.

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CHAPTER 1

Mobile Professional Voluntarism and International Development 'Aid'

Abstract Chapter 1 sets the research on which this book is based in context. It discusses the relationship that Aid has with concepts of equality and poverty, and distinguishes humanitarian (emergency) relief contexts from those focused on capacity building. It also questions the efficacy of Aid and raises the possibility that Aid itself may have damaging consequences. Moving from Aid to the wider concept of 'global health', the chapter discusses the role that forms of highly skilled migration, such as professional voluntarism, can play in capacity building. Finally, it discusses the methodological approach taken in this action-research study.

Keywords AID · International development · Professional voluntarism · Action-research

Introduction

This book reports on our experiences of managing and researching the deployment of professionals employed in the UK, primarily but not exclusively in the National Health Service (NHS), to public health facilities in Uganda.[1] The authors have been involved in interventions focused on improving maternal and newborn health in Uganda for the past 7 years through the work of a British charity known as the Liverpool-Mulago-Partnership (LMP[2]). LMP is one of many health partnerships active in Uganda and linked, in recent years, under the umbrella of the Ugandan

H.L. Ackers, J. Ackers-Johnson, *Mobile Professional Voluntarism and International Development*, DOI 10.1057/978-1-137-55833-6_1

Maternal and Newborn Hub.[3] In 2012, LMP received funding from the Tropical Health and Education Trust for the 'Sustainable Volunteering Project' (SVP). The 'SVP' was funded in the first instance for 3 years, during which time it deployed around 50 long-term and many more short-term volunteers. The whole project has been subject to intense ongoing evaluation focused both on volunteer learning and the returns to the NHS[4] and on the impact on hosting Ugandan healthcare facilities and health workers. This book focuses on the second dimension capturing the impacts of these kinds of intervention on the receiving/hosting country or the 'development' perspective.

Whilst the work is deeply and necessarily contextualised, the results create important opportunities for knowledge transfer and lesson learning in other fields of health and social policy and in other low- and medium-income countries.

Development, AID and Inequality

Countries, such as Uganda, are often described either as 'developing' (in contrast to the 'developed') or, more recently, as 'lower- and middle-income countries' (LMICs) in contrast to high-income or resource-rich economies. This characterisation suggests binaries: the 'haves' and 'have nots' or at least a continuum from high to low resource. Of course, you may have high-income economies (such as the USA or the emerging economies of India and China) with very high and increasing levels of absolute poverty and inequality. Even 'low-income' economies such as Uganda provide a comfortable and lucrative home to many very rich and highly cosmopolitan people with access to high-quality private health facilities both at home and across the world.

The complexity and relative character of inequality and its spatial dynamics are somewhat lost in this characterisation of 'international development'. The project we are reporting on is focused on the ***public*** health system in Uganda and, more specifically, on the delivery of services to those Ugandan people whose only claim to health care is on the basis of their citizenship. Or, put differently, those citizens who lack the income to access a wide range of other options. In Uganda (as in India or in the USA), health status is related directly to ability to pay; the more money you have the higher your opportunities. Only those with no other options will turn to the residualised 'safety net', that is, the public health system. Perhaps the only factor distinguishing a country like Uganda

from other countries is the fact that this is the case for a majority of its population and countries such as the USA (or China and India) have the resources, if not the political will, to significantly reduce health inequalities.

According to published data, Uganda has one of the highest levels of maternal mortality in the world. The Ugandan Ministry of Health's Strategic Plan suggests that little, if any, progress has been made in terms of improvements in Maternal Health (Millennium Development Goal 5) and, more specifically, in reducing maternal mortality (MOH 2010: 43). A United Nations report on the MDGs describes Uganda's progress as 'stagnant' (UNDP 2013: iii). Figures on maternal mortality in Uganda vary considerably depending on the source. The World Health Organisation reports maternal mortality ratios (MMRs) of 550 per 100,000 live births (WHO 2010).[5] However, the benchmarking exercise undertaken as part of the Sustainable Volunteering Project (McKay and Ackers 2013: 23) indicated wide variation between facilities in MMRs reported to the Ministry of Health. Perhaps of greater significance, it reiterated the very poor quality of reporting and records management resulting in significant underreporting. The figures for Hoima Regional Referral Hospital likely reflect improvements in records management following the intervention of a UK Health Partnership (the Hoima-Basingstoke Health Partnership) rather than a greater incidence of mortality. Indeed, more detailed audit of case files by an SVP volunteer indicated levels in Mbale regional referral hospital of over 1000 (more than double reported levels) (Fig. 1.1).[6]

These figures are shocking indeed. However, it is important not to gain the impression that all women in Uganda face an equal prospect of dying in childbirth. Data collected from the private ward in Mulago National Referral Hospital paint quite a different picture with only one maternal death recorded between January 2011 and October 2012 compared to 183 deaths on the public ward. Interestingly, the caesarean section rate on the private ward is more than double that on the main public ward (51.6% compared to 25.4%) (Ackers 2013: 23). Inter-sectoral inequalities within the country are as alarming as inter-country comparisons. And, in case of Mulago Hospital, the health care staff treating patients on the private ward are exactly the same as those on the public ward.[7]

The simple but important point we are trying to make at the outset is that the context within which the Sustainable Volunteering Project is deploying volunteers is best described as one of profound social

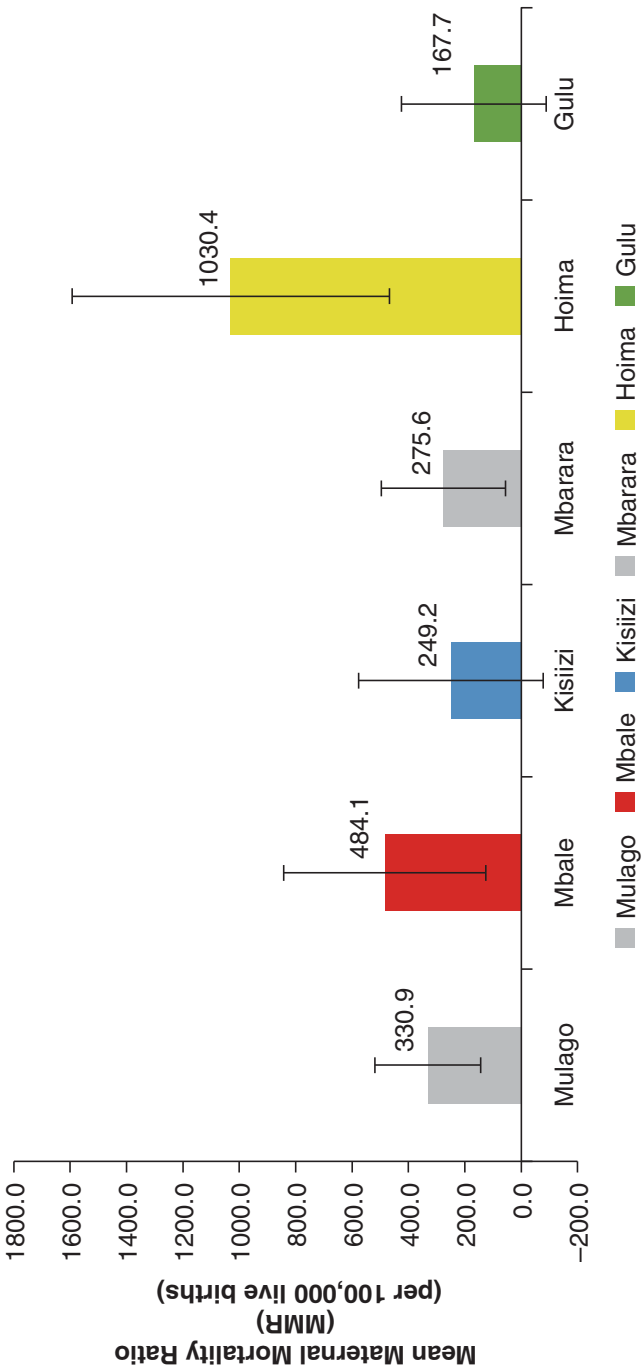

Fig. 1.1 Mean maternal mortality ratios by facility, Uganda, 2011–2012 (*Source*: Ackers (2013))

inequality rather than poverty per se. And, the 'low-resource setting' we refer to in this book is the public healthcare system in Uganda and not Uganda or Ugandan health care, as a whole.

One of the problems with the popular use of the word 'poverty', or even more so, 'the poor', is that they infer the kind of passivity displayed in media fund-raising campaigns with images of human 'victims' needing 'help' splashed across posters and television screens. And, the corollary of this is, of course, the 'helpers' or good-doers who dip into their pockets. This 'donor–recipient' model of development AID continues to taint international relationships. It is convenient and valuable to distinguish at this juncture two forms of intervention or perhaps, to avoid caricature, two contexts. Bolton suggests that, 'broadly speaking, AID can have two aims. It either provides humanitarian relief in response to emergencies, or it tries to stimulate longer-term development' (2007: 75). Humanitarian or emergency AID then seeks to provide an immediate response to catastrophic events such as famine, earthquakes or wars. In such situations, immediate service intervention is easier to justify and concerns around unintended consequences or collateral damage less pressing. This type of activity could, in theory and out of necessity, be achieved by foreign volunteers in the absence of local staff. The deployment of 'Mercy Ships,' for example, is designed to 'fill the gaps in health care systems' through service delivery.[8] And emergency AID may be provided in any context without in-depth analysis of a country's economic status or political decision making.

Bolton calculates that around 95 % of AID falls into the alternative category of 'development aid' – a form of investment which is both 'much better value' (in terms of promoting resilience) and 'harder to get right' (2007: 76). This AID comes from a diversity of sources including, as Bolton indicates, charitable donations and philanthropy (of which a sizeable component are linked to religious organisations pursuing their own agendas); National AID provided by governments and International AID provided by organisations such as the World Bank and the United Nations. The boundaries between these forms of AID are fuzzy and the political imperatives (underlying national and international AID and its links with diplomacy and trade) combined with the marketing functions of charitable fund-raisers together result in an opaqueness and lack of honesty about impacts. Bolton argues that the pressure to raise funds results in a tendency to simplify and exaggerate the effectiveness of AID and

concludes that, 'the outcome is probably the most unaccountable multi-billion dollar industry in the world' (p. 79).

To put AID in perspective, the Ugandan Ministry of Health published figures indicating an annual spend of 1281.14 billion shillings (about £156.5 million). Of this, 68 % (£150 million) is provided by the Ugandan government and 32 % (£106.5 million) by 'donors'. The growth in donor share is quite alarming, almost doubling from 13.7 % in 2011 (MOH 2015). Department for International Development (DFID) figures for 2015 indicate a spend of over £26 million in 2014/2015 on health in Uganda; the majority of which (63 %) goes on reproductive and maternal and newborn health (DFID 2011). These figures are indicative only and most certainly under-estimate the monetary value of AID, reflecting only the direct inter-governmental funding that travels down through the Ministry.[9] Health Partnerships are largely funded as local charities, and whilst the amount of money involved may be quite high, this is dwarfed by the real costs of in-kind contributions through volunteer labour.

Moyo's book, with its stark and 'incendiary'[10] title, *Dead Aid* (sub-titled: *Why AID is not working and how there is another way for Africa*), had a major impact on the design of the SVP. Moyo argues that the culture of AID derives from 'the liberal sensibility that the rich should help the poor and that the form of this help should be Aid' (p. xix). With reference to its impact on 'systemic poverty' (as opposed to humanitarian crises), Moyo concludes that AID has been and continues to be 'an unmitigated political, economic and humanitarian disaster for most parts of the developing world' (2009: xix). She goes beyond many other writers who express similar concern at the efficacy of AID to contend that AID is not only ineffectual but, of far greater concern, it also generates externality effects that actually cause damage. AID is 'consumed' rather than invested:

> Were AID simply innocuous – just not doing what it claimed it would do – this book would not have been written. The problem is that AID is not benign – it's malignant. No longer part of the potential solution, it's part of the problem – in fact, AID is the problem. (p. 47)

AID has been described as an 'industry' by actors in high-income (donor) settings; it is also seen very much as an industry in low-resource settings. Indeed, poverty is a magnet for AID and the more overtly poor and destitute the case, the greater the prospect of attracting investment.

Sadly, in the Ugandan context, this creates a vested interest for local leaders in the deliberate preservation and presentation of impoverishment and chaos in order to suck in cash and create opportunities for embezzlement. In that sense, poverty is both functional and profitable.

From 'AID' to Global Health

These kinds of anxieties, about the effectiveness of AID, fuelled by political correctness about the use of the term 'development' have led to new concepts to capture the investment dimension and focus on longer-term systemic change. The Tropical Health and Education Trust is one of a growing number of intermediaries funded by the UK's DFID and focusing on 'capacity building' and 'sustainability'. Locating itself within the 'global health' agenda, THET describes its mission as building long-term resilient health systems to promote improved access to essential health care as a basic human right (THET 2015). At the centre of this strategy is the concept of 'human resources for health' or 'HRH'.

The global health agenda has usefully shifted attention from the haves–have nots and donor–recipient binaries referred to before, talking instead, somewhat hopefully, of partnerships and 'win–win' relationships. Lord (Nigel) Crisp has pushed this agenda forward arguing quite forcefully that the UK's National Health Service has as much to learn from low-resource settings as vice versa. Focusing again on health systems (rather than poor people per se), Crisp suggests that the concept of global health 'embraces everything that we share in health terms globally' (2010: 9). Crisp's approach rest on two ideas. First, that health systems in high-resource settings are facing (growing) challenges in terms of resources and sustainability and, second, that globalisation is itself creating complex mobilities (both human and microbial) and interdependencies that effectively challenge the autonomy and resilience of nation states: we are all increasingly connected, whether we like it or not. The growing mobility of health workers or the spread of Ebola are prime examples. It is interesting also to see how Crisp and THET have started to slip the word 'innovation' alongside development, although they shy away from the language of competition in this fluffy consensual world.

In the context of global health, at least the growing emphasis on human resources has usefully shifted the debate from one about providing 'top-down' cash injections in the form of national or international

financial support to (corrupt) governments to supporting forms of knowledge exchange through grounded partnerships.

THET describes its focus on reducing health inequalities in low- and middle-income countries with a particular emphasis on improving access to essential health care (as a basic human right). Achieving this requires significant improvement in health systems and this in turn places the emphasis on human resources:

> The lack of human resources for health is a critical constraint to sustainable development in many lower- and middle-income countries. (THET 2015: 10)

This leads naturally on to what they describe as 'a unique partnership approach that harnesses the skills, knowledge and technical expertise of health professionals to meet the training and education needs identified in low-resource settings'. And 'international volunteering' is one of the key mechanisms it supports to achieve this skills harnessing process.[11]

The Health Partnership Scheme (HPS) managed by THET was launched in 2011 to 'build the capacity of healthcare workers and the faculty needed to train them with a focus on 'lasting improvements to healthcare [...] and service innovation' (THET 2015: 10). The scheme is funded by DFID at a cost of £30 million over 6 years. It is under this scheme and specifically the 'Long-Term Volunteering Programme', that the SVP was funded. THET guidelines set out the following objectives:

HPS Volunteering Grants aim to leverage the knowledge and expertise of UK health professionals by funding efficient, high-quality long-term volunteering programmes linked to development projects. HPS Volunteering Grants should [...] strengthen health systems through building the capacity of human resources for health (THET 2011).

In direct response to these objectives, the SVP set out the following objectives:

- To support evidence-based, holistic and sustainable *systems change* through improved knowledge transfer, translation and impact.
- To promote a more effective, sustainable and mutually beneficial approach to international professional volunteering (as the key *vector of change*).

These goals were then formulated as an action-research question framing the wider intervention:

> To what extent, and under what circumstances, can mobile professional voluntarism promote the kinds of knowledge exchange and translation capable of improving the effectiveness of public health systems in LMICs? (THET 2011)

With these thoughts in mind we designed the SVP evaluation around three potential 'scenarios:'

Scenario 1: Partial Improvement (Positive Change)

Under this scenario, evidence will indicate that the professional volunteering interventions we are engaging in are at least ***partially effective*** in promoting systems change. It is important that even this 'partial effect' relates to incremental long-term progress and is not short-lived. Moyo suggests that project evaluations often identify the 'erroneous' impression of AID's success in the shorter term – whilst 'failing to assess long-term sustainability' (2009: 45).

Policy Implications: Any positive collateral benefits to individual service recipients (patients), UK volunteers/health systems are to be identified and encouraged.

Scenario 2: Neutral Impact (No Change)

Under this scenario, evidence will indicate that the professional volunteering interventions we are engaging are generally ***neutral*** in terms of systems impact. They neither facilitate nor undermine systems change.

Policy Implications: Positive outcomes for individual service recipients (patients), volunteers (and the UK), free of unintended consequences, may be identified and supported.

Scenario 3: Negative Impact (Collateral Damage)

Under this scenario, evidence will indicate that the professional volunteering interventions we are engaging are generally ***counter-productive*** /damaging in terms of promoting long-term (sustainable) improvements in public health systems.

Policy Implications: Any positive gains to individuals (including Ugandan patients) or systems in the UK are tainted with unintended consequences and, on that basis, are unethical and should not be supported.

Our thinking at the time (project commencement) was heavily influenced by concerns expressed about the inadequacy or lack of transparency and honesty in evaluation (Crisp 2007; James et al. 2008: 7; Bolton 2007) and Moyo's powerfully expressed but seemingly ignored assertions about the damaging effects of AID. We were also building on 4 years' direct experience of deploying and managing long-term volunteers.

Interestingly, the literature on the effectiveness of AID (including Moyo's book) rarely if ever refer to the role of human capital investments in the form of 'voluntarism'. Bolton's chapter, 'Pass the Hat Round – Charity Aid', makes various assumptions about what he calls 'Aid's Sunday Drivers' – caricatured as 'amateurs with far too little expertise [. . .] who believe all they need to do is turn up and make a difference' (p. 89). Of course, there is some truth behind his concerns about 'foreigners coming from outside' to intervene in people's lives (p. 90). However, his response to his own question, 'is charity capable of providing the help that Africa needs to pull itself out of poverty? Unequivocally, the answer is no' (p. 92) indicates a failure to understand the skills base of many volunteers and the role that volunteers play within organisations (such as health partnerships). Furthermore, it fails to acknowledge the very real monetary value and costs associated with voluntarism and the role that nation states are playing in funding these processes (through intermediaries such as THET). The costs of the HPS scheme (30 million pounds) are dwarfed by the costs to individuals and NHS employers providing cover for released staff. The concept of 'volunteer' tends to detract from the significant economic costs of this form of 'AID'.

These concerns and experiences imposed a huge sense of personal responsibility on us as project managers deploying volunteers. Whilst we could understand the concerns about large volumes of taxpayers' cash being tipped into foreign governments and relate to Moyo's conclusion that this constituted 'Dead Aid' – we were less sure about the effects of voluntarism as AID. The immediate association of voluntarism with altruism, religiosity and 'giving' and the less obvious (but perhaps no less real) relationships with diplomacy and trade lead us to question whether volunteering ultimately had the same effects – hence, the subtitle for our book: 'Killing me Softly?' This is represented in Scenario 3.

Professional Voluntarism as Highly Skilled Migration

We opened this chapter with a discussion about development and AID. Not because this is where we located ourselves as 'experts', but because it is the dominant discourse within which our work is generally situated– and has been funded. Neither of us (as authors) came to this work with backgrounds in international development or global health. Ackers' background as a geographer and social scientist is in highly skilled migration and the role that internationalisation plays in shaping the mobilities of scientists as individuals and scientific capacity. It is interesting to note that the emphasis in this field is more often on the role that the mobility of the highly skilled plays in promoting scientific competitiveness and innovation. The role of human mobility is increasingly recognised as critical to the formulation of the kinds of knowledge relationships that lie at the heart of economic growth. It is important to point out that the processes of international mobility here are by no means unilateral, as is often inferred, echoing the haves (cosmopolitan northern professionals with extensive mobility capital) and have-nots (internationally isolated and parochial) binary. Our research experience suggests that Ugandan health workers and, especially, but not exclusively, doctors have access to very wide and varied international experience. Indeed, it is possible that the (funded) opportunities available to them exceed those open to their peers in the UK.[12] The Ugandan health workforce is surprisingly cosmopolitan and internationally connected especially but not only at senior levels.

Viewed through these disciplinary lenses, both the SVP volunteers and the many Ugandans who have spent time in the UK are first and foremost highly skilled migrants or, if the language of migration is off-putting for some,[13] people exercising forms of professional mobility. The label 'volunteer' (defined simply by the absence of a formal employment relationship or remuneration) does little to capture the motivations of the diverse groups of people involved and has an unfortunate tendency to characterise them, within the donor–recipient model, as 'helpers' (Bolton's Sunday Drivers) or, worse still, in an environment still dominated by religious values, as 'missionaries'. As noted earlier, our research has embraced the motivations, experiences and learning outcomes of volunteers. The findings of this are reported elsewhere (Chatwin et al. 2016). The point here is to consider what added value such volunteers bring to the host society and its public health system.

Ackers-Johnson's background, on the other hand, is in financial and human resource management. The emergence of the HRH agenda in global health immediately demands an understanding of complex human resource dynamics in terms of both ensuring a supply of appropriate 'volunteers' and creating the structures and relationships that support optimal knowledge capture. The Human Resource Management perspective encourages us to view both volunteers and the Ugandan health workers they are engaging with from the perspective of employment quality and career decision making and accentuates commonality rather than difference in human ambitions and the barriers to knowledge mobilisation. It will become clear as the story unfolds that maternal mortality in Uganda is as much about human resource management as it is about clinical skills.

For the purpose of the SVP and this book, we have coined the term 'professional volunteer' to overcome some of our concerns about the (value-laden) concept of volunteer and emphasise the fact that first and foremost the people we are referring to are highly skilled (mobile) professionals. Characterising them as professionals who are engaging in Uganda with fellow professionals (many of whom are also involved in various forms of international mobility) helps us to situate the project within the frame of both international knowledge mobilisation and human resource management. This is the frame within which we have previously engaged in international teams as research collaborators and not as donors. The word 'professional' also hints at motivational dynamics and the fact that, for the majority of 'volunteers', motivation is a complex concept combining altruistic, touristic and career progression components (amongst others).

Researching Complex Interventions: The SVP as Action-Research

Whilst the Crisp report[14] outlines the important potential strategic role of 'Global Health Partnerships' in the 'massive scaling-up of training, education and employment of health workers in developing countries' (Crisp 2007: 2), it also reflects on the very disappointing historical picture with 'any number of well-intentioned initiatives foundering after a few years' (2007: 5). This, argues Crisp, 'leads to a counsel of despair that, despite all the effort over the years, nothing has really

changed' (p. 5). He concludes that there has been, 'very little systematic application of knowledge and learning from successful – and failed – projects' (p. 9) and calls for more international studies that, 'show what impact they can make and how they should best be used' (p. 14). The Academy of Medical Royal Colleges' Statement on Volunteering (2013) similarly expresses concern at the quality of evidence on the impacts of volunteering:

> Monitoring and evaluation of volunteering activities does exist but is at present limited. The same is true of research on long-term impacts. There is a pressing need to develop consistent approaches to robust monitoring and evaluation. (p. 2)

And Bolton takes the argument further suggesting that AID organisations (or funding bodies) have a vested interest in showing that AID works:

> Most of the information we get about aid is from charities [who] need to convince us that aid is effective so they can get their hands on our money... most charities simplify and exaggerate how much effect aid can have. (2007: 78)

This echoes common criticisms of evaluation processes conducted in-house and within projects and, as such, tilted in favour of proving that interventions are both necessary and effective. And, most project evaluations in health partnership work are conducted by people who have little if any research experience in the evaluation of complex social processes. The SVP is perhaps somewhat distinct in this respect to the extent that the co-coordinator is an experienced researcher occupying an established academic post, embedded within an active research team, and as such not personally reliant upon the demonstration of project 'success'. Whilst this distance supported a degree of independence and objectivity, the fact that the authors were simultaneously designing, implementing and evaluating the intervention distinguishes the project from classical research. We were not seeking to 'measure' controlled static phenomenon, and reduce 'contamination' to a minimum (MRC 2008), but rather to institute change processes and capture their impacts longitudinally.

The emphasis on change processes in a program such as the SVP, coupled with the paucity of reliable secondary data, demanded an innovative and

iterative multi-method approach. Building on many years' experience of research on highly skilled mobilities and knowledge transfer processes, the evaluation strategy embraced a range of methods complementing and balancing each other through the process of triangulation (Iyer et al. 2013). As researchers, we were acutely aware at the outset of the limitations of facility-generated secondary data. Accurate, reliable data on maternal and newborn health simply do not exist in Uganda. We therefore conducted a major benchmarking exercise across the ten HUB facilities (including health centres and hospitals). This was an interactive process in itself and was as much about improving data collection and record keeping as it was about data capture; indeed, the process included training of record keeping staff. These data should be regarded with caution (as noted earlier).[15] As Gilson et al. note (2011), even in this 'hard data' context there is no single reality, no simple set of undisturbed facts and the data that we do see are essentially socially constructs.

The project has also used simple before-and-after testing schemes using Likert scales to assess learning and skills enhancement during formal training programmes. Capturing the impacts of volunteer engagement on health workers – and more specifically on behaviour and systems change – is far more complex. We have utilised a range of measures including qualitative interviewing of volunteers, structured monthly reporting schedule for all volunteers and bi-annual workshops. Wherever possible, volunteers have been interviewed at least three times (depending on their length of stay with interviews prior to, during and post-return). We have over 150[16] verbatim transcripts drawn from all 10 HUB locations. Most of these have been conducted face to face in Uganda or the UK with some taking place via Skype. Where appropriate, email has also been used to discuss issues.

The research has also involved interviews and focus groups with Ugandan health workers, line managers and policy makers (about 50 to date).[17] The authors have also spent many months in Ugandan health facilities and working with Uganda health workers in the UK. The project coordinator and manager each makes regular visits (around four per year) ranging from 2 weeks to 5 months in duration and we have deployed two social scientists as long-term volunteers embedded within the SVP. This intense ethnographic work is recorded in project notes and diaries and is perhaps the most insightful of all of our methods. The qualitative material has been coded into a software package for qualitative analysis (NVIVO10) and subjected to inductive thematic analysis.[18]

In addition to this, volunteers have been encouraged, where appropriate, to develop specific audits to support contextualisation and highly focused interventions. This has included audits on, for example, maternal deaths, triage and early warning scoring systems, antibiotic use and C-section rates. These audits are small scale and necessarily inherit the same problems with the accuracy of data and of medical records as the wider study.

We have described the study as an example of action-research. It is necessarily iterative and as such we did not set out to achieve a specific sample size or end point but continue to spend time in Uganda interviewing and observing work in public health facilities and facilitating active workshops to encourage discussion around key issues.[19] Indeed, it is through this iterative process that we have come to identify the challenges that we believe are central to understanding both resistance to change in Ugandan health systems and the efficacy of professional voluntarism.

McCormack concludes his chapter on action-research with the reflection that 'context is a constant tussle between conflicting priorities where everyday practice is challenging, often stressful, sometimes chaotic and largely unpredictable' (2015: 310). Understanding context is a labour-intensive longitudinal process that unfolds to inform and respond to interventions over time. For the action-researcher, there is no convenient chronological start and end point. Somekh (2006) echoes this sentiment suggesting that action-research is cyclical and evolves until the point at which, 'a decision is taken to intervene in this process in order to publish its outcomes to date' (2006: 7). And, 'it is unlikely to stop when the research is written up'. Both these sentiments capture perfectly our interventions in Uganda. The publication of this book marks a stage in a journey and what we have learnt up to this point.

The remainder of the book guides the reader through our own learning processes as 'action-researchers' reflexively managing and evaluating the Sustainable Volunteering Project.

The Structure of the Book

Chapter 2 discusses the first part of our journey in operationalising the SVP. This contextual learning predated the SVP and framed our initial application for funding. Our experience of deploying long-term

volunteers in the context of the Liverpool-Mulago-Partnership made us acutely aware of the damaging effects of labour substitution. Years of missionary or 'helper' style volunteering have shaped a culture within which the dominant expectation in Uganda was that volunteers were there to gap-fill and substitute for local staff, enabling them to take time off work. And many volunteers, influenced by similar discourses, are often quite (naively) happy to respond to these expectations. Clinical volunteers have a much more powerful ethical commitment to the prioritisation of immediate patient needs over systems' needs. The chapter title 'First do no Harm' is taken directly from the Hippocratic Oath – the ethical statement governing the conduct of the medical profession and prioritising patient needs.[20] Chapter. 2 reflects on the balancing and persuasive process that this has involved and how the SVP has developed and operationalised the 'co-presence' principle to guard against the systems damaging effects of labour substitution.

Chapter 3 takes a chronological step forward to the point at which the SVP was actively deploying professional volunteers into roles focused on training and capacity building based on the co-presence principle. Our experience of the project's progress began to raise concerns that the emphasis on and conceptualisation of 'training' imposed by most organisations funding volunteering (and embedded in indicators of success) fostered a kind of fetishism – with training. Our research suggested that, in practice, and in the context of Ugandan human resource management systems, training was failing in many respects to translate into active learning and was, in itself, generating worrying externality effects. Rather than generating empowerment and improving health worker behaviour, it was tending to compound the kinds of dependencies and corruptions identified by Moyo (2009). Chapter. 3 draws on research evidence to expose the unintended consequences of interventions focused on forms of continuing professional development (CPD) 'training'. It describes the SVP approach favouring on-the-job co-working and mentoring over formal off-site courses. This approach increases opportunities for genuine learning and confidence in deploying new knowledge. More importantly, this reduces the collateral damage caused by traditional CPD interventions. Notwithstanding these 'successes', our research suggests that the effects of even these interventions can be short-lived. It was at this stage in the project journey that we realised that co-presence, whilst essential, was not sufficient to guarantee knowledge translation and sustained impact. Ugandan public health systems are highly and actively resistant to change.

Chapter 4 marks the shift in conceptualisation emerging from both our own evaluation and learning but coinciding with wider policy agenda. The missing piece of the jigsaw it seems was the failure to understand both conceptually and in terms of operational dynamics, the step from training through learning to individual behaviour change. We have learnt that knowledge mobilisation does not automatically derive from learning; knowledge in itself is not empowering and may, indeed, be disempowering. Knowledge mobilisation is highly contextualised and needs to be understood within the frame of wider human resource management systems. In marked contrast to the approaches favoured in health sciences focusing on 'systematic reviews' of published research on similar (identical) interventions, we undertook a much broader horizon-scanning research review process. Our aim here was to identify any knowledge or ideas that could facilitate our understanding of the intervention–failure or systems stasis we were witnessing. Chapter. 4 reviews some of the work we identified and its impact on our learning and volunteer deployment model.

Chapter 5 applies the newly combined knowledge discussed in Chapter. 4 to two illustrative case studies. As we have noted, interventions in a project like the SVP take place and are modified over time. In many ways they represent a simple 'trial and error' approach underpinned by intensive grounded research to facilitate our understanding of change processes or change resistance. Tracking the identification of a 'need' and our experience of designing and monitoring the evaluation of that process, in the light of the new knowledge gained through ongoing research review improves our understanding of the complexity of social processes. Chapter. 5 redefines the objectives of our action-research project from the starting point where we believed we were setting out to capture the ingredients of positive change to one of pro-actively understanding and learning from failure. It attempts, in the context of this potentially debilitating reality, to take stock and identify the characteristics of least harm interventions to chart the next stage of our journey.

Notes

1. Annex 1 provides information on volunteer deployment in the SVP. In practice, SVP volunteers are drawn from a broad family of disciplines/cadres including clinicians, engineers and social scientists.
2. www.liverpoolmulagopartnership.org.

3. For details see www.liverpoolmulagopartnership.org.
4. This important dimension of the evaluation has been further supported by Health Education England funding. For further details, see http://www.salford.ac.uk/nmsw/research/research-projects/move. A companion book is due to be published (Ackers et al. 2016a).
5. The newly published Sustainable Development Goals (that replace the MDGs) cite a target MMR of below 70 per 100,000 births (UN 2015: 13).
6. These figures only capture recorded deaths in the facility and thus miss cases where mothers die in the community or where records are unavailable.
7. Staff–patient ratios differ enormously and more senior doctors are required to attend births on the private ward for which they are (relatively) generously remunerated. This does however suggest that training per se is not lacking.
8. http://www.mercyships.org.uk/mission-vision. We are aware that there is a great deal of controversy about the mechanics of providing emergency aid, especially in the post-crisis period.
9. UK and EU direct AID to Uganda was stopped in 2012 due to high-level corruption.
10. The term the *Daily Mail* used to describe it.
11. http://www.thet.org/our-work/what-we-do.
12. The Commonwealth Professional Fellowship Scheme is only one of many schemes offering fully funded fellowships to health workers.
13. Geographers increasingly use the concept of mobility to describe contemporary forms of highly skilled movement. THET defines a 'long-term volunteer' as someone who stays for at least 6 months. We would argue that stays of this duration would tend to fall within the frame of highly skilled migration (Ackers 2013, 2015; King 2002; Kesselring 2006).
14. Lord Crisp's report was written in response to an invitation from the prime minister and the Secretaries of State for Health and International Development to look at how UK experience and expertise in health could be used to best effect to help improve health in developing countries.
15. Full details are reported in Ackers (2013).
16. The numbers cited here are constantly increasing as we continue to deploy volunteers and assess impacts.
17. See Annex 1.
18. We have used the prefix UHW to identify Ugandan Health Worker respondents; FG for focus groups and V for SVP volunteers.
19. Two doctoral researchers, Hassan Osman and Natalie Tate, are currently developing dimensions of the research in Uganda.
20. This is also the subtitle of our sister book on Ethical Elective Placements (Ahmed et al. 2016a).

CHAPTER 2

'First do no Harm': Deploying Professional Volunteers as Knowledge Intermediaries

Abstract Chapter 2 discusses the first part of our journey in operationalising the Sustainable Volunteering Project. It discusses the factors underlying the perceived 'human resource crisis' that is typically blamed for high levels of maternal and newborn mortality in low-resource settings. This is the environment within which professional volunteers find themselves and that they, and their deploying organisations, must negotiate with care. The chapter presents the risks associated with labour substitution or gap-filling roles and explains the importance of the co-presence principle to the SVP.

Keywords Human resource crisis · Labour substitution · Co-presence

Introduction

Chapter 2 outlines the human resource context within which projects such as the SVP are deploying UK clinical volunteers. It begins with a brief presentation of global health 'metrics' emphasising the public view of the human resource crisis in LMICs. These stark metrics play an important (and intentional) role in stimulating the case for AID in all its forms including professional volunteering. Aggregate data on human resources in health form an important component of needs assessment. However, they are profoundly inaccurate in terms of conveying a statistical impression of health worker deployment on the ground due to the very poor and

H.L. Ackers, J. Ackers-Johnson, *Mobile Professional Voluntarism and International Development*, DOI 10.1057/978-1-137-55833-6_2

politically loaded nature of record-keeping. Furthermore, they present a profoundly distorted impression of the human resource context within which Health Partnerships and professional volunteers are attempting to promote capacity building. This chapter takes the reader through our own learning from the starting position where we assumed that we were engaging with the simple inability of LMICs to fund the training and deployment of health workers ('they need all the "help" they can get' approach) to our more contextualised understanding of the sheer complexity and power dynamics of human resource (mis)management. The immediate and obvious response to this simplistic 'health worker shortages' model is a labour substitution or service-delivery intervention. This response, whilst appealing to the altruistic and clinical learning needs of volunteers, lacks sustainability. It also undermines public health systems.

There is a strong tendency to assume that the solution to health systems crisis in countries like Uganda lies in clinical expertise and that clinicians are best poised to influence global health agenda. We have come to realise that this clinical expertise, whilst highly valuable, needs to be framed and managed within a much more multi-disciplinary and research-informed understanding of human resource systems. And this has important implications for the deployment and management of professional volunteers. The second part of the chapter introduces the concept of 'co-presence'. Co-presence is a well-known concept in the highly skilled migration and knowledge mobilisation literature and our familiarity with this framed our approach to volunteer deployment. Put simply, unless volunteers are working in co-present (or face-to-face) relationships with their peers, we run the risk of labour substitution and also fail to create the environment conducive to knowledge exchange and mutual learning.[1]

Global Metrics and First Impressions

The following section presents a brief overview of the some of the human resource problems that characterise Uganda's health system shaping volunteer engagement and goal achievement. According to the World Health Organisation (WHO), about 44.0 % of WHO Member States report to have less than 1 physician per 1000 population, and the distribution of physicians is highly uneven:

> Health workers are distributed unevenly across the globe. Countries with the lowest relative need have the highest numbers of health workers, while

> those with the greatest burden of disease must make do with a much smaller health workforce. The African Region suffers more than 24 % of the global burden of disease but has access to only 3 % of health workers and less than 1 % of the world's financial resources.[2]

The clamour for metrics in the development/global health industry encourages the collection and aggregation of data which, perhaps unintentionally, drives policy agenda and intervention strategies. Table 2.1 summarises data from the WHO's 'World Health Statistics Report' (2010).

It is important that we do not accept these figures as facts but approximations; numerous data bases report quite significant differences. However, the underlying message is clear: LMICs have far fewer skilled professionals than HRCs. In 2006, the WHO's World Health Report identifies a crucial threshold of 228 skilled health professionals per 100,000 population, below which countries were deemed to be in health workforce crisis (WHO 2006: 13).

Key stakeholders respond to this kind of data when designing their interventions. The Lancet Commission on Global Surgery 2030 (Meara et al. 2015) is just one example. Once again focused on 'global metrics', the Lancet Commission identifies five 'key messages', which include '5 billion people do not have access to safe, affordable surgical and anaesthetic care when needed' and '143 million additional surgical procedures are need in LMICs each year to save lives and prevent disability' (p. 569). On the basis

Table 2.1 Physician and nursing/midwifery density, regions and selected countries compared

Location	*Physicians*		*Nursing and midwifery personnel*	
	Number	*Density (per 100,000 population)*	*Number*	*Density (per 100,000 population)*
African region	174 510	2	802 076	11
Uganda	**3 361**	**1**	**37 625**	**13**
European region	2 877 344	33	6 020 074	68
United Kingdom	126 126	21	37 200	6[a]
United States	793 648	27	1 927 000	98

[a]This figure cannot be accurate. A recent UK report (HSCIC 2014) indicates that there are 347,944 qualified nurses in the UK NHS alone, suggesting a decimal place error

Source: World Health Organisation (2010: 122)

of this, they identify six 'core indicators', the second of which is focused on improving workforce density:

Kinfu et al. argue that the overall problem is 'so serious that in many instances there is simply not enough human capacity even to absorb, deploy and efficiently use the substantial funds that are considered necessary to improve health in these countries' (2009: 225). Although they don't single out development aid, this statement may well apply to this form of funding too. Their analysis suggests that current figures may represent a marked underestimation of staff shortages. However, data weaknesses preclude accurate analysis and even regional data 'mask diverse patterns' (p. 226).

The data presented above and typically cited focus on 'stocks' (overall numbers) but tell us little about how the existing workforce is deployed and managed on the ground and how foreign human resource investments (in the form of foreign expertise) can best be managed.

The Human Resource Crisis in Uganda: Contextualised Knowledge

The Ugandan Ministry of Health's Health Sector Strategic Plan III (MOH 2010) asserts that 'Uganda, like many developing countries, is experiencing a serious human resource crisis' (p. 20) restricting the country's ability to respond to its health needs.[3] It goes on to state that around 40 % of its human resource in health is working for the private sector (which includes the mission sector). One of the consequences of these shortages is a high proportion of unfilled vacancies in the public health sector. In 2008, only 51 % of approved positions were filled with vacancies reaching highest levels (67 %) in lower-level community-based facilities (p. 20). Facilities in urban areas and especially the capital city (Kampala) are less likely to experience problems with unfilled vacancies in comparison to more peripheral locations. The Strategic Plan reflects on the reasons behind this situation. And familiar concerns are raised over international migration ('brain drain') as health workers are attracted not only to resource-rich economies but also to neighbouring African countries such as Rwanda and Kenya where salaries are much higher and visas easier to obtain.

Other factors identified include insufficient training capacity, low levels of remuneration (forcing forms of 'internal brain drain' or deskilling as qualified workers move to other sectors) and poor working conditions.

However, even taking these factors into account does not explain the levels of staffing observed and experienced on the ground in Ugandan health facilities resulting in the pressures put on professional volunteers to gap-fill. The Strategic Plan goes on to identify low productivity as a result of 'high rates of absenteeism and rampant dualism' as the 'largest waste factor in the public health sector in the country' (p. 21). The World Health Report (WHO 2006) backs this up suggesting medical personnel absenteeism rates from 23 % to 40 % in Uganda (p. 190) and a World Bank Report (2009) quantifies the costs associated with absenteeism at UGX 26 billion. It goes on to identify the second most important source of waste as that arising from 'distortions from the management of development assistance', which constitute a 'major source of funding but are mainly off-budget' (World Bank 2009: 24).[4]

The ubiquitous 'human resource crisis' is repeatedly referred to in research papers in the field of 'human resources for health' (HRH) but remains underspecified with vague references to an overall lack of personnel and/or lack of necessary training and skills (Thorsen et al. 2012). Indeed, it is hard to find a paper that does not refer to the lack of skilled personnel in facilities as a major factor. However, the reader is often left wondering what lies behind this situation and what it means in practical terms for health workers and, in our case, professional volunteers. Generic reference to 'staff shortages' tells us very little about the situation on the ground.

When asked to explain the reasons for staff shortages in Ugandan health facilities, an experienced Ugandan health professional replied:

> To start with really they don't have enough people trained to fill all the possible positions. I know that almost all the big hospitals are advertising positions for doctors and nurses. I also know lots of doctors who don't want to practice as doctors because they can work as consultants in an NGO. They usually go to American funders, they basically look around everywhere for anyone interested in funding their opportunities. People are now trying to go for project jobs. One good thing that people have realised is you can work in a government institution because there you are guaranteed a lifetime job and, at the same time, there are so many projects that come into the government institutions and help people top up their salaries in one way or another (UHW).

The respondent identifies a number of contributory factors. In the first instance, he indicates problems in initial supply exacerbated by the

haemorrhaging of doctors from clinical work into (usually non-clinical) positions in NGOs. Others strategically seek to combine 'project' work with their full-time public roles (contributing to absenteeism and exhaustion). The respondent later refers to the problems of international brain drain suggesting that many Ugandan doctors are looking for better-paid work across the border in Rwanda, for example. But this is compounded by the often more damaging but neglected effects of 'internal brain drain' (Ackers and Gill 2008). In Uganda, this manifests itself in many doctors studying for Masters Degrees in either Business Administration (MBA) or Public Health (MPH), positioning themselves to work in NGOs in managerial positions.[5]

Linked to the above, remuneration is a key factor affecting the presence of doctors in public health facilities. At the present time, private work ('moonlighting') is, in theory, illegal. In practice, it is endemic. To some extent, this represents a natural and entirely rational response to low pay. The following Ugandan health worker explains both the need for salary augmentation and the importance of holding a position in the public sector to facilitate private work:

> Most doctors working in the private sector are working for themselves simply because they need to make a bit of extra money and that way they can even negotiate to take some of the patients from the public hospital to their private hospitals (UHW)

In reality, it is not so much that the private work 'tops-up' or brings in a bit extra – the balance is rather the other way around with private earnings dwarfing public sector pay. One specialist heavily involved in very lucrative fertility treatment referred to his public role as his 'charity work'. In other cases, doctors, most of whom do not own their own premises, clamour around NGO projects involving infrastructural investments in the hopes that the more attractive and functional facilities will enable them to attract fee-paying patients.

In addition to the low level of pay, serious administrative problems in many districts means that healthcare staff are not paid at all for months:

> Right now they are not paying them enough and it doesn't come on time. I know people who don't get paid for six months and they expect them to

> carry on smiling, offering the best services they can when their landlords are chucking them out because they don't have money to pay (UHW).

This respondent had personal experience having waited for over 6 months to be paid (in this case by a university). Remuneration remains a major problem but it is never the only factor (Garcia-Prado and Chawla 2006; Dielement et al. 2006; Mathauer and Imhoff 2006; Stringhini et al. 2009; Mangham and Hanson 2008; Mbindyo et al. 2009; Willis-Shattuck et al. 2008). And, it is not at all clear that a recent MOH initiative to significantly increase the pay of doctors in HCIVs (to 2.4 million per month – around £500) has translated into (any) increased presence on the ground.

In a rare study focused specifically on the absenteeism of health workers, Garcia-Prado and Chawla (2006: 92) cite WHO statistics indicating absenteeism rates of 35 % in Uganda. The reality is far worse. A senior manager of a Ugandan Health District reported (in an interview in 2015) much higher genuine rates of absenteeism, suggesting that during a personal visit that week, he found that over 65 % of his staff are 'on "offs"' at any point in time. This certainly confirms our experiences as ethnographic researchers and is likely to significantly over-estimate the presence of doctors. On one of the facilities we are currently involved with, the in-charge doctor has not been present at work for over 4 months (for no apparent reason).

Whilst overall health worker–patient ratios are relatively very low and many positions for which funding has been committed lie unfilled, it remains absolutely clear from our interviews and ethnographic work that the staff who are appointed and receive remuneration are very often not present for work. And the more senior the position the less likely they are to be present. In the following focus group with Ugandan midwives and doctors, respondents were asked about health worker absenteeism. They talked at length about midwives and nurses but did not mention doctors:

Interviewer:	You haven't mentioned doctors at all? (Laughter between everyone)
Respondent 1 (midwife):	Oh, sometimes we forget about them because most of the time we are on our own. You can take a week without seeing a doctor so we end up not counting them among our staff.
Respondent 2 (doctor):	Especially on a night, you never see them there (at the health centre).

Respondent 1:	Even during the day like most of the time.
Interviewer:	How often would you say a doctor would come to the facility in a typical month?
Respondent 1:	The medical officers have the rest of this centre to cover too so maternity will see them only if there is any problem. So they come for two hours three times a week but that's for the whole centre, the other wards as well.
Respondent 2:	Yes, like two times a week, sometimes once but most of that time even when they're on [duty] someone will not come to review the mothers.
Interviewer:	What would happen if a mother needs a caesarean? Would you call the doctor?
Respondent 1:	Initially they told us we should call before [referring] but every time you call that doctor he is going to tell the same thing: 'I'm not around, you refer'. And you use your own judgement but sometimes you follow protocol, because if anything happens . . . you call that doctor for the sake of calling.
Interviewer:	Just going through the process?
Respondent 2:	But you know he's not going to come (FG)

In another location, the facility manager (a nurse) explains that, at the time of interview, there were few other factors restricting the use of the operating theatre (for caesarean sections):

> *Now we have constant power – the power is there. We had issues of water now they've stabilised. Now water is flowing; the issue of drugs, we have sourced drugs.*
>
> *Interviewer: But the doctors are still not here?*
>
> *No, they don't even come and you have to keep calling. You will call the whole day and some will even leave their phone off. [Referring to a list of referrals] Take this [referral] is for a 'big baby' but this is a doctor, an obstetrician. [I asked] when you referred this case, why wouldn't you enter into theatre? We are making many referrals and the [hospital] is complaining. [The doctors] are very jumpy, they work here and there. So, we had a meeting and one doctor was very furious about [the decision to question referrals]. I said, no this is what is on the ground; we want people to work. And the reason [they give] is there's no resting room. There may be issues of transport (i.e. the doctors' personal transport), but there's also negligence (UHW).*

It is not simply that doctors work very few hours, but the unpredictability of their presence and the absolute resistance to commit to any set hours seriously impacts services and volunteer engagement. This situation has made it impossible for any of the facilities that we work in to run an electives caesarean section list, with the result that all cases become emergencies and are referred.[6] This not only causes serious delays for mothers but also makes it very difficult for professional volunteers to engage effectively with local staff and share skills for systems improvement.

Accommodation is a serious issue (as noted earlier), but it is not a panacea especially when it comes to doctors. In one case where our charity has funded a doctor's overnight room, it has yet to be utilised. On the other hand, where we have provided an overnight room for midwives (in another facility) we have achieved and sustained 24/7 working. Furthermore, in one of the health centres we are involved with where doctors benefit from the provision of dedicated (family) housing on site, this has not improved their presence. The following quote is taken from an SVP volunteer report:

> Caesarean section mothers operated on Thursday or Friday are generally not reviewed by a doctor over the weekend. One mother operated on for obstructed labour whose baby died during delivery had a serious wound infection, pyrexia and tachycardia and pleaded (4 days later) for me to help her (V).[7]

Another volunteer made the comments in a report she drafted for the District Health Officer just before she left:

> Medical attendance or lack of it caused many problems. [. . .] in my own experience employed staff negate their responsibility when other professionals are on the ground believing that they will do their work and that they are free to work elsewhere (V).

She was referring here both to (foreign) volunteer presence but also to a visit by doctors from the National Referral Hospital during which time local doctors disappeared.

Whilst absenteeism and poor time-keeping are endemic problems amongst all cadres in Uganda, the situation is most acute when it comes to doctors. 'In-charge' doctors (senior medical officers appointed as facility managers) are often the worst offenders setting a very poor example to medical officers in their facilities and failing to observe and enforce

contractual terms. As the following medical officer suggests, many if not most of the doctors in these leadership positions do not do any clinical work in the public facility they preside over:

> *Most of the (in-charge doctors), if you really look at them, want to do administrative work actually, they want to sit in the office – they sign out the PHC (primary health care) fund. It's at their discretion to spend it so.... And of course sometimes there's corruption, outright corruption.*
>
> *Interviewer: So really what they're doing is administration but not leadership.*
>
> *Leadership requires you to be around; you can't let people run the place when you're not there. Leadership needs your presence, so you know the fact that [the in-charge doctors] are not always there, it's difficult. (UHW)*

Where in-charges are nurses, midwives or administrators, they have very limited ability to hold doctors to rotas:

> [Enforcement] is a problem. Doctors don't want to be accountable to someone 'below' them. They don't want someone, even if someone has a degree but they're not a doctor, to keep instructing them. (UHW)

This problem of enforcement seems to stem from higher levels with District Health Officers (usually doctors themselves) seemingly powerless, or unwilling, to challenge poor behaviour:

> I think particularly in the health department they are still intimidated by doctors which is a bit surprising. It goes hand in hand with accountability because if I know I am accountable for something going missing and if it goes missing then something will be done to me; in terms of discipline then of course I will behave differently. I wouldn't want to be found doing something on the wrong side of the law because I know that there is action that is going to be taken against me. But because here people don't see anything being done then they can do lots of things. (UHW)

A recent audit conducted by a volunteer of referrals to the National Referral Hospital from a Health Centre IV facility clearly identifies the problem of physician presence. It is important to point out that there are five physicians employed to work in this facility – far more than most comparable health centres:

Figure 2.1 shows that 62 % of referrals relate to human resource issues with 59 % directly attributable to the failure of doctors employed in the facility to be present during their rota hours. The situation reported here is by no means unusual. In one of the Regional Referral Hospitals we are involved with the professional (obstetrician) volunteer has instituted a weekly maternal mortality review process. On average two women die every week in this facility. The weekly reports highlight the human resource factors contributing to deaths. In most cases, medical interns are having to take responsibility for the bulk of referred patients despite the fact that the hospital employs four consultants. These consultants are rarely present

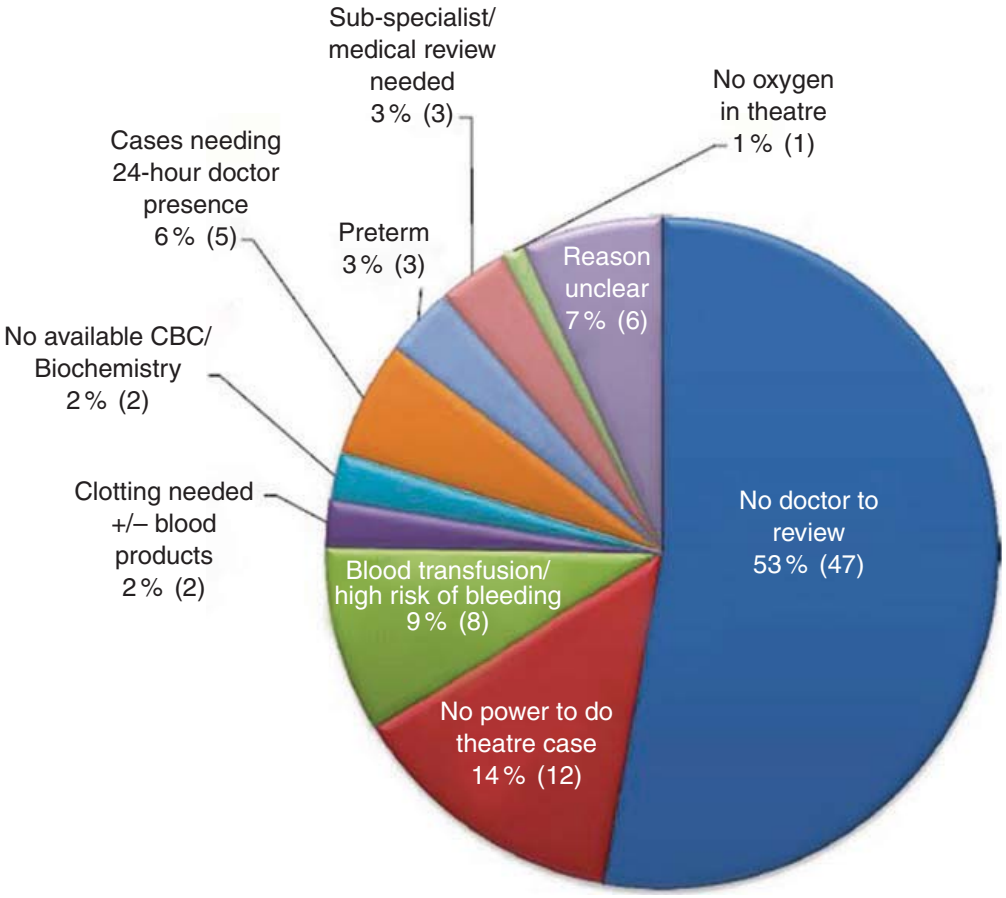

Fig. 2.1 Primary reason for referral from a Health Centre IV to the National Referral Hospital (*Source*: Ackers et al. 2016b: 7. *CBC* Complete Blood Count. (Numbers in brackets are numbers of patients.) All rights reserved, used with permission.

when needed and health workers are anxious about contacting them to review patients. The following comment in the report is typical:

> Consultant was not called – intern was in theatre and gave verbal prescription. Intern and midwife felt unable to call consultant out of hours. Midwife perception 'not my place' and intern 'we are expected to cope with it'.

It is also interesting to note that since the review process commenced, none of the consultants has attended the maternal mortality review meetings. It goes without saying that this situation has a very serious impact on health systems, intern supervision and patient outcomes. Its impact on the effectiveness of professional volunteer deployment is less well recognised. On the one hand, in an environment where absenteeism is neither recognised nor punished, the presence of skilled volunteers actually facilitates it. It is more difficult from an ethical and visibility point of view for a Ugandan health worker to leave a ward with no staff (although this is common); the presence of a British health worker renders it much easier. In that important respect, labour substitution encourages both absenteeism and moonlighting. On the other hand, if a deploying organisation takes the (correct) view that permitting volunteers to work on their own in such high-risk situations is in breach of our duty of care, and fails to contribute to capacity-building objectives, then facilities in real need of additional human resource will be denied it. And, sadly this was the decision the SVP was forced to take in Wakiso District Uganda after over 3 years of engagement and unsuccessful dialogue with the District Health Office. In the absence of an understanding of the causes of low staffing, the very conspicuous absence of local staff effectively justifies and encourages gap-filling behaviour by volunteers.

The Independent Risk Assessment commissioned for the SVP added further impetus to these concerns. Identifying lone working or 'unsupervised clinical activity' as a key element of 'unacceptable residual risk' in some Ugandan facilities, the Risk Assessment took an unequivocal position requiring that volunteers 'withdraw from undertaking clinical work in the absence of professional Ugandan peers, or should they become a substitute for Ugandan staff – even if this leaves the patient at risk' (Moore and Surgenor 2012: 20). At the time we were surprised to find that the Risk Assessment identified Mulago National Referral Hospital as presenting the most serious risk of lone working (Table 2.2)[8]:

Table 2.2 Residual risk exposure in SVP placement locations

Summary Analysis

Hazard Profile	Over all Residual Risk Exposure (Taking Control Into Consideration)								
	Kabubbu	Kassingati	Mulago	Kewempe	Mbale	Hoima	Kisiizi	Mbarara	Gulu
Access to safe supply of food and drinking water at location	10	10	10	10	10	10	10	10	10
Assault (verbal, physical, sexual)	10	10	10	10	10	10	10	10	10
Unsafe or unsupervised clinical activities	3	9	15	3	3	3	3	Unable to evaluate	3
Civil unrest/violent public disorder	10	10	10	10	10	10	10	10	10
Exposure to infection/tropical disease	12	12	12	12	12	12	12	12	12
Lone Working	5	5	15	5	5	5	5	Unable to evaluate	5
Lost (in unfamiliar and/or dark surroundings)	10	10	10	10	10	10	10	10	10
Needle stick injury (including provision of emergency HIV post-exposure prophylaxis)	10	10	10	10	10	10	10	Unable to evaluate	10
Personal accident or injury including road traffic accident	15	15	15	15	15	15	15	15	15
Slips, trips or falls on uneven, wet and/or muddy ground	6	6	6	6	6	6	6	6	4
Sun exposure	4	4	4	4	4	4	4	4	4
Terrorist attack targeted at volunteers or projects (suicide bomb, false imprisonment, kidnap or hostage)	15	15	15	15	15	15	15	15	15
Are all risk acceptable (i.e. controlled as low as reasonably practicable (Y/N)?	Y	Y	N Co-Presence & Lone working	Y	Y	Y	Y	N Unable to complete assessment	Y

Range of risk-exposure outcome scores (Severity × Likelihood)

Very low risk			Low risk			Medium risk		High risk		Significant risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25

Source: Moore and Surgenor 2012: 20. (The Risk Assessment and a Policy Report based on it is available on our website http://www.knowledge4change.org.uk/. A version of this is published (Ackers et al. 2014).

This hospital in the centre of Kampala is, of course, the facility with the highest number of healthcare workers and one of the very few facilities in Uganda employing specialists.[9] The Department of Obstetrics and Gynaecology at Mulago Hospital (in 2014) employed 47 specialists, 48 senior house officers, 100 interns (17 at a time on rotations) and 350 midwives. These figures may seem reasonable in a facility delivering 30,000 deliveries a year. However, how can the risk of lone working be so high in such a context?

The reality is that staff are often not present on the ground during their contracted hours and it is very rare indeed to see any specialists present on wards; they are conspicuous by their absence.

A study by a local clinician on the 'Decision-Operation-Interval' examined the time that lapses between the decision to perform an emergency caesarean and the operation taking place and the causes and effects of those delays. Whilst lack of theatre space emerged as the dominant factor delaying operations, the report also identified a whole range of 'personnel factors' (shift change-over delays, absenteeism or late coming) underlying delays (Figure 2.2):

There is no scope in this book to discuss the consequences of low and unpredictable remuneration in any detail. Salaries are certainly below subsistence level requiring health workers to undertake additional work to make ends meet. The absenteeism that we witness is not a symptom of laziness or general demotivation; the more senior staff are typically very highly motivated and work very intensively deploying a high level of skill. But the overwhelming majority of this work takes place on a private basis. They are 'otherwise engaged' but often working long days and through the night with private patients and in private clinics or, in some cases, on NGO-funded projects. Shrum et al. had a similar experience in a project concerned with the installation of Internet communication systems in Ghana. Here, key players frequently failed to 'show up' for work. The authors make the subtle observation that, 'It's not that anyone was trying to do anything except their job. . . . It's that they have a lot of jobs' and were constantly engaged in trying to make money (2010: 160).

Absenteeism and moonlighting present specific challenges for programmes, such as the SVP, committed to avoiding labour substitution wherever possible. Put simply, where Ugandan staff are regularly absent and the risk of lone working is high, we are unable to place professional volunteers (Ackers et al. 2014).

Rank	Factor	*Mean time lost (minutes), n = 351	% Mothers affected
1	No theatre space	366.5	94.0
2	Shift change-over period	26.1	22.2
3	Instruments not ready	15.1	21.4
4	Surgeon on a break	13.7	24.5
5	Anaesthetist on a break	11.7	6.8
6	Theatre staff on a break	6.4	13.7
7	Some theatre staff not arrived	5.1	12.5
8	Linen not ready	3.7	7.7
9	Irregular patient drug dosing	3.3	1.1
10	Anaesthetist not arrived	2.8	4.0
11	No theatre sundries	2.1	5.7
12	Patient unstable	1.7	2.3
13	Patient not seen on ward	1.6	0.6
14	Lack of I.V. fluids	0.5	2.0
15	Patient not consented	0.4	0.6
16	Surgeon not arrived	0.3	0.6

Fig. 2.2 Common factors determining decision-operation intervals (*Assume all 351 participants.' doi: could be affected by all the factors. *Source*: Balikuddembe et al. 2009.) All rights reserved, used with permission.

Challenging Traditional Volunteer Roles: Labour Substitution and Systems Damage

Whilst the concerns around risk in lone-working situations and the limited return on service delivery in terms of knowledge transfer and mutual learning are obvious, it is perhaps less immediately clear why substituting for local staff is actually counter-productive or damaging. Thinking in terms of the three hypotheses set out in Chapter 1, labour substitution may fall under Scenario 2: 'neutral impact'. And, certainly, if we believe the caricatures presented in the media and echoed in academic papers (that the human resource crisis in low-resource settings simply equates to poverty and pitiful staffing levels) then perhaps that is justifiable. Who could argue with the logic that overworked healthcare staff are exhausted and need a break?

The following section considers the role of professional volunteers from a more informed human resource perspective, arguing strongly that volunteer deployment must be framed and negotiated within an evidence-based understanding of local human resource dynamics. In so doing, it also emphasises the importance of multi-disciplinary expertise and not leaving these kinds of decisions to individual clinicians who may arrive in an LMIC with little understanding of human resource management in low-resource settings or even of international development.

The title of this chapter 'First do no Harm'[10] is taken from the Hippocratic Oath – an ethical statement governing the conduct of the medical profession. At face value, the Oath and its interpretation through the General Medical Council's 'Good Medical Practice' Guide (2015) do not suggest any major contradictions or tensions for doctors. Put simply, it requires doctors to pledge to put the needs of patients first and 'do no harm' to them. An earlier version of the GMC guide included a paragraph stating, 'Our first duty is to our patients, not to the Trust, the NHS or to Society' (2012). This implies a prioritisation of the one-to-one doctor–patient relationship – a highly individualistic approach to patient well-being which guards against political and pecuniary interference. However, it fails to grasp the potential unintended consequences of this approach when doctors are working as 'outsiders' in a foreign health system.[11] Hurwitz suggests that this simple message masks greater moral complexity in the face of 'bizarre moral predicaments' as 'new obligations thrust on doctors may conflict with their first responsibility to care for patients' (1997: 2). Although Hurwitz refers to the challenges of working in 'extreme circumstances', there is no explicit reference here to diverse international contexts. The updated (2015) version simply states: 'Make the care of your patients your first concern' (p. 0) potentially opening up opportunities for a more holistic interpretation.

The prioritisation of the doctor–patient relationship is often evident in the motivations expressed by professional volunteers applying for international placements through comments such as 'wanting to help people' or 'make a difference'. Many of the professional volunteers motivated to work in LMICs are motivated not only by clinical concerns but also by religious convictions. And these 'Good Samaritan' motivations often accentuate the desire to focus on individual patients rather than understanding and responding to systems.[12] Furthermore, whilst many professional volunteers – and especially those with prior experience in low-resource settings – articulate an interest in sustainability and longer-term change, they rarely interpret this as challenging their immediate commitment to

individual patients. In other words, that systems change and immediate patient care may lie in some tension.

Volunteer Roles and the 'Expectation of Labour Substitution'

> Every time I turned up, everybody disappeared (V)[13]

This comment made by an SVP volunteer captures the experiences of the overwhelming majority of volunteers when they first arrive. Although we advise them to expect this prior to departure, it continues to shock. This experience is by no means limited to Uganda; indeed, it is a feature of most low-resource settings. Hudson and Inkson cite a respondent in their research on voluntarism who experienced this situation:

> A bad day is filled with frustrations and lack of understanding . . . all staff will have mysteriously disappeared (2006: 312).

Similarly, respondents in an evaluation of the International Health Links Scheme (Ackers and Porter 2011) expressed concerns about UK volunteers being left to work in the absence of supervision:

> We should say that we wouldn't send over junior British staff unless there's a senior [local clinician] on the wards and I wonder if that might set a bit of an example.

The SVP evaluation is peppered with similar experiences. In one example, a very experienced professional (short-term) volunteer described in his post-return report how, as soon as he arrived on the ward, the local consultant made an excuse that his partner was not feeling well and left – and then failed to return. The consultant in this case explained how, in the time frame of his short (10-day) stay, he managed to clear the backlog of untreated oncology patients and relieve congestion. Clearly, the patients were direct and immediate beneficiaries of this process but it would be impossible to justify this kind of voluntarism from the perspective of skills exchange or sustainability. And as soon as the volunteer returned to the UK, the wards would rapidly re-congest. Indeed, a more impactful response generating greater patient benefit in the long term may have been to reply 'I'm sorry but if you go I have no choice but to do the same'. This is the culture that we have

been trying to embed within SVP relationships with an increasing emphasis on conditionality as relationships mature and mutual understanding grows.

In another quite different situation, the arrival of a group of American midwifery students at a Ugandan health centre was marked by staff absence. It is hard to say in this case if the arrival of foreign students encouraged staff to absent themselves – but they were certainly not planning to welcome them and the SVP obstetrician noted that the level of absenteeism was unusually high:

> The Americans have been covering up a shocking lack of staff at [facility] in the last two weeks which is good for the women but is making me grind my teeth. Essentially it seems that most of the staff have been individually summoned for trainings of various kinds by various agencies without any co-ordination with the sister or doctor in charge at the facility leaving us for days at a time without a neonatal nurse (V).

One of the most tangible signs of labour substitution is the placing of professional volunteers on staff rotas. And however much we discuss with the local partner, the problems with this is it remains a high expectation whether the visitors are consultants or students. We were aware of these tensions before the start of the SVP and issued clear guidance to all parties that professional volunteers should not be placed on staff rotas except in exceptional circumstances.[14] Quite understandably, local health workers are often upset about this and resent it, expecting volunteers to relieve them of very burdensome tasks. This reflects misunderstandings about the role of volunteers (and of Health Partnerships and AID more generally) accentuated by years of experience of missionary-style labour substitution voluntarism. Some local health workers will challenge the decision not to permit volunteers to go on rotas, suggesting that volunteers are work-shy voluntourists and more interested in going on safaris than supporting them. And this may well reflect their experience of volunteers. Challenging this culture of volunteering has proved a challenge within the SVP but we are confident that consistency in response is essential. The following Ugandan clinician who was part of a focus group argues forcefully against allowing volunteers to go on staff rotas on the basis that this will undermine co-working and encourage absenteeism:

> I don't support the idea that they go on the rota. I would not support that – they will leave all the work to her (the volunteer). I've seen it. Once you add

> someone extra on the rota someone in that group will disappear for a year as long as they know the volunteer is there (FG).

Whilst this expectation was almost always experienced at the start of placements, it is by no means only at this stage. For most professional volunteers, it is an ongoing process involving complex negotiations at many levels. In one case, a volunteer who spent over a year in Uganda was constantly under pressure not only from her peers but also from the hospital superintendent (in this case, a British volunteer himself) to become involved in routine service delivery and be placed on local staff rotas.[15] She battled on a daily basis to resist service-delivery roles for over a year. Sadly, when she returned to Uganda after some months in the UK she immediately found that the expectation had increased. Staff assumed, as she knew the place and had experience of working there, she could immediately substitute for local health workers. In her monthly report she identified the '*main obstacles to achieving her objectives*' as follows:

> It's just that I seem to be left to do things on my own now a lot. Frequently I am doing the ward round alone with or without the intern as the only other midwife on the ward is in the Waiting Home for half the morning. Because I have been here so long the midwives treat me as one of the rota staff, which is lovely as they accept me and trust me, but means I can't do admin and prep for teaching as they assume I am always going to be there to do the ward round. And as there is often literally no-one else to do it I can't really just disappear to do teaching prep etc. so my objectives changed – I think that is probably a natural progression in this type of work after one has been there for a while (V).

This case has encouraged us to reflect on another deeply held assumption within the international volunteer deployment community and among hosts – that long stays are far more valuable in terms of development impact. The issue of length of stay is discussed in some detail in Ackers (2013). What is clear from the experience of this volunteer is that the presumption of gap-filling increased with length of stay and became very difficult (impossible) to negotiate as time went on:

> It would seem offensive now to the staff who I have got to know so well and so closely if I were to stop working the moment there was no-one to work with.

This situation may reflect a failure on the part of local staff to understand the role of professional volunteers, which may itself reflect a failure on the part of the deploying organisation, the host management team or the

volunteer themselves to understand capacity-building approaches to international development. In many respects, we are dealing here with trying to effect in-depth ongoing culture change in an environment in which many of the actors involved either don't understand or don't subscribe to that (systems-focused) approach. One midwifery volunteer describes her experiences:

> On my first day all the midwives left to have their lunch. I was the only midwife on the ward of 27 labouring or newly delivered women. I think there will always be difference in opinion as to whether we are replacement labour or not (V).

This presents serious challenges when placing professional volunteers in the Ugandan healthcare system where the lack of senior staff or their failure to be present on the wards leaves more junior staff and students in situations where they have to work on their own and outwit the bounds of their competency. Lone working without supervision is normalised for Ugandan healthcare staff and it is unsurprising within this culture that volunteers are expected to do the same. One UK consultant clinician explained in her report how senior staff 'walked off the ward' the moment she arrived. These are common (normal) experiences in Uganda. The following excerpt from a blog written by an LMP obstetric volunteer working in a facility delivering 30,000 babies a year (over 80 a day) illustrates the problem in more detail:

> The 2 weeks leading up to Christmas were the most intense weeks that I've had at [the hospital]. All of the Senior House Officers [clinical trainees] were on exam leave and to make matters worse the interns [junior doctors] were on strike because they hadn't been paid. I was the only junior doctor on the rota to cover labour ward, theatre and admissions (there would normally be 3–4 SHO's and 4 interns)! Two seniors [specialists] were supposed to be covering labour ward during the exam period, however often only one would turn up and go to theatre leaving me alone. One day no specialists turned up at all, so I wasn't able to open theatre when there were 8 women waiting for caesareans. A woman presented with cord prolapse so I had to take her to theatre but she was the only caesarean that got done. To say I felt vulnerable would be an understatement, and in true [hospital] style everything you could imagine happened: eclampsia, twins, breech deliveries, abruptions, ruptured uteri. One particular incident happened when I was alone in admissions. A woman arrived in a semi-conscious state following an eclamptic seizure,

> and was having an abruption (premature separation of the placenta leading to heavy vaginal bleeding). It was very hard to auscultate a fetal heart beat and I feared the baby was dead. After delivering the baby with a vacuum it needed urgent resuscitation. I attempted to resuscitate the baby but it was futile, I didn't have a towel to dry the baby and the resuscitation equipment was broken. A very frustrating and upsetting day (V).

This volunteer was deployed via the LMP in the year prior to the SVP and her experience had a profound impact on project design. During that time, a HUB partner working in Gulu Regional Referral Hospital recounted the experience of a volunteer midwife who,

> *initially put herself on the staff rota. However, the local midwives stopped coming in because they thought, 'Oh she is there so that's OK'. So she took herself off the rota and started to come in at different times and did an assessment and made decisions about where her work was best needed. So she wasn't on the rota because, especially when it came to the evenings, she was invariably the only midwife there. I had a long chat with some other doctors and they said they'd seen the same thing. Two young [volunteer] doctors turned up and all the senior staff went on holiday the next day and that's unacceptable. It's very difficult to extract yourself from that situation.*

The case illustrates the relationship between lone-working and competency with early-career volunteers often under serious pressure to perform tasks that fall outside their experience and confidence.

This situation is by no means limited to obstetrics and gynaecology. This is just the department we are most familiar with. And as the SVP began to recruit and place anaesthetists we became acutely aware of similar problems. SVP anaesthetic volunteers were being repeatedly put under pressure to open theatres on their own due to a lack of local specialists. This came as something of a surprise as Mulago was one of only three hospitals in Uganda with specialist anaesthetists, most of whom have been trained with support from the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and partner organisations in the USA and Canada. The reality is that there is no shortage of specialist anaesthetists in Mulago. However, they are rarely present to fulfil their local public duties or to work alongside professional volunteers. The initial advice from the AAGBI was that we should only place anaesthetic volunteers in Mulago, Mbarara or Mbale where UK-trained anaesthesiologist were in post. One consultant anaesthetist

volunteer spent her first 2 weeks in Mulago and reported on her early experiences following initial meetings with local staff:

> As far as my activity in Mulago [I plan to have] a non-clinical role as my working hours coincide with the presence of skilled and experienced anaesthetic staff.

Several weeks later, her perspective shifted when the reality of working in the National Referral Hospital became clear:

> Staff absences and late starts are endemic and my presence alleviates the situation at times. As I have spent more time in Mulago I have got caught up in service provision. I'm feeling stressed, exhausted and like I'm failing on every front. The obstetric anaesthesia lead is rarely in labour theatre. There are always local practitioners (anaesthetic assistants) when I'm working but there has been 1 episode of me being the most senior anaesthetist on the floor with 3 Ugandan students for me to supervise. The senior Anaesthetic Officer (whom I contacted) who was supposed to be present felt no unease with the situation. The students' neonatal resus skills are not yet well established and I felt the whole setup left both me and the students exposed. The cases were of prolonged and obstructed labours and both mothers and babies were at high risk of complications.
>
> There is a clear roster of who is on and the [Ugandan doctor] on a few occasions had tried to get hold of all of them who are absent. The surgeons are there. On the few occasions I was the first [anaesthetist] to turn up there and sometimes I have been there and there is nobody there. I don't know how people get away with it. Because if you look at the roster there are doctors during the day, nights and during weekends but there are no doctors [present].

As a result of this feedback and the volunteer being put in a situation where she had to open up theatre on her own, we requested that she work in other facilities. Similar experiences were had by anaesthetic volunteers placed in Mbale where the specialist worked almost all of his time in the private facility. Mbarara was a significant and unique exception. The consultant anaesthetist in Mbarara embraced the logic behind the co-presence principle before we even used the term issuing instructions to his staff that they must remain in the workplace until the UK volunteer herself left. This placement had proved one of the most successful with clear signs of sustained improvement many years after the volunteer left due in large part to the attitude of the local mentor.

The final case presented here took place during the professional Risk Assessment process and was picked up by the risk assessors in their report (Moore and Surgenor 2012: para36):

> 36. As a condition of ethical approval by the Hospital Ethics Committee, we were told that medical students were required to work during the weekends and at night. Both the volunteer and medical students spoke about difficulties accessing senior medical colleagues during the night. We were informed of a particular night shift wherein there were 2 still births, a death on the Maternity HDU and an obstructed labour – obstetric and midwifery staff apparently refused to attend and assist because they were sleeping (which we were told is normal practise and they are not to be disturbed whilst sleeping). We understand it was left to volunteers to work through the problems as best they could. Medical students explained how they were often goaded into carrying out clinical examination or diagnostic procedures they did not feel competent to perform, and whilst they declined to carry out the procedures, they explained how this created some tension with Ugandan medical students also working at the Hospital. We were concerned here about the level of clinical supervision and support, but also the security implications of working at night.

This case was also reported to us by the volunteer, resulting in a formal complaint and the promise, on the part of the Ugandan facility, to investigate further. We were not aware that this took place. In fact, the British obstetrician did wake one of the sleeping Ugandan doctors who then refused to assist her and complained at being woken up. The British doctor reported this situation in the patient's medical notes precipitating angry exchanges as Ugandan doctors pressurised her to remove the comments. This incident took place in the final 2 weeks of a 12-month placement causing serious anxiety for the volunteer. And, the pressure to undertake data collection during the night (on the part of the British medical students) came from their UK obstetrician supervisor keen to gain round-the-clock data collection for his research paper. When we contacted the obstetrician about this he responded defensively expressing the view that 'clinical' mentoring should and could be distinguished from risk assessment. In other words, risk was not his problem:

> Risk assessments are really issues for [sending organisations] rather than clinical mentors and I would not like to [get involved].

Sadly, service-delivery roles are also a direct response to the demands of foreign visitors, often keen to gain access to patients and conditions that they are unable to achieve at home. One of the worst examples of service delivery we have witnessed in Uganda – in this case entirely focused on training American doctors – is described by an SVP volunteer:

> *The Americans have kind of taken over (one of the obstetric) theatres. They have got some senior residents in special training and they have got these really junior doctors who are increasing their caesarean section skills. They have been here for a month just doing a lot of sections. They work during the day shift.*
>
> *Interviewer: So their objective is to train the US junior doctors and they take up the whole theatre? Are there any Ugandans in there then?*
>
> *No, I think they have been doing this for several years they have got introduced to everybody in one of the morning meetings and one of the guys said we have been coming here for six years.*
>
> *Interviewer: So, you think the main point is to train the American junior doctors because they cannot get that access over there (in the US)?*
>
> *Yeah (V)*

This situation is entirely unacceptable and unethical – even if it did mean that Ugandan mothers were being treated for free during that period with US equipment and staff. Not only does this type of intervention undermine the Ugandan health system, but it also caused problems for SVP volunteers attempting to achieve a level of co-working with local staff.[16] The following paediatrician contemplating applying to the SVP describes her experiences of volunteering as a medical student and her concerns that these forms of gap-filling voluntarism generate dependency:

> I'm not sure whether to go again. I first went to Uganda in 1985 as a medical student to a mission hospital. All the doctors and nurses there were ex patriates. They had their fingers in the dyke really. Although the medical superintendent was Ugandan and they did a great job looking after patients when they were there, there was no succession planning. There was complete dependency on the foreign staff. I guess it was a mission hospital model (V)

Co-Presence and Knowledge Brokerage

The previous section has discussed the risks and unintended consequences of labour substitution models of volunteering. Chapter 1 described THET's mission in terms of 'leveraging the knowledge and expertise of

UK volunteers to build human resource capacity'. Clearly, deploying volunteers to replace local staff does not begin to operationalise that goal. The emphasis on knowledge in THET's mission could, arguably, be achieved through other forms of intervention such as donating books, providing on-line training or increasing training opportunities in the UK. It goes without saying that British health workers represent an important resource. They possess valuable knowledge gained through undergraduate education and subsequent continuing professional training and experiential learning. Of course, this is a diverse population and their skills, knowledge and personalities will vary widely. The fundamental question for projects such as the SVP is how can this resource (i.e. the embodied knowledge of UK health workers) be mobilised and deployed to offer optimal benefit to the Ugandan public health system? And what added value does flying them out to LMICs (human mobility) bring?

Our familiarity with the research on highly skilled migration and knowledge mobilisation made us aware of the complexity of knowledge itself and how difficult it is to simply 'move' it from one context to another and expect it to stimulate innovation or behaviour change. Although we are aware how complex these debates are, it is useful to summarise them here if only to help us understand what we mean by 'knowledge' in the Health Partnership context.[17]

Williams and Balaz (2008b) distinguish various types of knowledge suggesting that some forms of more explicit knowledge (such as technical skills) may be transferred internationally via text or virtual means. He contrasts this with 'embodied' knowledge where learning takes place through doing, is highly context-bound and requires greater co-presence (or face-to-face interaction[18]) and stronger relationships. Meusburger similarly identifies a 'missing distinction' in debates around the spatial mobility of knowledge, between knowledge and 'routine information' suggesting that, 'codified routine knowledge that can be stored in databases has to be distinguished from intuition, foresight and competence based on years of experience and learning' (2009: 30).

Whilst it is useful to identify explicit and tacit knowledge as opposite poles along a continuum, in practice, the categories are fluid (Meusburger 2009: 31). And the distinction begins to lose its significance when it comes to the *application* of knowledge. The capacity-building and systems change objectives of Health Partnerships demand highly complex forms of knowledge transfer, combining technical skills with mechanisms for their translation into socially relevant outcomes. In that sense, even much

standardised forms of knowledge (clinical skills) need to be complemented with highly contextualised knowledge to support effective implementation. As Williams notes, while it is important to distinguish different types of knowledge, 'one of the keys to their valorisation is how they are combined' (2006: 592).

Williams and Balatz's paper on knowledge transfer in the case of returning Slovakian doctors opens with the assertion that, whilst health worker migration is an 'inescapable feature of the health sector . . . there has been relatively little research on mobility as a conduit for learning and knowledge transfer' (2008a: 1924). The paper identifies a range of knowledge acquired by doctors including 'technical skills, academic knowledge, cultural knowledge, management know-how and administrative skills' (p. 1925). They suggest that whilst some knowledge may be transferred electronically perhaps through reading and published protocols, other forms of 'embodied knowledge' are 'rooted in specific contexts, physical presence and sensory information and may include participation in clinical practice'. And these forms of knowledge are 'grounded in relationships between individuals' and in socialisation processes. The successful application of knowledge combinations, according to Williams and Balatz, requires 'co-presence' (2008a: 1925). The authors describe the opportunities for actors in this knowledge exchange process to act as 'boundary spanners' operating in places of 'unusual learning' where perspectives meet. And the conditions for this higher level of comprehensive knowledge exchange are not simply met by crossing national or other boundaries but by the quality of relationships at those boundaries (p. 1926). Meusburger contends that understanding the 'spatial mobility of knowledge' demands awareness of communication processes (2013: 29). Even where levels of explicit knowledge/skills are deemed higher in the UK, complex communication and strong relationships are required in order to contextualise that knowledge and translate it into effective practice in a Ugandan healthcare facility.

Meusburger is quite right to identify a range of 'assumptions' that shape the quality of relationships, including the impact of asymmetric power and the importance of non-verbal communication emphasising the importance of co-presence or 'F2F' contact. He also usefully distinguishes the types of individuals involved on the basis that knowledge may move differently between different kinds of stakeholders and practitioners and identifies a number of factors influencing relationships and communication process.

These include the 'cognitive abilities, ideology, interests, motivation, attention, emotions, and prejudices of the recipients and the milieu they are embedded in' (2013: 33). The emphasis on communication here is essential but in the context of multi-lateral exchanges. And participants in this co-learning process will bring different forms of knowledge to the table.

In order to achieve the goals identified earlier – with a strong focus on co-learning to support systems change – Health Partnerships need to focus on identifying mechanisms to facilitate the kinds of relationship-building conducive to behavioural change. Co-presence is a necessary pre-requisite for the kinds of relationship formation conducive to knowledge translation.

The Sustainable Volunteering Project and the 'Co-Presence' Principle

Our experience of the risks associated with labour substitution or 'locum-volunteering' coupled with our research on knowledge mobilisation (albeit in a rather different context of scientific mobility) encouraged us to import 'co-presence' as a core operational principle shaping volunteer deployment in the SVP.[19] In this context, the doctor (or health worker) as a professional volunteer becomes a knowledge intermediary first and foremost rather than a 'carer'.

In practical terms, 'co-presence' simply means that UK professional volunteers should always be physically working alongside Ugandan peers in an environment that promotes opportunities for knowledge exchange. Co-presence does not imply that professional volunteers do not engage in clinical work. However, when they do so they must be appropriately mentored and engaged in active mentoring (according to their needs and the context). Co-presence is a composite concept representing the quality of relationships. Effective relationships play a number of distinct but related functions in the context of professional voluntarism. These include:

- The promotion of volunteer **safety** and mitigation of **risk** (discouraging lone working and ensuring compliance with competency principles).
- The facilitation of effective **knowledge transfer** (through training, mentoring and co-working).
- The process of embedding **reciprocity**, accountability and conditionality.

Implementing co-presence has been and continues to be a challenging process. It has met with resistance from not only local Ugandan staff (as noted earlier) but also some volunteers keen to optimise their opportunities for clinical exposure and often frustrated at the inability to intervene when local staff are absent. Nevertheless, we believe that is has begun to be understood and recognised as one of the features of the SVP. From an operational and evaluation perspective, it is implemented through a monthly reporting system which requires volunteers to state whether they have been able to comply with the principle and identify situations where the project managers need to intervene. This has been reinforced through regular interviews with volunteers and their hosts, site visits and bi-annual workshops. Co-presence now forms a core component of any Memoranda of Understanding governing relationships within the SVP and is increasingly subject to more concerted conditionality requirements. In more recent work it has shaped volunteer engagement in degree-level teaching and the functioning of the Ethical Electives Project (Ahmed et al. 2016b).

Summary

Following the discussion of objectives in Chapter 1, this chapter has outlined the dynamics of the human resource environment within which capacity-building projects, such as the SVP, deploy professional volunteers. The SVP, in common with most volunteering schemes, has faced the multiple dilemmas of attempting to place professional volunteers in contexts, often at the requests of senior managers, only to find them left to work on their own in high-risk and challenging service-delivery roles. Not only will volunteers find that many of the staff employed to work in these facilities are not routinely there but their very presence, as volunteers, will encourage others to absent themselves. And volunteers themselves (particularly doctors) perhaps motivated by ethical principles to respond immediately and unquestioningly to patient needs or, more commonly, by their own desire for clinical immersion and the opportunities to practice on complex cases, often enjoy and seek out such high-risk 'Ninja'[20] medicine. Enforcement of co-presence is essential to change the culture of volunteering and the systems damage caused by passive and dependency-generating gap-filling. In that respect, co-presence must avoid becoming one of the conditionality principles that Moyo suggests have 'failed miserably' to constrain corruption and bad government because

they were 'blatantly ignored and AID continued to flow' (2009: 39). Conceptualising professional volunteers as knowledge intermediaries in systems change interventions places a firm emphasis on the co-presence principle. Co-presence cannot guarantee effective learning, but it is a pre-condition of it.

Notes

1. Co-presence is also central to risk mitigation in the SVP (Ackers et al. 2014).
2. http://www.who.int/gho/health_workforce/physicians_density_text/en/.
3. Some of the material presented in this section is published in Ackers et al. (2016b).
4. The 'off-budget' quality of this AID enables it to avoid accountability procedures, leaving it open to corruption.
5. In a rather different (post-earthquake) context, Dr Pokharel, vice-chairman of Nepal's National Planning Commission, responded to criticism of the Nepalese government's response by suggesting that the 'huge salaries on offer in NGOs and the UN are causing a brain drain in Nepal's civil service. 'A government guy gets $200 a month, whereas you are paying $2,000 per month at an NGO, which is damaging' (reported in Cox 2015).
6. We discuss elective sections in more detail in Chapter 5.
7. In a pilot project, our charity has recently constructed purpose-built accommodation for a Ugandan obstetrician in order to enable a regional referral hospital to attract a suitable candidate (they were faced with the prospect of having no obstetrician present at all which also meant we could not place long-term volunteers there). We have attempted to link conditionality principles to occupancy to ensure that the doctor works to his employment contract. We are currently monitoring the project. This work has been undertaken in conjunction with a sister charity 'One Brick at a Time' (OBAAT). For further details see www.lmpcharity.org.
8. The Risk Assessment and a Policy Report based on it is available on our website http://www.knowledge4change.org.uk/. A version of this is published (Ackers et al. 2014).
9. Few Regional Referral Hospitals have specialist obstetricians on their staff.
10. This is also the title of our sister volume on ethical elective placements (Ahmed et al. 2016b) and a short item in the RCOG International News 2015 (pp. 32–33).
11. Of course, there are issues here also around private medicine that fall outside the scope of this book.
12. Volunteer motivations are discussed in Chatwin et al. (2016).

13. Some of the material presented in this section is published in Ackers, Lewis and Ackers-Johnson (2013) in a paper on risk.
14. We permitted it for a short time when a student examination period coincided with an intern strike.
15. This was an unusual placement in a Mission Hospital which was part of the HUB.
16. This is one of many cases where foreign NGOs undermine each other and confuse local health managers.
17. For a discussion of knowledge mobility in the context of research, see Ackers (2013).
18. The term 'F2F' is used by some authors as an equivalent to 'co-presence' (Taylor et al. 2013). For more discussion of the operationalisation of the co-presence principle see Ackers and Ackers-Johnson (2013 SVP Policy Report 1).
19. For more details see the SVP Annual Report 2013 http://www.lmpcharity.org/images/documents/SVP%20Annual%20Report%202013.pdf.
20. A phrase used by a junior doctor to describe his volunteering experience.

CHAPTER 3

Fetishising and Commodifying 'Training'?

Abstract Chapter 3 examines the effectiveness of traditional capacity-building roles focused on the provision of training through Continuing Professional Development (CPD) or Continuing Medical Education. It draws on research evidence to expose the unintended consequences of interventions focused on forms of CPD 'training'. It describes the SVP approach favouring on-the-job co-working and mentoring over formal off-site courses. This approach increases opportunities for genuine learning and confidence in deploying new knowledge. More importantly, this reduces the collateral damage caused by traditional CPD interventions. Notwithstanding these 'successes', our research suggests that the effects of even these interventions can be short-lived. It was at this stage in the project journey that we realised that co-presence, whilst essential, was not sufficient to guarantee knowledge translation and sustained impact.

Keywords Continuing professional development · Continuing medical education · Conditionality

Introduction

Chapter 1 set out the objectives of capacity-building approaches to international development as exemplified in the Tropical Health and Education Trust's Health Partnership Scheme and the focus this places on knowledge leverage to support systems change. In this context,

H.L. Ackers, J. Ackers-Johnson, *Mobile Professional Voluntarism and International Development*, DOI 10.1057/978-1-137-55833-6_3

we have conceptualised the role of the professional volunteer as a 'knowledge intermediary'. Chapter 2 emphasised the critical importance of context to the effective placement of such knowledge intermediaries and the damaging unintended consequences that may arise from labour substitution roles. This logically implies a highly specified, structured and supported role for professional volunteers focused on (bi- or multilateral) knowledge mobilisation. Indeed, the risks associated with labour substitution may be entirely mitigated by a role delineation explicitly prohibiting clinical work. And, many 'free mover' short-term volunteers (outwith organised programmes such as the SVP) have effectively chosen this option in order to avoid working without clinical registration[1] and professional indemnity insurance. In such cases, the desire to avoid complex legal and financial systems effectively drives the activity leading to a focus on fly-in-fly-out short courses.

Again, logically, these goals may imply a focus on initial (classroom) education taking place within the frame of education providers (colleges and universities). This would have the longer-term benefits of systematically training the next generation prior to their entry into the workforce. Deploying volunteers outside of health facilities, in formal (off-the-job) training encounters could protect them from the kinds of risks associated with clinical practice and increase their ability to focus on training. And, arguably, this approach, implying a focus on formal training, offers possibilities for substitution of physical presence with alternative (or complementary), environmentally responsible (low carbon) and cheaper modes of intervention. There are a number of reasons why professional volunteering, in the context of health partnerships, has tended not to focus primarily on initial education.

THET's Health Partnership Scheme (HPS) generally fosters or supports hospital–hospital relationships. In practice, this is less the case now than it used to be as universities and professional bodies (such as the Royal Colleges) are actively engaging in the HPS. Having said that, the pressures on organisations such as the Tropical Health and Education Trust to demonstrate value for money (and impact) have encouraged a focus on measurable short-term (in-out) interventions that are, at least in theory, amenable to metrics. THET fully acknowledges the importance of long-term relationships and the problems of achieving and capturing change in the short term. However, as with all funding bodies, project time frames are usually very short (20 months, for example) and THET are under pressure to demonstrate impact within these time frames.

Initial (diploma or degree-level education) is a longer-term investment and offers less potential for measuring specific and attributable systemic outcomes.

A second factor relates to the supply of professional volunteers. The majority of professional volunteers are motivated, at least in part, by their personal needs for learning and 'mobility /career capital'. International exposure has increasingly become a 'rite of passage' in medicine and other careers. Non-clinical placements are of little interest to many career track professional volunteers (Chatwin et al. 2016). As with funding bodies, professional volunteers are very keen to see change within the time frame and, wherever possible, directly attributable to their own activities. Whilst cautious progressive and collaborative incrementalism may be the most appropriate and effective mechanism for change in health systems, this approach may not appeal to funding bodies or volunteers.

Finally, and perhaps most importantly, it is widely accepted that education and training requires more than formal classroom teaching. Whilst classroom teaching may form a critical element of theoretical/explicit knowledge acquisition, ensuring the learning of more tacit knowledge and implementation skills requires co-present learning 'on-the-job' through supervised placements and mentoring. The emphasis on 'lifelong' learning in the UK also places firm emphasis on structured continuing professional development to update and reinforce learning. This is the regime that professional volunteers and professional organisations (including the Royal Colleges) are accustomed to and therefore seek to replicate in Uganda. In other words, CPD is part of the culture of professionalism in the UK linked to professional development review (PDR). And, in that context, it does not translate, literally, into a more general interest in lifelong learning but implies short courses and an almost box-ticking exercise.

Chapter 3 responds to the following questions;

- What do you do with co-presence when you have achieved it?
- How do you deploy professional volunteers optimally as knowledge intermediaries?
- How do we encourage systems change relevant learning in this environment? Or, put more simply:
  - Who do we train?
  - What do we train?
  - How do we train?

The Perceived Need for Continuing Professional Development in LMICs

There can be no doubt that there is a need for continuing professional development (CPD) or Continuing Medical Education (CME) in the Ugandan health system. This is not the same thing as saying that Uganda lacks the capacity to train its own health workers. The main need for CMEs and the one that is immediately observed by volunteers when they arrive is that the majority of staff they directly encounter on the wards dealing directly with patients and typically unsupervised are at junior level. Some hospitals depend almost entirely indeed on (unsupervised) student nurses and intern doctors to deliver services.

As we have noted in Chapter 2, this does not mean that there are no or even few very highly skilled and competent clinicians in Uganda but it is rare to find them on public wards or supervising/mentoring those staff who are. During a short (two week) visit, a senior British obstetrician working on one of the busy obstetric theatres in Mulago Hospital expressed dismay at his initial experience referring to the 'sheer butchery' he had witnessed. It was only later that he was made aware that all of the doctors in theatre were much junior interns with little experience or supervision. Add to this the overwhelming congestion and sense of chaos made worse by the absence of effective patient management systems (and triage) and it is not surprising that volunteers identify an immediate need for training. And perhaps this impression – of abject need – and absolute lack of resource – is functional in terms of attracting AID. On that basis, local managers may hesitate to challenge this naïve prognosis.

This situation has led to an emphasis in health partnership interventions on CPD or CME, a term used more commonly in Uganda and perhaps reflecting once again the dominance of the medical paradigm. Another factor reinforcing this emphasis on short-course interventions concerns the emphasis within internal (project) evaluation processes on easily obtainable metrics. The following caption frequently displayed by THET to promote the HP scheme indicates the emphasis on training and the challenges of trying to capture more holistic impacts on human resource management systems. The data presented here capture the easiest metrics: numbers of people trained. And measuring this is far easier if staff are taken off the wards and put into rooms where they can be counted. Unfortunately, this tells us nothing about the effectiveness of interventions and their impact on health systems (Fig. 3.1).

Fig. 3.1 Numbers of staff trained in the health partnership scheme (*Source*: THET 2015)

Having said that, we fully understand the challenges facing organisations like THET under pressure from their own paymasters (DFID) and seeking to justify the expenditure of public funds on development interventions in a time of austerity and swinging cuts in public services. Not only is this form of AID 'hard to get right', as Bolton (2007) suggests, but it is also incredibly difficult to capture. And providing the evidence base demands highly sophisticated and time-consuming approaches which fail

to sit easily alongside the 'smash-and grab' demand for 'objective' (read quantitative) proxy outcome indicators.

The dominant approach to improving care [in low-income countries] (as a result) involves continuing professional development but (as Byrne-Davis et al. point out), 'little is known about their impact on practice' (2016: 59). One might argue that the best way to deal with this situation is not to deploy British professionals as volunteers but to improve local human resource management systems to require senior staff to be present and take on training roles, and for the health system itself to develop CME systems rather than relying on foreign interventions. In the capacity-building work we are currently engaged in, in the area of bio-medical engineering aimed at increasing the skills levels of practising technicians, we are beginning to lobby for the development of a CME system and to support the development of its constituent modules. At present, no such thing is in place.[2]

However, for the time being, this is the context within which professional volunteers will engage on a day-to-day basis. One might argue that training in itself is innocuous and can only add value. And, the more people we train presumably the more potential there is for positive systems change. One of the SVP volunteers expressed this view in an interview and in response to a question about the role that volunteers could play in system change:

> I don't even know how [a volunteer] would go about [engaging with systems]. There are so many levels of mistrust and corruption. Where to even start to infiltrate the system and go about it in the right way especially if you're a foreigner trying to come in and introduce policy. It's not even a can of worms. It's like a reservoir of snakes. Education is something you can't take away from someone and so that's something we can do continually, teach and set an example and then it's up to that individual if they carry on what you have imparted.

As the respondent notes – this approach is aimed primarily at individual clinicians and not systems as such. To the extent that a system is the sum of its constituent parts, then training individuals may in the very long term have a systems impact. Or, the individuals could become so demotivated (threatened even) when trying to utilise these skills on an individual basis that they either give up or leave the system.

Certainly it is essential that deploying organisations (including foreign NGOs) adopt some humility and accept outright that they cannot begin to train all the health workers in Uganda and, as such, this individual ('drop-in-the-ocean') approach is unlikely to generate systems impact.

The Commodification of Training: Short Courses as Personal Income

In high-income countries, training is unashamedly commodified: CMEs are a commodity that individuals (or their employers) often pay a very high price for. And, failure to engage in these forms of portfolio training linked directly to compulsory and structured professional development review (PDR) have an immediate and serious career impact. In that respect, treating training as a marketable commodity is not novel. The commodification process in LMICs rather turns this on its head. In this situation, health workers expect to be paid in order to train.

In practice, we have identified some serious unintended consequences associated with formal training. It has been traditional in Uganda and is now quite expected that CMEs delivered by foreign NGOs take place off-site in hotels or educational facilities. This has two immediate effects. First, it takes staff off clinical duties in an environment when wards are already barely staffed. And there is no culture or system for providing staff cover. It is not at all unusual when we find no staff present to be told that they are 'on a course' as if training can ever be a justification for leaving neonates unattended. Referring to a recent visit to a low-resource setting, a colleague at a meeting on global health in the UK reported:

> It was the most depressing visit I've undertaken – all key staff were away on courses elsewhere.

Secondly, people attending these CMEs generally expect to be paid a 'per diem' (daily top-up) plus expenses. In an environment where wages are so pitifully low, CMEs have become a precious and competitive commodity. It goes without saying that foreign NGOs are entirely responsible for this situation, creating, as Moyo predicts (2009), new opportunities for absenteeism and corruption.

Who Are We Training: 'We Need Some Motivation'

This request, made to us repeatedly, was at first taken at face value to imply, literally, that staff felt deflated and low in spirits, given their levels of remuneration and working conditions. It soon became clear that the verb 'motivation' is being used rather differently, as a noun, to ask for money.

It is interesting that Mathauer and Imhoff explain how, in Benin, the term 'motivation allowances' is used to describe financial incentives to attend training and go on to explain how that has 'changed the meaning of motivation from a state of mind to that of an incentive [. . .] giving the word a new meaning' (2006: 6). In effect, this has devalued training as an investment in its own right and created perverse incentives to lobby for and attend formal training.

A focus group involving three Ugandan health workers who have worked alongside many SVP volunteers expressed a similar experience when asked about the progress of SVP involvement in their facility:

> What I will talk about is the motivation because the times I have been with health workers going to workshops, it is a case in Uganda if they go for a workshop they think they will get a transport refund or per diem. I think that's what has made it not go on very well. Because they think your [SVP] volunteers come for training, you just train them but they will not get any per diem so they tend not to attend the workshop.[3] I think it doesn't work very well just because most people in the public sector think of money. The health workers in the public sector think of money. That's what I have seen. Sometimes the [SVP] volunteers would organise CMEs but most of the staff were talking about money. Are they going to give us some money? So most of them did not attend. Or if they happen to attend they come in for 30mins and see if they are signing [for expenses] and if there isn't [signing] they will walk away. Others come at the end of the session [just to sign and claim expenses] (FG).

His colleague then asks us:

> *How does that affect the volunteers and people like you? Because ultimately the volunteers want to train people so that they can work more effectively in adverse conditions. You know you [SVP] are doing a lot of jobs and you work long hours. How can you benefit the trainings the volunteers offer if people have such a mind-set? How will that shape the relationship with the volunteers and people like you?*

> *[One of the participants responds] I think we should tell people we don't have any money to give. Yes, they should tell them that – there is always the expectation of money (FG)*

In another context, a workshop on placements involving a team of UK health trainers discussed frustrated attempts to achieve attendance at CMEs in Uganda and the constant pressure to pay per diems. One of the participants who had visited a Ugandan health facility on many occasions to do training stated:

> We are told we have to take into account their passivity but it isn't that they are passive; it is that basically they don't want it (the training). Facilitation would help. If we put £62k behind it they would love the education but we are where we are. If we don't pay facilitation they won't come.

Other participants at this policy meeting agreed and suggested that paying per diems could be a solution to attendance problems. As participants in the meeting ourselves we urged them not to fall foul of the pressure to pay people for attending training. In the medium term this does nothing to encourage learning over and above ensuring that there are 'bums on seats' (trainees to be counted).

The distorting effects of per diems also have the effect of denying training to many clinically active health workers so that the same people – often those seeking to avoid clinical work – attend repeated training. Mathauer and Imhoff, again in the context of Benin, emphasise not only the wasted opportunity but also the tensions this can cause within staff teams:

> Opportunities for training must be equitably allocated. They should not always privilege the same people (2006: 11).

The immediate association of CMEs and 'projects' with income colours relationships creating not only expectations of volunteers (in one case a UK doctor was referred to as 'Dr Donor') but also fomenting jealousies and suspicions. The following quotes from Ugandan health workers and cited in our Policy Report on 'Volunteer and Health Worker Relationships' (Ackers 2014) are typical:

> When projects get involved everyone assumes that someone is getting paid (by the project) – that there are backhanders going on – so we need to be very accountable.

Interestingly the word 'project' in Uganda has its own quite specific meaning connected to large income streams and often US AID. 'Project' for many health workers simply means income stream.

> There is this mentality I'm sorry to say – that if you are associated with white people they think you are getting something in the office . . . people need to be explained to, 'I am here to work. I am not paying people. I am here to exchange knowledge'.

Equity is an important issue and it is essential that clinically active front-line public health workers are immediately engaged in training. It is not always the case that senior managers (often doctors or clinical officers who refuse to engage in clinical duties in the public sector) attend the training. In some cases, SVP short courses have attracted staff cadres for whom the course has little direct relevance and where there is little, if any, chance that the skills will subsequently be utilised to improve patient services. Table 5 gives just a few examples of the cadres of students who presented themselves for a short course on emergency obstetric skills run by SVP volunteers. In this case, University staff organised attendance. One of the participants showing the greatest improvement in knowledge in post-training tests was actually a pharmacist. In the evaluation report, he noted that the 'main barrier' to using the obstetric skills was the fact that he was indeed a pharmacist.

Table 3.1 Before and after test results on a CME on emergency obstetric care

	Before	*After*
Nursing student	7	16
Midwife	13	17
Nursing officer/registered midwife	14	16
Nurse	10	16
SHO doctor	14	18
Ophthalmic nurse	12	12
Intern pharmacist	5	14
Public health student	8	18
Intern nurse	15	17
Nursing student	6	13

Source: SVP data

In June 2015, the authors held a workshop in Fort Portal on human resource management in the public health sector inviting what we hoped would be the in-charges of all local facilities. At first we were a little surprised and even disappointed that very few of the in-charges came – even though the District Health Officer and the Secretary for Health in the Region were addressing the event. However, the final session, which focused on gauging the views of the audience, made us realise some of the reasons why the target audience (more senior people) had not attended and the real benefits of this in terms of providing a unique opportunity for clinically active health workers themselves to attend an event and express their views. It transpired that a conflicting event[4] was being held in the town sponsored by an American NGO which provided generous per diems. These opportunities were then immediately taken up by the senior staff leaving scope for others to attend our event which provided a meal and local transport costs only.

Asked in the final session to identify their main concerns in terms of HR management, delegates immediately spoke about what they called 'delegation'. At first we found this concept hard to understand until they explained that they meant delegation of opportunities to attend events and CMEs:

> Delegation – somehow it is a problem in our health facilities – picking up knowledge is the most important thing about coming to these (training/knowledge exchange) days. [Managers] are not delegating to lower level staff – the in-charges are going on all the CMEs and they are not sharing the knowledge when they come back to the facility. So, for example, they may learn about hand washing but they are not sharing it so it is not becoming practice. The problem is the same people are going to all the seminars every week; others are not given opportunities: 'the work of my staff is to work and the work of the in-charge is to attend training'. The others are not getting access to the knowledge so it isn't affecting service delivery. Management can't delegate – this is the challenge (Participant 1)
>
> My in-charge goes on one workshop then the next week he goes to another and another – there is no way of implementing the learning and no way that other colleagues can go. It is unfortunate the DHO [District Health Officer] has gone [left the meeting]. If the in-charge has attended a seminar 5 times then they should send other people – this is what Baylor [a US NGO] is now doing (Participant 2)
>
> They attend too many workshops – the same workshop over and over again – they have not time to delegate or implement their learning (Participant 3)

One of the speakers suggested managers may need training in the art of delegation but it became clear that this was much an issue of personal income as lack of training:

> One of the problems is the implementing partners – the big NGOs organise many workshops and pay huge allowances so they all rush to those workshops and when there is a workshop where there is no money – everyone laughs – then, the point is – we get invited. If the in-charges get invited and there is no money they will delegate. Surprisingly the in-charges have communication with the organisers of the workshops and they know how much they will get paid- one million shillings etc. – so in fact we should make all workshops so people come here and pick knowledge without getting any money – they come away only with knowledge not money. If you got back with that knowledge and maybe a meal but no money you will go back with that knowledge and want to implement it.

One participant then suggested that, '*we should go back to all NGOs etc. and propose standardisation of per diems.*'

These comments emphasise the damaging effects that foreign engagement, even in such an apparently innocuous area as CMEs, can have and the importance of behaving responsibly and collectively. A study of the perceptions of per diems in the health sector in Malawi and Uganda (Vian et al.) came to remarkably similar conclusions that per diems resulted in unnecessary trainings, caused conflict, contributed to negative organisational cultures, fraud and 'were perceived to provide unfair financial advantages to already better-off and well-connected staff' (2013: 237).

Corruption is highly entrepreneurial and the incentives provided for training are a prime focus of such 'innovation' designed to extract personal gains from foreign partners and volunteers. A recent exchange involving a request for short course training for drivers of a motorcycle ambulance in Uganda is illustrative. In this case, we were requesting support from an HUB partner. The Ugandan lead willingly agreed to 'loan' us one their drivers trained by the Health Partnership for one week. When it came to payments we were taken aback by a request for us to 'provide his per diem of 150,000/ = per day for seven days'. This equates to a monthly salary of over 4,000,000 Ugandan shillings – ten times what a midwife gets paid. In this case we have learnt that such payments do not go to the individuals but involve a major top-slice (cut) for a number of intermediaries. Training becomes a lucrative

gravy train and 'donors' are made to look like fools. This provides a very valuable example of how localised tacit knowledge trumps the apparent expert knowledge of outsiders; a point we return to in Chapter 5.

In conclusion, this section has shown how short courses have effectively become 'cash-cows' valued for the financial incentives typically associated with them. This has the damaging externality effect of restricting access to those health workers who most need training and reducing the prospect that training is used or shared. In response to our emerging understanding of this local context, the SVP has progressively moved away from any association with per diems and has actively campaigned to discourage the per diem culture. We have also encouraged the practice of holding CMEs as close as possible to the health workers' workplace to ensure contextual relevance and reduce the losses to clinical work. This has extended to active infrastructural work to provide high-quality training facilities proximate to hospitals and health centres.

The next section returns to a point made before, about the role of foreign intervention in CPD training. In the UK, CPD is viewed as a system with opportunities for review and progression and within the frame of workload management. It is not simply a case of doing random courses as and when they arise. This is not the case in Uganda. The view that all training is good coupled with the received wisdom that attendance at training (even if only to 'sign') provides a legitimate reason for absenting oneself from work coupled with personal financial gain results in a high demand for training. On arrival, a professional volunteer or organisation will immediately perceive this as a thirst for knowledge and respond accordingly.

Arguably, training needs to be valued as a commodity as it is in the UK, not to generate profits for training providers but to render training sustainable. The following quote from a leading member of the MOH in Uganda explains the dilemma:

> [We have] reservations about funded programs because usually when the funding runs out, the life drains out too. Free trainings which are entirely dependent on funding are not self-sustaining, however, they can be sustained if the trainings are at a fee (minutes of meeting)

Notwithstanding the problems outlined earlier, CMEs undoubtedly constitute one of a range of potential knowledge transfer (often fairly

unilateral) mechanisms. In that context, the next section considers the content of the training (curriculum issues).

What Do We Train (In CMEs)?

When we first became involved in volunteer deployment in Uganda, one of the needs identified by UK doctors, perhaps fuelled by their initial exposure to clinical practice on the wards, was for 'emergency obstetric training.' And, the response was to develop short courses often based on established UK protocols with some adaptation to meet the rather different needs of a low-resource setting. At face value there can be no apparent problem with this. However, we became aware quite quickly of two concerns. First, that in an environment like the National Referral Hospital, any number of well-meaning NGOs from across the world could be devising such courses, based on their own national schemes and delivering them, often consecutively but on occasion simultaneously and often with the same cohort of staff (as noted earlier). A senior manager in Uganda made the following statement in a letter about CME input by international volunteers:

> We are happy to welcome colleagues from overseas but we need to ensure that their contribution is carefully evaluated, communicated and coordinated . . . to streamline the system. This will add significant value to the sum of international development effort and enable us to build sustainable collaborations.

Present practices not only result in duplication but worse still, confusion, as the participants are unsure – when information conflicts – which approach to use. We also encountered a surprising degree of defensiveness and territorial behaviour on the part of foreign clinicians reluctant often to compromise on specifics when a more simple back-to-basics approach would have been far more useful in that context. And, secondly, following communication with the relevant Ugandan professional bodies, we found that there were national CME programmes in existence and being delivered in areas such as emergency obstetric care. The Ugandan Association of Obstetricians, for example, was actively using an adaptation of the Canadian ALARM course, as the basis for CMEs using obstetricians and midwives trained in the use of that programme. SVP volunteers suggested to us that these programmes were fit for purpose although senior clinicians

working with international NGOs continue to argue over finer details restricting the potential for standardisation and local ownership.

Similar problems have emerged where foreign NGOs have intervened to teach neonatal resuscitation using their own protocols and found themselves overlapping with the Ugandan adopted 'Helping Babies Breathe' programme.

This duplication is certainly a major problem in contexts such as the National Referral Hospitals and other large facilities overwhelmed with NGOs. In other more remote areas, health workers may have received little attention from international NGOs. However, in practice, NGOs do venture to many places often 'imposing' (with the best intentions) their training schemes. Whilst communication with senior gatekeepers (such as the District Health Offices[5]) is often obligatory more active discussion with the relevant people on the ground and within the facilities is unusual.

It was interesting to meet two clinicians from a US NGO at a very small Health Centre III facility that we have been actively working in recently, setting up a training scheme for laboratory workers completely unaware that we had recently refurbished the laboratory and local staff were managing testing very effectively. One factor that tends to exacerbate this problem is the tendency of local managers not to advise NGOs about other actors on the scene in order to optimise engagement and opportunities for top-up payments and per diems. A British medical volunteer who contacted the SVP to discuss her potential involvement in training was clearly aware of this problem:

> I am very aware that when one visits these hospitals they are full of enthusiasm and make the visiting team feel not only welcome, but as if they are the only people helping. I have heard from other sources that both the Lifebox training and possibly the Safe Obstetrics course has already been delivered in [town], but apart from the WHO checklist in theatre, which is not used and a couple of lifebox oximeters, the staff deny all knowledge!!

An international conference on Healthcare Collaboration in Uganda held in Canada in 2014 (with very active Ugandan participation[6]) highlighted the need for improved communication and collaboration between external teams and with Ugandan leaders to encourage consistency in training; ensure awareness of the purpose of professional volunteers and promote mutual goal setting. A follow-up meeting between Professor Ackers and

the Deputy Director of Mulago Hospital suggested that professional volunteers engaging in maternal health work were failing to work together, often generating confusion, restricting the effective transfer and application of knowledge and skills through unnecessary duplication and contradiction. Feedback from the SVP evaluation indicates parallel concerns among professional volunteers. In some cases, international relationships blossom into fruitful co-working. In others, volunteers are faced with unexpected and at times unwelcoming/competitive co-presence with other international volunteers.

What do People Learn from Short Courses?

We know relatively little about the impact that CMEs have on health systems in LMICs. This is not the same as saying people do not learn much but evidence that learning translates into changes in clinical practice, which in turn improve patient well-being and outcomes is elusive. One approach we have been encouraged to use in the SVP, more as the basis for external evaluation for THET, but also replicating approaches used in UK CMEs, is the practice of pre- and post-testing. These tests typically take the form of a simple multiple choice questionnaire focused on explicit clinical/technical skills. The tests are quite useful in capturing immediate (and explicitly clinical) knowledge acquisition and identifying areas where healthcare workers need further support.

The SVP Emergency Obstetric and Neonatal Care (EmONC) Training Course

SVP volunteers, in common with many others, were keen to engage in short course training in the area of EmONC. A short report (Tate 2014) describes our intervention in this area, which was integrated within an on-going mentoring and co-working programme. It was designed by an experienced British clinician who has worked for many years in Uganda and other African countries as part of the Liverpool School of Tropical Medicine 'Making it Happen' programme. In order to avoid taking staff off wards for too long, the SVP course took the form of an intense 2-day programme using

Table 3.2 Pre- and post-test results

Role	*Pre-course (%)*	*Post-course (%)*
Doctors	77.5	87.5
Registered midwives	58.5	83.5
Enrolled midwives	62.5	81.5

Source: Tate (2014: 7)

mannequins in practical stations to encourage hands-on learning. We also used the conference room that we developed with a tent on hospital premises. The curriculum is focused on clinical skills including, for example, neonatal resuscitation, observation and early warning scores, management of eclampsia, sepsis and haemorrhage. A pre- and post-course questionnaire comprised 20 true/false questions including the following:

1. Low blood pressure is an early sign in haemorrhage T /F
2. Intravenous fluid should be given at a rate of 1 litre every 2 hours in hypovolemic shock T /F
3. Raised respiratory rate is a sensitive measure in shock T /F
4. In septic shock, patients should be given fluids at a rate of 1 litre over 20 minutes T /F

The tests results showed improvement in all of the participant's post-course knowledge (Table 3.2):

In this case, given the ongoing co-presence of volunteers on the wards, we were able to gain some feedback on the immediate impact of the training on staff. Volunteers noted improvements in their behaviour and practice:

> The midwives have shown improvement in their clinical practice and drug knowledge, as well as spotting and managing obstetric emergencies (V).

Working in Mulago Hospital with a junior doctor who had attended, a volunteer noted that observations were being taken with greater care and with closer attention to detail:

> The interns were also sharing their improved knowledge with other interns on the ward, it was received with interest and enthusiasm and was actively being used in clinical practice. One recommended: The confidence with the improved knowledge was infectious (V).

A midwife participant also reported:

> A few days after the course I had a patient overnight with severe PET, I felt I managed it better than I would have previously, I was confident to manage instead of referring (UHW).

On the basis of this experience we can assert, with some confidence, that the teaching is translating into relevant learning and that this is shaping individual practice and, on occasions, being shared with peers. The courses also provided opportunities to identify skills areas that prove a particular challenge to health workers. In one case, for example, an SVP neonatal nurse developed a CME programme involving short (2-hour) courses every week over a 6-week period (again delivered proximately on site). The test results showed overall improvement in knowledge with some significant weakness in their ability to understanding the mathematics behind dilution of medication for neonates. This enabled her to do further work on this area. It is difficult to say whether the staff later improved their practice mainly because the majority were not working on the neonatal unit and those who did were rotated out of it or left on a regular basis. Only one of those trained continued to work with our volunteer after the course ended. Staff rotation remains a persistent barrier to achieving any critical mass of trained staff in one facility/location capable of even beginning to change the culture and practice.

Another area which has a very high and continued demand for CMEs is neonatal resuscitation training in response to high levels of neonatal mortality and stillbirth. As managers of the SVP we are constantly asked to provide such training. However, the experience of professional volunteers working in the facilities indicates a very poor level of skills application. In one case quite shortly after the completion of this training, a baby was born in the facility requiring resuscitation; local staff were unwilling to use their skills and insisted that SVP volunteers resuscitated the baby. This may reflect a perfectly understandable lack of confidence in their new clinical skills – it is one thing to resuscitate a mannequin in a training room and quite another to resuscitate a newborn baby. But this experience

Table 3.3 Improved outcomes as a result of short courses

Indicator	*Baseline*	*Endline*
Partograph use	4 % (Jan 2012)	79 % (Feb. 2015)
Active management of third stage of labour	5 % (Jan 2012)	97 % (Feb 2015)
Screening for pregnancy-induced hypertension	48 % (Nov 2013)	68 % (Feb 2015)
Successful resuscitation of asphyxiated babies	67 % (Aug 2013)	81 % (Feb 2015)
Provision of essential newborn care services	1 % (Jan 2012)	85 % (Feb 2015)
Family planning counselling	40 % (Jan 2012)	91 % (March 2015)
Family planning update	10 % (Jan 2012)	67 % (March 2015)

Source: http://savingmothersgivinglife.org/our-work/reports.aspx

is replicated across all facilities even where training has attempted to achieve a level of 'saturation', suggesting that training in many cases is failing to translate into behaviour change (implementation).

As we noted in Chapter 1, funding bodies and projects are understandably keen to 'prove their concept' and this results in the development of metrics that appear to suggest significant attributable outcomes. A recent blog by a senior Ugandan actor in an ambitious and highly lucrative USAID project (Saving Mothers Giving Life) is an extreme example of this. The short report claims overwhelming successes arising from what he refers to as 'high-impact interventions over a short period of time'. This statement is backed up by a table providing quantitative indicators of success (Table 3.3):

These figures purport to relate to public health facilities in the Fort Portal region – an area we are very familiar with. Sadly they bear little relation to the reality on the ground and create an entirely false impression that short course training immediately impact systems.

A far more cautious and in-depth review of another major training intervention funded this time by the UK's Department for International Development (DFID) of its 'Making it Happen' programme (Phase 2) presents data showing that between 2012 and 2015, 17,000 health workers were trained in emergency obstetric and neonatal care across 11 African countries.[7] The intense EmONC course is 6 days long and is delivered by multi-disciplinary teams using 'expert' volunteers. It aims to train a critical mass of 80 % of healthcare providers in the facilities involved. The programme has cost £18 million to date. However, the 2015 Annual Review refers to the 'difficulties of measuring the impact' and, on the basis of the data they could collect, reports that three out of

the four outcomes are 'off track'. It is important to note that the report presents evidence of some post-course improvements but these are often quite minimal. Outcome 1, for example, aimed to increase the number of women attending participating healthcare centres for delivery by 20 % over 12 months: in practice, the improvement was around 1.5 %. And, Outcome Indicator 4: 'to reduce facility level newborn deaths by an average of 15 %' seemed to have failed with a reported increase of 44 % in just under half of the facilities. The point here is not to criticise this programme but to raise fundamental questions about the efficacy of short-term CME-style training and also the quite impossible metrics that funded projects are having to try to align themselves with. The Making it Happen report reflects on the need for 'qualitative research' to help provide a 'better understanding of the causes of deaths' and the impacts of the programme. It also suggests that more work needs to be done with governments to 'stabilise human resource situations' and 'reduce staff rotations', which undermine both the efficacy of training and the ability to control for and measure outcomes.

The effect of staff rotation ('turnover or transfer of trained health workers in the overseas institution') on the ability to embed and/or evaluate impacts is so well known that it is explicitly identified as a 'barrier to change' that applicants are required to respond to when making an application for THET funding (THET 2015: para 4.4).

In the SVP context, a strong pattern has emerged of rotation of Ugandan staff either during or immediately after training and mentoring interventions. In some cases, Ugandan healthcare workers have been transferred from the facilities or wards where volunteers have been working as soon as training has taken place and in the absence of any communication to either UK partners or the Ugandan health workers. Clearly, it is the prerogative of Ugandan authorities to manage their staff appropriately and this will imply moving staff at times. However, this practice has taken place following the return to Uganda of health workers supported for training in the UK under the British Commonwealth Professional Fellowship scheme and represents a significant loss of UK resource and disrespect for the scheme. In many cases, the re-deployment of Ugandan staff who have established strong relationships with volunteers and health partnerships appears to represent a deliberate attempt to break relationships and 'punish' Ugandan health workers. This may reflect a perception, once again built up through many years of voluntarism, that Health Partnerships are privately remunerating local health workers. This has a

very damaging effect on health partnerships, on volunteer–health worker relationships and represents a highly inefficient way of deploying development resource.

Schaaf and Freedman document the effects of what they term 'Mission Inconsistent' (MI) posting in low-resource settings. They argue that the focus on 'calculating [skills] deficits and organising training' (2015: 1) has overlooked challenges that 'those who work on the ground' often see. And one of these is the effect of 'posting' or staff transfers on motivation. They identify two common scenarios. In the first place, health workers themselves may 'employ clientelism or bribery or obtain a post in a desirable area' (perhaps a location where they can optimise income from commodity sales or bribes). De Zwart (2000) refers to these as 'earning centres'. On the other hand, managers (as in the case earlier) may 'express displeasure' with a healthcare worker by re-locating them. This displeasure may be tripped by a perception that the health worker has established close (and potentially fruitful) relationships with volunteers or NGOs. Schaaf and Freedman conclude that in-depth qualitative methods are necessary to generate an 'emic understanding' of how posting and staff transfers are negotiated:

> Emic research will inform efforts that can work with the grain, by understanding the nuances of a particular social, political and economic context, and identifying avenues for meaningful change. (2013:7)

Consideration should be given to the idea of developing firm contracts with managers perhaps through Memoranda of Understanding (MOUs) or local 'Human Resource Compacts' with agreements to 'bond' or retain trained staff for periods of 3–5 years to enable the training to embed and project objectives to be achieved. Breach of these conditions should be responded to accordingly through a reporting mechanism to the Ministry of Health (via the Uganda-UK Health Workforce Alliance) and withdrawal of Health Partnership support. This is an area we are currently working to implement in the Fort Portal Health Partnership.

Intense off-the-job training via CMEs, in isolation, appears to be quite effective in terms of conveying explicit clinical or technical information in the short term at least. There is minimal evidence to show that this knowledge is retained or, of greater concern, utilised. And, our observational research within the frame of the SVP would suggest that there is

little evidence that this is taking place. Of course, it is also difficult systematically to argue the opposite – that it is not taking place. What we are aware of is that when CMEs are embedded within on-going mentoring and reinforced through co-working during SVP volunteer stays the chances of knowledge translation and application are much greater. Some of the factors contributing to this process are as follows:

First, exposure to a new clinical skill may not lead to implementation because the knowledge is partial, not fully understood or because the participant needs supervision/support to enable them to use the skill for the first time. Confidence in actually using a skill is often built up over time in a supportive environment.

Secondly, from a knowledge perspective, the transmission of explicit clinical skills may not in itself be enough: explicit skills may need to be nurtured 'on-the-job' in combination with more highly contextualised tacit skills to begin to achieve implementation. And this tacit knowledge may be valuable both for the Ugandan health workers and the UK professional volunteers seeking to improve skills. Foreign fly-in-fly-out 'experts' are unlikely to possess the kinds of in-depth tacit knowledge that enables them to understand the healthcare context within which the 'new' skills could be utilised. Ironically, they are likely to be seen by many local actors as naïve and lacking in contextualised local knowledge.

From Training to Mentoring (Or Combining Training with Mentoring)

> All you do is train, train train (UHW)

This comment was made to Professor Ackers during a review of the placement of SVP volunteers by a senior Ugandan midwife. She went on to urge the SVP to deploy volunteers in roles that 'enabled them to work alongside us – to work together'. Her point was well made and perfectly understandable in a small health centre IV facility that had so few local staff it could barely function and an in-charge doctor who refused to do any clinical work at all. In practice, the depletion of local midwifery staff exacerbated by the removal of doctors prior to completion of their fellowships in the UK (as a form of punishment) by the local District Health Officer eventually meant that co-presence was unworkable and we regretfully made the decision to withdraw.

Chapter 1 introduced the principle of co-presence as a necessary but not sufficient basis for effective knowledge exchange. Of course, co-presence is relatively easy to achieve in educational programmes and CMEs – to the extent that the co-presence is with students and learners. We would argue however that co-presence at this level requires also that professional volunteers are co-present with Ugandan trainers and educators – in a co-teaching format. This was the approach taken in the SVP EmONC course where Ugandan clinicians returning from advanced training at the Liverpool School of Tropical Medicine worked alongside their UK peers. Unfortunately, on the next planned delivery of the programme the Ugandan trainers demanded a much higher level of remuneration than previously paid (now that they had UK certificates!) and failed to join the training team. Their skills had become commodified and they were using them as an income-generation device, having set up their own training NGO rather than in their clinical work.

In a clinical context, co-presence is more difficult to achieve but absolutely essential to knowledge transfer and, more specifically, to the processes of knowledge translation and utilisation. Professional volunteers with clinical skills acquired from the UK need these relationships to be able to apply these skills in the very different cultural and resource context they find themselves in. And their Ugandan peers need this level of support and mentoring to build confidence to translate and apply skills learnt in CMEs. Building on our previous evaluation experience, the SVP began to focus on mentoring and co-working as the primary mechanism for knowledge translation and application.

Mentoring, Co-working and Knowledge Translation

Our awareness of the limited impact and externality effects associated with formal 'off-the-job' CME training interventions combined with the risks and systems damage caused by labour substitution encouraged us to promote a mentoring approach to knowledge mobilisation. We have used the concept of mentoring rather than supervision to capture the bi-lateral co-learning and knowledge exchange quality of these processes. The idea has been to place professional volunteers, as knowledge intermediaries, into situations where they can work alongside their peers to promote learning-through-doing. This may both play a role in identifying the need for formal intense off-the-job training, perhaps

creating opportunities for short-term 'fly in' clinical support or act as a critical follow on from this.

We noted earlier on the tendency for programme audit or internal evaluation requirements to skew interventions framed around the quest for metrics. Whilst we know that this approach to knowledge mobilisation is far more effective and less damaging than traditional approaches, it presents significant challenges in terms of project reporting (and perceived impact/success). Under pressure from THET to deliver regular quantitative data on training numbers, we invited one of the SVP volunteers to try to estimate her mentoring encounters. In the following excerpt, the volunteer (a British obstetrician) describes one working day and the kinds of mentoring she was engaged in:

> I teach all day every day and each session runs into others. If I give you an example of my day today you will see what I mean.
>
> In my ward round with 2 interns and a midwife the first patient was in obstructed labour at fully dilated. I discussed with them the use of syntocinon and how it should not be used in multips for augmentation. I discussed the indications and contraindications for instrumental delivery. I discussed with them the value of being able to ascertain positions and the likely causes of obstructed labour in a multip. The second patient was an IUFD at 35ks with a genital ulcer. We discussed the causes of genital ulcers, the investigations and treatments. We discussed the options for delivery including induction and the different methods of induction that can be employed. We talked about the riskes of doing an induction in a patient with a previous CS. 2nd patient cord proplapse with IUFD; we discussed management of cord prolapse and the best method of delivery in cord prolapse with IUFD.
>
> The third patient had premature rupture of membranes. We discussed the role of augmentation and antibiotics. The fourth patient had preeclampsia and was undergoing induction. We went through the signs and symptons of PET and the value of assessing them. We discussed the fact that syntocinon in the presence of intact membranes can cause amniotic fluid embolus. Would this count as teaching 2⁄3 people on 11 topics?
>
> I then assisted the intern at c-section. I talked him through what to do in a transverse section. He struggled to deliver the head so I took over. We then discussed techniques to help in the delivery of the head. I then assisted the intern at a second c-section. This one had a previous caesarean section and we discussed the likely complications and how to avoid them. We did the c-section and again I assisted with the delivery of the head. We talked

about the lack of tone and the deformities that made it difficult. I then went with an intern and a midwife to labour suite to see another woman with three previous c-sections and 4 normal vaginal deliveries and a malpresentation. We discussed risk of scar rupture and risk of cord prolapse. I did a caesarean section for a woman with 3 previous c-sections and a malposition. Prior to the c-section I took the intern through the delivery of breech at c-section (and at vaginal delivery). During the caesarean I discussed what I was doing and why. At all three caesarean sections I went through the theatre check list with the interns, including checking of the FH where appropriate. I also discussed with them both the importance of counting swabs afterwards and initiated this with each case. I did this in front of all the theatre staff and the anaesthetist, although not directly talking to them.

In the breaks between theatre I discussed a topic that we talked of yesterday, the exteriorisation of the uterus and closure of the peritoneum. I brought along some papers and evidence including Cochran reviews for this and we discussed it briefly. I encouraged them to go and read the papers then we would talk again.

At the end of the day one of the interns discussed with me the value of vaginal birth following caesarean section. We discussed this and the value of pelvimetry for about 30–40 minutes.

As individual teaching events to individuals this day I'm guessing in the hundreds. This is just one day, and it is not unusual. There is no way I could count individual teaching events in a month; it will be in the thousands. I could count hours involved in teaching, but it will probably be about 6–8 hours a day. I try to do no clinical activities without it being an educational exercise.

This discussion illustrates the complex and significant contribution the volunteer is making on a daily basis to knowledge mobilisation. However, it also shows how the pressure for evaluation metrics is tending to shape interventions and mentoring is a case in point. In many respects,

Q – Our approach is to mentor health workers. How should we count the number of trainees?
A - Please report to number of health workers you have mentored. You may need to ask your volunteers to tally them over the course of each reporting period.
Q – We train health workers on the job. How should we count the number of trainees?
A - Please report to number of health workers you have trained on-the-job. You may need to ask your volunteers to tally them over the course of each reporting period.
If you train the health workers in two distinct areas or topics, we would like you to count the health workers twice even though they are the same people. If you spread training on a single topic over a long period then please do not count the health workers twice.

Fig. 3.2 THET frequently asked questions (*Source*: THET 2016)

it defies quantitative measurement. In recent months, THET has responded to this 'challenge' by producing guidelines on how to measure mentoring (Fig. 3.2):

We do not believe it is possible or methodologically appropriate to even attempt to capture data in this way. Certainly the results will massively increase the volume of 'encounters', but how should we interpret these? Fully capturing the effects over time and space of knowledge mobilisation through co-presence demands a quite different, more ethnographic, approach. Our experience with SVP volunteers suggests that mentoring is a far more successful mechanism for volunteers acting as knowledge intermediaries, providing a fruitful environment for mutual learning and doing. Having said that, we have to report the fact that in most cases the impact of even these interventions can be relatively short lived and rarely if ever extends beyond the period of co-presence. Where changes in behaviour are observed, there is typically a rapid time decay in implementation reverting to prior behaviour very quickly once co-presence ceases. One of the British Doctors involved in a Health Partnership described this experience as 'dipping your finger in a pool of water and then taking it out and watching the ripples disappear'. (Ackers 2014, Volunteer and Health Worker Relationships Policy Report, p. 2).

Conclusions

Chapter 3 has built on the concerns expressed in Chapter 2 about labour substitution and its impact on Ugandan human resource systems. The chapter has exposed some of the problems and externality effects associated with the particular form of training that many, if not most, foreign organisations and professional volunteers are engaged in; namely, short courses or forms of continuing professional development. There is undoubtedly a need for continuing medical education as many of those health workers that volunteers directly encounter on the wards will be in need of additional training and support. However, the approach to CME provision by external bodies has developed into a culture in which training has been commodified – not to the extent that it is in the UK where the trainee has often to pay very high fees in order to receive training – but rather where the trainer is expected to pay learners for the privilege. In practice, this means that many of those people attending training are not intrinsically interested in the

skills and many of those health workers who really need training are not given the opportunity to attend. Training also becomes one of a range of factors reducing (quite significantly in many cases) the amount of time more senior health workers spend in clinical work. Many doctors will never undertake clinical work in their public sector roles.

The kind of training that takes place off-site in CMEs may be effective in terms of transferring explicit technical or clinical skills but is unlikely in most cases to transmit the complex knowledge combinations essential to the effective translation and operationalisation of knowledge. When used in combination with mentoring and co-presence on the job, there is greater evidence of impact and skills utilisation and some real progress can be made. However, even in these cases, systems seem to be able to slip back as quickly as they progress once volunteer presence ceases. Why change is so short lived and so conditional on volunteer presence is a conundrum challenging many health partnerships. The 'exit strategies' that funding bodies and development organisations talk so much about appear hard to achieve in practice. Chapter 4 explores some of the reasons for the short-lived quality of systems change.

Notes

1. This is technically illegal but commonplace as many short-term volunteers operating outside the frame of structured (and funded) programmes are unwilling or do not understand these quite bureaucratic, time-consuming and expensive processes.
2. For details of the THET-funded bio-medical engineering project, see www.Salford and/or http://www.knowledge4change.org.uk/.
3. The SVP does not pay per diems as such but will cover essential expenses where necessary.
4. It is very hard to organise events without such conflicts arising as there is a received wisdom locally that it is best not to encourage NGOs to cooperate as this may reduce personal opportunities.
5. This is right and proper and the SVP has taken every step to build such relationships and ensure that senior managers are aware of and in support of interventions. It is however important to point out that in some cases local managers use this 'opportunity' to extract personal financial inducements; a kind of personal top-slice from all foreign NGOs as a price for permitting the engagement. This was another reason why the SVP, as a project, has withdrawn from engagement in Wakiso District.

6. Indeed, there were so many Ugandan obstetricians at this event which was followed by another event in Canada that some regional referral hospitals had to close obstetric theatres.
7. Annual Review 2015. The programme is implemented by the Centre for Maternal and Newborn Health at the Liverpool School of Tropical Medicine (CMNH-LSTM).

CHAPTER 4

Can (imported) Knowledge Change Systems? Understanding the Dynamics of Behaviour Change

Abstract Chapter 4 reviews a wide range of theoretical material in search of effective explanations for the intervention failures we have observed, and the resulting impact on the SVP volunteer deployment model. The step from training through learning to individual behaviour change was not fully understood conceptually or in terms of operational dynamics. We have learnt that knowledge mobilisation does not automatically derive from learning; knowledge in itself may be empowering or disempowering. Knowledge mobilisation is highly contextualised and needs to be understood within the frame of wider human resource management systems. Chapter 4 presents a critique of behavioural science theories, which have essentialising tendencies, and proposes ideas from evolutionary economics around 'imagined realities' and action planning which help to understand the contextual dynamics impacting on systems change.

Keywords Motivation · Behaviour change · Imagined realities · Action planning

Introduction: Theoretical Insights from Diverse Disciplines

Chapter 2 discussed the importance of volunteer roles to an understanding of the outcomes associated with professional voluntarism focusing, in particular, on the risks and systems damage associated

H.L. Ackers, J. Ackers-Johnson, *Mobile Professional Voluntarism and International Development*, DOI 10.1057/978-1-137-55833-6_4

with service delivery and labour substitution. Drawing on theoretical insights and grounded research, the SVP operationalised the principle of 'co-presence' to protect against lone working and labour substitution and foster the kinds of relationships conducive to optimal knowledge exchange and co-learning.

Recognition of the externality effects (unintended consequences) associated with service delivery (by volunteers) has led to an increasing emphasis on 'capacity-building' amongst key stakeholders and funders. And, in most cases, this has been interpreted to imply that professional volunteers should be primarily engaged in training/education and knowledge transfer activities. Chapter 3 reported evidence of the role that professional volunteers (in carefully structured programmes) can play as 'boundary spanners' and knowledge brokers. However, whilst transferring knowledge is evidently possible, it also reflected on the failure of these approaches to stimulate and sustain lasting and effective systems change. Put simply, the knowledge is being shared but the impact is minimal and short-lived, rarely extending beyond volunteer stays.

Chapter 4 addresses the 'why' question: why is systems change so elusive even in an environment of carefully managed knowledge transfer, translation and exchange? These concerns, drawing directly on a wealth of lived/empirical evidence, stimulated the authors to search for theoretical insights capable of throwing light on the dynamics involved and informing future interventions. It is highly unusual to place a chapter of this nature towards the end of a book. The fact that it is where it is reflects the essentially iterative quality of our research journey and the inter-weaving of theory with empirical work. In this case, it is the empirical work that led to our search for new theoretical ideas to help us to understand our findings as they emerged and then, in turn, stimulate new empirical questions.

Theories exist to facilitate understanding and explain social phenomenon. Sadly, they are (almost always) associated with the construction of concepts and language that render them inaccessible to anyone outside the narrow disciplinary confines responsible for their development. Disciplinary silos tend to generate exclusive language that restricts the very objectives of theorisation (understanding) to the point at which small groups of people are essentially communicating only with each other. This chapter seeks to interpret a complex (if not comprehensive) range of theory to assess the potential for more holistic, multi-disciplinary, insights into the dynamics of health worker behaviour.

Our 'Journey' through the Disciplines

As noted before, and discussed in more detail in Chapter 2, the whole process and more specifically, the SVP project, was profoundly shaped by theoretical work coming primarily from geography but drawing on other disciplines (business and education). Theories of knowledge and the conditions shaping its mobility across international space informed the development of the volunteer agreements, associated partnership agreements (Memoranda of Understanding with Ugandan partners) and, most notably in operational terms, the co-presence principle that lies at the heart of the SVP. As our evaluation of the SVP led us to question the efficacy and sustainability of interventions involving professional volunteers in terms of longer-lasting systems change and patient outcomes, we began to search for other ways of understanding these complex change/inertia dynamics.

In the first instance, perhaps because our search was (somewhat unwittingly) influenced by the clinical focus of our Ugandan work (i.e. on improving maternal and newborn *health*) it took us directly to a burgeoning literature associated with the disciplines of behavioural psychology, implementation science and evidence-based medicine. We refer loosely to this collection of theories as 'behavioural science' (BehSci). In some respects, these theories share common ground with classical economic theory centred on the concept of the individual decision maker underpinned by ostensibly quantitative 'data'.

This corpus of work offered immediate and poignant insights into the relationship between knowledge/learning and individual behaviour change. And the work had a major influence on our thinking, encouraging us to conceptualise the 'problem' as one relating to behaviour change. However, as we explored the work in greater depth we began to realise that the concepts used, the approaches to the theorisation of knowledge and the associated privileging of quasi-scientific methods coupled with a profound emphasis on the individual failed to resonate comfortably with our research experiences and observations in Uganda. The BehSci literature examined the relationship between individual 'capabilities' and motivation. Ackers' background in socio-legal research and the supra-national impacts associated with European law reminded us of very different conceptualisations of 'capabilities' and encouraged us to revisit socio-legal theory, which itself draws heavily on social philosophy. This work takes us beyond individuals and organisations to more structural and over-arching elements of context

and, specifically, the role that legal systems and social policy (sometimes referred to as 'soft law') play in shaping individual and organisational behaviour. Of particular interest here is the emphasis on agency and empowerment – on individuals as active citizens in complex and 'tiered' or 'nested' relationships with the State rather than as isolated and passive victims. This literature, which is primarily theoretical, also draws interesting parallels with philosophical concepts of positive freedoms (enabling social rights) sometimes known as the 'freedom to' (do something) as opposed to the more familiar 'freedom from' (laws protecting citizens from legally sanctioned behaviour). We shall refer to this very loosely as the 'capabilities approach' (CA).

The emphasis on employment in Barbard's socio-legal paper (2001) sparked an interest in another flourishing area of research focused on human resource dynamics. There is a considerable literature applying human resource management (HRM) ideas and theories to an understanding of health worker motivation in high- and low-resource settings. Interestingly, this literature focuses primarily on the organisational context and tends to be characterised by more qualitative (case study) approaches. Our first reaction to this body of work was to identify with the emphasis on organisational dynamics and the deeply contextual quality of these – something that is present but remains largely peripheral in the behavioural science work. And also to nudge us into a significant if obvious realisation that health worker motivation is fundamentally not a clinical question – so there is little surprise that 'evidence-based *medicine*' (with its origins in clinical trials) fails to capture adequately the dynamics involved and perhaps lacks the tools to do so.

Somewhat by coincidence (serendipity[1]) we stumbled upon another approach espoused by evolutionary economists but using language and ideas that, to us at least, seemed remarkably different to classical economics. This fundamentally theoretical work uses rather different concepts to discuss essentially the same challenge: how to mobilise knowledge in order to optimise outcomes.

We shall group the work reviewed here loosely under the heading of 'Evolutionary Economics' (EE). It will perhaps come as no surprise that this group of theories utilising concepts including 'imagined realities' and 'innovative intentionality' (as with the socio-legal ideas mentioned earlier) are unapologetically theoretical and largely untested in empirical contexts. It is perhaps for this reason that they are able to engage so luxuriously with context and imagination.

This chapter reviews the work referred to earlier. The aim here is to draw on our existing grounded empirical knowledge and experience to identify approaches and concepts that appear to be most relevant and offer greatest potential to an understanding of the role of the individual health worker in the advancement of health systems change in the Ugandan public sector. We have tried, wherever possible, in order to optimise engagement and inter-disciplinary communication to avoid excessive use of complex terminology and referencing. And we apologise in advance if this has failed or results in an over-simplification.

Insights from the Behavioural Sciences (BehSci)

The Behavioural Science work reviewed here shares three key premises. First, that 'improving the implementation of evidence-based practice and public health depends on behaviour change' (Michie et al. 2011: 1). This focuses attention on the importance of individual behaviour change. BehSci theorists contend that, 'Progress in tackling today's major health and healthcare problems requires changes in the behaviour [...] of healthcare professionals' (Michie et al. 2009: 1). Second, and this is where the attraction of the theory first sparked our interest, it explicitly recognises that knowledge in itself cannot change behaviour:

> For most health behaviours [...] **knowledge is not an important source of variance** (Cane et al. 2012: 15).

This implies that knowledge in itself will not automatically generate capacity-building or systems change. To understand variance we need to look elsewhere. Finally, 'behaviour change techniques' form part of what proponents describe as the 'science and technology of behaviour change' (Michie et al. 2011: 2). This underlines the epistemological[2] underpinnings of BehSci theories; the privileging of 'scientific' methods and the inference (by reference to 'techniques') that change lies at individual level and that interventions targeted at that level can work.

The behavioural science literature reviewed here is applied to two rather different phenomena: first (and perhaps this is where the more clinical orientation derives from), it is used in public health contexts to try to improve patient behaviour (smoking cessation, addiction or healthy eating, for example). The same ideas are then applied to a rather different context; namely, the behaviour of healthcare professionals.

And, in this sphere, they are applied to more readily 'measurable' specific clinical behaviours (such as antibiotic prescribing).

Evidence that such interventions have largely failed to generate the intended impact have raised concerns that impact is limited not because of the quality of the knowledge transferred per se (or knowledge transfer mechanisms) but because the 'behaviour change intervention' is neither evidence-based nor theoretically informed (i.e. linked to a comprehensive model of behaviour). Michie et al. argue that interventions need to be designed so as to 'bring healthcare professionals into line with evidence-based practice' (2009: 1). A systematic review of published interventions by Michie et al. leads them to conclude that researchers were 'less confident about being able to replicate behavioural interventions compared with pharmacological interventions' (2009: 2). Attributing this to low levels of investment in research in this area (in comparison with pharmacology) rather than any more fundamental differences involved in comparing the relationships that humans have with inanimate objects (such as a statin or aspirin) with those more inter-subjective relationships that humans have with each other, they propose the development of a science or 'technology' of behaviour change to support accurate replication.

Whilst we would absolutely support their argument in favour of strengthening the reporting of observational studies, we would challenge the appropriateness of extending existing guidelines for the reporting of pharmacological research to analyses of health worker behaviour given the complex inter-subjectivity that the latter involves. Perhaps it is the language used and its reference to 'ingredients' and the 'science of behaviour' that makes us cautious about the applicability of these ideas to Uganda health workers:

> Just as medicines are described in detail in the British National Formulary (BNF) we need a parsimonious list (nomenclature) of conceptually distinct and defined techniques, with labels that can be reliably used in reporting interventions across discipline and country (2009: 4).

Working with another group of authors, Michie proposed the now familiar model of the 'Behaviour Change Wheel' as a 'method for characterising and designing behaviour change interventions' (2011: 1). The 'COM-B'[3] model is designed in the first instance to predict patients' responses to public health interventions around smoking cessation and obesity in England. It defines behaviour change interventions as those 'designed to

change specified behaviour patterns' signalling a focus on individuals (as patients and healthcare workers). It is perhaps interesting to note that the emphasis at this point is not on understanding behaviour but changing it. Subsequent reference to 'behaviour change techniques' reinforce this assumption: dysfunctional individuals lie at the heart of the problem. Michie et al. outline the methods used to develop their model grounded in 'systematic review'. The concept of systematic review is very much linked to the evidence-based medicine movement and derives from methods developed through the Cochrane Collaboration.[4] The NHS Centre for Reviews and Dissemination (CRD) defines a systematic review as, 'a review of the evidence on a clearly formulated question that uses systematic and explicit methods to identify, select and critically appraise relevant primary research, and to extract and analyse data from the studies that are included in the review' (CRD 2001: 3)

There is no scope here to discuss and critique the relative merits of systematic reviews and their claims to objectivity. Certainly their value and approach in understanding clinical drugs trials is undisputed. For us, as social scientists more accustomed to the concept of 'literature' or 'research review', they present a certain narrowness in focus that may risk excluding highly relevant and innovative multi-disciplinary knowledge and/or grey literature (Benzies et al. 2006). The emphasis in systematic review processes on the 'clearly formulated question' tends to lead to a funnelling approach, progressively narrowing inquiry to an ever-smaller group of highly similar studies. Whilst this approach may form a key component of the comparability criteria necessary in clinically oriented systematic reviews (to compare like with like and reduce extraneous 'noise'), it lies in some tension with more expansive and exploratory 'searchlight' or horizon-scanning approaches to literature review explicitly seeking new knowledge and innovative insights (as represented in this chapter).

Furthermore, the 'quality appraisal' component of systematic reviews is based on the premise that research can be ranked according to its quality, reliability and replicability. In practice, this involves a weighting process based on metrics to assess 'the rigor of the research methodology' (Jones et al. 2013: 3) effectively privileging quasi-experimental techniques. At the apex of this epistemological hierarchy (Levels 1 and 2) lies the randomised controlled trial (developed from clinical research) and, at the base, opinion pieces. Qualitative research receives no specific mention in this schema but presumably falls within the generic category (Level 3) of 'non-randomised,

controlled or cohort studies, case series, case controlled studies or cross-sectional studies' (Benzies et al. 2006).[5] We are also concerned that the notion of 'validated' tools appears to ignore the fact that the validation process may take place in a quite distinct context (UK- or US-based addiction studies, for example) and is then applied to a quite different context (health worker behaviour in low-resource settings).

Just as the systematic review process employed in this material has the tendency to encourage blinkered approaches and restrict the exploration of new knowledge, their approach to theory has the same effect. Cane et al. contend that, 'behaviour change interventions informed by theory are more effective than those that are not' (2012: 1). Certainly, a robust theoretically informed approach promises greater chance of success than what are often ad hoc, uncoordinated and often conflicting interventions. And 'opinion pieces' would generally not be published in peer-reviewed journals in the social sciences.

However, the 'comprehensive theoretical model' presented by Cane et al. involved engaging with 18 psychological theorists and 30 health psychologists (2012: 2). They were in effect talking to each other. The important point here is that concerns (that we share) about the lack of theoretical foundations are interpreted within such myopic disciplinary lenses. Interestingly, the authors propose that their integrative 'Theoretical Domains Framework' (TDF) developed through work with the aforementioned groups will 'make theory more accessible to, and usable by, other disciplines' (2012: 2).[6] This approach has parallels with surrogacy: the genetic map is intact and 'given' and the surrogate discipline is then able to apply it but not to re-combine it with its own knowledge to alter the essential architecture.

Having discussed some of the concerns underpinning the generation of behaviour change models, we now turn to assess the potential value of the models themselves in terms of supporting our understanding of the failure of professional voluntarism to stimulate sustainable health sector reform in Uganda.

The 'Behaviour Change Wheel' is described by Michie et al. as a 'potentially elegant way of representing the necessary conditions for a volitional behaviour to occur' (2011: 4). In this 'behaviour system', capability, opportunity and motivation interact to generate behaviour, which, in turn, influences these core components. Or, put more simply, individual behaviour change is the sum of an individual's

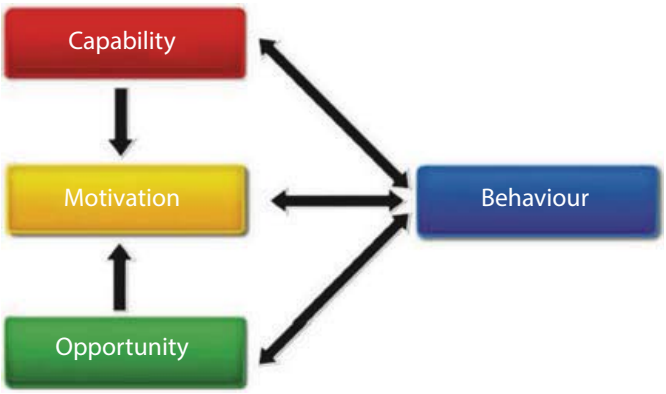

Fig. 4.1 The COM-B system (*Source*: Michie et al. 2011.) All rights reserved, used with permission.

capability (their knowledge and skills); the opportunities they have to utilise those skills and, critically, their motivation to do so. Much CME interventions, as discussed in the previous chapter, focus attention only on improving individual capability. These relationships are illustrated in (Fig. 4.1).

Whilst Michie et al. argue that this system gives no priority to individuals, groups or environmental perspectives – or intra-psychic or external factors – in controlling behaviour the emphasis in practice is very much on the individual. Capability in this model has a specific, individualised, definition – namely, 'the individual's psychological and physical capacity to engage in the behaviour' including knowledge and skills (2011: 4). Motivation is also defined in individual terms as 'all those brain processes that energise and direct behaviour' (2011: 4).[7] Finally, opportunity is 'all those factors that lie outside the individual that make behaviour possible or prompt it'. Michie et al. argue that this framework 'incorporates context very naturally [through] the "opportunity component"' (2011: 8). It is clear then that both capability and motivation are internal to the individual in this model.

The simple elegance of this model is what attracted us to it in the first instance. It immediately captures the errors behind the 'training fetishism' described in Chapter 3 and helps to explain why endlessly training Ugandan health workers in neonatal resuscitation or triage fails to translate into sustained behaviour change and improved patient outcomes. The concept of motivation has an immediate resonance too with ethnographic observations and the narratives of volunteer interviews. Certainly, at face value, the

majority of employees in the public healthcare system in Uganda give the appearance of and readily describe themselves as 'demotivated'. And, it is all too obvious that the lack of opportunities to utilise skills due to lack of equipment, drugs or stationary inevitably leads to both a lack of motivation to learn and also a frustrating inability to exercise newfound skills. The logic of this model 'explains' why the deployment of professional volunteers solely to teach and train (transmit knowledge) is failing to impact systems.

The COM-B system outlined earlier is positioned at the heart of a 'wheel' which identifies potential 'intervention functions' and policy categories that may or may not form part of an intervention depending on the analysis of the situation and where the problem lies (Fig. 4.2).

In a further development, Cane et al. map their 'theoretical domains framework' onto Michie's wheel suggesting that the two approaches work together well in informing interventions (Cane et al. 2012: 12) (Table 4.1).

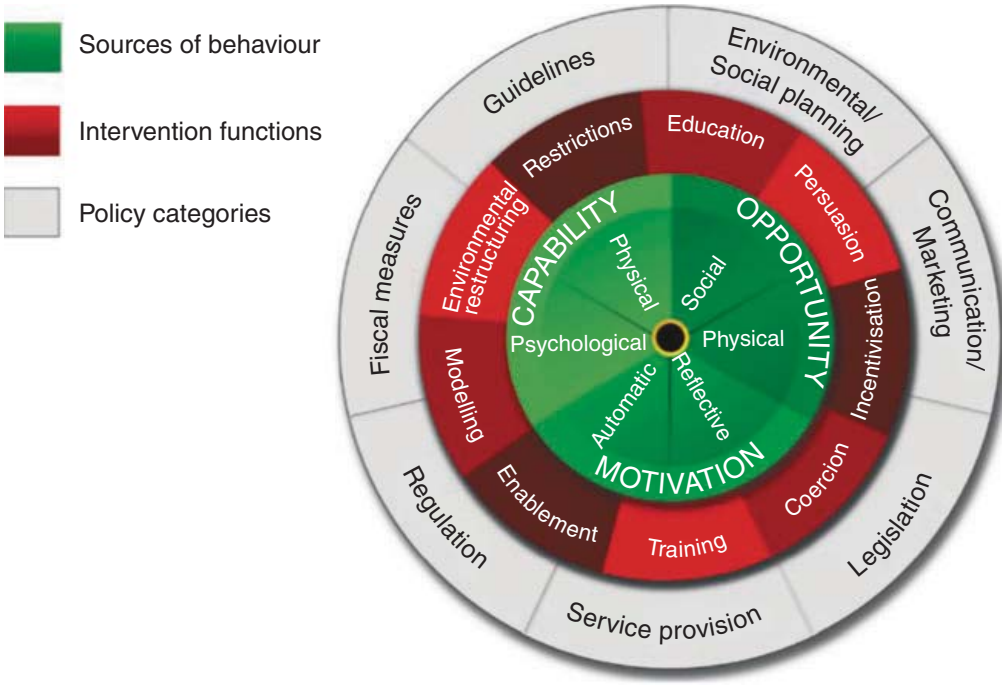

Fig. 4.2 The Behaviour Change Wheel (*Source*: Michie et al. 2011: 1.) All rights reserved, used with permission.

Table 4.1 Mapping of the Behaviour Change Wheel's COM-B system to the TDF domains

COM-B		*TDF domain*
Capability	Psychological	Knowledge
		Skills
		Memory, attention and decision processes
		Behavioural regulation
	Physical	Skills
Opportunity	Social	Social influences
	Physical	Environmental context and resources
Motivation	Reflective	Social/professional role & Identity
		Beliefs about capabilities
		Optimism
		Beliefs about consequences
		Intensions
		Goals
	Automatic	Social/professional role & identity
		Optimism
		Reinforcement
		Emotion

Source: Cane et al. 2012: 15. All rights reserved, used with permission.

Once the convenience of the model had sunk in and we began to consider more carefully how this related to our own experience and knowledge of volunteer engagement in Uganda, concerns emerged about its ability to capture the complexity of the real-world context. The explicit individualism of this model and the assumption that health systems are a collection of individuals rather than complex social and relational structures raised some concerns. In many ways, this is reminiscent of Margaret Thatcher's famous declaration that, 'There is no such thing as society. There are individual men and women and there are families' (**Interview in Women's Own 1987).**[8] The implied emphasis here is on dysfunctional individuals and the 'techniques' that can be devised to render them functional. We became particularly interested in the concept of 'capabilities' used here as something internal and reducible to an individual: a 'given'.

Certainly our understanding of health workers had made us very aware that the same person could show a high level of motivation and capability in different contexts. We have been involved in hosting many Ugandan

health workers in the UK through the Commonwealth Professional Fellowship Scheme and with few exceptions in this context there is no evidence that they lack skills or motivation. Equally, staff members working on a private ward in a public hospital or in private clinics appear to work far more effectively than they do on the public wards. Does this suggest that capability is not an individual trait as such but contextual and also that 'opportunity' is everything?

Perspectives from Socio-Legal Studies and Social Philosophy (CA)

It was at this point that we reviewed some of the work on capabilities from the perspective of socio-legal studies, which itself draws on social philosophy and citizenship studies. This research would most certainly not be picked up in a systematic review. We have called this group of theories the 'capability approach' (CA). Once again, this literature uses complex concepts and language, potentially limiting accessibility and opportunities for holistic multi-disciplinary thinking. Barbard's paper addresses 'capabilities' from the perspective of the development of the European Union and its associated legal institutions. It is concerned primarily with the conditions necessary for the realisation of the European Council's strategic goal of becoming 'the most competitive and dynamic knowledge-based economy in the world capable of sustainable economic growth with more and better jobs and greater social cohesion' (2001: 464).

At first sight we may dismiss this work as somewhat peripheral to our concerns (with professional voluntarism and health systems in low-resource settings). The language used is more up-beat; less about 'problems' and more about knowledge for foresight and innovation. However, the immediate link with 'investing in people and combating social exclusion' lies at its heart. What initially interested us was the quite different approach to the concept of capabilities. Here they are not reduced to intrinsic or raw attributes of individuals but linked to concepts of agency and 'proactive security' (2001: 467). Barbard first critiques neoclassical economic theories which conceptualise what they call 'individual self-sufficiency' as a function of individual endowments, 'consisting of genetically-inherited capacities for work, and the financial and other resources made available to them' (2001: 465). In this model

then outcomes are a function of inputs (individual innate ability) and resources. Drawing on the work of Sen (1999), Barbard proposes the addition of other functions identifying capability as 'a kind of freedom: the substantive freedom to achieve alternative functioning combinations' (citing Sen 1999: 75):

> Mobilising the economic potential of individuals is not simply a process of providing them with the necessary financial resources to exploit their endowments. Rather, the institutional framework of the market has to be examined in order to establish how far it facilitates or constrains the potential of individuals to achieve their desired economic functionings (p. 466).

Put simply, mobilising the economic potential of individuals is not simply a combination of innate endowments (intelligence) and resources (intellectual and physical). Capabilities in this approach are less reductionist and more composite than in BehSci theories: capabilities are not knowledge as such but mobilise (convert) knowledge. The practical example Barbard gives to illustrate her point helps to clarify the argument. Whilst sex discrimination law in the EU formally sanctions overt discrimination against female employees (a negative freedom or freedom 'from' discrimination), it is the more positive form of 'freedom to' sometimes referred to as soft law or policy, in the form of subsidised childcare or paid maternity leave, for example, that alters incentive structures enabling women to make personal investments in skills and training. Achieving gender equality demands both approaches.

For Barbard, individual behaviour (if we can phrase it that way) requires an assessment of how far the labour market (or the 'environment' in the COM-B model) facilitates or constrains the potential of individuals to utilise their knowledge and abilities. Barbard uses the concept of 'institutionalised capabilities' to describe the infrastructure of social entitlements (social rights and associated support) that facilitate and enable active participation. For Barbard, this infrastructure is not a luxury but a fundamental precondition of a functioning labour market providing the necessary incentive structures (proactive security) to enable and facilitate individual behaviour change. Indeed, the logic of this model is that, in the absence of institutionalised capabilities, investment in training is ineffective and wasteful: training inputs focused on generating changes in aggregate individual behaviour will not work. As critics of market liberalism have argued, society is more than a sum of its parts. And people need rights and resources to engage with knowledge.

Can this model be applied to the very different context of low-resource settings and the specific institutional context of health systems? We cannot see why not. Barbard's conclusion that the European Social Model needs to combine social rights, economic commitment with high-quality employment opportunities and industrial relations (dispensing with the idea that economic growth or institutional change can be achieved with a poorly skilled, low productivity, workforce) seems just as relevant to the Ugandan health system. And her proposal that such change requires a 'multi-level regulation' apposite.

Pfister (2012) similarly approaches capabilities from the perspective of European citizenship. Pfister suggests that Sen's 'capabilities approach', or 'CA', places important emphasis on individual freedom. He suggests that this can be further developed to situate individual freedom within strong relational and political elements:

> [The capabilities approach] is a powerful tool to put individual circumstances in the broader political, economic and social context (2012: 241).

Pfister emphasises the importance of context and differentiated needs to an understanding of the relationship between resources and functionings (or 'opportunities' and 'behaviour' in the COM-B model):

> Differences between persons with equal resources in achieving functionings should not be explained with purely individual intermitting variables, such as (lack of) ambition, responsibility or (wrong) personal choice. [Rather we should be attentive to] differences in the capabilities of people to turn resources into functionings (2012: 242).

Capabilities then are not a given; they are a product of the interaction of resources (opportunities) with agency. The CA perspective shares Barbard's emphasis on the role of the State (or of citizenship) in providing citizens with the 'positive ability' and encouragement to participate in society (or their own workplace) and invest in their own social capital and training. The concept of 'agency freedom' (the freedom to achieve whatever the person, as a responsible agent, decides he or she should achieve) is then introduced and linked to the notion of 'goals':

> We not only have to be able to achieve a goal but should be genuinely free to decide whether we actually want to achieve it or find an alternative

> objective (even one which others might view as less beneficial to our well-being) (Pfister 2012: 243).

Pfister suggests that the CA approach does not go far enough in terms of shifting the emphasis from the 'individual' (*Homo economicus*) to the person as 'situated self' and the fundamental importance of context to an understanding of human interaction and relationships. He suggests that the CA approach underplays the importance of power relations and the 'positional' quality of relationships and 'struggles'. Pfister's comment that 'even entitlements to certain capabilities have to include a notion of who is responsible for providing them' (2012: 249) immediately resonates with our empirical work in Uganda, placing an emphasis not only on the individual health worker but also on their employing organisation or the State (Ministry of Health) to ensure that salaries are paid with some predictability (which they are not) and equipment and consumables provided. In this context, should the failure to remunerate be conceptualised as a simple lack of 'opportunity' as in the COM-B model or as a denial of fundamental rights (and disempowerment)?

The focus on citizenship in Pfister's paper reminded us of the (taken for granted) importance of the relationship that individual citizens have with the State in Western democracies. Citizenship, as a form of social contract, is what binds individuals to the state and vice versa. The concept is used extensively in debates about European social policy to frame discussions about agency, marginalisation and exclusion. How relevant are these debates to an understanding of malfunctioning health systems in Uganda? Might it be, for example, that the quality of these relationships, between Uganda as a State and its citizens, is a factor at least partially explaining the apparent 'demotivation' of healthcare workers? Indeed, could some of the behaviour characterised as demotivation or disinterest (or even limited individual capacity) be otherwise conceptualised as 'social struggles on the ground.' A form of civil disobedience: perhaps a rational response to marginalisation and oppression? (2012: 244). Or, what Kostakopoulou refers to as 'tactical subjectivity' (cited in Pfister 2012: 245).

It is interesting to take a step back here and consider the role that the National Health Service (NHS) plays in the UK not just in the provision of health care but also in symbolising the relationship between citizens and the State. The NHS (in common with the Ugandan health service) is

a universal public service, free at the point of use. However, for the time being the NHS remains the sector of choice for the majority. The Ugandan system, on the other hand, is a residualised (ineffective) safety net for the poorest people who have no choice and no means to access private services. Even the majority of Ugandan healthcare workers would not use the services they provide. In this context, it is 'easier' to categorise the system and the patients who use it as 'other' or even as the 'undeserving poor' (Marshall 1950).

Environment is not then a disconnected or disembodied 'given' facilitating or obstructing individual choices in the public health environment. It is itself constituted through social interaction: 'law, political institutions, the economy and technology are always created, interpreted and endowed with meaning through social interaction [. . .] they are human constructions influencing our agency' (Pfister, 248).

We have noted that this work is primarily theoretical. However, it is interesting to note Pfister's reflections on the methodological implications of these approaches. He suggests that the majority of 'empirical operationalisations' of the CA approach are quantitative, 'drawing on aggregative data, indices and statistics' (p. 251) and necessarily retrospective. In conclusion, he advocates complementing CA with 'qualitative interaction-oriented' dimensions to 'investigate human beings as creators of the world they inhabit' (p. 252).

The work reviewed earlier introduces a variety of complex concepts to an understanding of health worker behaviour. What is most interesting is the weighting attached to context and the emphasis on employment and the *quality of work*. The clinical focus and epistemology underpinning the behavioural science approach has the (unintended) effect of drawing us away from the obvious: that understanding the behaviour of health workers in low-resource settings is fundamentally about work and not health as such. Moving on from the concept of capabilities, we also began to feel uneasy about the (apparently highly individualised) concept of 'motivation' in behavioural science and how it sat alongside our experiences of Ugandan health workers. Coupled with the emphasis on labour markets in Barbard's paper, this led us to return to and widen our knowledge of the literature on HRM or the more specialist sub-field identified as 'human resources for health.'[9]

Finding Commonality? Perspectives from Human Resource Management (HRM)

> What the world wants is a good job. That is one of the biggest discoveries Gallup has ever made. It is the single most dominant thought carried around in the heads of most people . . . it establishes our relationships with our city, our country, and the whole world around us (Clifton 2007: 3).

Social science, and perhaps research in general, has a tendency to seek out the abnormal or exotic unintentionally glossing over the mundane everyday commonality that unites rather than distinguishes us. This quote from a Gallup survey underlines the most obvious but often overlooked issue that lies at the core of health worker motivation. It does not provide all the answers or angles but it presents a sound universalising, rather than essentialising, starting point from which we can begin to understand context and diversity.

There is a lively and burgeoning corpus of research focusing on health worker motivation from what can be loosely described as 'human resource management' (HRM) perspectives. Buchan, with reference to the UK context, argues that 'the importance of the management of human resources to the success or failure of health sector reform has often been overlooked' (2000; 319). Interestingly a review of a large number of papers from a range of international contexts suggests a powerful commonality of 'drivers' in diverse low- and high-resource settings. The work by Nzinga et al. on the implementation of guidelines in Kenyan hospitals concludes that 'the barriers identified are broadly the same in theme to those reported from high-income settings' (2009: 1).

One of the things that distinguish the HRM approach from behavioural science is the concept of 'motivation.' As noted earlier, behavioural science tends to treat motivation as an intrinsic variable: internal to the individual. In a recent presentation on behavioural science approaches and their potential contribution to understanding behaviour change in global health, Byrne-Davis argued that 'when we as behavioural scientists talk about motivation it is very moment to moment [. . .] motivation [is about] automatic reflexes; about what we're going to do – a kind of in the moment reflex' (presentation to the THET Patient Safety Program meeting, November 2015).

The HRM literature centrestages motivation but the key to motivation lies not with intrinsic individual attributes but organisational contexts: it is relational and in some contexts disproportionately extrinsic. In this model, the structural/organisational context lies at the heart not the periphery of behaviour change. The study by Nzinga et al. is interesting as it positions itself within the behavioural science spectrum as an example of evidence-based medicine (2009: 1). However, the qualitative approach utilised (interviews) generates a whole range of findings, nearly all of which are focused on local contextual conditions and weaknesses in HRM. It is perhaps no surprise that they conclude that, 'Future research might benefit from the disciplines of organisational management as well as behavioural sciences' (2009: 8).

The organisational focus characteristic of HRM theories tends to define motivation quite narrowly as 'an individual's degree of willingness to exert and maintain an effort *towards organisational goals*' (Dieleman et al. 2006: 2). The emphasis on the organisation is further exemplified in the definition of HRM offered by Mathauer and Imhoff: 'Human Resource Management is the management of people in **an** organisation' (2006: 4). Having said that, Mathauer and Imhoff (2006) take a broader view of motivational dynamics suggesting that 'Health workers are demotivated and frustrated precisely because they are unable to satisfy their professional conscience' (2006: 1). This latter approach certainly resonates better with our experiences in Uganda perhaps because of the sheer lack of effective and tangible HRM in most (dysfunctional) facilities. The views of the following Ugandan health worker suggest an identification of himself as a professional rather than as an employee (although the issues he raises pertain to wider aspects of resource management):

> Poor working conditions means you have the knowledge but people are dying in your hands. Emotionally, professionally, you feel you should not be in that area. For us health workers we feel touched when these people die in our hands yet we know we could have saved their lives if 1, 2, 3 things were in place. And we know it is possible to put them in place but somebody somewhere has not put them in place. So, as a professional, when people are dying in your hands because you don't have some of the things to help them and you know what to do – you feel you should not be in that place actually – you feel those people shouldn't come to you (UHW).

Khan and Ackers (2004) critique the 'unitarist' perspectives of what they term 'Western HRM' advocating a more pluralist approach capable of 'institutionalising some elements of the "African social system" into formal

HRM policies and strategies' (2004: 1330). They are not referring so much here to multiple employment or systems within systems (i.e. corruption) but more to the role of 'normative stakeholders' such as extended family clans and religious brotherhoods. In the Ugandan context, tribal affiliation plays an important role both within existing organisations and as external, interlocking organisations. Tribal affiliations also compete with and lie in some tension with national and organisational identities. For now the main point here is that viewing motivation from the perspective of 'the' single employing organisation may be far too narrow.

The following section summarises some of the key findings reproduced in a selection of papers on health worker motivation.[10] There is a strong tendency to distinguish financial from non-financial variables. Whilst, unsurprisingly, especially in low-income settings, pay is a key driver of health worker motivation, it is by no means the only or even the most important factor. Pay emerges most powerfully for less-well-paid cadres where pay is currently below subsistence level; it is impossible to maintain a basic quality of life through full-time public employment. This is the case in Uganda for most cadres of staff. A typical nurse or midwife in Uganda earns between 400,000 and 800,000 Ugandan shillings a month (£100–£170) depending on levels of qualification.[11] Length of service continues to have a major influence on pay in Uganda, despite its discriminatory consequences.[12] This reduces incentives for individual investment in career development.

A further complication arises due to administrative inefficiency and poor financial governance resulting in health workers often not being paid at all for months. Doctors (and specialists) are generally less likely to stress pay as a key motivating factor no doubt because they are able to top-up their wages through private work (as noted in Chapter 2). The qualitative research by Mathauer and Imhoff on non-financial incentives acknowledges the importance of financial incentives, 'especially in those situations where income is insufficient to meet even the most basic needs of health professionals and their families'. [However] 'Increased salaries are by no means sufficient to solve the problem of low motivation . . . More money does not imply more motivation' (2006: 2). Indeed, and unsurprisingly if we reflect on our own experiences as employees,[13] issues like security, leadership, recognition, clear understandings of roles and workloads, equitable access to opportunities for professional and career development, equality, autonomy, participation and access to the resources essential for effective work (consumables, equipment and medicines etc.) are all frequently cited (Fig. 4.3).

Lack of **leadership** (poor role models) and supportive management: lack of active engagement in development of organisational goals

Lack of collaborative and inter-professional decision making & **team working** (hierarchy and disrespect especially from doctors) contributes to the development of a culture in which knowledge is not valued or shared (envy and isolation)

Overwhelming **workloads** and lack of workload management compounded by endemic absenteeism (see below).

Poor **communication**

Lack of **recognition** and appreciation (blame culture)

Absence of 'open recruitment' (**meritocratic and transparent**)

Lack of clear **Role Descriptions** (especially for task-shifting cadres)

Lack of **Performance Review/Appraisal** systems: lack of incentives and lack of disciplinary action/enforcement

Lack of **career development**/progression opportunities (career ladders)

Lack of /unfair access to **continuing professional development** resource

Poor working environment, **working conditions,** infrastructure (lack of equipment, consumables and drugs) due to resource shortages and endemic corruption

Fears about **personal safety and health**

The pervasive influence of **systemic corruption** at all levels

Daily challenges to **professionalism; the** inability to work effectively and witnessing the immediate consequences of that.

Fig. 4.3 Non-financial human resource variables influencing health worker motivation in low-resource settings (*Source*: Authors' summary of reviewed HRM literature)

There is insufficient scope in this chapter to discuss these components of HRM in any detail. A clear message emerges that the health systems crisis in many low-resource settings is conceptualised as a crisis in human resource management and not inadequate capabilities per se. Indeed, Mbindyo et al. conclude their study (in concordance with BehSci theories) with the following statement:

> Interventions that aim to change worker practice simply by offering training are likely to fare poorly unless attention is paid to those factors influencing the motivation of health workers to change and perform well at individual, organisational and system levels (2009: 9).

According to the HRM model, the quality of the work environment (i.e. extrinsic factors) determines health worker motivations and poor performance/outcomes. It is the lack of congruence between individual goals (which may derive from their training, education, experience and professionalism), the goals of the organisation they are employed by and their ability to achieve these goals that impacts motivation.

From a methods point of view, it is interesting to note that the HRM work reviewed here is quite eclectic, often drawing on multi-disciplinary perspectives. And, most of the papers reviewed are based on in-depth qualitative research in the field. Mbindyo et al., for example, argue that qualitative methods are necessary 'to explore the depth, richness, and complexity of staff motivation' (2009: 2).

Perspectives from Evolutionary Economics

At this point in our 'journey' we came across, quite by chance (or serendipity), another body of work. We had in fact worked in collaboration with Carolina Cañibano,[14] an economist, for some years (on research careers) and it was while searching for a paper linked to that work that we came across a publication with the term 'capabilities' in the title. On initial reading we realised that, despite the complexity of its theoretical underpinnings[15] and language and entirely different context, this new area of work (to us) had surprising relevance to the work we had been doing in Uganda.

Their work is presented as a critique of economic theories, including neoclassical and neo-Darwinian theories which fail, in the authors' views, to capture the role played by 'purposeful human action'. The same critique could be levelled at the concept of 'automatic behaviour' represented in the COM-b model.

Along with most of the evolutionary economics literature and the contributions to the discussion on capabilities from organisational and management studies, this work is targeted on innovation processes taking place within organisations with an implicit focus on the context of the 'firm' (i.e. private, market-oriented, for-profit, organisations) and economic systems change. One might question the relevance of this framework set within the context of 'knowledge economies' to an understanding of the role of professional voluntarism in public health systems in Uganda. At face value, the diversity of context and language may suggest that opportunities

for policy transfer are minimal. Again, a systematic review would have screened this kind of work out.

However, if we can see beyond this diversity, core commonalities emerge.

With reference to scientific mobility, Kuvic defines 'productivity' and 'innovation' in a way that appears immediately relevant:

> Productivity is about the quality of work produced. Innovation entails specialised knowledge or creativity that is 'less easily measured' and the output is also based on the level of motivation of the individual. It is essential that employers build an environment in the workforce that can foster this type of work (2015: 16).

If we take the view that low-resource settings (such as Uganda) are also part of the global knowledge economy, conceptualise health systems change in terms of innovation and health workers as economic actors (within these systems) and the logic of understanding health worker outcomes in terms of 'productivity', then the relevance is clear. Indeed, we would argue that using this form of language allows us to avoid the risks of essentialising health worker behaviour in low-resource settings (capabilities and motivations) and emphasising the core commonalities between firms in high-resource settings and public health organisations (in both high- and low-resource settings). The language of innovation and entrepreneurship is also far more positive and aspirational.

The following section distils some of the key concepts and processes represented in the work of these economists enabling us to identify the links with the theories discussed earlier and the potential for more holistic, multi-disciplinary, theoretical underpinnings to support the deployment of professional volunteers in health systems change.

Muñoz et al. (2011) propose an 'action plan framework' to focus on the theoretical concept of intentionality. Intentionality, that is, the dynamics of goals formation towards which agents direct their action, plays a major role in driving economic change. In pursuing their intended goals agents activate learning and the potential for new knowledge combinations emerges. This is the key mechanism for the evolution of capabilities. In addition, goals may be of different sorts. Agents (read health workers) may conceive highly transformative goals and direct their action towards new imagined realities but they may also formulate action plans with poor transformational potential. To

account for this qualitative difference between types of action goals, the authors define 'innovative intentionality' as 'the will to conceive or imagine realities with the purpose of making them effective' (Cañibano et al. 2006: 319). Economic agents, as individuals or organisations, can in turn be qualified as operating with higher or lower levels of innovative intentionality. This approach and the weighting given to *intentionality as the key driver* can be contrasted both with the behavioural science model and, as Muñoz et al. explain, with the economic literature which, 'argues that knowledge is the only foundation of capabilities' (2011: 194). For Muñoz et al., economic evolution (systemic change) does not come about as a result of the growth of knowledge per se. Intention, not capability, is the starting point.

The concepts that immediately captured our imagination and resonated most starkly with our experience in Uganda included the explicit engagement with agency and the emphasis the model places on existing knowledge. Learning is not something that *happens to* people as passive actors/victims (or empty vessels) but something that is essentially relational, interactive and cumulative. The individuals concerned are not devoid of (or lacking in) knowledge per se; indeed, it is their experiential (tacit and highly contextualised) knowledge – 'their perceived realities' – that shapes their response to new learning and imported knowledge. Agency is explicitly recognised in this model, which assumes that 'humans have sufficient intelligence and incentives to anticipate and avoid the selection effects' associated with evolutionary, Darwinian theories (Muñoz et al. 2011: 194 citing; Witt 2004: 128).

This approach to intentionality helps us to see motivation as contextualised and as much about extrinsic as it is about intrinsic factors. In the first instance, health workers are heterogeneous and this heterogeneity is 'not only a matter of differences in knowledge [or innate ability], but also of differences in action goals and intentions' (Cañibano et al. 2006: 319) and their subjective responses to means (opportunities) or plans will shape their approach to new learning. Furthermore, a health worker's motivation will vary over time and space and in relation to diverse plans. A person, according to this model, cannot be placed on a linear motivation–demotivation or innate intelligence continuum: their degree of motivation will necessarily vary according to specific plans (places, conditions and relationships). Seeing motivation as fundamentally context-driven helpfully removes some of the essentialising (and potentially racist) elements of the behavioural science model.

Although Muñoz and Encinar (2014a) locate their paper within the paradigm of innovation systems and speak of knowledge-based economies and 'firms' their point that 'the systemic properties of the system emerge as a result of agent interaction' (2014a: 72) appear just as relevant to an understanding of public healthcare systems. The system is as it is (and is subject to change through) the interaction of agents operating at multi-levels (from the Ministry of Health, through District Health Authorities, tribal boundaries and down to health facilities and individual health workers employed within them).

Whilst similar concepts are identified in the work discussed before, the 'action plan' model places unique emphasis on intentionality (the intention to do something) and conceptualises it as part of action planning or goal setting. It is this intentionality and planning that drives the process and activates learning and not the other way around (albeit in a constantly iterative and reflexive process).

The (subjective) process of planning so central to this approach is informed by deeply localised knowledge of the opportunities and constraints open to individual agents. The concept of 'information stocks' by Muñoz et al. (2011: 198) captures for us the importance of recognising pre-existing contextualised knowledge *as* knowledge and not simply lack of interest/demotivation. This may take the form of explicit, experiential knowledge (of delivering countless dead babies, for example[16]) and/or tacit knowledge (defined here as know-how,[17] skills, competencies, routines, capacities, capabilities' (Muñoz et al. 2011: 312).

Rather than the lack of knowledge it could be the sheer weight (grinding heaviness) of tacit knowledge that influences attitudes to new learning. Arguably, it is precisely this knowledge that newly arriving professional volunteers lack, limiting their own ability to formulate innovative knowledge re-combinations that restrict progress. It is not to say that the cutting-edge clinical expertise they bring is not of value but needs time (and humility) to settle and recombine with local knowledge in order to identify effective and sustainable and contextualised interventions. As Williams and Balatz (2008a) assert, this kind of knowledge travels less easily and requires co-presence.

This model doesn't privilege new learning and helps to explain how new learning (introduced by professional volunteers) must be seen to work in combination with existing knowledge (rather than displacing it). Echoing the work of Williams and Balatz (2008a) and Polanyi (1959), Muñoz et al. suggest that a significant proportion of organisational and

individual knowledge is tacit (2011: 312) and yet when professional volunteers and development organisations intervene in low-resource settings they tend to focus on training in explicit (clinical) skills and, in the process, assume that the failure to behave in certain ways is a reflection of the absence of knowledge rather than the presence of it and its impact on health workers' perceived reality.

'Action planning' is described by Muñoz et al. as the 'analytic unit connecting means/actions and goals' (2011: 195). And connections play a very central role in this model: 'Agencies (individuals and organisations) make plans and planning implies making connections' (p. 196). It is the 'recombinant process of connections' that may generate what the authors term 'novelties'.[18] The concept of connections here goes beyond a narrow definition of connections as social capital (networks and contacts) to embrace the boundary spanning /brokering qualities of knowledge itself. This fits with the authors' assertion that 'learning consists of testing (and eventually retaining) new connections that prove useful for agents to reach their goals' (p. 196).

Furthermore, imagination plays a central role in action planning. The concept of 'imagined realities' resonates powerfully with our work with Ugandan health workers and captures perfectly the dynamics of their highly contextualised situations. *Is it possible in the context within which Ugandan health workers are placed to imagine a different reality?*

Muñoz and Encinar (2014b) point out that economic processes (systems) are historical and action planning by agents takes place in a context of 'radical uncertainty' (p. 319). In that sense planning is not an objective, linear, exercise but a reflexive, subjective and uncertain process.

The fundamentally subjective quality of the concept of perceived/imagined realities, coupled with the acknowledgement of existing deeply experiential and localised knowledge (as knowledge rather than the absence of it), enable us to understand the equally important concept of 'bounded rationality' (Simon 1985; Jones 1999) employed by these authors. Behaviour (or the lack of it) that may be interpreted by the outsider observer (a professional volunteer, for example, or clinical 'expert') as irrational or unproductive may, when understood in context, be rational (a new reality may not be possible).

The 'action plan' model identifies the importance of 'means,' conceptually equivalent to the 'opportunities' represented in the behavioural science model, and an implicit component of context and perceived realities. Conceptually it is present but underspecified in what is essentially

a theoretical model. This is an area where the HRM research coupled with our own contextual knowledge can add flesh to the conceptual bones (framework). The fact that the economics model was not specifically designed to 'fit' the context to which we are now seeking to apply it perhaps explains this lack of specificity which, in the case of the Ugandan health system, will have profound effects on its application.[19] This is captured poignantly by Muñoz et al. as a 'dialectical dance between feasibility and desirability' (Muñoz et al. 2011: 198). Health workers, as agents, evaluate and formulate their plans in the context of their own experience of what works.

Cañibano et al. (citing Teece et al. 2000) define 'dynamic capabilities' as 'the ability to reconfigure, redirect, transform, and appropriately shape and integrate existing core competences with external resources and strategic and complementary assets to achieve new and innovative forms of competitive advantage' (2006: 313). Furthermore, the process of acquiring or developing dynamic capabilities is a 'collective learning process from which an organisation improves its ability to achieve its goals' (p. 313).

The reference here to learning as a collective process is interesting from the perspective of professional voluntarism and health partnership activity where learning, whether in the classroom or in one-to-one mentoring, is almost always seen and planned as an individual process (taking person X from point A to B along a continuum of measurable (quantifiable) learning outcomes. It would be interesting to assess whether developing more active forms of learning focused on collectives[20] (multi-disciplinary teams within facilities) and working with their imagined realities may activate learning and improve outcomes.

It is the interaction of intentions and action goals that drive the evolution of 'dynamic capabilities'. Capabilities in this model are certainly not reducible to genetic (inherited) capacities (such as intelligence). Rather they are informed by existing knowledge and constantly reshaped.

Intentionality linked to goals is what 'activates the development of capabilities, the testing of new connections within a system, and, therefore, the generation of new knowledge' (Muñoz and Encinar 2014a: 75).

The 'action plan' model presents learning as a (hyper-)active process involving the 're-combination'[21] of new knowledge with existing explicit and tacit knowledge. Muñoz and Encinar describe intentions as 'triggering [. . .] driven learning processes' configuring connections which give

rise to evolving capabilities. (2014a: 75). In the language of evolutionary economics, these may stimulate 'entrepreneurial experimentation'. The reference to the creation of 'new genetic material' (p. 76) represents an interesting challenge to the more essentialising tendencies of behaviour science and classical economics, which assume that genetics are fixed and determine capabilities (or are the same thing).

Ultimately, innovative intentionality is the activator of constantly and reflexively evolving 'action plans' that interact with 'social reality' to drive transformative change. Of course, such change is not always wholly or even partially effective: the authors accept the possibility that planned action may fail to lead to intended outcomes as a result of unintended consequences or externality effects (Muñoz and Encinar 2014b: 318).

As noted earlier, this area of work is entirely driven by theory and remains untested in any empirical context. This in part explains its luxuriousness and ability to deal with complexity.[22]

A Synthetic, Multi-disciplinary Approach?

Echoing the conclusions of Nzinga et al. (2009), Muñoz et al. conclude that Understanding human behaviour lies at the 'frontier of economics and psychology' (2011: 317 citing Brocas and Carillo 2004). Indeed, all of the authors reviewed here advocate the need for multi-disciplinary approaches even if they themselves resist the challenge. Having reviewed the approaches in the context of our much grounded action-research on professional voluntarism, we feel that the model that best fits the situation is that represented by the SI Framework.

We are particularly attracted by the attention the economic 'action plan' approach pays to existing knowledge or 'information banks' and the effect this knowledge has on perceptions of what reality is and could be. We feel that this theory helps us to understand why so many interventions fail. Knowledge does not activate change: rather intentions organised through plans (and agency) drive and activate learning. And new learning builds connections between people and knowledge to create the conditions in which change can begin to be imagined and actioned. The emphasis on the collective and connected quality of active learning is also very helpful and encourages us to see beyond learning as an individualised process.

Having said that all the models share broad ideas, each one discusses individual behaviour in some form of structure-agency/choice-constraint framework. Each recognises the importance of tacit knowledge. Each refers to motivation and to goals or plans in some shape or form and to opportunities or resources and each pays some attention to multi-level contexts. The capabilities approach is focused primarily on supranational and national systems using the concept of citizenship to describe the relationship between individuals (as citizens) and the state. The state is important but we must see this as multi-level too and, in the Ugandan case, transected by other critical elements of identity, belonging and political affiliation: tribes remain of great importance, brokering the kinds of citizenship relationships identified in the European Union. Schaaf and Freedman's work on health worker posting emphasises the importance of recognising that the 'state' is not a unified or necessarily benevolent actor but reflects many conflicting interests and norms that shape individual and organisational behaviour (2015: 7).

With the exception of HRM, all of the approaches tend to gloss over the organisational context, which plays a vital intermediary function. Only HRM theory really captures the everyday reality of employment relations and the quality of work. However, it tends to perhaps over-emphasise 'the organisation' and the impact of employer–employee relations on wider motivational dynamics. Many employees in Uganda and elsewhere will move between employers or (as is very common) have more than one job. The reference to professionalism illustrates the notion that a person's identity and sense of responsibility may not always align first and foremost with a particular employer. Indeed, doctors in Uganda (and elsewhere) often identify themselves with their profession more than a specific health facility that pays what is in most cases a tiny fraction of their overall income. International organisations (NGOs and health partnerships) may also be important organisational actors here perhaps interfacing with local employing organisations (such as the SVP) or directly with individual health workers (through salary top-ups or moonlighting).

Certainly it is widely recognised that individual employers play only a partial role in contemporary career planning. Perhaps reflecting its empirical strengths (and grounding in qualitative research) the HRM literature is important to our work not so much because of its theoretical contribution but the attention to detailed analysis of employment quality that resonates so sharply with our own understanding of Ugandan health worker's

experiences. This level of analysis has supported our ability to design very practical evidence-based interventions.

This concept of bounded rationality (in the economic model) is perhaps far more relevant than the architects of these papers anticipated. One of the limitations of the papers, perhaps reflecting the level of abstraction, is the lack of attention to conflict and power: the possibility of multiple realities and parallel organisational cultures. Corruption is systemic in Uganda especially within the public sector; it can be described as a culture. It is pervasive and starts from the very top of organisations and the systems within which they are based and operates through powerful, organised syndicates. Health workers (and patients) are acutely aware of its existence, the personal benefits that derive from it and the profound risks associated with challenging it. It is interesting to note the reference by Muñoz et al. to the entrepreneur as a 'destabilising agent' (2011: 199). 'Destabilising' in this context could imply creative disruption triggering innovation (in the right direction). Alternatively, or simultaneously, it could refer to the impact of corruption. This detailed (tacit and explicit) knowledge of how corruption works at every level and in every decision necessarily shapes both imagined realities and action plans. In this sense, there may be two parallel systems operating in marked tension with each other within a health facility or authority. Chapter 3 has discussed the impact of corruption on professional volunteers and their relationships with Uganda health workers identifying the dynamics of power and hierarchy (positionalities). None of the theories reviewed pays explicit attention to these dimensions of context. Interestingly it is often the lack of knowledge on the part of foreign agencies and individual volunteers rather than their superior clinical knowledge that limits impact and generates unintended consequences.[23] Of course, corruption pollutes not only organisations but also the wider system that nurtures it, fundamentally weakening a sense of identity with the state at national or local level and also with 'leaders' (at every level).

Whilst we can identify closely with the concept of 'action planning' as a vehicle for the exercise of individual agency based on the recombination of disparate knowledges, we have some concerns that the emphasis in the material reviewed, perhaps reflecting the business/private sector context, fails to explain inaction or stasis. Or, situations when human action, qua rational, as Muñoz and Encinar (2014a: 75) put it, could amount to non-decisions or inaction. On a practical level, it may prove impossible to imagine returns on an investment (in training, for example,

or even coming to work regularly). Equally (and commonly) the risks associated and predicted (as a component of perceived reality) may lead a person to consciously decide not to challenge a corruption syndicate or even show some initiative. Indeed, we have seen a number of innovative individuals motivated to formulate plans which activate new learning and bring about systems change effectively punished and threatened by their peers and their line managers for stepping out of line. Simply being seen with 'muzungus' leads to perceptions of financial gain and ensuing envy followed by punishment. Just as the association of 'immobility' with competitiveness has been challenged (Ferro 2006), inactivity needs to be seen as rational in certain contexts.

Conclusion

The research review work that formed the basis of this chapter was entered into following our growing realisation grounded in evidence gained from in-depth qualitative research, that many if not most of the interventions utilising professional volunteers as knowledge brokers have largely failed to generate visible and sustainable impact on health systems. Or, put more simply, training Ugandan health workers has failed to translate into evidence of individual behaviour change. The exploration of other research marked an attempt to answer the 'why' question and, if necessary change our methods of intervention.

All of the approaches reviewed here offer important insights and we would not wish to privilege any disciplinary or theoretical approach but rather to identify those aspects that we feel are most applicable. Recent studies applying the COM-B model to an evaluation of behaviour change in CPD interventions in low-resource settings concluded that 'None of capability, opportunity or motivation were found to predict either behaviour or behavioural intention' (Byrne-Davis et al. 2016: 68). The authors suggest that this may reflect the fact that the validation of these tools took place in 'resource-rich, high-income environments' which may 'reduce the applicability of some behaviour change theories to this [low resource] context'. Having said that, the other theories reviewed here have not attempted empirical verification remaining at 'ideas' stage.

Our empirical work confirms the importance of the three components of the COM-B approach: namely of capabilities, opportunities and motivations. However, it rather turns the equation on its head

suggesting (as SI theory proposes) that intentionality comes first: you have to be motivated to learn. And this motivation is not intrinsic but, and especially in low-resource settings, is fundamentally extrinsic and context bound. And, in that frame, local knowledge, especially tacit knowledge of what works and can even be imagined to work, drives motivation. So knowledge can act as a break on individual intentions (if we have learnt repeatedly that plans or interventions do not work or cause us personal risk/harm).

Chapter 5 builds on the material presented in this and previous chapters to reflect on the learning that has taken place since we began to deploy professional volunteers to Uganda. Perhaps unusually at this stage in a book, it organises this reflection around two empirical case studies. These are used to illustrate the iterative quality of our evidence-based interventions and the role that research has played in taking us to the conclusion that the primary learning is learning from failure and not quantifying success.

Notes

1. Serendipity or happenchance has been increasingly recognised as important sources of social capital in research (Ackers and Gill 2008).
2. Epistemology is defined in the *Oxford Dictionary* as 'the theory of knowledge, especially with regard to its methods, validity, and scope, and the distinction between justified belief and opinion'.
3. COMb stands for Capabilities, Opportunities, Motivation and Behaviour.
4. www.vichealth.vic.gov.au/cochrane.
5. An example of how this approach can be applied to the evaluation of health partnership interventions can be seen in Jones et al. (2013).
6. The authors then developed a complex scientific tool incorporating a Delphi-style consensus process and a range of 'open and closed sort tasks' and 'fuzzy cluster analysis' as the basis for the refinement of the TDF.
7. This definition of motivation as 'processes in the brain that energise and direct behaviour' is taken directly from Robert Wests' PRIME Theory (2006). It is important to point out that PRIME theory was developed in the context of alcohol and drug addiction in the UK and not health worker behaviour.
8. See Guardian http://www.theguardian.com/politics/2013/apr/08/margaret-thatcher-quotes.
9. This is the title of a journal which captures a lot of this material.

10. As noted, the objective of this chapter is not to present a comprehensive literature review across all disciplines. Our aim has been to identify work which we feel 'speaks to' our objectives and has the potential to contribute to the evidence base informing our interventionsevidence base informing our interventions. This section reviews the following papers: Buchan (2000: 2004); Chen et al. (2004); Chopra et al. (2008); Dieleman et al. (2006); Franco et al. 2002); Mangham and Hanson (2008); Mathauer and Imhoff (2006); Mbindyo et al. (2009); Nzinga et al. (2009); Stringhini et al. (2009); Willis-Shattuck et al. (2008).
11. Our estimation of the level of income required in Kampala to meet basic subsistence needs (housing, food and school fees) for a family with two children is around 2 million Ugandan shillings (about £500 a month).
12. Seniority-based pay is explicitly prohibited as discriminatory under European Union employment law.
13. Similar findings came out of a study on pay and remuneration in research in the UK (Ackers et al. 2006).
14. We are very grateful for the opportunity to present a version of this chapter to Dr Cañibano's group in Valencia and to have received her insightful comments on this chapter.
15. Helfat and Peteraf (2009) suggest the level of complexity in the SI framework may have generated some confusion even within the field.
16. Ugandan health workers will have considerably more hands-on experience of many obstetric complications than their professional volunteer counterparts.
17. Gebauer refers to this as 'procedural knowledge' as distinct from 'declarative knowledge' (2012: 59).
18. The concept of 'novelties' is new to us and at first seemed rather strange. If we understand this as meaning new ideas or innovations it works well in the context of our work. Muñoz and Encinar define novelties as 'new realities' (2014b: 319).
19. Muñoz et al. do refer specifically to monetary and non-monetary elements of action plans echoing a core distinction in the HRM literature (2011: 195).
20. The concept of the 'collective understanding of knowledge' through 'assimilative learning' is also referred to by Gebauer et al. (2012).
21. This echoes Williams and Balatz's (2008a) reference to knowledge combinations discussed in Chapter 2.
22. Muñoz and Encinar point to criticisms that the SI approach is in fact 'overtheorised'.
23. In practice, this is a difficult but necessary component of induction processes and may be a factor to take into account when considering the efficacy of length of stay.

CHAPTER 5

Iterative Learning: 'Knowledge for Change'?

Abstract Chapter 5 applies the knowledge discussed in Chapter 4 to two illustrative case studies. Many interventions tend to represent a simple 'trial and error' approach underpinned by intensive grounded research to facilitate our understanding of change processes or change resistance. Tracking the identification of a 'need' and our experience of designing and monitoring the evaluation of that process, in the light of the new knowledge gained through ongoing research review, improves our understanding of the complexity of social processes. Chapter 5 redefines the objectives of our action-research project from setting out to capture the ingredients of positive change to pro-actively understanding and learning from failure. It attempts, in the context of this potentially debilitating reality, to take stock and identify the characteristics of least-harm interventions to chart the next stage of our journey.

It concludes with a series of recommendations aimed at policy makers and volunteer deployment agencies.

Keywords Complex interventions · Intervention failure · Corruption · Knowledge deficit model

H.L. Ackers, J. Ackers-Johnson, *Mobile Professional Voluntarism and International Development,* DOI 10.1057/978-1-137-55833-6_5

Introduction: Understanding Failure in Complex Interventions

Chapter 5 takes stock of the material presented in the previous chapters and the cumulative knowledge gained from 8 years' experience of intensive action-oriented evaluation research. Our learning and 'knowing' as activists and researchers has been a continuous process: there was no point at which we went into the field knowledge or value-free and we have and will never reach the point of knowledge saturation (ultimate truth). Research of this nature is a journey. Perhaps the greatest single quality of any researcher (or volunteer) embarking on this type of journey is the honesty and humility to accept that we are always learning and also that, in many respects, we are not simply (or usually) measuring positive outcomes but trying to understand intervention failure and inertia. This may not be the message individual researchers, volunteers or their funding bodies want to hear. However, observing and understanding policy failure does not imply failure on the part of the actors/projects concerned. Far from it. Indeed, a growing body of research documents the specific quality of higher-level entrepreneurial learning that arises from 'hard knocks' or 'discontinuous events' (Cope 2003, 2011). In a rather different context, Mayer suggests that errors present the learner with robust feedback that can act as scaffolding for future learning (2008) and Somekh identifies 'episodes of substantial friction' or 'knots' as starting points for deeper collaboration (2006: 23).

On a broader and more ethical note, interventions and associated research are not there to benefit individual actors, be they researchers, volunteers, projects, funding bodies or 'the industry' (Valters 2015), but rather to 'maximise the likelihood that knowledge generated will be ultimately of benefit to humanity' (Richards 2015: 3).

The Sustainable Volunteering Project (in common with other similar projects and probably most Health Partnership interventions) has very broad and ambitious objectives focused on systemic improvements in maternal and newborn health through professional voluntarism. This type of project is perhaps best characterised as an example of a 'complex intervention'. If we accept the UK Medical Research Council's definition of complex interventions as those involving 'several interacting components' (MRC 2008: 6) then, as Richards argue, 'simplicity is probably a chimera[1]' and most interventions should be considered as 'complex' (2015: 2). Richards clarifies this definition suggesting that complexity is

not so much about the intervention itself but the questions we are posing. Where context is seen to be of great importance and where we are interested not so much in 'does' an intervention work but 'how' or 'why' it works (or perhaps how/why it does not work) then it must qualify as complex.

Furthermore, Hallberg argues that complexity is relevant when we are addressing interventions with several or multiple individual components and when considering how these interact with one another (2015: 17). According to these criteria, it is clear that the SVP qualifies as a 'complex intervention'. And that intervention comprises numerous constituent interventions that have emerged in a very iterative and reflexive way throughout the duration of the wider programme. The unplanned nature of these may indicate a lack of planning or element of what the MRC refers to somewhat dismissively as 'pragmatism' (2008: 9). We would rather contend that this represents a necessary commitment to democratic engagement and subsidiarity supporting grounded policy engagement and development. And, a degree of 'planned happenchance' (Malecki 2013: 87) or serendipity (Ackers and Gill 2008: 59) has been identified as a key component of social networking, creativity and entrepreneurialism.

The chapter opens with the presentation of two case studies illustrating the kinds of learning arising from the progressive failure of specific constituent interventions. The two cases are chosen as they represent generic/foundational 'back-to-basics' initiatives that lie at the heart of many, if not most, Health Partnership interventions in low-resource settings. For the purposes of this chapter we have adopted the approach advocated by the MRC for the evaluation of complex interventions. This involves identifying 'a theoretical understanding of the likely process of change'[2] (2008: 9); identifying outcomes and then, in a break from traditional experimental methods, assessing causal mechanisms and contextual factors.

Case Study 1: 'Waiting Kills': Congestion, Disorder and Patient Management

The need for improved patient management is immediately evident on arrival in any large public health facility in Uganda. Stark visible evidence of over-crowding with patients and attendants on floors and spilling over into corridors and outdoor areas confronts and shocks every recently arrived professional volunteer. Similarly, every Ugandan health professional

visiting a UK facility is immediately struck by the image of orderliness and effective patient management. Triage[3] is a foundational component of basic patient safety and underpins all subsequent clinical interventions (in that facility). It is perhaps no surprise that so many volunteers and HPs visiting Uganda have identified triage as a priority and sought to intervene.

Initial 'Theory of Change': The Development of a More Structured System to Prioritise Patients According to Clinical Need Will Improve Clinical Interventions and Patient Outcomes.

Case study 1 reports on a series of constituent interventions that together comprise a more composite and complex intervention. We have reported it here in a way that infers linearity. To some extent, the intervention did emerge over time in one facility becoming more complex and multi-faceted as the interventions progressively failed to impact and our knowledge of the context and failure dynamics deepened. However, similar interventions (with slight differences in approach reflecting the particular qualities of individual partnerships and institutional settings) all met with similar resistance and none has delivered sustained impact. In that respect, we are combining (rather loosely) a longitudinal and comparative case study approach.

In the first instance, and perhaps reflecting presumptions about roles and a profound belief in the value/logic of training (as noted in Chapter 3), a common starting point is typically the co-production/adaptation of protocols and associated short-course training.

Intervention: Skills Deficits

The identification of the 'problem' during the early phases of LMP intervention was that the failure to triage patients effectively is immediately and directly linked to skills deficits among Ugandan public health workers. In the language of behavioural science theories, we were focusing attention here on individual (clinical) **capabilities**. The operational *Theory of Change* at this point can be described as follows: Engagement of UK professional volunteers alongside Ugandan counterparts in the co-production of appropriate protocols and associated (CME) training and local awareness-raising will encourage effective patient triage.

At this stage, the intervention could be described as alarmingly simple involving the transmission of explicit clinical skills (how to do, record and

interpret basic patient observations) in order to prioritise care. So simple, in fact, that our early interventions now look incredibly naive and must have been the source of much amusement on the part of local Ugandan managers.

Evaluation of this intervention is often achieved through straightforward 'measuring' tools recording the volume of staff trained, testing skills acquisition before-and-after CMEs and assessing subsequent implementation through (numerical) evidence of completion of observations in patient notes. We combined these (obligatory methods) with ongoing ethnographic fieldwork involving the project evaluator, the professional volunteers (as action-researchers), a dedicated social science volunteer and local collaborators.

Outcomes

Unfortunately, the outcomes associated with this form of intervention have been consistently disappointing. While it is common to recruit large numbers for CME training and to report strong evidence of initial skills acquisition among the cohort trained it is rare to see any evidence of sustained behaviour change. Limited short-term compliance is typically witnessed in defined areas (spaces/units) where volunteers involved in the intervention remain co-present for a period of time. Training in triage showed greater initial success in the 6-bed obstetric High Dependency Unit set up through LMP with funding support from THET. In many of the typical fly-in-fly-out CMEs where volunteer 'faculty' unfamiliar with the context leave immediately upon completion of training, implementation failure is unlikely to be recognised. Ongoing ethnographic observation combined with qualitative interviews and continual review of patient notes provided immediate evidence of impact failure and an emerging understanding of implementation gaps.

Identifying and Responding to Failure

In the initial stages of our intervention we were advised by local health workers that they were unable to use their new skills because they lacked resources, including stationary (for recording purposes) and basic equipment to take observations (stethoscopes and blood pressure machines, etc.). A review of parallel interventions in other settings (through literature and policy review work) identified similar outcomes and drew our attention to work on 'neglected processes'. At this point we held a workshop[4] in the UK inviting stakeholders from the UK and Ugandan arms of health partnerships

(plus a representative from the Ugandan Ministry of Health) to share experiences. The workshop achieved some consensus on problem definition and an ostensible commitment on the part of the MOH to prioritise, integrate and roll-out protocols (such as the African Maternal Early Warning Scoring System[5] or AMEWS). This failed to happen.

On the basis of expert advice, this led to a refined intervention involving the production of a personalised observation kit to be provided to every health worker in target locations with the aim of achieving a degree of saturation that would empower and motivate individuals to utilise their triage skills.

Intervention: Physical Resource Deficits

The revised *Theory of Change* was focused on the opportunities that individuals (who have received the above training) have to utilise skills: providing personal observation kits would, we hoped, enable individuals to take observations in a timely fashion and empower/motivate them to do so. And, ensuring continuous supplies of stationary (by external organisations) will facilitate compliance. In the language of behavioural science theories, we were focusing attention here on individual (clinical) **opportunities**. Further complementary audit tools were co-developed (and discussed with health workers) to capture use of the kits and reduce the risks of theft/misuse.

Outcomes

The intervention was a stark failure: outcomes associated with it were very limited with patchy and short-lived compliance. The co-presence of volunteers enhances compliance for the duration of their stay with almost immediate slippage once the volunteer leaves. Stationary remained a problem, especially in high-volume settings. The provision of personalised equipment failed to empower/motivate health workers and/or promote skills implementation. Personalised kits proved unsustainable even with audit systems in place.

Identifying and Responding to Failure?

The approach proved to lack sustainability as the facility resisted demands to integrate the provision of stationary within the mainstream hospital system. Kits (as valuable commodities) were (very) favourably received and immediately utilised in zones where volunteers were actively present. However, equipment was 'lost' and the practice of using equipment suffered (very) rapid decline.[6]

Intervention: Physical Resource Deficits (revised)
A follow-up intervention negotiated with volunteers and senior line managers (who had it has to be said actively resisted the idea of providing personalised kits) involved 'permanently' affixing robust equipment and clocks to the walls of a dedicated triage area aimed to overcome the risks of theft and exploit the apparent benefits of establishing discrete and manageable 'zones'. This was supported by the institution of a simple and clear 'traffic light' system using colour-coded boxes affixed to the walls to prioritise patients: cases regarded as urgent were given a simple laminated red card. A US NGO later provided a high-tech electronic notice board to improve patient waiting, which soon after became dysfunctional.

Outcomes
Outcomes were initially strong with some excitement and pride in the new facility and equipment. However, compliance was short-lived. The co-presence of volunteers enhanced compliance for the duration of their stay only. Equipment became damaged and stolen almost immediately. The use of traffic light boxes became redundant as soon as the volunteer left; laminated red cards used to signify emergency cases mysteriously vanished. The continued (high volume) of staff rotations in this highly congested area made it harder to build cultural change and ensure a saturation level of training in the use of protocols.

Identifying and Responding to Failure
There was apparent confusion over the loss of equipment from the walls and disappearance of the laminated red cards (which have no monetary value). Confidential qualitative interviews with mid and senior facility managers (conducted off-site) revealed the presence of endemic and highly organised corruption 'syndicates'. They explained that triage (as prioritisation according to clinical need) lies in profound tension with organised and systemic corruption that is effectively smoke-screened through the appearance of chaos. The 'inert' knowledge deficit model fails to take account of in-depth local tacit knowledge (entrepreneurial destructive/confounding knowledge) impeding implementation. We learnt that chaos is planned and highly functional. It is also systemic: attempts to improve individual behaviour through investments in training (individual capabilities) and personalised equipment (opportunities) stood little chance of altering a system functioning effectively for many health workers and managers on the basis of corruption.

There is insufficient scope here to discuss corruption in more detail (see Ackers 2014). It is important to note however that corruption not only impacts local health workers and their ability to imagine new realities but also has a major impact on volunteer deployment and impact. The following example provided by a Ugandan health worker who had worked alongside SVP volunteers is illustrative:

> There is a problem with Ugandan midwives (working with volunteers). I've seen it. They think, 'oh she is white she will know what to do – she can do it by herself'. There is a problem of attitude amongst us – bad attitudes which give off a bad signal. I was in [a health facility] doing a delivery with a white volunteer and there was a retained placenta and oh my goodness the local midwife made a noise in her own language. She wanted money from the patient. She didn't want the white lady there so I said, 'you know what, let's go to another patient.'
>
> [Would the midwife try to get money from a patient even at the point at which she had a retained placenta?]
>
> Yes, of course. They are opportunists. They will look and think, 'behind that curtain that patient has nice bedsheets' so she won't want the volunteer there (UHW).

The very stark conclusion we have come to is that triage will fundamentally fail to work effectively in most (larger and congested) Ugandan public facilities where accountability is absent and efforts by volunteers to support it will be met by marked resistance: triage as a method of sorting patients according to clinical need lies in immediate tension with the sorting of patients according to their ability to pay.

Adherence to basic protocols (and in particular the AMEWS) was initially stronger in the dedicated 'High Dependency Unit' set up by the LMP charity with support from THET. This unit had only six beds and (necessarily) higher staffing levels. Equipment in such a confined space was less likely to be lost/stolen as greater accountability was in place. It was also easier to ensure a constant supply of stationary (via project funding). However, even in this more controlled setting, whilst the act of taking and documenting observations was more common, the logic of this process is that once certain critical points in the protocol are reached a doctor must be called. Midwifery staff were failing to 'escalate' care and call doctors when critical observations were recorded. Ethnographic work *in situ* combined with confidential qualitative interviews revealed unwillingness and, in some cases, fear of following this through. In practice, the staff

either could not/would not use their own mobile phones for this process (at their own cost[7]) or had grown tired of repeated fruitless attempts to contact on-call doctors. In (many) other cases, midwives had experienced heavy criticism/chastisement from doctors for disturbing them. This is an endemic problem in Ugandan public health facilities.

Our analysis of failure at this stage illustrates the importance of combining explicit clinical skills with tacit knowledge and an emerging understanding of the impact of hierarchy and power (positionality) on relationships and implementation. We are no longer dealing with individuals but with complex organisations and 'systems within systems' founded on subversive knowledge rather than a lack of knowledge per se.

Intervention: Human Resource System Deficits

Continued CME training provided by volunteers and local staff was introduced to manage (clinical) skills gaps caused by staff rotations (this is really a restatement of the initial *Theory of Change* but emphasising the importance of continuity and repeat training). Further engagement with senior managers was pursued to improve accountability, build relationships between staff cadres improving the empowerment of midwives and responsiveness of doctors. The behavioural science model may characterise this as an individual motivation 'deficit.' At this stage in the process we tried to combine our earlier interventions targeted at individuals with a firmer focus on advocacy and policy implementation processes. This included more active engagement with high-level stakeholders and managers to remove barriers to the escalation process, reduce the potential for corruption to influence patient prioritisation and ensure that doctors are accountable and accessible.

Outcome: This proved to be a total failure: improving the presence and responsiveness of doctors has proven to be fundamentally resistant to change in spite of managerial interventions. Corruption continues to disrupt processes and resist change. Even the highest-level managers openly admitted that they lacked the power to challenge organised syndicates, the behaviour of senior doctors and corruption dynamics.

Review and Theory Development: At this point the search for relevant research and explanatory theories fans out beyond the initial 'simple' intervention spanning multiple disciplines to generate new and highly complex knowledge combinations; clinical knowledge declines in significance as theories of corruption, human resource management and knowledge transfer take on a new significance. The relevance and value of systematic review

declines as the search for more composite and complex theories capable of understanding wider systemic and structural dynamics becomes essential to future interventions. Fundamentally, acknowledgement of the complexities of researcher/volunteer positionality and the very limited scope for foreigner engagement in anti-corruption interventions highlights the resilience (functionality) of existing systems and the limited scope for impact from external professional volunteering and Health Partnership intervention.

This case study has shown how the implementation of something as apparently simple as triage with the potential to significantly reduce maternal and neonatal mortality (and the need for emergency intervention) whilst also substantially reducing the costs of public services has proved impossible to implement.

Grounded local knowledge achieved through ongoing ethnographic methods has enabled us to begin to understand the importance of tacit knowledge and the barriers to change. Interventions focused on individual capabilities or opportunities and individual behaviour change will not achieve systems change in public health facilities in Uganda. The powerful impact of subversive (tacit) knowledge and vested interests render the current system fully functional for the status quo. In this environment, those health workers and managers (and there are many) who genuinely hope and strive for systems change inevitably find it impossible to imagine a new reality and engage in action-planning to achieve that. And, sadly, the system will close ranks on those individuals who risk putting their heads above the parapet. Table 5.1 summarises the processes outlined before and the emphasis on deficits at each stage.

Case Study 2: Managing Obstetric Emergencies

The majority of UK/Ugandan Health Partnerships focus on hospital–hospital relationships.[8] And most are headed up by senior clinicians, mainly doctors (Ackers and Porter 2011). Volunteer clinical trainees are also usually keen to be placed in large, congested, hospitals where high patient volumes and clinical complexity meet both altruistic and clinical exposure needs (Tate 2016).[9] This, coupled with the policy emphasis and associated metrics (embedded in the Millennium Development Goals) on maternal mortality, encourages an emphasis on those facilities where the majority of recorded deaths take place.

Table 5.1 Summary of triage (a 'complex intervention')

	Problem definition	*Theory of change*	*Unit of change*	*Intervention type*	*Knowledge type*	*Methodological approach*	
					Knowledge deficit/functional		'Facts'/metrics
1	Skills deficit	Co-production of protocols coupled with co-delivered CMEs will improve patient outcomes	Individual capability'	Simple	Explicit/clinical/ imported	Enumeration numerical test results	Empiricism
2	Physical resource deficits	Providing resource (infrastructural improvements) will support implementation of new knowledge	Individual opportunity'	Complex	Explicit/technical	As above Audit	
3	Human resource Deficits	Improving human resource management and accountability will enhance implementation	Individual opportunity'	Complex	Knowledge deficit/ functional tacit	Enumeration (staffing levels)	
4	Power deficits	Implementation of co-produced knowledge impeded by systemic resistance/positionality	Organisational/ systemic intentionality'	High complex	Knowledge combinations tacit/ localised/embedded functional/ subversive	Ethnographic/ qualitative focus on process and system	Understanding Why?

The SVP benchmarking process collated facility-held data on maternal mortality. Table 5.2 lists the main 'causes' of maternal deaths in Mulago National Referral Hospital in the 12 months from January 2012 to December 2012:

The data presented here should not be regarded as 'facts.' Certainly each maternal death recorded here is a sad fact but the process of establishing (single factor) causation is highly problematic. Significant pressure fuelled by SVP volunteers has encouraged a process of maternal mortality review, but compliance across the HUB remains patchy. As such, all facility-generated data must be regarded as a social construction.[10] Nevertheless, it serves one of the most important functions of quantitative data: it indicates trends and raises critical questions. During the early months of the LMP project (and very much playing the role of handmaiden to the obstetrician lead) we took it at face value that these were the causes of maternal deaths rather than the final 'hit' on the protracted 'road to death' (Filippi et al. 2005).

Faced with the alarming volume of maternal and neonatal deaths occurring in these referral facilities and the earlier 'evidence' on causation, it may come as no surprise that the overwhelming initial response was to advocate the introduction of (imported/amended) protocols and

Table 5.2 Causes and frequencies of maternal deaths in Mulago (Jan-12 to Dec-12)

Causes of death	*Number of instances in 2012*
Abortion	26
Eclampsia	22
Post-partum haemorrhage (PPH)	17
Anaemia	10
Ruptured uterus	11
HIV-related	21
Respiratory distress	2
Cardiac arrest on table	2
Puerperal sepsis	33
Malaria in pregnancy	8
Tetanus	0
Ruptured ectopic	4
Dead on arrival	1
Total	**157**

Source: McKay and Ackers 2013.

associated CME-style short-course training packaged under the generic title of 'Emergency Obstetric and Neonatal Care (EmONC)'. This was certainly our experience during our early involvement with the Liverpool-Mulago Partnership and, subsequently, in the Ugandan Maternal and Newborn Hub. And, in the first instance, as non-clinicians, we lacked the experiential knowledge and confidence to challenge the dominant medical paradigm. Indeed, in our report on Emergency Obstetric Skills Training conducted by SVP volunteers, we describe the intervention as an 'intensive two-day course designed to address the *main causes of maternal mortality* in resource poor settings in a systematic fashion' (Tate 2014). Several years and experience later we would question this 'diagnosis'.

The identification of the 'problem' at this stage in our learning was twofold: first, that many women are dying from (emergency) conditions that are preventable if staff had the right skills (to treat emergences). And, second, that Uganda lacks human resource capacity (clinicians do not possess the appropriate level of skill). Once again, this is immediately (evidently) apparent on the wards which are manned mainly by intern (junior) doctors.

Initial Theory of Change: The engagement of UK clinical volunteers alongside Ugandan counterparts in the adaptation of established 'Green Top Guidelines'[11] from the UK and associated (CME) training will reduce maternal and neonatal mortality.

Intervention: Skills Deficits (Capabilities)

The intervention could be described as relatively simple[12] involving the transmission of explicit clinical skills. These included training in the value of observations and early warning scores (Case Study 1) and management of conditions such as eclampsia, haemorrhage and sepsis. As in Case Study 1, following the requirements of our funding body (THET), the immediate evaluation involved counting the volume of participants and simple before-and-after testing of skills acquisition (during the 2-day period). Combined with feedback forms, these instruments indicated a very marked improvement in skills and a strong expressed intentionality on the part of participants to utilise them.

In many interventions, this is where evaluation ends and training teams then 'fly-home.' Whilst pre- and post-testing measures typically indicate a high level of immediate impact, attempting to assess/project any causal (attributable) impact on mortality rates, etc., is ambitious and highly unlikely to succeed. Ethnographic observational methods combined with

interviews indicated the application of some of the skills acquired amongst some of the trainees for a limited period of time and when in co-present relationships with volunteers. In practice, the ripples of good practice extending from these forms of training soon disappear.

Outcomes

Sadly, our research indicates that, although skills such as these can never be entirely wasted in terms of individual learning and potential; the investment in short CME-style interventions does not deliver the kinds of behaviour change capable of impacting public health systems in an effective, sustainable and efficient manner. Staff rotations make it especially difficult to monitor the skills use of those individuals whose skills gain is highest (junior doctors, interns and students). Whilst methods could have been developed to track individual journeys and attempt to assess skills use, the focus of the project on highly contextualised specific public facilities within the HUB discouraged this approach. Whilst we could have expended research resource to track individuals, we also felt quite strongly that implementation depends on achieving a level of critical mass capable of influencing cultural change within organisations supported by managerial buy-in.

Furthermore, many more established staff – and especially doctors – are not present on public wards with any degree of regularity to enable skills utilisation to take place (or be observed). And, many clinicians who are motivated to engage in training do so to facilitate career moves out of clinical work altogether, into the private sector (internal brain drain) or to clinical work in other countries (external brain drain). This proved to be the case with many of the clinicians who came to the UK supported by British Commonwealth Fellowships. Whilst the SVP objectives in bringing people to the UK were initially to enhance capabilities through training, the majority of fellows have used the credentials gained and networks established to exit clinical work in Uganda. In many cases they gained a new appetite for and confidence in international travel, immediately moving onto other courses in Sweden, Australia and Kenya (among others). Others have established their own NGOs or private training enterprises and become trainers themselves in Uganda, positioning themselves to harvest international NGO funding for CMEs. Others have sought direct employment in the private or NGO sector. Certainly the individual motivation in many cases is to use this experience to exit or reduce reliance on public sector clinical work.

When we assess data on human resources in Ugandan facilities, it is immediately apparent that the staff who are visibly present to professional volunteers (and form the basis of the presumption of a major skills shortage) represent the most junior of cadres (intern doctors and students). Large volumes of more experienced and highly trained staff, many of whom have had remarkable opportunities for international training, are simply not present on the wards to implement skills.

Training Protocols in CMEs

In the course of the SVP project, we were made aware of serious problems arising from varieties of foreign organisations coming into Uganda and training to their own national protocols/guidelines. This was resisted by local stakeholders who felt that they had perfectly sound guidelines endorsed by their own professional organisations and that using different systems confused staff and undermined efficacy. Attempts by the SVP to encourage multi-disciplinary and international collaboration, although welcomed, failed to encourage the necessary cooperation required (even within the UK).

The problems associated with selecting appropriate guidelines and protocols extend beyond this concern with imposing imported national systems. One might argue (as we did at one point) that internationally agreed protocols would overcome this tension. Our experience of working with WHO guidelines in our current Hand Hygiene Project[13] identifies further sources of complexity. In this case, Ugandan infection control specialists accustomed to training according to WHO 'African Partners for Patient Safety' (APPS) protocols[14] are also experiencing major implementation gaps. The problem arises when training ignores local contexts and assumes the existence of critical 'opportunities'. In our recent work, this included an assumption manifest in MOH guidelines (Fig. 5.1) that all facilities have running water, hand soap and single-use hand towels (or paper towels):

Such a situation would be unique in Ugandan public health facilities. Indeed, when we sent our project manager to visit the trainer's own facility, she advised us that recently they had no water due to the fact that bills had not been paid. On this occasion the staff and patients launched a protest, which forced authorities to restore water to the facility. On the basis of this lesson we then proposed that our own training in Fort Portal would be targeted very specifically to local conditions and embrace

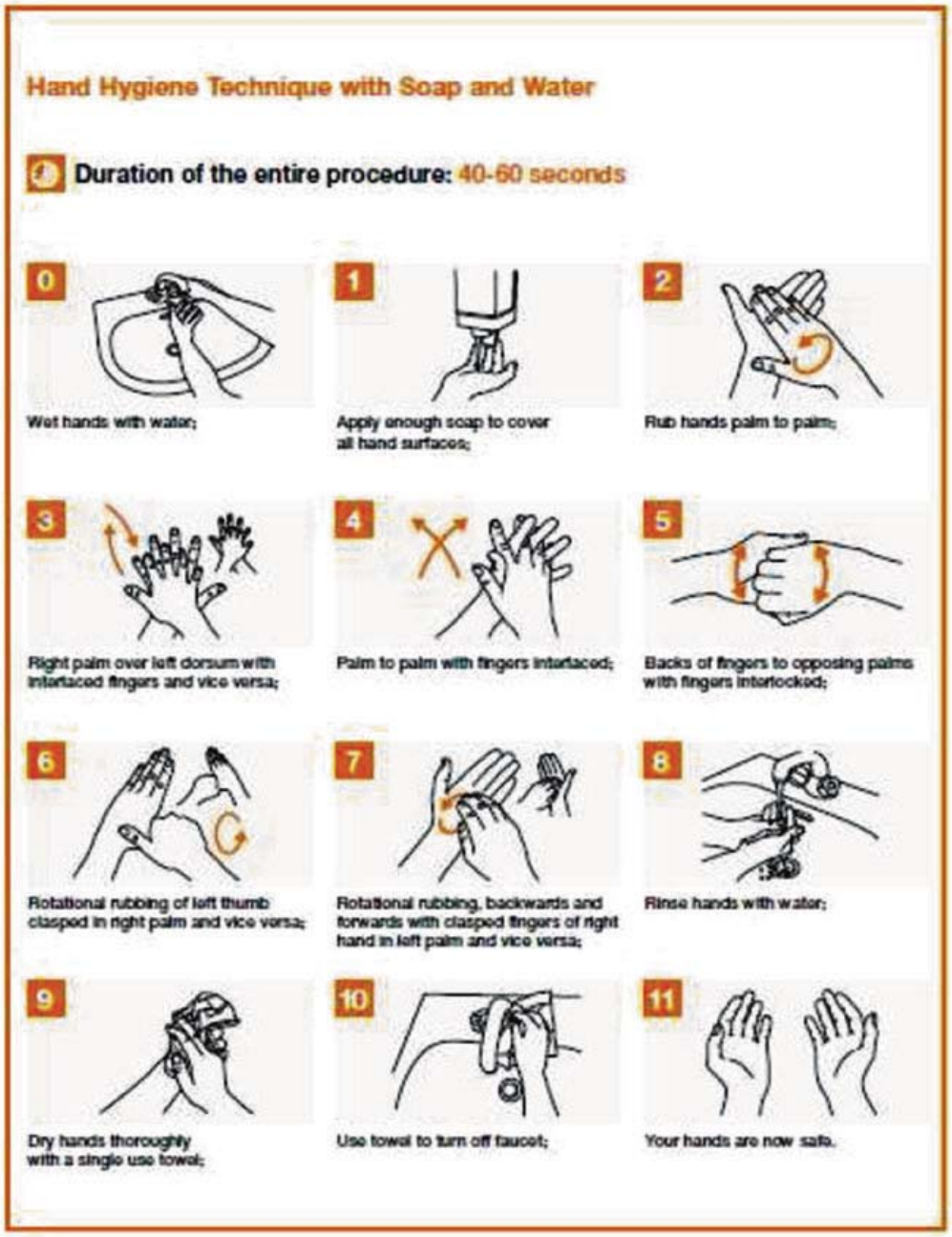

Fig. 5.1 Ministry of Health guidance on Hand Hygiene (2014) (*Source*: Ugandan national infection prevention and control guidelines (MOH 2013))

an element of empowerment of local health workers and patients. Training Ugandan health workers using the APPS tools without careful attention to local conditions achieves nothing in practice and may even contribute to low morale.

This emphasises the importance of the 'opportunity' dimension of behaviour change. Certainly in the case of hand hygiene, we would argue that most health workers understand the need to wash their hands both for their own protection and that of their patients. But faced with the lack of running water, soap and single-use towels, they find it impossible to see the benefits of training and imagine the reality of improved patient safety.

The SVP Benchmarking data underlined the importance of context to behaviour and outcomes. In Mulago hospital, between January 2011 and October 2012, only one maternal death was recorded on the private ward compared to 183 on the public ward. The same staff, with the same training, are responsible for both groups of patients. Figures for the same time period evidence marked differences in C-section rates for the private and public ward.

C-section rates on the private ward are around double those on the public ward. Ongoing engagement with colleagues in the hospital made us aware of the 'policy' that all c-sections on the private ward should be undertaken by obstetric specialists and must be prioritised. These doctors receive 'top-up' pro rata payments for such procedures that dwarf monthly salaries. Given this information the need for EmONC training becomes less obvious.

Intervention: Physical Resource Deficits (Opportunities)

As with Case Study 1 a logical complementary measure responding to claims on the part of healthcare workers that they lack basic physical resources to support emergency obstetric interventions was to provide equipment, infrastructure and consumables – the 'opportunities' enabling them to utilise their skills. And, the problems associated with resource management in Ugandan public health facilities underline the legitimacy of this claim. Few, if any, operating theatres in Health Centre IVs are fully functional and available for use.[15]

It is with this in mind that the SVP shifted its emphasis mid-project (and following requests by Ugandan stakeholders) away from large referral hospitals to address the efficacy of referral systems. This shift was also informed by evidence on the ground of the failure of CME interventions in congested hospitals to effect any perceptible systems change and further

review of the research on maternal delays. These alternative conceptualisations of the causes of maternal deaths involving more longitudinal and holistic analyses and multi-disciplinary insights encouraged us to reconsider the data on the stated causes of maternal deaths (Table 5.2). Informed by research on the 'three delays' (Kaye et al. 2011; Pacagnella et al. 2012; Thaddeus and Maine 1990; Thorsen et al. 2012; Tuncalp et al. 2012) and our own research on the ground, our focus then became one of reducing delays in order to avoid preventable problems turning into obstetric emergencies (or deaths).

One of the sites in which this intervention took place was Kisenyi Health Centre IV, which refers patients into Mulago Hospital. At the time of intervention, this purpose-built facility with a full remunerated staffing complement had not been available to delivering mothers since opening 7 years previously.

Our revised *Theory of Change* at this point indicated a focus on restoring functionality to Health Centre IV facilities in order to increase deliveries, thereby reducing congestion in referral facilities and complications arising from maternal delays.

Intervention

The initial intervention (building on previous experience in two other facilities) involved an intense 1-week multi-disciplinary problem-solving exercise. In practice, most of the infrastructure, consumables and staff were present but small 'snagging' problems such as the lack of a sink in the delivery suite, the lack of drainage to wash floors and some basic equipment repair work and a lack of leadership had blocked progress. Within one week the first baby was delivered and, with new local leadership, the facility swung into action.

Outcome: Within 1 year, and following a series of very minor infrastructural and equipment interventions (costing the charity less than £1000 in total) the facility achieved a sustained average monthly delivery rate of over 800 (Ackers 2016). Every mother delivered in Kisenyi is one less mother delivering in Mulago. From that perspective, the impact on congestion and delays is tangible but not directly measureable/attributable[16] as many other factors will intervene to shape admissions (such as the closing of another major referral Health Centre at that time and a significant outbreak of typhoid).

Despite these successes in building Kisenyi into a fully functioning midwifery-led unit, the operating theatre remained under-utilised.

Improving functionality and providing associated training (including EmONC) supported by volunteer mentoring failed to reduce referrals for c-sections, which remained high, resulting in preventable deaths (Ackers 2016). At this stage, we could have significantly reduced referrals if we had allowed SVP volunteers to operate on patients in the absence of local doctors. We did not allow this breach of the co-presence principle. Chapter 2 reported on the audit conducted by the then SVP volunteer revealing key factors participating referrals (Fig. 5.2).

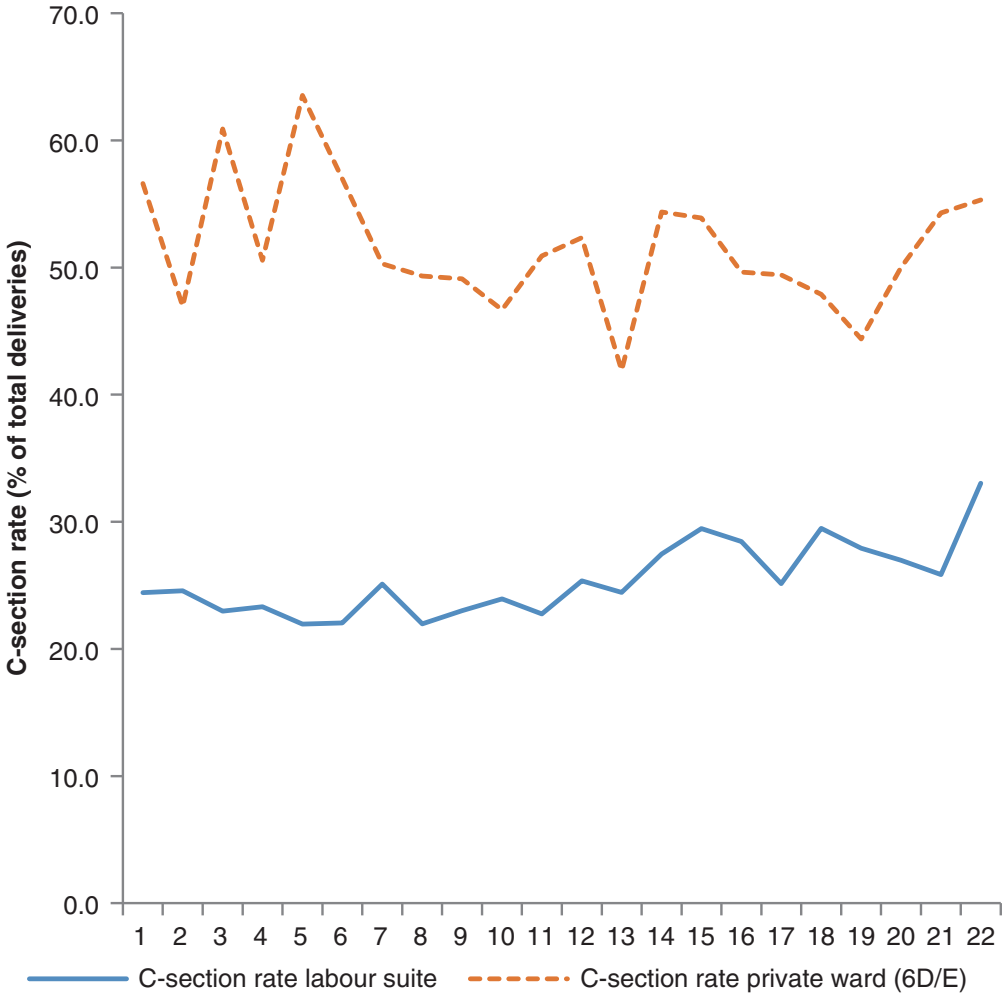

Fig. 5.2 Caesarean section rates on the private and public wards, Mulago Hospital (*Source*: McKay and Ackers 2013: 23)

These included supplies of blood, oxygen and power and the presence of doctors. Each of these components, whilst apparently 'simple', is in practice a can of worms. The availability of blood is itself a composite problem reflecting power supply (electricity); the adequacy and efficacy of the blood donation system, elements of corruption and also transportation. Power is also far more complex than meets the eye; shortages may reflect a failure to pay bills (and disappearance of relevant funds), (political) power play and funding shortages related to the purchase of fuel for back-up generators (a common problem in Uganda[17]) and the inflated costs of solar power in low-resource settings. On occasions any of these elements may be used and manipulated as excuses for inaction. However, as we have seen, the most common factor precipitating unnecessary referrals concerns physician presence.

Rather than go into detail about any of the aforementioned, we have decided to focus here on a more clinical follow-on intervention; namely, the institution of elective c-sections. Attempts to institute elective c-section lists have been repeatedly made by SVP volunteers across all HUB facilities. As one volunteer explains in her monthly report:

> It would help facilities if there was a regular elective day/s for cases that need a caesarean section to prevent mothers having to await labour and all its inherent risks when there are likely time delays in access to theatre. This would possibly reduce transfers, emergency sections and increased mortality/morbidity.

The institution of elective c-sections would further reduce maternal delays and the need for emergency/crisis intervention.

Intervention: Implementing Elective (planned) Caesarean Sections

The overwhelming majority of caesarean sections in Uganda are undertaken as emergencies allowing complications to develop, delays to lengthen, outcomes to worsen and cost to escalate. A recent audit in Mulago Hospital (Acen 2015) found that of 200 C-sections undertaken in September to November 2014, 184 (92 %) were emergency sections. Introducing an electives c-section list in Health Centre IV Facilities would build on the success of SVP intervention to ensure more timely intervention, reducing complications and unnecessary and time-consuming referrals. On the face of it, this is a very simple intervention requiring

training/mentoring in the clinical indications for c-section coupled with a staff rota and booking system.

Intervention: Skills Deficits
Most of the short courses in emergency obstetric care discussed in Chapter 3 include the discussion of indications and guidelines for elective sections. And this training has been embedded in the SVP through further short-course skills drills, ongoing mentoring and audit work to support implementation on the ground.

Intervention: Resource Deficits (Stationary and Records Books)

A desk-book was made available to enable staff to book women for elective procedures.

Outcome: Sporadic Minimal Improvement
The provision of training, protocol development and mentoring coupled with the institution of an (unchallenged) booking system failed to improve c-section rates. This failure is in large part due to the persistent resistance of local doctors (and at times anaesthetic assistants) to be present and for local midwives to book patients (anticipating the former and resorting to the cultural 'if in doubt refer' logic). At this point the intervention develops a level of complexity implying engagement with highly sensitive power dynamics and generating problems of positionality both within the Ugandan human resource management system and in the relationships that 'outsiders' have with local staff and managers.

Figure 5.2 indicated that the presence of doctors was a major factor contributing to over 53 % of referrals. IF we discount referrals made at night over a quarter of referrals made during normal daytime working hours cite the lack of medical presence as a key reason (Fig. 5.3).

At this point, the level of complexity involved coupled with the difficulties that Health Partnerships and volunteers face as 'outsiders' with no real power to influence policy makers we attempted to offer moral support to brave local managers keen to incentivise and enforce accountability in human resource management systems. The in-charge midwife made considerable efforts to encourage doctors to be present and to expose those who were not present during their allocated working hours. And the City authorities (KCCA) increased doctors' pay (quite considerably) in Health Centre IV facilities and considered the potential of installing an electronic

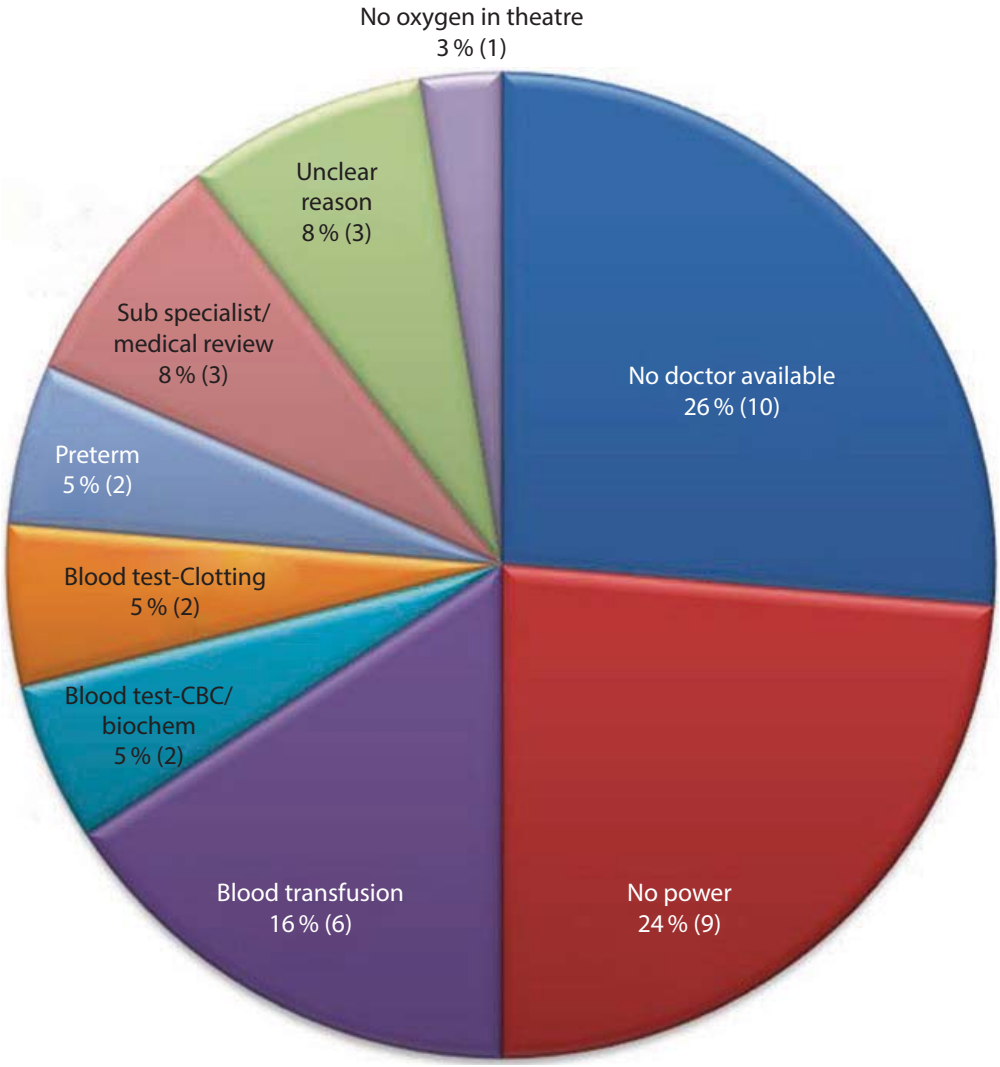

Fig. 5.3 Reasons for referrals between the hours of 08:00 and 17:00 Kisenyi Health Centre (*Source*: Ackers 2016 [*CBC*: Complete Blood Count])

system to record staff presence. In practice, this resulted in short-lived and minimal behaviour change and significant resistance to change among all doctors.

Somewhat surprisingly, some months later, continued facility benchmarking identified a sudden marked increase in elective c-section rates. Our first inclination was to celebrate the apparent success of ongoing

interventions and regret our impatience. Our presence on the ground, however, and localised knowledge raised immediate concerns about this sudden shift. We were aware that one doctor was making a concerted effort to improve practice. However, we became suspicious that other 'entrepreneurial' practices were emerging as local doctors began to use the improved premises for private (fee-paying) elective c-sections. SVP volunteers are unable to 'prove' this situation empirically, given the subversive quality of corruption and the risks involved in openly asking questions – but they expressed concern when 'surprise' elective sections were observed to take priority over emergency cases. This is not the first time that investments made by our programme in improving infrastructure have stimulated an increase in private cases. Rather than indicating a problem caused by skills or knowledge deficits, we would conclude that our interventions have been manipulated through the use of highly entrepreneurial subversive local knowledge. summarises the processes outlined in the Case Studies:

The aforementioned case studies do not reflect the total (zero-sum) failure of interventions; capability-enhancing training combined with a focus on improving the opportunities for skills utilisation are necessary but insufficient constituents of change. Change can be seen to occur in terms of individual skills enhancement and, during volunteer co-presence, some partial skills utilisation and adherence to protocols. But these are key components in far more complex interventions. Understanding why these interventions, which typify the overwhelming majority of Health Partnership-style initiatives internationally, fail to translate into sustainable systems change is essential if we are to avoid wasting public money and undermining health systems.

The Knowledge Deficit Model

Why is it, given the lack of tangible evidence that AID, in any of its guises, works that funding continues to grow exponentially and continue to fund interventions that either do not work or generate damaging externality effects? And why, given the clear failure of existing evaluation metrics to capture the processes responsible for impact failure, is the solution seen as one of honing metrics? Public and political concern at the lack of impact of huge volumes of public funding has led to an increasing obsession with metrics and quantitative outcome measures.

The UK Department for International Development's 'logframe' methodology has had a major 'structuring impact' generating a common template for the evaluation of international development interventions. This formulaic approach has led to the emergence of a new (and highly confusing) conceptual vocabulary requiring projects to report, in a 'theory of change' approach on 'activities', 'inputs', 'outcomes' and 'outputs'. The THET, almost entirely reliant on DFID funding, has necessarily had to import this approach and apply it to all Health Partnership work. Sadly, this has forced a situation in which the 'tail has begun to wag the dog' as the clamour for funds begins to shape interventions around the demands of the funding bodies and their evaluation metrics rather than perceived needs or a grounded understanding of what works or does not. And this has a major impact on the use of evaluation resource; so great is the need to count 'outcomes' that there is little time to try to understand and make sense of failure. And failure is and has been the dominant outcome of development interventions for many decades.

The Lancet Commission's 'Global Surgery' report opens with the statement: 'Remarkable gains have been made in global health in the past 25 years' (Meara, J.G. et al 2015: 569) but provides no evidence to substantiate this claim. It goes on to present a very holistic and comprehensive case for multi-professional interventions informed by the three delays model and focused on 'broad-based health-systems solutions' (p. 570). The concluding section argues that 'research, monitoring and assessment play a crucial part in the future of global surgery' together with a 'commitment to better understand the problems and solutions' (p. 616). We would agree wholeheartedly with this prognosis. Having said that, we firmly believe that attributing this to the 'complete absence of globally accepted surgical metrics' entirely misses the point.

A recent report on International Development Funding by the UK Government's Public Accounts Committee found that, despite the trebling of public funding for humanitarian crises, 'the Department for International Development did not have a full understanding of where its money went' (House of Commons Report 2016). DFID defended its record arguing that it had a system which enabled it to 'aggregate the success of each intervention into a score which it can track month by month across interventions' (p. 10). However, it failed to report its portfolio score. What

we are doing here is attempting to measure the measurable (as information or 'data') rather than the meaningful (as knowledge):

> Simplistically conceptualising knowledge as information makes its valuation and trade measurable but loses most of the originality of the empirical phenomenon. By contrast when scholars conceptualise knowledge as complex capabilities embodied in people and organisations, it no longer fits into the concept of an economic good that can be valued, traded, and accumulated, and its exact measurement becomes an impossibility. (Gluckler et al. 2013: 6)

These reports underline the fact that we know so little about the effectiveness of AID and that the solution to this problem is seen to lie in the production of ever-more quantitative metrics. No attempts are made to question the underlying epistemological biases of this logic or, put more simply, the fact that metrics have never worked and never will capture the 'problems and solutions' facing health systems in LMICs (or indeed the UK).

Fundamentally, we are suffering from a form of myopia generated by the domination of medical science perspectives or knowledge paradigms which determine the diagnoses, the interventions and epistemological approaches to evaluation. The quest for statistical outcomes (ideally gained through the gold standard of randomised controlled trials) underpinned by the narrowing blinkers of systematic review restricts our ability to understand social processes. There is also a tendency within this paradigm to pathologise or patronise individuals whilst failing to understand the impact of structural constraints. Despite growing recognition of the importance of context, this is often in the form of lip service at best acknowledging it as a cluster of variables that we don't understand (as external 'noise') or, at worst, rather than understanding and capturing its iterative quality, trying to insulate our interventions from it through vain or inappropriate attempts to control it. Trying to cleanse data through what feminist researchers have called a 'sanitisation process' (Harding 1987, 1991) will not generate cleaner facts. It will take us further away from the truth as the cleansing process strips data of its real value: of understanding the social processes that shape phenomenon. It may be that what we are swilling away in the effluent is that which is of greatest value.

This narrow conceptualisation of knowledge not only affects the approach to evaluation, but it also reproduces a partial understanding of knowledge mobilisation as an activity. The emphasis on explicit clinical skills and neglect

of tacit knowledge leads to the identification of a 'knowledge deficit' encouraging uni-directional flows (from the host to the LMIC or from doctors to midwives). We are not adding skills to context (as the COM-B model implies): context lies at the heart of complex fluid and, oftentimes confounding knowledge combinations. Or, as McCormack puts it: 'nothing exists and can be understood in isolation from its context' (2015: 3009).

On the basis of our research and learning, we would argue that far from a skills deficit we are in a situation of knowledge saturation; clinical skills/information are not the primary problem and using clinical 'experts' as conduits for yet more skills-forcing interventions is neither efficient nor effective. To the contrary, it is both arrogant and wasteful. This arrogance does not derive solely (although this certainly does contribute) to the imposition of 'expert information' from the global North: from well-meaning but narrow thinking foreign clinical experts and 'donors'. It is the consequence of a failure to see the bigger picture – of narrowing disciplinary knowledge paradigms. Although the lack of patient management is recognised as an issue by all UK clinicians working in Uganda: it was a visiting Ugandan obstetrician who proposed the initiative to introduce the African Maternal Early Warning Score (AMEWS) into Mulago Hospital. Enthralled by its apparent success in the UK (visiting foreigners are often not exposed to or fail to see the fundamental weaknesses of UK systems) she quite understandably attempted a 'policy transfer' approach: she 'saw' a clinical solution to a clinical problem and tried to transfer it. And as a project we sought to support her in this without comprehending the localised knowledge that would ultimately render it unsuccessful.

Knowledge can be both enabling and disabling; it is not only a deficit of skills/knowledge that hampers progress; narrow siloed knowledge (focused on harvesting facts) can limit our ability to see the social world and the truth that lies behind interventions. Resistance to change may be fuelled by knowledge and often quite entrepreneurial tacit localised knowledge. From an individual perspective – how to make ends meet and sustain your family – or, from a systems perspective – how to organise and funnel the rewards from systemic forms of corruption – requires a level of localised tacit knowledge and rational/entrepreneurial decision making that foreign volunteers may fail to 'see'.

The overall conclusion of this book, based on intense multi-method action-oriented research over a period of 8 years, is that international development initiatives in the form of Health Partnerships and through

the mechanism of professional voluntarism (staff exchanges) are failing to bring about significant sustainable systems change in the Ugandan public health sector. Having said that, we believe that Health Partnership activity has the potential to mitigate the forms of systems damage associated with AID. More importantly, we believe it has the capacity to form the basis of evidence-based incremental systems change. Achieving this will require a much more structured approach to professional volunteer deployment based on principles of negotiated conditionality. Whilst we emphasise the importance of understanding the benefits and humility of incrementalism in policy change, from an epistemological perspective we need a paradigm shift.

If we reflect on the three scenarios presented in Chapter 1, we can conclude that the risks associated with Scenario 3 (negative impact through collateral damage) remain very high and most AID activity falls into this category. In terms of long-term sustainability, most of what we have achieved through the SVP would fall under Scenario 2 (neutral long-term impact but with minimal externality effects). More optimistically, and informed by the iterative learning we have experienced ourselves as researchers and project managers, we believe that Scenario 1 is achievable (partial improvement with minimal collateral damage).

The book opened and is peppered with firmly expressed concerns about the externality effects of AID focused on gap filling and service delivery. We have talked a lot about collateral damage, the unintended consequences of well-intentioned interventions and the critical importance of co-presence. When interventions, such as the SVP and the Health Partnership Scheme more generally, are based on sound conditionality principles, externality effects may be positive. Certainly the co-presence principle supports the active clinical engagement of professional volunteers. In this process, the collateral benefits of systems focused intervention are enormous. We have no doubt and are reminded on a daily basis of the impacts of our work and of professional volunteers in particular on patient services and individual patients. SVP volunteers are saving the lives of mothers and babies in Uganda on a daily basis. Finally, the key beneficiaries of the SVP model are those patients who rely on public welfare to meet their healthcare needs, both in the immediate term (through the daily hands-on engagement of volunteers) and through longer-term systems change.

The following section outlines some key elements of structure and conditionality that we have identified through our action-research journey. These concerns and the recommendations that accompany them may not be directly applicable or transportable to other LMIC or disciplinary contexts but when carefully contextualised and translated they could inform policy making and volunteer deployment.

Policy Recommendations

1. Corruption

Health Partnership interventions, as with all AID, generate vast opportunities for corruption. Opportunities for corruption are identified and exploited in every interaction we engage in from the use of disposable gloves to the donation of equipment. This is a highly entrepreneurial and innovative process which is very hard for 'outsiders' to see or to challenge. In this context, professional volunteers are often viewed as 'spies' and as such are open to forms of harassment. More commonly, they are unable to function effectively as clinicians and knowledge intermediaries.

Recommendation 1: Whistle Blowing
Health Partnerships and Volunteer Deployment Agencies need to work closely with their Ugandan partners on the ground and provide support mechanisms for volunteers to encourage them to recognise and report corruption. Health Partnerships are often loath to acknowledge or take action on corruption for fear of damaging relationships. This, in itself, damages relationships.

2. Labour Substitution

Our research indicates a significant potential for system damage when interventions are framed inappropriately to the context and when the context is itself misunderstood. Labour substitution is a huge risk. It undermines systems, distorts local labour markets and accentuates existing human resource management problems actively encouraging absenteeism and moonlighting (dual working). It is also profoundly arrogant. This 'style' of volunteering stems from traditional donor–recipient models and is particularly associated with missionary-style volunteering. The focus on 'helping' individual patients and creating parallel institutions

for this purpose (mission hospitals etc.), whilst perfectly understandable, in the wider scheme of things undermines universal public health systems.

Recommendation 2.1: Advocacy in Human Resource Management

The efficacy of professional voluntarism will not improve unless key stakeholders in LMICs introduce and enforce accountability in human resource management systems. Measures must be put in place to ensure the timely payment of salaries and to discipline and/or dismiss staff members who fail to comply and present themselves for work. Unless local staff are present in the workplace, the opportunities for knowledge mobilisation and systems change are minimal. Specific attention needs to be paid to staff in leadership and senior positions, especially doctors. If leaders fail to present themselves for work in a timely manner, the lack of effective role modelling reinforces a culture of bad practice. Leadership is seriously lacking in most Ugandan health facilities. We do not believe this represents a need for training, however, but for improved accountability.

Recommendation 2.2: Co-Presence

All efforts should be taken to respect and embed the principle of co-presence when deploying professional volunteers. This should be interpreted as a key component of conditionality and where co-presence is not possible volunteers should be required to withdraw from that context. The only exception to this should be in carefully managed and documented emergency situations. The failure to respect co-presence by volunteer deploying organisations and individual volunteers undermines the position of those who are respecting the principle and generates resentment. Managing and operationalising co-presence requires the development of highly structured programmes for volunteer deployment with clear role descriptions and reporting mechanisms. 'Lone Ranger' and Missionary-style volunteering undermines these processes.

The enforcement of co-presence as a key dimension of accountability in human resource management systems requires high-level action at ministerial level and involving consortiums of international NGOs working in collaboration. This is the single most critical element of conditionality.

3. Equality and Ethical Standards in Volunteer Deployment

The THET has played a major role in supporting (and requiring) more structured, risk-assessed and ethical approaches to volunteer deployment. We believe that this has gone a long way to ensuring that the recruitment and deployment of professional volunteers complies with UK equality law and policy. However, we have witnessed behaviour on the part of UK-registered Charities operating in Uganda, particularly those involved in Mission Hospitals (affecting both Ugandan health workers and UK volunteers) which would seriously breach all equality rules in the UK. This includes overt discrimination on grounds of sexuality, gender, race, religious beliefs and breaches of the principles of the Working Time Directive and work–life balance.

Recommendation 3: Equality and Charitable Status

We have noted (earlier) our concern at the role that faith-based NGOs (charities) play in running parallel organisations independent of the Ugandan public health sector. As a general rule, we believe this process undermines the public system and creates opportunities to extend damaging forms of missionary-style colonialism. These exist in a 'bubble' with apparent immunity from both Ugandan and UK law and policy and attract religious fanatics. All UK charities operating in LMICs should be required to abide by both Ugandan and UK Employment, Charity and Equality Laws. Failure to comply should result in loss of charitable status.

4. The Commodification of Training

It is inappropriate and wasteful to pay people (per diems) to receive training. The payments attached to training have distorted the whole meaning of training and created a situation where people are training for the wrong reasons and the wrong people are consuming the opportunities on offer. The failure of LMICs and development organisations to develop a common policy on this generates tensions and a competitive environment, which further detracts from knowledge mobilisation objectives. AID organisations have commodified training, creating new opportunities for corruption and serial absenteeism especially among senior staff and 'leaders'.

Recommendation 4: Per Diems

The practice of providing per diems for training should be immediately stopped. We urge the Ugandan Ministry of Health and District Health Offices to create protocols to regulate these practices so that training interventions reach the people they are designed for and perverse incentives are extinguished. Providing essential assistance with transport and refreshments is less of a problem. Organising training events as close as possible to health workers' work place and, where possible, in the workplace reduces these costs (and risks) whilst also reducing the amount of time health workers are away from the wards.

5. Internal Brain Drain

Often overlooked, internal brain drain has a far greater impact on the human resource 'crisis' in LMICs than external brain drain (emigration). And development interventions create significant opportunities for this through the employment of staff in project management and other roles. This is a complex issue. What is clear from our research is that the clamour for 'project employment' is having a hugely distorting effect on national labour markets and career development strategies. The effect of this is to encourage an emphasis on non-clinical postgraduate qualifications (Masters in Business Administration or Public Health for example) as part of a planned exit from clinical work. This is often seen as the alternative to dual working (internal brain drain into the private sector whilst in full-time public employment), which blocks positions for early career health workers.

Recommendation 5: Remunerating Staff in LMICs

There is no simple solution to this complex ethical problem. We are, quite rightly, encouraged by funding bodies to employ local staff where possible and build capacity in leadership and management. However, we believe that local staff should receive a level of remuneration broadly parallel to what they would (or should) receive in their public roles. We have tried to identify the level of pay that delivers a 'living wage' as opposed to the (below) subsistence-level pay that health workers are receiving in Uganda. Ultimately the MOH needs to increase health worker pay quite significantly for all cadres and impose a level of accountability to ensure that those who are paid are present and work effectively.

We would propose that a doubling of health worker salaries could be achieved at no cost and with marked efficiencies by dismissing all those staff who fail to report for work. Once this level is achieved and staff members are paid on time, foreign organisations should remunerate at national rates. From a system perspective, it is irresponsible and unethical to remunerate health workers in Uganda at rates common in the UK or the USA.

6. Continuing Professional Development (or Continuing Medical Education)

Health Partnership interventions have focused on the provision of short courses aimed at health workers. Uganda lacks an active CPD programme in most professional areas and there is little evidence of active Professional Development Review Systems. In some areas such as bio-medical engineering they are entirely absent. This leaves a vacuum for foreign organisations. In isolation and without follow-up, one-off short courses do little to change professional behaviour; ongoing mentoring on the job increases the opportunities for health workers to gain confidence and skills; this is a necessary but insufficient condition for individual behaviour change.

Recommendation 6.1: Professional Development Review
CPD/CME training needs to be embedded within a comprehensive PDR process for health workers so that needs are identified by line managers and training is organised to meet those needs.

Recommendation 6.2: Post-Training Mentoring Is Critical to Knowledge Mobilisation
One-off formal CMEs are effective in transmitting information. Operational isation and application of that learning needs support on the job to build confidence and hone skills. Professional volunteers along with their peers have a potentially valuable role to play in this process. Notwithstanding the pressure on health workers, Uganda does have many experienced clinicians. It is important that these staff members are required to support volunteers in the training and mentoring process as part of their professional role (and not on a top-up fee basis). At the present time, there is very little evidence of supervision and mentoring on the part of experienced Ugandan clinicians and we should take care not to substitute or commodify these roles. Careful thought should be given to the value of taking staff away from their clinical

duties for one-off training if there are no mechanisms in place to support post-course co-working and mentoring.

7. Donations

Donations of equipment, consumables or cash distort relationships and generate misunderstandings, which pose problems for subsequent interventions and volunteer activities. Professional volunteers are often seen first and foremost as 'donors' or, more crudely but accurately, 'cash cows'. The SVP and its sister bio-medical engineering project have drawn attention to the serious problems associated with donated equipment, much of which lies unused or unusable creating problems for storage and infection control. It also means that managers often lack awareness of what equipment there is in their facilities. On a more mundane level, it is important to explain to prospective volunteers the importance of discussing donations and requests for cash support, etc., with the project managers.

Recommendation 7: Donations Policies
All organisations, both in the sending country and in the LMIC, should adopt a transparent and joined-up donations policy. However kind and generous the intentions, the act of donation can pollute relations and generate problems. Care should be taken whenever providing infrastructural support to public facilities. The provision of consumables and equipment generates dependency, encourages opportunities for corruption and is entirely unsustainable. Where support is provided, the objective should be to provide the very minimum of support to leverage local systems rather than substituting for them. We consider this to be an example of 'snagging' where a whole facility can be out of action because there is no sink, for example, but local staff exist to install the sink. When providing support the SVP and our sister bio-medical engineering project developed a firm policy on donations.[18]

8. Evaluation: Efficacy and Meaning

We have described the SVP project as a journey. This has been mainly a research journey. We embarked upon it with an extensive background in multi-methods, comparative, high-impact social research. Throughout this journey we have experienced a creative tension with the evaluation arm of the funding body and with other organisations and stakeholders in

the global health field. This discomfort has generated active learning for us as researchers unfamiliar with the foundations of medical research, its dominance across health sciences and the quite similar metrics paradigm framing international development. Our concerns about the epistemological bias of these approaches and their inability to capture social context and process are well rehearsed in the book. But we have another concern about the efficacy of evaluation. The Health Partnership Scheme in common with so many other funders of global health has begun to conceptualise every actor in a funded project as a researcher. On one level we commend that and it resonates with our ethical commitment to co-researching. The problem is that researching such complex interventions requires a very high degree of research expertise and is hugely time-consuming. Partners in HP projects do not have the time or necessarily the expertise to undertake extensive literature reviews or policy analysis work; neither do they possess the skills to develop research plans and operationalise mixed-methods studies. And, they may well not have the experience, time or desire to engage in complex data analysis and writing up. Whilst all actors can become engaged in action-research projects and we have certainly viewed our Ugandan colleagues and professional volunteers as co-researchers, finally a considerable research expertise is required to design, manage and make sense of the data.

On that basis we would question the pressure put on all projects to conduct in-depth, expensive and time-consuming evaluation. Certainly attempts to aggregate core indicators across the diversity of projects will achieve nothing apart from churning out meaningless and potentially misleading statistics.

Recommendation 8: Evaluation Policy

We would recommend that valuable resource expended on evaluation be used more wisely to conduct expert research on a sample of interventions managed by researchers with proven expertise. Many private consultancy organisations lack academic research training and experience and constitute an expensive and poor-quality 'offer'. The British Academy Report on the role of the Humanities and Social Sciences in Public Policy Making (Wilson 2008) expressed concern at the very high proportion of UK government department's research budgets that were being 'allocated to short-term projects to meet current political and administrative demands' arguing that the government was failing to leverage the academic research

base. Identifying the demands of complex inter-departmental collaborations straddling the boundaries of departments, it argues that 'many challenges require a more sophisticated understanding of human behaviour' (Executive Summary p. 1). The report concurs with our recommendation that research funding should be focused more into support longitudinal peer-reviewed knowledge development.

Knowledge for Change?

A common response when we present our research findings is to ask us why we carry on with the work when the outcomes are so bleak and depressing. We do not find the work depressing. Indeed, to the contrary, it has been quite liberating. We cannot begin to develop interventions that have the potential to bring about systems change unless we have the knowledge base to understand the context and the processes involved. Trying to understand another country and co-design complex interventions takes time; it also challenges our skills as researchers and activists. This book has been written at a particular juncture in this learning process. We will carry on learning but we feel that we have achieved a level of understanding (and knowledge base) now that can and should be shared with others to reframe interventions.

We have always enjoyed the company of our Ugandan colleagues. We do not regard ourselves as 'donors' or them as 'recipients': rather we regard each other as fellow professionals. And we would like to move away from the language of helping or volunteering to speak more collegially about international faculty. We know from previous research and common experience that international exposure tends to reinforce rather than challenge stereotypes. Researchers and volunteers new to the field will unwittingly been drawn into absorbing and echoing those stereotypes: of Ugandan health workers as poorly trained and under-skilled, lazy, demotivated, lacking respect for fellow humans and corrupt. And the landscape we 'see' may reinforce this perception. Some of the research we have encountered along the way, notably from behavioural science perspectives, has the unintentional tendency to add intellectual credibility to these stereotypes often essentialising human behaviour. The work of evolutionary economics has given us fresh insight and lifted us from the traps of individualism, enabling us to forge genuine human relationships with our Ugandan colleagues as fellow human beings. Finally, there is more that we share than that which distinguishes us: context is indeed everything.

Notes

1. Which, according to the *Oxford English Dictionary*, is 'a thing which is hoped for but is illusory or impossible to achieve'.
2. The term 'theory' when used in the context of a 'theory of change' either in health sciences research or, quite commonly, in international development evaluation has a much narrower and more specific meaning than 'theory' in social science. It may be easier to view it as a form of working hypothesis.
3. According to Wikipedia: '**Triage** is the process of determining the priority of patients' treatments based on the severity of their condition. This rations patient treatment efficiently when resources are insufficient for all to be treated immediately'.
4. Funded by THET as part of the Ugandan Maternal and New born HUB grant.
5. Various adaptations of UK Maternal Early Warning Scoring systems have been introduced throughout the HUB. In practice, it has proved impossible to encourage all HPs to adopt the same system. The MEWS is a form of patient management system designed to enable staff to identify the sick patient and respond accordingly.
6. It is important to point out that our subsequent decision, as part of the THET-funded bio-medical engineering project we are running in parallel to the SVP has engaged with the 'opportunities' dilemma by providing the technicians that we are training across the HUB with a toolkit. WE also provided high-quality tool boxes for the technicians to store their tools in. This has been a resounding success with very little evidence of losses or thefts over 2 years after the intervention. In this example, the technicians have been working as part of a close team or Community of Practice with close attention to personal ownership and accountability.
7. Land lines are rare and staff are usually expected to use their own air time for such calls.
8. We are using the example of EmONC here but the same conclusions apply to all similar forms of CME-style training that volunteers have been involved in including neonatal resuscitation courses, which rarely if ever translate into effective practice and safer anaesthesia programmes.
9. Volunteer motivations are discussed in detail in Chatwin et al. (2016).
10. Language is also a problem; the term 'abortion' is used in Uganda to refer to miscarriages. Many of these are in fact (illegal) abortions.
11. https://www.rcog.org.uk/en/guidelines-research-services/guidelines/?p=5.
12. In the sense that training in critical care was seen as the primary objective.
13. For details see www.knowlege4change.org.uk.
14. See http://www.who.int/patientsafety/implementation/apps/en/.

15. The Health Sector Strategic Plan (2010/2011–2014/2015) includes a target of 'increasing the functionality of the HC IVs from 5 % to 50 %' (p. 48).
16. There was a drop in admissions to Mulago for the first time since 2000 but we cannot claim attribution.
17. Wherever fuel is involved there are high risks of corruption and a lack of 'petty cash'.
18. The K4C Induction Pack advises students and volunteers about donations: www.knowledg4change.org.uk, p. 24.

Annex 1 – The Sustainable Volunteering Project

Background and Objectives

The Sustainable Volunteering Project (SVP) is managed by the Liverpool-Mulago Partnership (LMP) and was initially funded by the UK Department for International Development via the Tropical Health and Education Trust's Health Partnership Scheme. Financial support has also been received from the Royal College of Obstetricians and Gynaecologists (RCOG) and the Association of Anaesthetists of Great Britain and Ireland (AAGBI). The THET-funded project began in April 2012 and ran for a 3-year period, ending March 2015. The SVP continues and is now funded in association with our partner charity Knowledge for Change (www.knowlege4change.org.uk/).

The LMP had been placing professional volunteers in Kampala for over 4 years before applying for funding for the SVP. The SVP, however, marked a substantial increase in the scale and scope of this activity; widening the LMP's focus outside of Kampala to support other Health Partnerships involved within the Ugandan Maternal & Newborn Hub (UMNH) and also broadening the cadres of Health Professionals supported to include not only obstetricians but also paediatricians, anaesthetists, midwives, nurses and biomedical engineers. UMNH is a consortium of UK-Uganda Health Partnerships established by the LMP in 2011 and encompassing the LMP, the Basingstoke-Hoima Partnership for Health,

H.L. Ackers, J. Ackers-Johnson, *Mobile Professional Voluntarism and International Development*, DOI 10.1057/978-1-137-55833-6

the Gulu-Manchester Health Partnership, the PONT-Mbale Partnership, the Bristol-Mbarara Link, the Kisiizi-Chester Partnership, the Kisiizi-Reading Partnership and a partnership between Salford University, Mountains of the Moon University and the Kabarole Health District.

The professional volunteers complete placements of varying lengths (between 6 and 24 months) and engage in a variety of initiatives, training programmes and on-the-job mentoring schemes which aim to increase capacity and improve the skills of the health workers, both in Uganda and in the UK. The SVP's focus is on capacity building and systems change and its objectives are twofold:

1. To support evidence-based, holistic and sustainable systems change through improved knowledge transfer, translation and impact.
2. To promote a more effective, sustainable and mutually beneficial approach to international professional volunteering (as the key vector of change).

The SVP does not have a focus on service delivery or workforce substitution as this activity is not judged to be sustainable.

LTV Management and Support

Recruitment

All SVP volunteers are recruited, selected and managed by the LMP (and more recently also K4C). The main organisations targeted during the initial LTV recruitment were the Royal Colleges of Obstetrics and Gynaecology, Anaesthetists, Nursing and Midwives. The Royal Colleges either circulated an advertisement by email or posted it on their websites. The advertisements were also circulated by UMNH members to their local deaneries and hospitals. This initial advertisement process was successful in raising sufficient interest from prospective LTVs; the key to the success being the LMP's ability to utilise the existing links and networks established over previous years. As the project matured, an increasing number of LTVs were recruited through word-of-mouth advertisement by previous SVP LTV's and during project dissemination events, national and international conferences and workshops. Examples of such events include the British Maternal and Fetal Medicine Society's 'Annual Conference' (2013), the AAGBI's

'World Anaesthesia Society Conference' (2013), the Global Women's Research Society Conference (2012) and the Development Studies Association's 'Annual Conference' (2013).

Selection

Following an initial expression of interest, two processes are run simultaneously before a candidate can be recruited to the SVP. The first process involves prospective LTVs completing an application form and attending an interview (usually face to face) in order to ascertain, for example, whether a candidate would be suitable, when and why they wish to undertake a placement, what support they might require, what they hope to achieve and what skills they possess which would be of benefit to the health system in Uganda. Two references are required to objectively verify a candidate's suitability and identify any additional support they may require.

The second process involves circulating the candidates' details to UMNH partnerships to assess which of them would be interested in hosting the candidate should they be recruited to the SVP. This process was designed to align the supply of LTVs with demand on the ground in Uganda and the ability of the local UMNH partnerships to host them. An LTV is only recruited if both of the aforementioned selection processes yield positive results.

Placement Logistics

The subsequent stage following an LTV's recruitment is their pre-placement induction. Each LTV is provided with a comprehensive induction pack containing useful information on UMNH placement locations, what to expect in Uganda, placement logistics and travel, insurance and emergency contact details, health and safety and advice on pensions and other personal finances. LTVs receive a 'Volunteer Agreement' to sign and return to LMP management, which outlines the LMP's organisational expectations, a code of conduct, a statement on co-presence, potential disciplinary procedures and a personalised role description. Volunteer agreements are drawn up in conjunction with the LTV, the relevant UMNH partner organisation and the in-country counterparts to maximise stakeholder involvement and ensure all parties remain informed and satisfied.

Each placement location/facility and all LTV accommodations was professionally risk assessed at the beginning of the SVP. This risk assessment is shared with LTVs in advance of their placement, advising them of the potential risks of placements in Uganda, how the risks can be mitigated and what to do in the case that the risk materialises. The LMP also purchased a bespoke and comprehensive travel and medical insurance policy at the beginning of the SVP to cover all LTVs, ensuring each of them had adequate and sufficient cover throughout their placements. Having one familiar and reliable insurance policy and emergency contact number for all LTVs is beneficial in terms of project management and reduces individual LTVs and organisational risk.

In addition to insurance, the LMP also arranges LTV flights, clinical registration, visa/work permit, accommodation, airport transfers and the majority of placement-related travel in line with the recommendations of the risk assessment. The risk and logistical burden put on LTVs is reduced by, for example, using safe and reliable drivers for travel, only selecting flights that arrive at suitable times and only using safe and risk-assessed accommodation. Controlling these processes centrally allows for better coordination and achieves some economies of scale in terms of the procurement.

Placement Support

LTVs have access to a wide range of support during their placements. In terms of financial support, LTVs receive a monthly stipend to assist them in covering their costs at home and in Uganda. The stipend is paid directly into their bank account, with the initial payment being made on the date of their outbound flight and consecutive recurrent payments made at monthly intervals. The Tropical Health and Education Trust's Health Partnership Scheme is able to fund the employer and employee pension contributions of those LTVs previously employed by the UK NHS for the duration of their placements, marking a less direct yet potentially hugely beneficial provision of financial support for LTVs.

Each LTV is assigned a UK and a Ugandan mentor to provide clinical, mental and pastoral support and advice during their placement. Suitable mentors are selected by the LMP in collaboration with UMNH partners and in-country stakeholders, and usually come from the same disciplinary background as the LTV as well as having previous experience of working/volunteering in Uganda. Many of the UK mentors selected are themselves former SVP LTVs who have returned to the UK but are keen to retain

links with the project. The mentors serve as a first point of contact for LTVs; however, frequent communication with LMP management is also encouraged in case any problems arise that the mentors cannot deal with. LTVs provide written reports to LMP management on a monthly basis so their health and well-being can be monitored.

SVP workshops are held every 6 months. All SVP LTVs and stakeholders are invited to attend along with other LTVs working on similar projects; for example, the 'Global Links' project run by the Royal College of Paediatrics and Children's Health. Each LTV conducts a short presentation detailing their placement activity, successes and any challenges faced. The events stimulate useful discussion and learning and enable the LTVs to build networks which provide platforms for effective peer-to-peer support, partnership and co-working.

Project Evaluation

An extensive and comprehensive evaluation programme has been carried out for the duration of the SVP. Data are collected by LMP management and evaluation teams, PhD students and the LTVs themselves for evaluation purposes and includes the following:

- Pre-, mid- and post-placement interviews with LTVs
- LTV written monthly reports (containing qualitative and quantitative data)
- Interviews with Ugandan Health Facility management and staff
- Interviews with UMNH partnership coordinators
- Interviews with LTV mentors
- Recorded workshops and focus groups
- Site visits and observations made by the LMP evaluation team
- Logging of stakeholder email communication
- Reviews of new and existing literature relating to professional volunteering
- Publications and presentations conducted by the LTVs at conferences and other dissemination events

All data are collected, anonymised, coded and analysed using Nvivo software. The SVP has evolved and strengthened on an iterative basis since its beginning in April 2012, based on the outcomes of the project evaluation and the growing experience of the project managers.

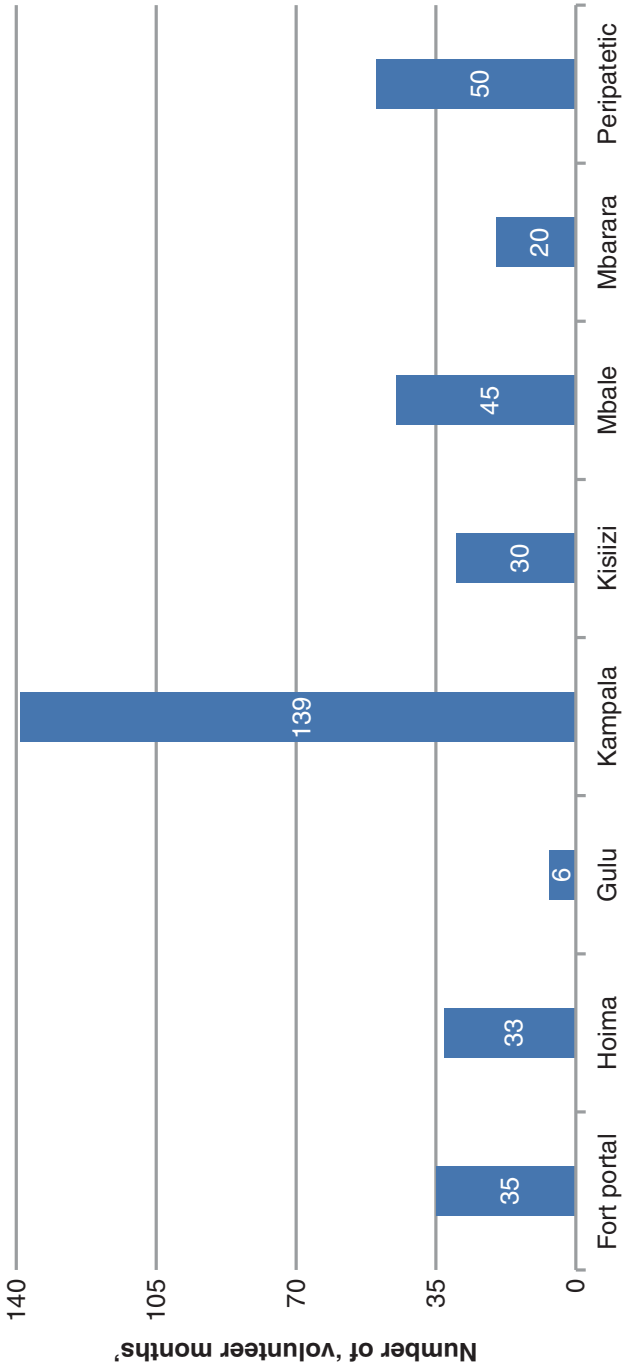

Fig. A.1 Number of 'volunteer months' spent at each UMNH health partnership location

LTV Deployment within the SVP

The SVP placed 44 professional volunteers across the UMNH partnership locations over the course of the initial 3-year period between April 2012 and March 2015, achieving a combined total of 358 'volunteer months'. The total number of volunteer months spent at each UMNH location is illustrated in Fig. A.1. The average (mean) placement duration across all disciplines was 8.1 months; however, the most common placement duration (modal average) was 6 months. The shortest placement duration was 1 month (the volunteer ended their 6 months' placement early) and the longest placement was 26 months.

The professional volunteers came from nine broad professional backgrounds; the highest number coming from Anaesthesiology (10) and the lowest number coming from General Practice (1) and Biomedical Engineering (1). Table A.1 details the number of volunteers deployed from each of the disciplinary backgrounds and the total number of volunteer placement months completed. Multidisciplinary team working was a key feature within the SVP and was believed to be the most effective way of achieving the desired outcomes of the project.

Table A.1 SVP volunteers by professional background

Health professional disciplinary background	*Number deployed during the SVP*	*Total combined number of volunteer months*
Anaesthetists	10	71
Obstetricians	9	60
Midwives	8	60
Nurses	6	48
Foundation Year 2 doctors	4	30
Paediatricians	3	33
Social scientists	2	24
Biomedical engineers	1	26
General practitioners	1	6
Total:	**44**	**358**

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H.L. Ackers, J. Ackers-Johnson, *Mobile Professional Voluntarism and International Development*, DOI 10.1057/978-1-137-55833-6

The Ethics of Educational Healthcare Placements in Low & Middle Income Countries: First Do No Harm?

palgrave pivot

THE ETHICS OF EDUCATIONAL HEALTHCARE PLACEMENTS IN LOW AND MIDDLE INCOME COUNTRIES

First Do No Harm?

Anya Ahmed,
James Ackers-Johnson,
and Helen Louise Ackers

The Ethics of Educational Healthcare Placements in Low and Middle Income Countries

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ISBN 978-3-319-48362-7
ISBN 978-3-319-48363-4 (eBook)
DOI 10.1007/978-3-319-48363-4

Library of Congress Control Number: 2017934487

Printed on acid-free paper

This Palgrave Macmillan imprint is published by Springer Nature
The registered company is Springer International Publishing AG
The registered company address is: Gewerbestrasse 11, 6330 Cham, Switzerland

Acknowledgements

We would like to thank all of those organisations who have supported the development of the Ethical Educational Placements project. The placements could not have been operationalised without the active support of our partner organisation, Knowledge for Change. As authors and project managers, we have received significant support and enthusiasm from the School of Nursing, Midwifery, Social Work and Social Science at the University of Salford. We would like to thank Health Education England (HEE) for the funding we received through the Global Health Exchange (GHE)[1] that enabled us to provide bursaries to students in nursing, midwifery and allied health professions. This support played a major role in enabling us to realise our ethical commitment to widening access to international placements to a cohort of students that previously had little access to such opportunities.[2] The Santander Travel Bursary Scheme also provided important support to students in social policy and environmental and life sciences. Collectively, this support has provided critical time for research and evaluation enabling us to improve and share the EEP model. Salford University has also provided funding for Ms. Natalie Tate to conduct her doctorate in this field (with a focus on

[1] More information on HEE and GHE can be found on their website: www.globalhealthexchange.co.uk

[2] The views expressed are those of the authors, and do not necessarily reflect the views of the University of Salford, Health Education England or the Global Health Exchange

midwifery students). Natalie has contributed significantly to data collection. Ms. Maaike Seekles has played an important role in data analysis. Dr John Chatwin has assisted in the editorial work.

Our gratitude extends to all of the Placement Managers in our partner Universities who have supported the programme. These include: Edge Hill University, Liverpool John Moore's University, Liverpool Hope University, the University of Central Lancashire and the University of Salford.

The Ugandan placements could not have been a success without the support of our Professional Volunteers. We would like to extend particular thanks for the commitment and care shown by Dr Robert Ssekitoleko, Dr Rosie Townsend, Mrs Jean Skeen, Dr Andrew Mullett, Dr Lesley Milne and Mrs Hannah Webster.

We would like to thank all of the 125 undergraduate and postgraduate students who have taken part in placements through Knowledge for Change over the past 24 months and so generously taken part in the evaluation process. They are each and every one a credit to their universities and the UK, and have made a significant contribution to our health system work in Uganda.

Finally, of course, we thank our partners in India and Uganda. In Uganda, we extend particular thanks to Mountains of the Moon University; Kabarole District Health Office; Buhinga Hospital Management; Virika Hospital Management; One Brick at A time (OBAAT); the Kyaninga Children's Development Centre (KCDC) and the Youth and Women's Empowerment Foundation (YAWE). The project could not have been a success in Uganda without the support of K4C's Uganda Placement Manager, Mr Allan Ndawula.

In India, we would like to thank M.S. Ramaiah Memorial Hospital Management, in particular the Departments of Nursing and Medicine, and the Gokula Education Foundation (GEF) for their generous support and assistance in organising the project and providing supervision for the students whilst on their placements. We would also like to thank the nursing student 'buddies' who worked alongside our UK students and assisted them both professionally and socially.

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CHAPTER 1

Introduction: Why Ethical Educational Placements?

Globalisation, Internationalisation and Undergraduate Mobilities

Internationalisation has emerged as an increasingly important metric in UK university league tables and marketing. Indeed most, if not all, UK universities now actively promote an 'Internationalisation Strategy' (Coey 2013; De Wit et al. 2008). Much of this development has taken place within the past decade often as a key element of 'marketisation' (Molesworth et al. 2011). This does not imply that universities have not been involved in international relationships for many years; the more prestigious universities have been involved in international activities for over a century. Altbach and Knight (2007) point to a clear relationship between institutional prestige (and by implication resource) and historical engagement with internationalisation processes. Historically, internationalisation has been concerned primarily with research relationships and academic (staff) mobility (see De Wit 2008). In recent years, the internationalisation of education has become more firmly associated with the selling of educational programmes to international fee-paying consumers. The importance of English to these consumers, coupled with the relatively poor linguistic skills of young people in the UK, has influenced mobility flows and shaped the outward mobilities of UK undergraduates. In more recent years, and in some respects linked to the international 'offer', with the intention of making UK courses more relevant and attractive to foreign

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consumers, attention has shifted to incorporate an international dimension into teaching. And, linked to this but perhaps rather differently motivated, the broadening of curricula and educational experiences has been viewed as essential to the future employability, resilience, connectedness and culture competence of graduates. Additionally, as evidenced by Health Education England's interest in funding the Ethical Educational Placement (EEP) project, internationalisation has been recognised as a mechanism for accessing new knowledge which students who participate in study and work abroad programmes can bring back to enrich home institutions.

It is difficult to talk about internationalisation without acknowledging and placing it within the context of globalisation (De Wit et al. 2008), and internationalisation and globalisation are often conflated. However, several writers indicate the importance of separating the two concepts. Altbach and Knight (2007) describe globalisation as the wider economic, political and social forces which steer universities towards internationalisation. In this rendering, globalisation can be understood as a set of macrostructures or processes, framing and shaping the internationalisation of the higher education sector: or as the forces which propel higher education towards greater international involvement. In other words, globalisation is an inevitable feature of modern society which has social, economic and political influences and education is becoming increasingly subjected to the wider global economy. On one level then, internationalisation can be seen as universities' responses to globalisation. Equally, internationalisation processes in the university sector reinforce and shape globalisation (De Wit 2008).

Brooks and Waters (2011) add to this complexity arguing that globalisation is itself intrinsically linked to neo-liberalism in the context of increasing marketisation processes. On this basis, they argue that globalisation should be problematised particularly with reference to education. Altbach and Knight (2007) identify three features of the relationship between globalisation and higher education. In the first instance, this concerns the role that universities play in the commodification of programmes. Here, demographic trends are significant with student (consumer) flows showing a marked directional imbalance (from the global South-East to the global North-West). Secondly, the authors point to the rapid emergence of private, for profit universities, particularly in Asia and Latin America. And finally, they refer to new ways of delivering

international higher education programmes through e-learning, franchise operations, satellite campuses and split-site arrangements.

Clearly, the global context within which higher education institutions operate is changing and internationalisation comprises an increasingly wide range of initiatives (De Wit 2008). In this environment, recent studies suggest that institutions are not adopting internationalisation strategies in a comprehensive and uniform manner. Further, an emerging body of research questions the compatibility of these marketisation (or neo-liberal) approaches with wider ethical concerns (De Wit 2008). Globalisation tends to concentrate wealth, knowledge and power in resource-rich institutions and international academic mobility favours these systems. As such, and left to its own devices, it compounds global inequalities (Altbach and Knight 2007).

Student Mobility

Student mobilities play an important role in internationalisation and globalisation processes. Until recently, student mobility has not been a major focus in academic research on international migration and population movements, and researchers interested in human mobility, particularly those investigating international migration, have neglected the importance of international student migration (Findlay et al. 2005). This is beginning to change as authors such as Brooks and Waters (2011) and Findlay et al. (2005) have drawn attention to the growth of this phenomenon and the factors involved. Findlay et al suggest that international student mobility is, in part, precipitated by 'rite of passage' aspirations [amongst] young postmodern individuals (2005: XX) rather than factors associated with traditional economic migration. Certainly, the role of travel has become increasingly important in young people's lives fuelled by the promotion of the 'gap year' and other forms of mobility associated with and stimulated by higher education and commercial actors. In society as a whole, the role of travel has increased and student mobility needs to be seen within the context of that wider framework (Brooks and Waters 2011). Indeed, travel for (middle class) young people is now an almost taken for granted part of the life-cycle. Technological developments including mobile phones, Skype, Internet access and social networking have made it much easier and cheaper for young people to spend time away and keep in touch with family and friends reducing the 'discomfort' involved. Spending time

overseas is becoming an increasingly attractive (and necessary) 'option' with personal, professional, institutional and societal benefits. The British Council (2013) suggest that international experience is particularly beneficial when competing for future employment and often mobility is seen as a way for graduates to make themselves distinctive and gain a competitive edge in the labour market (Brooks and Waters 2009). Indeed, over the last twenty years the 'gap year' has become a recognised phenomenon (Simpson 2004) and volunteer tourism, something of a rite of passage for growing numbers of young people. Although future employability is a key motivation to travel, mobility also plays a key role in identity development among young people as part of self-exploration and self-development and short-term electives may be important vehicles for this (Brooks and Waters 2009).

In summary, a complexity of processes combine to drive and potentially facilitate international student mobility. At the macro scale these include economic and cultural globalisation and internationalisation of systems. These are complemented by institutional level initiatives and individual motivations including the desire for adventure and future employability.

In March 2012, a Joint Steering Group on Outward Student Mobility[1] submitted a report to David Willetts – the UK's University Minister – making a series of recommendations to encourage outward student mobility. These included:

1. There should be a national strategy for outward student mobility;
2. There is a need for stable funding for mobility for example from philanthropy, scholarships and bursaries;
3. There needs to be flexibility in the curriculum so students can spend time abroad during their studies and for their experience to be more widely recognised;
4. It is necessary to collect available data on mobility and there needs to be some consensus about which data are required in evaluation;
5. Best practice and greater institutional collaboration is needed to deliver greater efficiency and effectiveness and also to increase diversity regarding student mobility; and

[1] The Joint Steering Group on Outward Student Mobility was formed in October 2011 at the request of David Willetts, the then Universities minister.

6. There should be a stronger promotion of international electives at school level, at the stage before students enrol at University.[2]

The report also asserts that a national strategy on outward student mobility has the potential to support the widening participation agenda in UK universities[3] by allowing widening participation activities to be integrated into the mobility strategy. The idea here is that that such opportunities should be promoted to less privileged social groups who historically have not participated. At the present time, students who exercise mobility tend to come disproportionately from privileged backgrounds, are relatively wealthy, have some foreign language skills and come from families who have a history of mobility and high educational aspirations. Brooks and Waters (2009) point to the gains to students from international mobility in terms of the acquisition of mobility, social and cultural capital. The concepts of mobility and social 'capital' are of immediate relevance to the current study. Mobility capital is best understood as the benefits accrued from international experiences which translate into enhance employability whereas social capital refers to benefits that travel brings in terms of social networks (Bourdieu and Passeron 1990). Larsen and Jacobsen (2009) argue that even ostensibly touristic activities can have a profound impact on mobility, social capital and future careers. The challenge facing the new generation of educational placement providers is to ensure that access to such career enhancing opportunities are, as far as possible, open to all.

The type of mobility referred to in Altbach and Knight's work (2007) concerns 'whole programme mobility' with students moving to another

[2] This is a prime example of how the mobility imperative is being pushed into ever earlier phases of the educational experience with potentially major impacts on equality of opportunity.

[3] Coventry University describes the widening participation agenda as, 'a philosophical position taken by the recent government to re-structure Higher Education and is based upon notions of equality. The aim of this agenda is to offer opportunities to groups within the population, who are under-represented in Higher Education, notably those from socioeconomic groups III-V; people with disabilities; people from specific ethnic minorities'. http://www.jobs.ac.uk/careers-advice/working-in-higher-education/1146/what-you-need-to-know-about-widening-participation

country for an entire degree programme. A second form of mobility is sometimes known as 'in programme mobility', where students undertake short exchanges, usually for taught elements of their programmes. In the UK context this is often within the frame of funded European Union mobility schemes dominated by ERASMUS.[4] The final form of mobility involves students who are registered in one country and undertake their taught programme there spending a short period of time on an elective (optional) placement.

The 'Elective'

The 'elective', an optional form of study spent away from a student's Higher Education Institution, usually for a period of 6 to 12 weeks (Banerjee 2010)[5] has historically been – and remains predominantly – a feature of medical education. It is estimated that two-thirds of UK medical students take up electives overseas (Hastings et al. 2014). These typically involve students from high resource settings (such as the UK, US, Canada and Australia) choosing placements in low resource settings. The factors influencing the development of medical electives include a recognition of the diverse communities served by doctors and the need for them to understand these; the desire for students to expand their horizons by learning how other systems operate and the impacts of globalisation (Murdoch-Eaton and Green 2011). Although small in comparison, there are growing numbers of veterinary, nursing (Norton and Marks-Maran 2014), occupational therapy (Horton 2009; Clampin 2008), dentistry, midwifery and social-work students taking up international electives. Yet, in spite of the increase in the take-up of electives across academic disciplines, little attention has been paid to the ethical issues encountered by students and even less consideration has been given to their impact on host countries (Ackerman 2010).

[4] The Erasmus scheme was founded in 1987 and provides funding for students to spend a period of their education in other EU member states. Until Erasmus, student mobility was largely individual but once this was established it then became the major route through which students exercised mobility. As part of the scheme students are funded to study in another EU country for between three months to a year. This scheme is widely credited as one of the most successful examples of EU policy. For a detailed discussion of the logistics of whole programme and in-program mobility.

[5] Although this varies across institutions and programmes.

The term 'ethics' refers to the moral principles that govern individual or organisational behaviour. There are thought to be three schools of ethical thought in Western philosophy: first, derived from Aristotle, the virtues of charity, justice and generosity are believed to be dispositions to act in ways that benefit the individual (agent) and the society in which an individual is placed. Second, influenced by Kant, ethics comprise duty, morality, rationality and the imperative to respect other (rational) beings. And, third, the Utilitarian position on ethics is that the guiding principles of conduct should be of the greatest benefit to the greatest number in a society. These schools of thought share a common focus on the moral responsibility of an individual or organisation to act in a manner which does not cause harm to other members in society. The phrase 'First do no Harm' (*Primum non nocere*) is a guiding principle for physicians in their practice and forms part of the Hippocratic Oath, the moral code for ethical conduct and practice in medicine. Derived from this is the principle of 'non-maleficence' (Sharp 1997) which denotes non-harming, or inflicting the least harm possible, to reach a beneficial outcome. For the purposes of this book, we borrow this maxim to frame our focus on undergraduate educational placements, and our examination of the learning and impacts which occur when students from high resource settings spend time in low resource settings as part of their university education. The concept of 'Ethical Educational Placements' raises two broad areas of ethical concern. The first area concerns practice in the sending country; in this case the UK. As noted above; the concept of an 'elective' in the UK has been closely associated with the mobility of medical students, and electives in that context have formed an increasingly important 'rite of passage' amongst this relatively privileged student cohort. This growing 'expectation of mobility' (Ackers and Gill 2007) or 'mobility imperative' (Cox 2008) is also seen in many other disciplines and places increasing pressure on students to build and evidence mobility capital. Although essentially extra-curricular, this experience forms an increasingly critical component of CV-building shaping access to career opportunity. To the extent that international elective placements are just that: namely 'electives' (implying optional choices out with the core curriculum)[6] they raise serious concerns around equality of opportunity.

[6] The University of Notre Dame defines 'An elective course is one chosen by a student from a number of optional subjects or courses in a curriculum, as opposed to a required course which the student must take' (http://firstyear.nd.edu/glossary).

Widening participation to university education in all areas, including medicine, coupled by the extension of this 'expectation' to a wider range of professions where students are less privileged and increasingly debt burdened presents ethical challenges. The Royal College of Midwives National Survey of student midwives (2011) suggests that 70% of student midwives reported having dependents; 70% earned less than £24,000 prior to entry into the programme; 73% anticipated accruing debt on completion and 70% received a means-tested bursary. Less than 31% held three or more A levels[7] and 29% completed an Access entry course. This presents a markedly different profile to the student cohort entering medicine.[8] On this basis we have used the concept of 'Ethical Education Placements' (EEPs) to distinguish them from 'electives', recognising that 'choice' always takes place within an environment of constraints. This also usefully distinguishes EEPs from forms of gap year 'voluntourism' facilitated through the growth of highly profitable companies as a component of tourism rather than education. The concept of 'voluntourism' is discussed in more detail in Chapter 5.

The second major ethical concern is with impacts in host (low resource) settings. Central to our discussion is a consideration of how sending institutions and students can avoid causing harm to host institutions and the communities they serve. In other words, we are concerned with the ethics and ethical practices of electives when there are power differentials between high and low resource settings. The aims of the book therefore are twofold; firstly, through our analysis of rich qualitative data generated with students, sending institutions and host institutions in Uganda and India, we provide new knowledge of the learning and impacts of international educational placements. Secondly, we present the Ethical Educational Placement Project (EEP) as a model embodying a set of guiding principles for ethical policy and practice in international educational placements across multiple disciplines. We now introduce the reader to the idea of the elective, its conceptualisation and the different forms they take before examining the EEP concept.

[7] A-levels are the qualification that most young people take at the age of 18 in the UK as the primary means of accessing university.

[8] For further discussion of the impact of social class on educational choices.

International Health Electives

Since the 1970s and 1980s in particular, international health electives have been a feature of undergraduate university medical education. Electives provide students with the opportunity to gain experience 'in different cultural and clinical climates and have the opportunity to explore parts of the world that interest them' (Dowell and Merrylees 2009: 122). There are different curricula elements to prepare students for electives, and various models exist which can have different impacts on student learning and host communities (Murdoch-Eaton and Green 2011). Electives can be a few weeks or a few months in duration and usually have a clinical focus, whether that is related to direct clinical practice or more towards data collection, audit or research which can feed into dissertation or publication writing. Some students engage in hands-on clinical practice during electives. There is growing pressure to regulate this in an increasingly risk aware (and potentially risk averse) environment with concerns about insurance, supervision, indemnity and liability. Placements for those students not allowed to engage in clinical practice are usually observational in nature. Aside from the clinical settings, more 'packaged' electives such as those offered by for-profit organisations may include either compulsory or optional cultural 'add-ons' or experiences which enable students to engage in learning foreign languages, crafts or tourist activities. Travel forms a key part of most electives and students often arrange personal holidays before, during or after their 'core' placement.

The potential gains of electives for students are well-documented (see Brookfield 1995; Elit et al. 2011; Murdoch-Eaton and Green 2011) and encompass in general terms, both professional and personal development and the acquisition of new knowledge in and of different contexts (Ackerman 2010). In more specific terms, these positive impacts for students are believed to include: the development of clinical skills in a new context; knowledge of and experience in different health systems; professional development; the development of generic skills, including organisational skills, communication, negotiation, self-evaluation, cultural competence, compassion towards patients, awareness of resource use, confidence, goal setting, widening students' perspectives, independence and personal growth; reflective questioning of both the challenges and assumptions of practices; greater understanding of different value systems; and 'social accountability' (Brookfield 1995; Elit et al. 2011) leading to a

range of 'socially responsible' educational outcomes (Murdoch-Eaton and Green 2011).

However, throughout the book we question whether it is possible for students to unproblematically acquire such skills and attributes since merely participating in an elective does not necessarily guarantee compassion and competence, cultural or otherwise. Furthermore, a lack of understanding of the broader structural processes at play may preclude meaningful reflection (Hanson et al. 2011). There are concerns across a number of disciplines, including nursing, dentistry, veterinary and social work, that electives are a form of 'benevolent imperialism' (Razak 2002 cited in Huish 2012) contributing to Western students' assumptions of superiority (Elit et al. 2011). This in turn undermines the achievement of socially responsible outcomes. We discuss this in more detail below. In the following chapters, we also problematise the concepts 'cultural awareness' and 'cultural competence' and frame this discussion within the context of historical structural inequality between high resource and low resource settings (Hanson et al. 2011) and the differences in the positionalities[9] of students from high resource settings and students/health workers in low resource settings.

The Ethical Educational Placement (EEP) Concept

There is a growing literature on the challenges of integrating ethically sound global health training into research and educational partnerships (see for example Dowell and Merrylees, 2009; Petrosoniak et al. 2010; Hanson et al. 2011; Huish 2012; Dasco et al. 2013). International medical electives are demand driven: some students have altruistic motivations and want to have the experience of serving in resource poor settings, while others are more career motivated and want to enhance their CVs (Huish 2012). On a global scale, medical schools and gap-year companies have responded to this increase in demand but ethical considerations have not kept pace, resulting in two broad challenges. First, in relation to the hubris[10] of Western

[9] The term 'positionality' is used in social science to refer to the 'adoption of a particular position in relation to others usually with reference to issues of culture, ethnicity, or gender' (https://en.oxforddictionaries.com/definition/positionality).

[10] Excessive pride or self-confidence (https://en.oxforddictionaries.com/definition/hubris).

(medical) students; and second, the creation and perpetuation of structural dependency for host countries and inequalities between sending and hosting countries (Huish 2012). Although the benefits of electives for students are widely recognised, the returns to students often outweighs the benefits to host organisations (Elit et al. 2011). It is becoming increasingly apparent that there are educational and moral reasons to develop more considered and ethical approaches to the design and operation of electives to avoid the pitfalls of medical or poverty tourism (Dowell and Merryless 2009) and minimise the potential harm caused to host communities (Petrosoniak et al. 2010).

Most research on the ethics of electives has focused on international placements in medical education with a primary focus on student experience and safety (Huish 2012). The British Medical Association (BMA 2009) guidelines on ethics in medical electives focus primarily on issues of competency arguing that students should always act within their competence even when dealing with emergencies. The guidelines also emphasise the importance of maintaining ethical standards required in home placements with an emphasis on honesty and integrity, dignity and respect, non-discrimination, prioritisation of patient needs, confidentiality and communication. The guidelines do recognise the importance of cultural openness and the potential burden on the host country but there is little specification of what this means and how it should be handled. The BMA is clear that medical students are not doctors, and that the main benefits for them are an increase in global health knowledge and understanding health service provision in another context: the acquisition of new clinical skills is not seen to be the goal. However, the development of clinical skills is often expressed as a motivation for students or as an intended outcome of electives (see for example Murdoch-Eaton and Green 2011).

It remains apparent then that there is uncertainty and a lack of clarity on behalf of students, sending and host organisations about how to ensure best practice on electives. Despite guidelines, while navigating different medical cultures, students often work out of and beyond their competencies (Elit et al. 2011). There is also concern that the presence of elective students can be a burden on systems already struggling to manage patients with limited staffing and scarce resources (Hanson et al. 2011; Huish 2012). In this way, electives may exploit low resource settings. Significantly, the important issues of whether electives can better meet the healthcare needs of host countries and their contribution to global health remains under-researched, and feature less in discussions of ethics.

Planning and preparation of the elective is important in order to avoid 'voluntourism' approaches as this will negatively impact on both the learning opportunities available and the host country. It is generally accepted that for electives to be ethical, there needs to be genuine partnerships between sending and host organisations, and the establishment of mutually agreed goals to ensure that host settings are not exploited (Murdoch-Eaton and Green 2011). Dasco et al. (2013) propose a 'host country first approach' which focuses on social justice, academic equity, exchange, transparency, cultural competence and the establishment of mutual defined goals. Huish (2012) calls for a restructuring of international health electives curricula to incorporate issues around social science and moral ethics pedagogy and clarify how 'global health inequity is ultimately a social constructed, anthropocentric phenomenon' (2012: 14). Hanson et al. (2011) further suggest that Western students and host institutions need to have or develop 'epistemic humility.'[11] We revisit these issues when we present the Ethical Educational Placement Project in Chapter 2. It is important that the curriculum, augmented by pre-departure training for those who do travel, prepares students to understand the context in which they will be placed (Murdoch-Eaton and Green 2011; Huish 2012). In other words, for educational placements to be ethical, students and sending organisations need to have a deep understanding of the environment and the application of concepts and values such as justice, power, fairness, cultural knowledge and self-awareness (Hanson et al. 2011). Further work with students on their return is critical to optimisation of learning. Mentorship is also an integral part of ethical placements and students need proper mentorship, informed and structured by ethical considerations (Ackerman 2010; Huish 2012). Finally, for educational placements to be ethically conducted and educationally efficacious for students, there is a need for explicit attention to their design, delivery and evaluation (Clampin 2008; Murdoch-Eaton and Green 2011).

The Remainder of the Book

Chapter 2: *The Ethical Educational Placement Project* describes the development, conceptualisation and operationalisation of the Ethical Educational Placement Project and identifies participating student cohorts and Higher

[11] Indicating an uncertainty about what you know, not assuming that what you know is more important than what others know.

Education Institutions (HEIs). We also summarise the evidence base for the presentation of a suggested 'model' for the development of EEPs.

Chapter 3: *Student Learning on Ethical Educational Placements* focuses on what students learn from educational placements in low resource settings. The term 'learning' is used quite fluidly to embrace wider experiential learning – what students often describe as 'life changing' or 'transformational impacts' and more specific curriculum or employment relevant skills.

Chapter 4: *Ethical Placements? Under What Conditions Can Educational Placements Support Sustainable Development?* focuses on the ethical aspects of the EEP concept to ask how and in what circumstances can hosting students from high resource settings be of benefit to low resource settings.

Chapter 5: *Managing Reciprocity: No Harm Approaches to International Educational Placements* draws together the research findings and reflects on what they contribute to the development of a more coherent body of knowledge about student mobility and especially student experiences in low resource settings. It ends with a summary of the key ingredients of Ethical Educational Placements.

CHAPTER 2

The Ethical Educational Placement Project

Introduction

In the introduction, we highlighted that international health electives have been a growing feature of medical education since the 1980s (Banerjee 2010) and that these are now viewed as important contributions to a diverse range of health-related undergraduate programmes. It is widely accepted that electives are beneficial to and popular with students (see, for example, Hastings et al. 2014), and that they have positive impacts on skills acquisition, personal and professional development, and knowledge of medicine and healthcare systems in different contexts. Electives are also considered to be important for students to learn about preventative health and social responsibility, so there are identified humanitarian as well as academic, professional and clinical benefits (Ackerman 2010). However, we emphasised that there are limited meaningful assessments of the outcomes gained on placements. Importantly, little attention has been paid to the ethical issues faced by students and, in particular, the impact of electives on host organisations, communities and countries.

The Background

The development of the Ethical Educational Placement (EEP)project originated from the experiences of the Liverpool-Mulago Partnership (LMP). In 2010, LMP held a workshop in Liverpool inviting

A. Ahmed et al., *The Ethics of Educational Healthcare Placements in Low and Middle Income Countries*, DOI 10.1007/978-3-319-48363-4_2

representatives of other UK-Uganda health partnerships. This resulted in the setting up of the Ugandan Maternal and Newborn Hub (HUB)[1] whose role it was to support individual health partnerships through knowledge sharing and, where appropriate, volunteer mobility. One of the first actions we undertook was a HUB-wide benchmarking process to capture, as accurately as possible, facility-based data on admissions and services. This provided our first opportunity to trial student placements and we deployed 12 students from the University of Liverpool, placing them in pairs in HUB facilities and tasking them to work with local records managers to build capacity in records management and data collection. This provided the basis for our first HUB-wide benchmarking Report. Both Ackers and Ackers-Johnson accompanied the students on this ambitious project.[2]

At this time, and building on our successful model of professional volunteer deployment, we successfully applied for funding to set up the Sustainable Volunteering Project (SVP).[3] The SVP was a professional volunteering project funded by the Department for International Development (DfID) through the Tropical Health and Education Trust (THET). The SVP deployed 55 long-term Professional Volunteers[4] (PVs) from medical, nursing, midwifery, engineering and social science backgrounds to nine health facilities spread across Uganda over a three-year period between April 2012 and March 2015. Each PV engaged in knowledge exchange and capacity-building activities, such as classroom training sessions, workshops and on-the-job mentoring in order to share skills and make improvements to their personal practice and the Ugandan Public Healthcare System.

Throughout the SVP, PVs frequently reported instances of poor practice relating to the organisation and implementation of international – usually medical – student elective placements in their facilities.

[1] The Tropical Health and Education Trust provided financial support to establish the HUB.

[2] The results of this are reported in Ackers-Johnson (2010).

[3] For more detailed information on the SVP and the impact of professional voluntarism on LMICs, see Ackers and Ackers-Johnson (2016).

[4] We have used the term 'Professional Volunteer' to refer to qualified professionals deployed for periods of three months to over three years. We critique the use of the term 'volunteer' to accurately describe these roles in Ackers et al. (2016).

Students would often arrive seemingly unannounced at health facilities and engage in unsupervised, unstructured and often risky activities. Many were reported to be acting over and above their level of training and competency, potentially putting themselves and their patients at risk. Some students worked unpredictably, appearing only sporadically between various safari excursions and mountain treks, reinforcing the negative and often damaging 'voluntourism' stereotype. Others struggled to build relationships and integrate into the local facilities, leading to unproductive and disappointing placements. On many occasions, PVs found themselves supervising and supporting international students during their placements, despite them making financial payments to private and host organisations for such services. During the SVP, a number of students approached the LMP directly for assistance in organising medical elective placements in Uganda; many had discovered the LMP's activities online and wished to get involved in ongoing projects. The LMP assisted in organising the logistics of these placements, the majority of which were self-funded. PVs played a key role in assisting in the placement planning process and providing mentoring and supervision during the placements.

The impacts of the students' placements were monitored in terms of their effects on the PVs, the hosting facilities and their personal placement satisfaction and learning outcomes. The results were very positive; students benefitted greatly from having the PV to guide, supervise and educate them which improved learning outcomes. The PVs appreciated having the students working with them as they often offered fresh insights, inspiration and motivation. Any potential damaging effects on the hosting facilities were minimised; patients were put at less risk and the students conducted concrete, meaningful placements devised in conjunction with the LMP and the local facilities which were of mutual benefit to all parties. These overwhelmingly positive results formed the basis of the EEP; linking structured short-term student placements to long-term professional volunteer placements to design and implement sustainable interventions.

Despite the success of the SVP and the positive impacts of the PVs on the Ugandan Healthcare System, the project came to an end in March 2015 as continuation funding could not be secured. This is a problem associated with project funding which is often relatively short-term and unpredictable. However, through the student placements an opportunity to create a self-sustaining model which was not reliant on

precarious funding streams was identified. The vast majority of international student elective placements are funded by the students themselves and are organised through private organisations such as 'Work the World'. As indicated in the introduction, very little research has been conducted into the impact of educational placements; including their ethics, learning outcomes, sustainability and value for money. This highlighted a gap in the international student placement market for supervised, risk assessed and effective educational placements which focused on mutual learning, safety, sustainability, ethics and positive local impact.

The Concept

A concept paper was written by members of the SVP project management team based at the University of Salford (UK), in collaboration with colleagues at Mountains of the Moon University (MMU) in Uganda and trustees from a UK based charity, Knowledge for Change (K4C).[5] The objectives of the EEP concept were to establish, operationalise and develop ethical and sustainable undergraduate educational placements, capable of enhancing public health services in Uganda, whilst also providing optimal placement experiences and learning outcomes for British and Ugandan undergraduates and the professionals working with them.

Fort Portal was selected as the primary Ugandan placement site because of K4C's ongoing relationship with Kabarole Health District, Buhinga Regional Referral Hospital, Mountains of the Moon University and the University of Salford. This relationship had been formalised two years previously, with a Memorandum of Understanding in place outlining expectations, roles and responsibilities. Fort Portal was judged to be one of the safest places in Uganda to host student placements in terms of its location, road safety and the local environment. Additionally, there were relatively few international organisations working in Fort Portal, compared to places such as Gulu, Kisiizi and Kampala, which meant not only could our project (including PVs) have more of an impact on the local area but also any impacts on the students or local area would be more easily attributable.

[5] K4C is a registered charity (registered charity no. 1146911) in both the UK and Uganda, committed to stimulating improvements in well-being and livelihoods in Uganda by strengthening public services and systems through partnership and the mutual exchange of knowledge.

The first phase of the project aimed to build directly on relationships established and experienced gained during the SVP and focused on public health systems. This would include improving public access to health services, improving the quality of services and patient outcomes, improving referrals systems in order to reduce delays in accessing health services, and reducing patient congestion in referral hospitals. A comprehensive evaluation of the SVP had previously identified a number of key challenges facing the Ugandan Healthcare system, which included:

- Human resource management systems were characterised by high levels of absenteeism, 'moonlighting' and very low levels of employee motivation.
- Improvements in initial degree level education.
- Increased opportunities for, and equitable access to, relevant continuing professional development.
- Management of physical resources such as infrastructure, transport, drugs and other consumables.
- Empowerment of patients through improved information and communication systems.
- Improved evidence-based approaches based on evaluation, record-management and audit.
- Identification of tools to improve accountability and good governance.

To achieve the aforementioned objectives, the organisation of the EEPs was aligned with a holistic framework of priorities. The first priority was to enhance patient wellbeing through improvements in the referral systems. This would be achieved by targeting local facilities at key points in the public referral system which were not fully functional, but whose functionality could be restored with minimal resource intervention. The overall goal of this intervention was to reduce congestion in larger health facilities further down the referral pathway, such as the regional and national referral hospitals. The second priority was to support continuing professional development (CPD) for local staff and students; this would be achieved through the deployment of experienced professional PVs to provide and sustain CPD (known as Continuing Medical Education or CMEs in Uganda). PVs would contribute to initial education by co-teaching on local degree programmes to invest in the current workforce. This linked to the first priority of enhancing patient well-being through increasing referrals, as functioning facilities are essential to effective

volunteer engagement and to ensure co-presence with local staff. The third priority was to support Higher Education systems in Uganda. The project would support a local partner, Mountains of the Moon University (MMU), in the delivery of undergraduate and graduate level education and the design and operationalisation of new degrees in Nursing and Midwifery to invest in the future workforce. Again, having functional facilities is critically important in enabling effective education and training, especially in placement settings. The locations highlighted in priority one would be carefully selected to ensure that they could act as effective placement training sites for MMU students.

The fourth priority was to provide structured educational placements with enhanced learning outcomes. The knowledge and experience gained during the SVP provided the basis for the operationalisation of a programme of student placements. These were to be structured and managed to minimise risk and enhance learning outcomes and were negotiated to ensure that they supported local services and objectives including: local health facilities, MMU education programmes and capacity-building in evaluation. The placements would be operated on a not-for-profit basis and would be jointly managed by UK and Ugandan institutions and partners with full co-ownership and co-stewardship in place. The fifth and final priority was to support evidence-based policy transfer; ensuring effective evaluation and dissemination to encourage similar initiatives in other areas of Uganda and elsewhere.

A funding application, along with the EEP concept paper, was submitted to Health Education England's 'Global Health Forerunner' fund, proposing the aforementioned EEP model for international educational placements for Nursing, Midwifery and Allied Health Professional students and funding was requested to pilot 40 such placements in Fort Portal, Uganda, over a 12-month period. Negotiations with HEE led to the inclusion of an additional 40 elective placements in India to be used as a comparison setting.[6] It was also decided that the placement opportunities should be opened up to Universities from across the North West of

[6] Although we supported the organisation and delivery of the India placements, these were included at the request of the funding body. K4C had no prior engagement or experience with projects in India. The placements were organised on an observation-only basis in a private not-for-profit facility. We extended our evaluation system to these placements to provide an element of comparison.

the UK and, on this basis, the funding was approved. The initial placement location selected for India was New Delhi, however risk assessments carried out during staff scoping visits judged this location to be too dangerous for students, in terms of both the city itself and the huge congested hospital facility. A smaller and safer city and hospital facility were selected; MS Ramaiah Hospital in Bengaluru. Bengaluru was identified as one of the safest and cleanest cities in India which made it more appropriate for hosting a large number of UK students. The placements were to be evaluated in terms of the students' learning outcomes and the impact of the placements on Uganda and India and their respective health systems. The end result was to devise a cost-effective model for student placements in low-income settings that could be up-scaled in Uganda and India, and potentially replicated elsewhere.

Project Setup

The EEP project began on the 1 April 2015 with an official end date for the first phase of 31 March 2017. The initial stages of the project included various stakeholder meetings with partners in the UK, Uganda and India to discuss, negotiate and confirm the viability of the placement project and ensure the necessary levels of buy-in and support. As experienced during the SVP, strong and mutually beneficial relationships with clear reciprocal expectations are crucial when developing and sustaining projects of this nature in LMICs. The relatively hierarchical nature of organisations in Uganda and India increased the need for effective communication at multiple levels. In India, this included most importantly the director of M.S. Ramaiah Hospital and the principals of M.S. Ramaiah's Schools of Medicine and Nursing. In Uganda, where we had already established relationships, negotiations were made at health district level with the Kabarole District Health Secretary and District Health Officer. Negotiations were also made with the directors of the various health facilities and organisations which would be hosting the students. These included: Mountains of the Moon University, Buhinga Regional Referral Hospital, Mulago National Referral Hospital, Virika Hospital, Bukuuku Health Centre, Kibiito Health Centre, Kagote Health Centre, Kataraka Health Centre, Kyaninga Children's Development Centre, SOS Children's Village, Good Shepherd School, the Agency for Community Development and Welfare, the Youth and Women Empowerment Foundation and Baylor Uganda.

Risk Assessment

Whilst stakeholder meetings and negotiations were taking place, comprehensive risk assessments were carried out at each of the proposed placement locations. These assessments updated and built upon a risk assessment of the SVP locations in Uganda completed by the Chief Risk Officer and Head of Global Health at the University Hospital of South Manchester in 2012,[7] highlighting and analysing risks to inform mitigation strategies for personal risks for the students and organisational risks for the University of Salford and K4C. The risk assessments for Uganda and India yielded relatively similar results, with road traffic accidents being identified as the greatest risk to the health and well-being of students and vicarious liability[8] being the greatest organisational risk. Other risks identified included assault and theft, illness resulting from unsafe food and drink, exposure to infection and tropical diseases, terrorism, civil unrest, the risk to students arising from unsafe or unsupervised clinical activities, getting lost in unfamiliar surroundings and excessive sun exposure.

The risk assessment was key to the design and implementation of the EEP, leading to the implementation of a variety of measures to mitigate the risks highlighted. For example, risk assessed accommodation was selected to host the students, safe and reliable transport was arranged for students between the airport, their accommodation and their placement locations. Also, rules regarding student travel outside of placement time were introduced to reduce the risk of road traffic accidents. To reduce the organisational risk of vicarious liability, policies were drawn up governing student placement activities and the required levels of supervision. The risk assessment advised that a single comprehensive insurance policy cover all the staff, PVs and students involved in the project to ensure an adequate level of cover for all parties and avoid them having to trawl through multiple different policies in the case of an emergency which may cause confusion and delays. Fortunately, the University of Salford's insurance

[7] The risk assessment is discussed in more detail in Ackers et al. (2016) and is available on the K4C website: www.knowledge4change.org.uk

[8] Vicarious liability refers to a situation where someone is held responsible for the actions or omissions of another person. In a workplace context, an employer can be liable for the acts or omissions of its employees, provided it can be shown that they took place in the course of their employment.

policy was judged to be suitable for this purpose and was able to provide the necessary cover.

Over the course of the EEP, there has been only one instance in which the insurance policy was required; this occurred when a student in India aggravated an existing back injury, possibly whilst driving on a bumpy road or carrying luggage up a flight of stairs to their accommodation. The insurance policy worked well; the student received the necessary treatment at a high-quality private hospital in Bengaluru before being returned to the UK with a medical escort. We had not been aware of the back injury prior to the placement commencing; this led to the implementation of a written medical questionnaire, given to students prior to their placements, requiring the disclosure of any physical or mental health conditions that they are aware of. It was made clear that failure to do this could cause serious individual problems, destabilise the whole placement group and potentially void the insurance policy putting the individual and organisation at risk.

Where a pre-existing medical condition was declared, advice was sought from both the insurers and the PVs on the ground in the placement location as to the suitability and viability of the placement. The opinion of the PV was particularly important as they had experience and knowledge of the local health system and would also often be the first port of call in any emergency situation. We took careful steps to support a number of students who disclosed health problems, for example autism and deep vein thrombosis, and the placements passed successfully. There was only one instance in which a student was refused a placement; this was due to a complex long standing heart condition which, although insurable, was judged by the PV to pose excessive risk as it could not have been treated locally should the condition have worsened during the student's placement. Naturally, the principle of equality of opportunity was always respected despite any disclosures and placements were only refused as a last resort. Both risk and insurance formed core elements of the student induction process which is explained in greater detail below.

Student Recruitment and Selection

Once initial stakeholder meetings and negotiations had been completed, information on the project was circulated to the programme leaders for each discipline at each university; it was their responsibility to share this information with necessary staff and students within their respective

institutions. Students were initially invited to attend an information day, during which they were given more general information about the project including what it would involve, our expectations, logistics and the timeframes of the placements. There was a great deal of interest and, almost immediately, large numbers of applications were received from students.

The application and selection process comprised three main stages; the first stage involved each student submitting a completed written application form consisting of three main sections, the first being basic personal information. The second section asked students to answer three questions in no more than 250 words each. The first question related to their reasons for applying for a placement, the second question asked what they hoped to achieve and experience during their placement, and the third question asked how they believed the placement would impact on their learning and future employability. The final section of the application form required students to select their preferred placement dates which varied from cohort to cohort. The candidates who submitted the highest quality application forms and suited the eligibility criteria relating to their university, study discipline and level of study were invited for interview. Achieving a representative sample of students from the multiple different institutions, disciplines and study levels was extremely challenging given that each group had conflicting 'mobility windows' (times in the year at which they could travel) and the need for the project to begin immediately and be completed within an 18-month period. Midwifery students in particular struggled to find time within their academic and UK placement timetables to be able to complete a four-week placement and some had to use some of their annual leave allowance. The need for flexibility increases further when placements are part of the curriculum and are assessed. Rather than sticking to rigid placement timings, the EEP placements offered flexibility throughout the year to try to accommodate as wide a group of students as possible.

Although the EEP evaluation strongly suggests that all students, at any stage in their degree programme, have benefitted hugely from their placement, the optimal placement timing was found to be towards the end of their penultimate year of study. These students tended to have a better attitude towards learning than less advanced students and were better able to share their learning and experience with peers upon their return to the UK (students completing placements at the end of their final year would tend to move straight into employment roles). These students were also

better able to contribute to the low resource setting as a result of their higher level of academic knowledge and workplace experience. Many of the students were mature students who had previous experience and/or degrees; these students tended to show greater resilience and confidence and were able to contribute more to local facilities. Therefore, in terms of the selection process, students in their second year of study onwards (with the exception of Masters' level students) were preferred.

The interview processes consisted of both individual and group interviews which were moderated by members of the project management team. The main qualities sought during the interviews were communication skills, team working skills, leadership skills, resilience and motivation. Again, building on SVP experience, these skills were deemed to be the most important in ensuring that students were able to cope emotionally and work efficiently during their placements. As a final stage of selection, the relevant programme leaders and/or personal tutors for each student were contacted to ensure that the student was able to travel on the selected dates and that there were no circumstances unbeknown to the project management team that would prevent the student from undertaking a placement, or expose the student or project to unacceptable levels of risk. Such circumstances expressed during the project included potential exam resits, outstanding coursework submissions, poor academic performance, poor attendance and health issues which had not been disclosed by the students themselves. Not all of these circumstances led to placement offers being withdrawn; for instance, some coursework deadlines were extended to enable students to complete the placement.

Over 350 application forms were received from students over the course of the project, and over 200 students were interviewed. The selection process was far more competitive for certain disciplines than others depending on the number of applications received, the dates of travel and the number of placements available. The most competitive discipline was usually adult nursing; one particular round of selection saw over 40 applications for just four placements. Other courses, such as podiatry, received very few applications which meant the majority of applicants were successful. There were a number of other factors which affected the number of applications received, the main being the methods and timing of information dissemination about the project within each institution and discipline, and the course structures and mobility windows available.

Student Induction

A formal induction process was held for successful applicants, and this began approximately ten weeks before their placement start date. The first stage of this process was the dissemination of a comprehensive 'Induction Pack', 'Local Guide', a short film and a local phrase book which contained detailed information about many aspects of the placements including the locations, logistics and travel arrangements, health and safety, emergency contact details, code of conduct and disciplinary procedures, insurance, leisure activities, finances, language, food and drink, dress and cultural sensitivity. Similar topics were covered again during a compulsory 'Induction Day' which was four hours in duration and run approximately six weeks before the placement start date. The Induction Day provided further information to the students and enabled them to ask any questions they had. Where possible, visiting colleagues from the LMIC hosting institutions were invited to provide input and advice. The induction session gave students the opportunity to meet the placement group with whom they would be placed prior to travelling. This was greatly appreciated by the students who often formed groups on social media to stay in touch, offer peer support and arrange weekend activities, as the following quote illustrates:

> It has been nice to have that support since the induction, [our group] have been talking for a few weeks now and we have a good grasp of each other's personalities. It's good that we are going out as a team now as opposed to getting there and having to become a team (Nurse, Uganda)[9]

Students were also provided with 'EEP Placement Agreements' (Appendix 1) to read, sign and return. These formally outlined our expectations of them whilst on placement, such as hours of work and conduct. A final induction and orientation session was held for the students once they arrived at their placement location which involved a tour of the accommodation; local area and health facilities; the provision of a mobile phone and local sim card for emergency usage; an introduction to their long-term volunteer supervisors and local staff in placement facilities; and further information about the placements and what to expect.

[9] Sample characteristics are provided in Table 2.1. Where appropriate we give the discipline and location of the respondents in brackets after the quote. Unless otherwise stated, these refer to the students.

Placement Cohorts and Locations

All cohorts of students were accompanied on their flights to Uganda or India by a member of the EEP team; this proved important especially when small problems arose such as delayed flights and lost baggage. If flights arrived in the late afternoon or evening, students were accommodated at a secure hostel near the airport and travelled to their placement location the following morning. A number of students were anxious about travelling at night, even when accompanied by members of staff. Students were always collected from and returned to the airport by a known and trusted driver.

Over the course of the project, 111 students completed four-week educational placements in Uganda ($n = 92$) and India ($n = 19$). The number of placements in India was reduced from the proposed 40–19 due to logistics and timeframes; only one cohort could be run per year (in November) to coincide with M.S. Ramaiah's 'International Student Winter School Programme'. The remainder of the placements allocated for India were instead run in Uganda. The sample included students from 11 different Higher Education Institutions; University of Salford ($n = 49$), University of Central Lancashire ($n = 19$), Liverpool John Moore's University ($n = 15$), Edge Hill University ($n = 12$), Liverpool Hope University ($n = 4$), Lancaster University in partnership with Central Manchester Foundation Trust ($n = 4$), University of Cambridge ($n = 2$), University of Cumbria ($n = 2$), University of Glasgow ($n = 2$), Anglia Ruskin University ($n = 1$) and Queen Mary's University ($n = 1$).

The first three cohorts of students, 36 in total, completed four week educational placements in Uganda between June and September 2015. The fourth cohort of six students and the fifth cohort of 19 students completed placements in Uganda and India respectively in November 2015. Eight further cohorts, 50 students in total, completed placements in Uganda between March and October 2016. The students' disciplines and placement locations are provided in Table 2.1. With the exception of the Prosthetics, Orthotics and Biomedical Engineering students, all the placements in Uganda were run in Fort Portal. The placements for the Business /NHS Management Trainees were split between Kampala and Fort Portal. All the placements in India were run in Bengaluru and Kaiwara, as explained in more detail later.

The optimal size of each cohort was found to be between six and eight students. Larger groups can lead to financial economies of scale, however they tended to fracture internally resulting in tensions and the breakdown of relationships, which detracted from the overall placement experience.

Table 2.1 Students' disciplinary background, gender and placement locations

	Placement location			
	Uganda		*India*	
Discipline	*Male*	*Female*	*Male*	*Female*
Adult Nursing	5	17	2	13
Midwifery	0	14	0	2
Children's & Young People's Nursing	0	9	0	0
Business/NHS Management Trainees	2	6	0	0
Mental Health Nursing	0	5	0	2
Social Work/Social Policy	2	5	0	0
Physiotherapy	2	3	0	0
Medicine	0	4	0	0
Prosthetics & Orthotics (in Kampala)	1	3	0	0
Integrated Practice (Nursing & Social Work)	0	3	0	0
Occupational Therapy	0	3	0	0
Paramedic	0	3	0	0
Podiatry	0	2	0	0
Bioscience/Human Biology	1	1	0	0
Biomedical Engineering (in Kampala)	1	0	0	0
Sub totals	**14**	**78**	**2**	**17**
Totals	**92**		**19**	

Source: Created by the authors.

Multi-disciplinary (mixed) placement groups were found to work well and provide exposure to new ideas and problem solving both within the UK team but also in their engagement with local health workers and systems. However, such groups demanded more complex project planning and tighter logistical management on the ground across multiple facilities. There was inevitably a greater strain on accommodation with larger groups and often students were required to share one bedroom between two, each bedroom containing two double beds. Only a small number of mature students expressed concerns about sharing bedrooms, however other shared facilities such as washrooms and kitchen areas did come under pressure, often becoming messy and attracting ants and mice

despite the employment of daily cleaners. It is very important to ensure that accommodation is of adequate standard and that the students are comfortable, otherwise it can lead to disputes within the group and can have a strong effect on students' wellbeing and placement experience.

Placement Structure and Activities in Uganda: the Role of the Professional Volunteer

As noted above, all students were accompanied on their journeys to both Uganda and India. The Ugandan placements are also supported by the services of a full-time Ugandan Placement Manager who is on site at all times to support the students and the various K4C projects. In addition to regular visits by the UK team and the presence of a local placement manager, Professional Volunteers (PVs) play an important, complex and multifaceted role in the design and structure of placement activities in Uganda. First, they form a crucial link between the students, project managers and the hosting facilities and institutions, and are responsible for students' safety and learning whilst on placement. They were able to supervise students during their placements providing on-the-job training, debriefing and support their wellbeing. Although logistically they cannot be co-present with each student at every point in time, they are readily available. Regular (daily and weekly) debriefings take place with the Placement Manager, the PVs and the students. This is particularly important in cases where students encountered patient deaths or 'near misses'. Students based on the neonatal units all witnessed neonatal deaths; in two cohorts, this happened on their first day. Of course, such deaths are traumatic in themselves and the way of dealing with dead neonates in Uganda shocked students; there were clear cultural differences regarding the care of the newborn and the contact between the mother and her dead baby. Time was spent during induction sessions discussing this in order to prepare students, but the fact remains that this will happen and students will find it stressful at first, as the quote below illustrates:

> It was very hard to deal with, even though we were told what it would be like and to expect to see death. I don't really think we could be more prepared for it because even if you told somebody all about it, if it actually happens to you it's different. (Nurse, Uganda)

All students have coped well in these circumstances during their EEP placements as a result of the high level of support the model provides. It is important to add that the students also provided strong support for the PV in similar circumstances. Indeed it is clear that the presence of UK students contributed significantly to the learning, experience and support available to professional volunteers. For example, midwifery students working alongside PVs often assisted with complex deliveries and particularly with neonatal care and resuscitation (areas where skills are often found lacking in Uganda). The PVs have really enjoyed mentoring the students, gaining motivation from this experience in what are often quite difficult environments. Students also provide strong social support for them and the project as a whole which contributes in important ways to the overall (integrated) sustainability of the EEP model as the quote from a PV suggests:

> I've felt much less isolated over the last few weeks and having the students here has really helped with that. (Professional Volunteer, Uganda)

The second benefit of having PVs on the ground derives from the relative longevity of their placements which enables them to build and maintain strong relationships with local stakeholders such as the district health officers, facility in-charges and local staff. This not only leads to the mutual development of new and exciting project ideas with Ugandan stakeholders, but also expedites the students' transition into local organisations, health facilities and staff groups enabling them to begin their placements immediately on arrival in Uganda. This also avoids the problem observed during the SVP relating to local staff often being suspicious of – and occasionally unwilling to work with – unfamiliar foreign staff and students. Third, the PVs played an 'anchoring' function to sustain project activities in between cohorts of students, allowing one cohort to easily and effectively continue the work of their predecessors, thus maintaining momentum and improving the efficiency of development activity. Fourth, the PVs provided training to local staff and students within health facilities and by teaching on Mountains of the Moon University's nursing and midwifery degree programmes. This marked a positive ethical and sustainable step towards ensuring mutual benefit to both Uganda and the UK. Finally, the PVs played a useful role in project evaluation; providing feedback about the successes and challenges face by the students and the impact the project was having on the local health systems.

The EEP directly funded a PV midwife to supervise the first three cohorts of students travelling to Uganda in the summer of 2015. When the midwife completed her placement, an obstetrician took her place and remained in post for 12 months until the end of the EEP. Obstetric/midwifery focused PVs were recruited since the majority of care in Uganda, particularly in smaller rural health centre 4s, is maternity focused, and other ongoing K4C projects were predominantly focused on maternal and new-born health. Given that students were not continuously deployed on the ground in Uganda, it meant that PVs had the capacity to assist with these other K4C projects, boosting the development impact of the charity. Fortunately, K4C had other PVs based in Uganda but primarily working on different projects. These PVs included two biomedical engineers based in Kampala. All of these PVs were willing and able to assist in supervising the students whenever necessary. This was particularly helpful when the group of prosthetics and orthotics students travelled out to Uganda. The active engagement of our sister bio-medical engineering project (see www.knowledge4change.org.uk) provided excellent opportunities for prosthetics and orthotics students to spend time in Kampala under the direct supervision of our PV in the large prosthetics and orthotics departments in Mulago Hospital and Kyambogo University. This demonstrates the benefits of having a number of diverse ongoing projects and a wide-ranging network of knowledge and relationships within the host country.

Local Supervision

In practice, it is impossible in the Ugandan public heath setting to guarantee one-to-one supervision in all placement locations given the turnover of staff, shift patterns, absenteeism and also cultural attitudes towards the supervision of students.[10] We tried to work towards this over the course of the EEP through close engagement with local staff and facility management but by the end of the project it was still occasionally lacking. This is partly the reason why students were placed in pairs, wherever possible, and were required to report any incidences of lone working to the placement manager or PV as a matter of urgency. The level of local supervision received by students was monitored through the weekly reporting process, which required students to state how often (never, rarely, sometimes, usually or always) they had been

[10] Ugandan students rarely receive active supervision whilst on their placements.

working alongside Ugandan colleagues and whether they had any concerns about this. The most common responses for the first three cohorts of students in 2015 were 'rarely' and 'sometimes'. By the end of the project, this had improved to 'usually' with many students selecting 'always'. As a project, we successfully applied for a significant number of Commonwealth Professional Fellowships which enabled us to bring Ugandan colleagues working in these facilities over to the UK for periods of between one and six months. This has played a very valuable role in augmenting relationships[11] and exposing them to the environment in UK universities and hospitals. The Fellows continue to play a very valuable role in supporting student information days, awareness raising and induction processes.

In the evaluation, no students reported any concerns about the level of supervision they received from local staff since many received sufficient supervision from a PV. Students believed they could access supervision quickly should it be required as the following excerpt suggests:

> Obviously being a student and being unsupervised isn't ideal however if I ever had any questions or needed support I could always call [the PV] and she would inform me about what to do or come over if it was an emergency. (Child Nursing Student, Uganda)

In most situations, particularly during placement in the smaller health centres and community based organisations, students have worked alongside excellent local staff and other students in mutual learning contexts. Given the breadth of disciplinary backgrounds this has been a learning curve for the placement managers who are now in a better position to select placements and also anticipate situations where students may experience staff shortages and potential lone working. Responding to these situations has proved beneficial both to the students but also to local health systems enabling us to leverage improvements in staffing, in attitudes towards student supervision and staff behaviour. By emphasising the necessity of supervision during placements for the UK students we are pushing ahead a model of good

[11] We have received three Fellowships to support Ugandan midwives in one of our smaller EEP training sites.

practice for Ugandan students. Co-locating the students in training sites[12] is making this possible and efficient.

Flexibility versus Structure

The educational placements in Uganda offered considerable flexibility to students based on their study discipline and personal areas of interest. Following the induction session, each student was given the opportunity to describe their personal interests and the ideal type of placement they were hoping to undertake and the types of facility they would prefer to be based in. Although it was made clear that not all requests could be fulfilled and that all placements would be negotiated with the various stakeholders involved in the project, the students' preferences were taken into consideration during the placement planning process. The main factors influencing the students' placement activity were the needs of the health system requested by local stakeholders, informed by PV opinions and verified by K4C and University of Salford management to ensure activities rested within the longer term organisational objectives. Given the iterative nature of the project, we were able to make a number of changes over the lifetime of the project to ensure that the placements were optimised to best achieve our objectives.

There was a careful balance to be achieved between autonomy and structure, and the level of flexibility to allow the students within their placement schedules was often difficult to gauge. Nursing and midwifery students tended to expect higher levels of structure, support and supervision in line with their experience of placements in the UK. This contrasted with, for example, the NHS graduate management trainees who requested a higher degree of autonomy and medical students who expected – and often actively sought – more intense autonomous clinical exposure rather than wider systems-focused placements. Often students expressed a desire to be placed in many varying locations in order to gain as wide an experience as possible, but this caused a number of problems. First, it

[12] The concept of 'training sites' has come from the EEP. It has included the improvement of infrastructure and equipment in the health centres nominated so that students can be placed in contexts where there is at least basic functionality and, where possible, examples of and opportunities for good practice. In the process systems and services are also being improved for patients.

made it difficult for them to integrate into the local health teams and build up strong relationships and the level of trust required for efficient co-working. One local physiotherapist explained how they were able and willing to supervise two students coming for multiple consecutive days; however, when three or four students were coming on different days, they failed to build relationships and it took much more time and effort having to explain the same things repeatedly. In moving around frequently, students were perceived as 'voluntourists' rather than colleagues by local staff which made them more suspicious of new students and therefore less likely to engage.

A second problem caused by placing students in a variety of settings was the additional burden placed on the UK and Ugandan project management team. Communication became more difficult as did organising the resulting more complicated placement schedules, supervision and daily transport plans. Third, a number of students reported feeling disappointed that they had not achieved as much as they had hoped as a result of moving around too frequently and therefore not having sufficient opportunities to engage in useful, tangible and impactful projects. Finally, it was observed that giving students a certain level of timetabling structure meant they were better able to maintain a positive routine; students who moved placement locations on a regular basis often reported greater confusion and stress which negatively impacted on their wellbeing. Additionally, some of the student requests (to spend time in local schools for example) had tenuous links to their study disciplines. However, although the learning from such placements would not be as directly relevant to the students' courses, it was acknowledged that they could help improve the student's knowledge and experience of health, education and social systems in LMICs. A decision was made to allow students to have half a day on Fridays away from their formal placements to engage in such 'side placement' activities, providing they were beneficial for the students' learning and experience and did not lead to additional risks or expense.

Placement Timetabling

As emphasised in their 'EEP Placement Agreement', students are required to complete a normal working week of 36 hours. Most student placements begin at 09.00 and end at 17.00; however some also began at 08.00 and ended at 16.00 to fit with the timings of the PV, local doctors' ward rounds or NGO community visits. The students were allowed 45 minutes

for lunch each day. The importance of beginning and ending placements promptly was emphasised to the students as this served as a form of role modelling for local staff and students. Students were only allowed to complete placements at night if it was in their personal interest and adequate supervision and transport arrangements could be provided to minimise risk. The main risks of working at night, as highlighted by the risk assessment, include transportation to and from placement when it is dark and the increased aforementioned risks associated with students being left to work alone and without adequate supervision.

At the beginning of the project, students would be on placement for five full days per week. Report writing for the purposes of the project evaluation, group meetings and debriefing were conducted in the evenings and weekends. However, many students reported that they did not feel they had sufficient time to debrief and write their reports, particularly as they were spending relatively long hours on placement compared to the UK. In addition, they indicated that the placements were often more difficult and/or stressful as a result of increased numbers of traumatic experiences, more demanding working conditions and a more debilitating climate. Also, students often engaged in personal leisure activities or relaxation during evenings and weekends which put pressure on the free time they had. It was therefore decided that each Friday would be split, with the morning dedicated to the 'side placements' and the afternoon involving a team meeting between project managers, PVs and students, a reflection and debriefing session and time for report writing.

Student Placement Activities

The majority of nursing and midwifery students competed hospital and health centre based placements. These included observational elements on the wards and theatres, along with hands-on clinical training under the supervision of the local staff and PVs across multiple facilities. Students were not permitted to work on their own without local or PV guidance for a number of reasons: this could potentially put them and the project at risk of litigation following medical malpractice as noted within the risk assessment; it does not foster efficient and mutual learning between the students and LMIC partners; and it detracts from the relationship building and team working. Students were generally placed in pairs as this reduced the risk of lone working, improved integration and simplified arrangements for supervision and transport. One Ugandan midwife reported how larger

groups of students often found it more difficult to integrate into the local workforce as students tended to 'stick together' as a group. This midwife also explained how larger groups tended to be *a 'greater burden on both local staff and PVs in terms of their management and supervision'* and could *'occasionally intimidate local staff and patients who were not comfortable in dealing with large groups (of foreign students)'*.

Initially the physiotherapy, occupational therapy and podiatry students also began placements in the hospital facilities. However, these were not successful for a number of reasons, the main one being that these professions were not well recognised in Uganda and therefore the students had little or no support from local staff. Also, staff working in the public sector, particularly in these less recognised areas, are often poorly paid, poorly managed and as a result poorly motivated and frequently absent. This meant the students – particularly the physiotherapy and occupational therapy students – were sometimes left unsupervised and finished their placements early each day. The gaps in the Ugandan health service left by these poor or non-existent services were often filled by the non-governmental organisation (NGO) sector funded and/or wholly run by international individuals and organisations. Using existing relationships and networks, we were able to locate and approach a number of these organisations and successfully negotiate the possibility of them hosting students. 'Kyaninga Children's Development Centre',[13] for example, proved to be an extremely successful placement location for physiotherapy and occupational therapy students. Similarly, the 'Youth and Women's Empowerment Foundation (YAWE)' NGO was able to provide effective placements for Nursing, Integrated Practice and Social Work students.

Other organisations hosting students on non-health focused placements included the Fort Portal Juvenile Centre, Fort Portal Open Prison, Kyaka II Refugee Settlement, Kyambogo University and Mountains of the Moon University (MMU). These organisations were particularly beneficial in hosting Social Work and Business students. A number of students from various disciplinary backgrounds (including health) ran teaching sessions for MMU students. These teaching sessions

[13] Kyaninga Children's Development Centre (www.kyaningacdc.org) is an NGO in Fort Portal which supports children with physical and mental disabilities such as cerebral palsy, cerebral malaria and brain injuries. They hosted six physiotherapy and occupational therapy students over the course of the EEP.

were negotiated and arranged by the UK students in partnership with MMU staff to ensure the content was relevant for the Ugandan students and could be taught to an acceptable standard. The sessions included (amongst others) lectures run by Social Work students on the potentially harmful effects of drugs and alcohol, workshops run by Midwifery students on safe childbirth, lectures run by Nursing students on infection prevention and control and lectures by NHS management trainees on the principles of management.

Placement Structure and Activities in India

The placements in India were established and managed quite differently to those in Uganda, mainly due to the nature and history of the partnership. The partnership with M.S. Ramaiah Hospital was formed solely for placement purposes, rather than being an ongoing partnership focused on capacity building, health system development and sustainability. This meant that there were no existing networks, relationships, experience or knowledge to build upon. There were also no PVs on the ground to support the project's development or the students on their placements. The India placements offered more a more formal and rigid structure and far less flexibility for the students since the placement timetable, accommodation and transportation were all prearranged by M.S. Ramaiah Hospital with relatively little input from the UK project management team. In effect the placements were organised as a 'package' put together by the India leads and charged to the UK project.[14]

During the in-country induction, each UK student was paired up with an Indian 'buddy' whose role was to provide support and guidance during placements. The buddy system worked very well in most instances. All the buddies were studying similar courses to the UK students at M.S. Ramaiah Nursing School, and this enabled them to exchange knowledge and experience; they were particularly instrumental in overcoming language barriers and would translate conversations between doctors, nurses and patients. The UK students and their buddies often formed friendships, which gave them increased insights into each other's lifestyles and

[14] The package provided by M.S. Ramaiah was priced at £850 per student to include in-country accommodation, transport, supervision and food.

cultures. Socially, the buddies played a useful role in showing the students around the local area and advising them where to buy food and clothes.

The first two weeks of the placements were spent in M.S. Ramaiah Hospital, a large non-profit private hospital, where students observed on wards and in operating theatres alongside their buddies. Throughout the placements, the students were wholly supervised by local medical and nursing staff. Students were rotated through many varying hospital departments, offering wide ranging of clinical exposures. Students followed a prescheduled timetable whilst placed in the hospital, spending each morning in one location and rotating to a different location in the afternoon. Students were collected from their accommodation by bus at 08.15 each morning to begin their placements at 09.00. They were allowed 45 minutes for lunch then finished at 16.30 when they were returned to their accommodation. All the placements in India were observational only and the students were not permitted to engage in any hands-on care of patients. There were two main reasons for this; first, as the hospital environments were less familiar we could not guarantee a sufficient level of supervision for the students and therefore needed to avoid the risks related to lone-working. Second, the regulatory environment in India tends to be stricter than in Uganda. Both project management and Indian colleagues were keen to minimise the risk of litigation against the students arising from medical negligence or malpractice. This was made clear to the students during the induction process. However, the vast majority students expressed a strong desire in their feedback for hands-on clinical placements, stating its anticipated benefits for their own learning and their sense of efficacy and desire to 'make a difference' as the following quote illustrates:

> I just feel I could have contributed so much more if we were allowed [to engage in hands-on practice], it felt awkward just standing and watching when we could have been helping at least with basic, routine care like wound dressings and changing beds which we do all the time in the UK. (Adult Nursing student)

The second two weeks were spent attending the Gokula Education Foundation 'Winter School'. This was a formal residential school which took place in a rural town called Kaiwara. The 19 UK students were split into groups of four or five, within which they worked alongside a large number of medical students from M.S. Ramaiah's School of Medicine to

conduct a wide range of projects designed to benefit the local community. Such projects included designing hand hygiene protocols and conducting training in infection prevention and control; devising plays and fun activities to deliver healthcare messages to small surrounding villages and schools; assisting local clinicians with patient assessment and treatment during health camps and assessing safe water collection and storage protocols. All the students appreciated being able to experience both placement locations and being able to compare and contrast the urban and rural settings. Each location offered differing placement activities, health facilities, cultures, environments, accommodation, placement groups and patient demographics. As with the placement in Bengaluru, all the accommodation, transport arrangements and placement activities were organised by M.S. Ramaiah through their Gokula Education Foundation.

Leisure and Free Time

It was made clear to all students in both Uganda and India that the evenings and weekends could be used for their personal leisure and free time. The activities that the students completed during these times depended on their location, personal preferences and finances. In Uganda, the majority of students completed tourist activities such as safari trips, mountain hiking, touring crater lakes and visited a variety of sights and attractions. In India, the students went on an organised visit to a temple at Mysore, attended a traditional Indian wedding and visited local tourist attractions within Bengaluru. The students were allowed to take part in any activity provided it was covered by the insurance policy, was not judged to put them at risk and did not negatively affect their formal placements. Completing such leisure and tourist activities was found to be greatly beneficial to the students as it allowed them to relax, experience more of the culture and environment within the LMIC and generally improved their happiness and wellbeing. The only instances in which the project managers were required to intervene concerned students consuming excessive amounts of alcohol whilst socialising in bars and clubs in the local towns. On two occasions, students were warned that their behaviour put them at personal risk and that continuing to engage in such behaviour might lead to disciplinary action. As a result, an additional clause was added to the student placement agreement regarding the

consumption of excessive amounts of alcohol and the potential risks and consequences.

Some students wanted to prolong the duration of their placements to allow for personal holiday time and this was permitted and flights were arranged accordingly. However, the students were required to pay any additional airfare and had to agree that any extra time spent in the placement country before or after their official placement was undertaken completely at their own risk and expense since the project would take no responsibility for them and they would not be covered by the University's insurance policy.

Placement Costs and Student Contributions

The first five cohorts of students who completed their placements in Uganda and India over the course of 2015, with the exception of the self-funded students, received full funding. This covered the cost of flights, accommodation (including free Wi-Fi), visas, 'in country' airport transfers, placement transport, insurance, supervision and pastoral support, an emergency mobile phone with a local sim-card and a small amount of airtime and, in the Ugandan placements, a direct investment of £150 per student into the local host health facility. The only costs that these students faced personally were for vaccinations, antimalarial prophylaxis, UK airport transfers, food, drink, tourism and leisure activities. Only one student out of 52 in this group reported experiencing difficulties in raising sufficient funding to be able to complete a placement, although this was mainly as a result of family circumstances and them having to support a dependent family member using the income from their part-time job.

A decision was made in January 2016 to ask students to contribute £395 towards the cost of their placements. This decision was made following student feedback which indicated that the students themselves thought they should be required to contribute something towards the placement costs. The figure of £395 was determined by the students as they deemed this amount to be affordable and fair given the experience they were having and the relatively small costs they were incurring. Of course, the introduction of a student contribution improved the project's cost efficiency and meant placement opportunities could be offered to a greater number of students. It was also felt that asking the students to make a relatively small

contribution would dissuade those students who were more interested in exploiting the attractive offer of a 'free' international trip without actually being committed to the objectives of the project. A number of complaints were received – from both a local host organisation and fellow UK students – about some students (who did not make a contribution towards the cost of their placement) who did not seem to care much about their placements and instead were more interested in taking photos with children for their social media pages or engaging in tourist activities. It was found that students who did make a contribution towards the cost of their placement demonstrated higher levels of interest, motivation and engagement with the project which led to improved outcomes both in terms of students' learning and also the impact they had on the hosting facilities.

Students in the nursing, midwifery and allied health professions were generally less able than medical students to draw on personal and family resources to fund electives; they were a more diverse group and many had families and undertook paid work to support their education. A small but significant number of these students could not have engaged in the placement if they had to contribute large amounts, although even these students said they would be able to fund £395 if they had around six months' notice and/or support with fund raising and applying for travel bursaries.

In total, 86 of the 111 students had their placements funded by Health Education England; of these 52 were fully funded and 34 made a contribution of £395 to K4C. The remaining 25 students completed the placements on a self-funded basis at a cost of £1495; however, 13 of these received bursaries of £1000 from the aforementioned contributions received by K4C, meaning they each contributed only £495. A large number of the self-funded students and the students who made a contribution are known to have received bursaries or travel grants from external sources, such as University student support services, to fund all or the majority of the cost of their placements. The figure of £1495 has been assessed to cover the full cost of each student placement in both Uganda and India based on a group of eight students travelling on four-week placements every month (not including the cost of UK project management time). Larger group sizes can achieve cost savings as a result of economies of scale in relation to student induction, airport transfers, in-country transport and accommodation (plus PV supervision in Uganda). However, the main cost of each placement is the flight cost which remains fixed between £450 and £650, becoming higher at peak times in the year (Fig. 2.1).

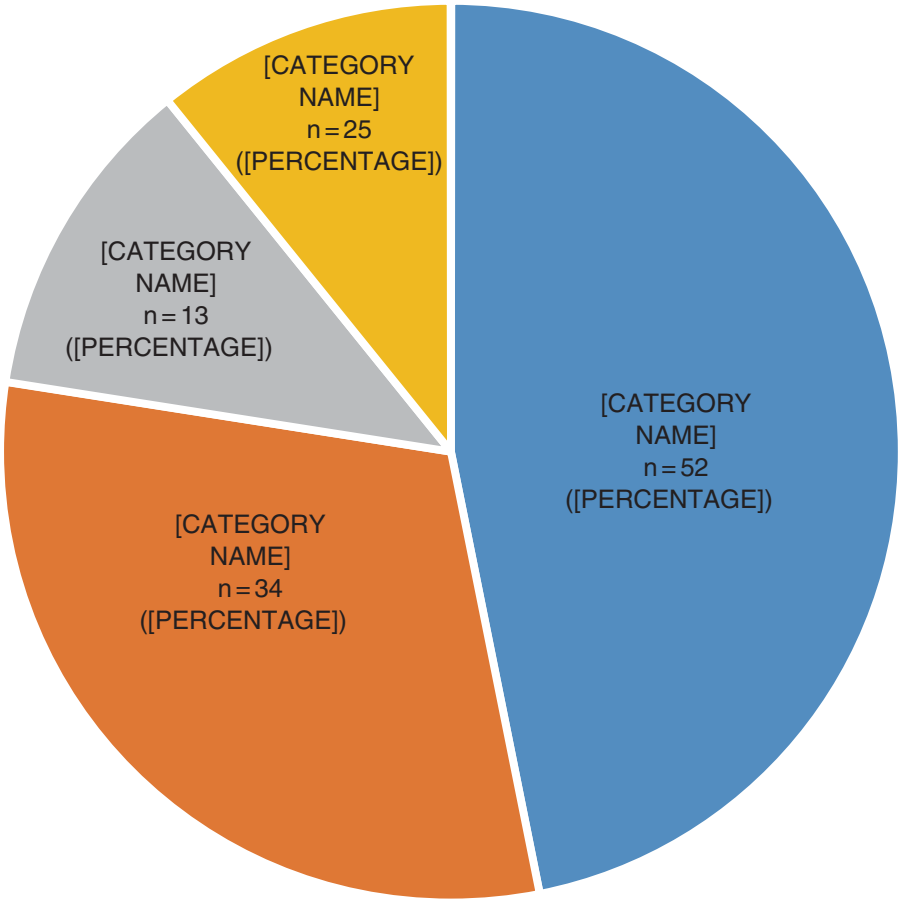

Fig. 2.1 Placement funding. *Source*: Created by the authors

Project Evaluation

The fact that both the educational placements project and the wider health systems intervention in Uganda is based in an established research group (Knowledge and Place) at Salford University has supported high-level evaluation. The evaluation has taken a complex multi-method approach combining qualitative and quantitative methods. All of the data collected has been anonymised, coded and analysed using Nvivo10 software. A grounded approach was followed in generating a node framework, into which all qualitative data was imported and coded. The main sources of data collected during the EEP evaluation are summarised below:

- Weekly reports during placements.
- Comprehensive end of placement reports by all students.
- Pre-, mid- and post-placement interviews with all students.
- Post-placement survey sent out to all students.
- Interviews with UK HEI programme leaders.
- Interviews with Professional Volunteers (Uganda only).
- Interviews with staff in hosting LMIC facilities.
- Reports from staff in hosting LMIC facilities.
- Observations by UK and LMIC project management, evaluation staff and post-doctoral researchers.
- Transcribed focus groups, meetings and workshops with students, LMIC hosts, PVs and project management.
- Email communications between project management and PVs, students and hosting LMIC staff.

The pre-placement interviews aimed to assess how the students thought they would benefit from the placements and how these expectations related to their programme of study. They also focused on the financial implications of the placements and identified any areas where students may require additional support. The mid-placement interviews addressed practical issues such as placement logistics, supervision and student wellbeing; this informed the evaluation of the difficulties faced by students whilst on placement and the nature of pastoral care required to remedy any concerns. As the mid-placement interviews were carried out after just two weeks of the students being on placement, they did not focus so closely on learning outcomes or the impact the students perceived they were having on the LMIC. The post-placement interviews were carried out roughly a month after the students had returned to the UK from their placement. A month was found to be an appropriate delay before conducting the post-placement interviews as it gave the students the opportunity to settle back into regular life and reflect more clearly on their placements. Before, during and immediately after placements, students were sometimes overly focused on the short-term problems and stresses experienced over what was often a highly emotional four to six-week period for them, such as group dynamics, traumatic experiences and fatigue. Many students explained how their thoughts and feelings about their placements had changed hugely once they had had time to think and reflect properly, usually becoming more

positive and continuing to do so the longer the time that elapsed after the placement.[15]

The weekly reports included questions about the students' general wellbeing, their roles and activities completed during the week, their learning and personal development, the extent to which they had been working under supervision and alongside UK and LMIC colleagues and any issues of concern they might wish to raise. The purpose of the weekly reports was two-fold; they informed the overall project evaluation and also provided an opportunity for students to raise any concerns which then enabled project management to take immediate action or make changes to placements. Many students used the written reports as useful form of reflection on the challenges they had faced during the preceding week and the actions they planned to take the following week to prepare for, avoid or overcome them. Similarly, the comprehensive end of placement student reports prompted the students to think back over their placement as a whole to summarise successes, achievements and challenges, and to provide productive feedback to inform necessary changes and improvements to the EEP.

The post-placement survey was designed using Survey Monkey and was disseminated to students over WhatsApp by means of a web link (Appendix 2). The survey was relatively short, comprised of only seven questions which aimed to collect quantitative data on the impact that the placements had on the students' learning, their future career and employability and on the LMIC. The survey also asked the students to rate their overall placement experience. Sixty-five responses were received in total when the survey was circulated in October 2016, which represented a response rate of 59% of the 111 students that completed placements.

Interviews were also conducted at regular intervals throughout the duration of the project with PVs and local hosting LMIC stakeholders. The main focus of these interviews was to establish the impact the student placements were having on the hosting LMIC and their constituent facilities, staff, health workers and patients. Interviewees were asked about both personal and professional impacts, as well as the impact they perceived the EEP to be having on their organisations and the health system

[15] Further research on the long-term impacts of midwifery placements is currently underway as part of Natalie Tate's doctorate; this will involve repeated interviews at six and twelve months post-return.

in general. The impact on the PV in terms of their learning, professional development and the impact their placement might have on the UK NHS was also evaluated (see Ackers and Ackers-Johnson 2016).

Summary

This chapter has described in some detail the operationalisation of the undergraduate educational placements that we have been involved with. The EEP model has evolved over time in an evidence-based fashion building on the experience of the Sustainable Volunteering Project and our experience then of managing a placement whilst also observing students on placement from other institutions across the world and the UK. We have included in this discussion the organisation of placements in India specifically requested by Health Education England. Having outlined the organisation of these placements and students' response to this, the following chapters move on to consider the outcomes and impacts associated with these kinds of placement.

CHAPTER 3

Student Learning on Ethical Educational Placements

> I grew in confidence and became a level headed professional, not just an awkward student. (Nurse, Uganda)

Transformational Learning

As with the findings from our study of Professional Voluntarism,[1] it is difficult to isolate the different elements of learning experienced through placements since personal and professional skills overlap and some aspects of learning are almost intangible, particularly those transformational elements which characterise most students' accounts. The following two responses illustrate the transformational impacts as perceived by the students on placement:

> I just feel like it's helped me change my outlook and personality. (Midwife, Uganda)

> During my time there I went through a wave of different emotions from anger, frustration, passion, amazement and joy to name just a few . . . After returning home and having more time to reflect I believe that the experience had changed me on a level I wasn't expecting. (Nurse, India)

Fee and Gray capture the gains in capabilities and the value of skills gained in low resource settings to contemporary workplaces. They conclude that

[1] See Chapter 3 in Ackers and Ackers-Johnson (2016).

A. Ahmed et al., *The Ethics of Educational Healthcare Placements in Low and Middle Income Countries*, DOI 10.1007/978-3-319-48363-4_3

such skills are not easily codified and taught: they are distinctively generic, rather than technical; tacit rather than explicit; higher order rather than basic; portable rather than profession or situation-bound and 'soft' (interpersonal) rather than 'hard' (technical):

> Notably, expatriates experienced learning outcomes that were more frequently transformational, involving fundamental changes to their values, perspectives or assumptions. (2013: 196)

There is strong evidence to suggest that stays in low resource settings create opportunities for accelerated and complex learning and that the outcomes of these are precisely the kinds of competences needed to drive innovation and efficiency in an increasingly resource-constrained NHS (Norton and Marks-Moran 2014). The potential gains of international elective placements for students are well-documented (see Brookfield 1995; Elit et al. 2011; Murdoch-Eaton and Green 2011) and encompass in general terms, both professional and personal development and the acquisition of new knowledge in and of different contexts (Ackerman 2010). In more specific terms, these positive impacts for students are believed to include: the development of clinical skills in a new context; knowledge of and experience in different health systems; professional development; the development of generic skills, including organisational skills, communication, negotiation, self-evaluation, cultural competence (Jeffrey et al. 2011), compassion towards patients, awareness of resource use, confidence, goal setting, widening students' perspectives, independence, and personal growth; reflective questioning of both the challenges and assumptions of practices; greater understanding of different value systems; and 'social accountability' (Brookfield 1995; Elit et al. 2011) leading to a range of 'socially responsible' educational outcomes (Murdoch-Eaton and Green 2011). Figure 3.1 summarises the findings of existing research on learning outcomes associated with international placements in low resource settings.

These domains map directly onto the UK's NHS Knowledge and Skills framework or 'KSF'.[2] The KSF is focused on staff development and appraisal and designed, 'to make it easier for staff to identify the core skills that they need to do their job and their development needs'. As such it is a

[2] http://www.nhsemployers.org/SimplifiedKSF

1. **Knowledge and Skills**

1.2 Clinical (Academic) Knowledge

Substantive knowledge of contexts and health systems
Resource awareness, management and efficiency
Knowledge of research, evaluation and audit methods

2.2 Clinical and Technical Skills

Exposure to a high volume of (usual) clinical cases and new (unusual) cases
Generic, soft, interpersonal skills
Organisational and administrative skills

2. **Values**

2.1 Personal

Compassion/care

2.2 Social

Ethics, morality, social responsibility, social accountability; global citizenship
Equality and diversity
Cultural competence

3. **Service improvement and Leadership**

Problem solving, innovation and project management
Team working including multi professional working

4. **Communication** (links to cultural competence and leadership)

Teaching /presentational skills
Negotiation
Language skills

5. **Personal Growth and Professional Development**

Confidence
Goal setting
Independence
Self-evaluation and reflective questioning

Fig. 3.1 Summary of learning outcomes. *Source*: This summary is drawn from the authors cited above complemented by Dowell and Merrylees (2009) NHS HEE Toolkit (Longstaff 2012)

useful benchmark against which to evaluate learning on international placements. The KSF focuses on six dimensions:

1. Communication
2. Personal and people development

3. Health, safety and security[3]
4. Service Improvement
5. Quality
6. Equality and Diversity

The following sections present the survey and interview findings under the headings outlined in Fig. 3.1.

Knowledge and Skills

Perhaps the most obvious and tangible perceived benefit associated with international placements concerns the acquisition of new knowledge and skills. Indeed, for many, this may be the 'make-or-break' component underlining any justification for embedding such placements within higher education curricula (and committing resource to them). Drawing on the distinction between explicit and tacit skills (above) we have distinguished two components to this. Firstly, we discuss the acquisition of new knowledge. This includes both clinical and technical skills directly linked to the students' curricula and future profession and more foundational areas of knowledge about contexts, systems and resource management. We then move on to discuss the more operational dimension facilitating translation of knowledge into useable skills.

Systems Thinking

One of the areas students commonly referred to in terms of new knowledge could be loosely described as systems thinking. Students working in a narrow pocket of a large complex organisation (such as the NHS) often find it difficult to step back and consider the system as a whole. Spending time in a low resource setting where systems are malfunctioning is so very tangible that it forces students to engage in systems thinking as a component of problem–solving (see below). And, in the process of this, and from their position outside of the NHS they are then able to reflect on the NHS *as a system*.

Knowledge of how other health systems operate (Murdoch-Eaton and Green 2011) and experiencing different clinical environments (Dowell

[3] This is the only area that does not map directly onto identified learning outcomes. However, this forms a key focus of placement organisation in the EEPs.

and Merrylees 2009) are often cited amongst the motivations for students to undertake elective placements and also as potential outcomes of them. Of the EEP students surveyed, 57% believed their placement had a very strong impact and 29% believed that their placement had strong impact on their learning regarding systems thinking. Some students felt that the insight gained through being placed in an unfamiliar context was illuminating in terms of facilitating their understanding of healthcare systems and different ways of working to those in the UK:

> It gave me a really good insight into health care systems abroad and different ways you know, the different methods that they use to do things. I thought it was really interesting to see how health care's developed . . . and sort of the managerial aspects of the hospital 'cos it was run very differently to the way we run a hospital, so that was very interesting. (Nurse, India)

This student's experience while on placement also influenced her thinking about the status of the nursing profession in different cultural and clinical contexts. Through reflective questioning of the challenges and assumptions of practices she identified the seemingly paradoxical relationship between gender, nursing and status, where nurses in India were very highly trained and respected, yet were not able to utilise their clinical skills in practice:

> I think nursing is viewed very differently over there to what it is here, and so I think they've got a lot of advancements to make in terms of autonomy and decision making. They [nurses] don't get the credit they deserve, self-esteem is very low. But that's very much a gender thing and a hierarchy sort of issue. Nursing is very low down, they have a lot more clinical skills than we are taught but they are not even allowed to dress wounds. (Nurse, India)

Other students commented on the way systems and practices operated in their placement organisation comparing this with the UK. Some went beyond simple learning to demonstrate 'epistemic humility' (Hanson et al. 2013), noting how the availability of resources and organisational hierarchies significantly influenced practice:

> We didn't want to be too intrusive, and tell them that that this is how they should do things because a lot of the ways that we would have done things used resources they didn't have. It is quite difficult having to take a step back and having a lot of listening and watching and not stepping in. It was quite a hierarchical system there. (Prosthetics & Orthotics, Uganda)

Some students were able to reflect and apply the learning gained while on placement to a deeper understanding of nursing practice in the UK, and were able to make improvements to their own ways of working on return. This highlights how reflective observation gained within one context can allow learning from concrete experiences to be applied to another:

> I think about it all the time when I'm on placements [in the UK]. It's just so different; we're all patient centred, patient focused, whereas over there it's more like task focused, like get the job done. And I mean, don't get me wrong, I think a lot of nurses over here can get like that too, when your workload is so big you can be like: 'Oh, you know we need to get this done, this done and this done' and when you're busy you know it can be like that, but I think that's what it's taught me as well, try to take your time with your patient and just explain what you're doing and, you know just have a chat and things like that. (Nurse, India)

For some students, being in a different context and experiencing different ways of working and learning from healthcare professionals facilitated a more questioning mind-set on return:

> I think we learnt more from them, definitely the really good nurses and doctors, more from them than they have learnt from us. They were showing us things, the procedures and such. There's not really much over there that we see over here, it's completely different . . . I think it is really useful to see that 'cos it makes you come back and question why you do things in a certain way. (Nurse, Uganda)

It is clear from the evaluation that simply being outside of the system you are accustomed to and have been weaned in generates a capacity for systems thinking both in the host setting but also in relation to the UK NHS. And this form of learning applied to some degree in both hands-on (EEP) and observational-only (India) placements. One component of this system concerns management of scarce resources.

Resource Awareness

Awareness of resource use and resourcing of healthcare is an important learning outcome of international placements (Brookfield 1995; Elit et al. 2011; Murdoch-Eaton and Green 2011). From the post-placement survey, 74% and 14% respectively believed their placement had a very strong

or strong impact on their resource awareness. Many students expressed shock and surprise at the lack of resources in the host countries:

> I'm going from having all of your staff, equipment, tools and everything and going a month without it and then going back to it – it is a real shock. (Mental Health nurse, Uganda)

> We've got the resources whereas they don't. Sometimes they just wouldn't have the medication in stock and that's just the way it is. If it wasn't in stock and the family couldn't afford certain medications, they'd just go without it, so that was quite tough. (Nurse, Uganda)

Some students were able to make direct links between the lack of resources in their placement setting to (global) structural inequality, and how this constrains the agency of healthcare workers:

> The main challenge I saw in every clinic, workshop and teaching syllabus is the lack of resources. I know this is due to the lack of money available to the hospital and very little can be done to change this in the present economic state. (Prosthetics/Orthotics, Uganda)

Through concrete experience of the constraints in Uganda, students identified the challenges faced by healthcare workers and demonstrated an awareness of how these impacted upon practice. This was particularly marked in disciplines like prosthetics which rely quite heavily on materials:

> I have been able to experience first-hand the numerous challenges encountered in a low-resource healthcare setting. It is clear that the greatest issue here is access to materials and machinery. (Prosthetics & Orthotics, Uganda)

In the following case, a nursing student describes the lack of consumables and equipment that are essential to the effective performance of even the most basic nursing in Uganda:

> One of my biggest challenges was the lack of resources that they had. This included equipment, gloves, medication and fluids. The lack of resources was not really overcome as we just had to work with what we had. I was fortunate that I had brought my own stethoscope and sphygmomanometer from home so I took that with me during my placement. (Nurse, Uganda)

Although, as in the case described above, the lack of resources made it hard to perform even the most basic of tasks, others indicated that being in a low resource setting made them very conscious of how wasteful practices in the UK often were, and through this concrete experience, tacit knowledge and subsequent reflection, they changed their way of thinking about practice in the UK. This level of resource awareness also developed on observational placements in India but without the intensity of personal frustration:

> They don't have the advanced equipment we have . . . they need the same equipment like we do. Because, at the end of the day they are patients as well. They are people so it's quite sad that we have all this technology. We probably waste so much. And they don't waste anything; they use everything they have. If we used less we could send it over there or to Africa. Or, to other countries where they need them. (Nurse, India)

These comments are interesting as they highlight the risk that students may generalise their experiences to caricature wider Indian or Ugandan health systems as facing severe resource and technology constraints when of course both countries have private sector hospitals with state of the art technology. This underlines the importance of reflective practice and having experienced mentors in country and on their return to the UK to frame and challenge the students' immediate experiences and systems thinking. Also, perhaps to encourage students to consider the practical impacts of donations. Nevertheless, in the context of NHS financial crisis, their experiences foster an acute awareness of waste:

> I look at practice in a different way. I'm very conscious of the waste we produce now and the sort of the practice that we have. We're a bit nonchalant about things so I think it's been really good in that respect because you're very mindful of what you're using and whether you definitely need that or not. (Nurse, India)

Another student echoes this sentiment:

> I learnt that people in the NHS take things for granted. I learnt that even though they had limited resources they made the most of what they had and in the NHS they waste so much. (Nurse, India)

Clinical and Technical Skills

Clinical knowledge and skills have been identified as key learning attributes during electives (Dowell and Merrylees 2009). Practically all of the students felt that they had acquired clinical and practice-based knowledge, or technical skills (Williams 2006; Williams and Balatz 2008). Of the EEP students surveyed; 28%, 26% and 32% respectively thought their placements had a very strong, strong or moderate impact on their skills and competence. In many cases they spoke of having access to more specialist skills in their field or at the margins of their field that they have difficulty accessing during placements in the UK.

As we explained in Chapter 1, the India placements were organised via HEE on an observation-only basis whereas students in Uganda had the opportunity to practice, under supervision. The learning outcomes (in terms of clinical skills) are quite different. Students undertaking hands-on clinical placements reported intense and accelerated learning (Norton and Marks-Moran 2014; Stephens 2015). The following example is typical:

> It was an experience and a half, I loved it. We did so much. I did more in those four weeks than I did in my whole first year and learned more in those four weeks than my first year. (Nurse, Uganda)

In the next case the occupational therapy student was able to gain key paediatric experience during her Ugandan placement:

> It was good to get some paediatric experience, that was amazing because I don't think I would be able to get that experience [in the UK] because when you go to do something like that they want previous experience so that broke a bit of a barrier. (Occupational Therapist, Uganda)

Respondents used the concepts of 'exposures' or 'spoking-out' to identify unique learning encounters that they would not have had the opportunity to experience in the UK. Adult nursing students had the opportunity to work with babies or gain exposure to maternity cases, for example, which they had not had access to at home:

> I've never really done [observations] on babies so being able to monitor them and see how they care for them. (Nurse, Uganda)

> I gained some clinical skills even doing clinical observations. Also the maternity side of things, I would never have otherwise known. (Nurse, Uganda)

> I had lots of personal achievements. I assisted in the delivery of twins and 3 little girls. I took part in cervical screening which was an amazing experience and I was part of the hand hygiene training at Bukuuku health centre. (Nurse, Uganda)

Our ethnographic experience of working alongside students on placement, backed up by their interviews, suggests that placements in the UK are often quite narrowly defined in line with the specialisms they are working towards and students have limited opportunity to see beyond these and experience work at the interface of professional boundaries. This does not imply that the skills they gain are irrelevant. In some cases, students explained how the experience had influenced their future career ambitions perhaps involving a shift in emphasis. In other examples students referred to the value of this more holistic learning when they came to have placements in accident and emergency contexts (for example). In such environments, an adult nurse may well be faced with a pregnant mother or a child. Paramedic students who also spent time in health centres dealing primarily with maternity cases and children spoke of the value of this more multi-disciplinary learning to their future roles and the confidence it had given them to manage such cases. The broader exposure to cases that a student may not have immediate access to in the UK was also mentioned by mental-health nurses in Uganda who worked both at the very hard end of institutionalised and highly medicated patients and in community out-reach work:

> In terms of mental health specifically, I've learned more about variation in diagnosis and how it can manifest and present differently. My placements so far [in the UK] had been quite stable and I just had to discharge patients, but there I could see crisis situations, which was quite an eye-opener. Eventually I will have to assess people in these conditions so it's given me knowledge of that. (Paramedic, Uganda)

In addition to this 'spoking out' most students in the Uganda placements referred to the level of access they had to more complex and emergency cases in their area of specialism. This was often related in their interviews

to the issue of responsibility and confidence as the knowledge they had learnt from lectures and textbooks could now be applied in practice:

> It has been invaluable to gain such varied clinical exposure and to have been given a level of access and responsibility that is beyond anything we have experienced in the UK... The hands-on exposure has allowed us to build upon our practical skills through assessing and providing patients with relevant treatments. (Prosthetics & Orthotics, Uganda)

The same comments would doubtless be found amongst students who had taken part in traditional unsupervised electives and we are acutely aware of the line here between giving students access to cases that whilst presenting unique learning opportunities could challenge their competency. It is important to emphasise that all of the students in Uganda were supervised by both Ugandan and UK professionals and were not operating on their own.

Students were able to reflect on this new learning both in terms of clinical skills but also critical thinking. In the following case a prosthetics student suggests that this has contributed to her development as a rounded professional:

> This placement was a great opportunity for me to develop my knowledge and develop skills required to become a more rounded and efficient healthcare practitioner. The clinical exposure allowed here in Uganda was almost incomparable to those received in the course so far in the UK. Being in a developing country also increases the amount of critical thinking required to fulfil a job role of an orthotist or prosthetist . . . Going during this aspect of our studies has been extremely beneficial in terms of clinical exposure and I have learnt a tremendous amount of information, skills etc. (Prosthetics & Orthotics, Uganda)

In the final example in this section the nursing student reflects on the value of her learning to her wider professional role. However, she also makes an important point; that the placement enhanced some skills but did not cover all aspects of her 'skills book':

> On reflection it has made me a better nurse not because I've seen any wild animal attacks or rare diseases. I didn't work on all of the skills from my skills book but I did work on getting the basics of care right. I realised how important it is to monitor the small changes in patients and how crucial documentation is to understand how the patient is progressing. (Nurse, Uganda)

In this case, she emphasises the back-to-basics quality of her learning rather than the exotic learning she may have anticipated. Certainly, it is these skills that she will now be utilising in her placements in the UK. Her point about not working on all the skills is important however. It is much more difficult in a low resource setting to ensure a comprehensive skills enhancement in line with any UK curriculum and this has implications in terms of skills mapping and potential augmentation on return. This would certainly be the case if the skills map included working with specific forms of equipment, for example. A number of students explained how the clinical exposure helped develop their self-awareness and shape or confirmed their future career aspirations:

> I've learnt more in that month in Uganda than the four months on my placement in the UK. I want to work in adult mental health. (Social Work, Uganda)

> It has definitely been beneficial to my course and to what I want to do in future . . . It has made me put a specific thing in a bigger picture. We have to look at those things in our course but we've never had to deal with it practically, until we went out there. (Business studies, Uganda)

In our sister book on the learning of professional Volunteers, we noted the contribution that placements made to confidence in using existing skills (Ackers et al. 2017). Most of the students on the EEP placements spoke of their new-found confidence in their clinical skills. The idea of 'deliberative practice' is associated with a particular theory of learning that emphasises the value of repeated engagement with a particular skill or skill set (Ericsson et al. 1993). In our work on the gains associated with professional voluntarism, we noted the gains that NHS professionals experienced through repeated exercise of pre-existing skills (Ackers et al. 2017). This dimension of learning was also in evidence amongst the students on clinical placements in Uganda.

> I feel a bit more confident if something happened to be able to actually resuscitate a baby. (Nurse, Uganda)

> It's given me an awful lot of confidence. I thought I was quite confident any way but it enhanced my confidence to step forward in the skills I use in the UK. (Nurse, Uganda)

In the final case the nursing student explains how this had an immediate impact on her professional practice in the UK:

> Confidence was the most important thing. I went back to accident and emergency and I was just so much more confident; when emergencies came in I didn't lose my cool, I had a lot more calm after being there because we dealt with lots of emergencies. I wasn't as panicky because I had been in that situation before. (Nurse, Uganda)

Personal Values and the Patient Interface

We noted above the focus on equality and diversity in the NHS Knowledge and Skills framework and the emphasis of personal values and value systems in the literature on international placements (Brookfield 1995; Elit et al. 2011). For convenience, the following section distinguishes learning directly related to personal values from that concerning wider social values although of course the two are intrinsically related.

The Francis Report (2013) emphasised the importance of care and compassion at all levels of the NHS workforce. This stimulated a drive toward a 'value-based' strategy (Waugh et al. 2014) which has placed the '6 Cs'; Care, Compassion, Competence, Communication, Courage and Commitment (NHS 2016) at the heart of the skills enhancement agenda. In addition to the more explicit clinical skills identified above respondents identified a wide range of less tangible skills and knowledge acquired on placements. These included both personal and professional development and again, embodied tacit rather than explicit (or technical) knowledge (Williams 2006).

Through concrete experience augmented through reflection and self-evaluation, students identified care and compassion as important components of their clinical practice. 57% and 32% respectively stated that their placement had a very strong or strong impact on their perception of compassion and the importance of empathy. The following comment is typical:

> In terms of nursing, it just highlighted to me how important it is to have that relationship with your patient and to just to be reassuring and things like that because there is nothing worse than when you feel like no one really cares about you, when you're ill. (Nurse, India)

For some students on observational placements in India, this profound experience coupled with their inability to intervene and assist if a patient was in pain caused some anxiety:

> You're not used to seeing patients that are like severely in pain, severely distressed and that in itself is just really hard to deal with and you don't, you're never prepared for that because that's just not something that you would see here. And obviously as a nurse you want to look after people and you want to do your best to care for people and make them more comfortable and settled and you feel like you can't do that for them, and you're like, what am I here for? What's the point, what am I doing? You're just making a dent in it you know, you're not making a difference. (Nurse, India)

As we have explained (in Chapter 1) the India placements were not a part of the Ethical Education Placements Model and our experience of them as observation-only placements has lead us to question their impact on student learning and, perhaps more significantly, their compliance with ethical principles. Having said that, students on clinical placements will also experience a sense of disempowerment at the lack of resources and human resource context and the impact this has on their ability to demonstrate care and compassion:

> Throughout my three years [at university] everything that they've taught us is all about the patient, caring for the patient and having empathy and sympathy and you know looking after their needs . . . once you're out there you just see people dying of reasons that you could literally treat them with no problem over here. (Nurse, Uganda)

> It touched me a bit because there was a lot of preventable death over there, people just died but if they were over here probably wouldn't have died . . . you feel a bit helpless. (Nurse, Uganda)

Many students found being in a different setting challenging and some felt that systems themselves thwarted practice and their ability to provide appropriate levels of care. It is quite different to witness an absolute lack of resources as opposed to an apparent systems failure resulting in inefficient use or abuse of resources. In the following case the nursing student interpreted the situation as a lack of care on the part of Ugandan health workers:

> In some situations it just seemed as if people didn't really care. If someone was in a lot of pain and they were asking for pain medications, they were like: 'No, the [medicines] round isn't until this evening they'll be fine', you know not really caring that much and obviously nursing is a caring profession. (Nurse, Uganda)

For others, experiencing different systems challenged their own world view. Being aware of the conditions and constraints host systems operated in allowed them to place their worldview in context, and realise that practice is framed by context;

> There were only two doctors working different shifts, so I think a lot can't be helped. They try to do the best they can but it could easily be much better, there's no dignity or respect. (Nurse, Uganda)

In other cases, students experienced situations that, in themselves, did not reflect resource shortages in any simple sense. In the following case in India, a midwifery student observed a lack of attention to privacy or consent:

> Women had no privacy, even in the antenatal there was more than one woman per room and there was no curtain or anything and it was hard to sleep . . . and also the fact that they didn't have to consent to anything, the doctors just did it, although they may have consented but we didn't know, it could have been the language or culture, but it's just second nature to do that here. They also took the baby away straight away, just to make sure it was ok, but it was in a different room. So they didn't get much chance to bond, the baby was just left crying. (Midwife, India)

The historical legacy and enduring effects of structural inequality between high and low resource settings and the differences in positionalities of students from high-income countries[4] and populations in low-income countries means that there can be assumptions of superiority (Elit et al. 2011). Additionally, 'benevolent imperialism' (Huish 2012) and hubris[5]

[4] It is important to point out that many of the students on placement were themselves from diverse backgrounds including students of African or Asian descent.

[5] Defined as dangerous overconfidence.

(Hanson et al. 2011) can characterise the perceptions and interactions of students:

> The main problem really is their culture and their beliefs . . . I'd say it makes you appreciate people's dignity much more, because over there they don't do that over there, there's no dignity or respect. It makes you more aware of different cultures. (Nurse, Uganda)

Once they had time to reflect on their experiences, some students recalibrated their initial perceptions of staff in host organisations and were able to place their actions in context:

> It's mad because I remember thinking 'Oh my god the way they are doing that is so bad; that is terrible' but actually it's not. Now I've come home and thought about it, that's just how they cope, that's how they deal with such low resources and you know those people are still being treated as best as they can be. It's not bad, it's just they are doing what they can with what they've got. But for us, at first it's shocking. (Nurse, India)

Some students referred to what they perceived as a lack of motivation of healthcare workers in their placement setting.[6] Again, this was something that had been raised with them prior to undertaking placements in Uganda and most were able to place the behaviour of individuals within a particular structural context, recognising that people's apparent motivation would be shaped by extrinsic factors and the way that systems operate:

> Motivation wise that's a big issue of course in Uganda, we went to lectures about motivation and absenteeism. That's part of it I'm sure – other reasons as well – but lower motivation because obviously people would be thinking I'm doing the work of more than two or three people and they are not here. Obviously it affects the motivation, they could be overworked which results in them not going to work and it could snowball out of control. (Nurse, Uganda)

[6] Health-worker motivation has formed the basis of much of our project work in Uganda. Students attended a workshop on this in June 2016 involving local health workers and senior managers. The impact of motivation on health-worker behaviour is discussed in Ackers and Ackers-Johnson (2016).

These examples emphasise the continuing impact of placements and the important learning that happens post return as students reflect upon and make sense of their experience. Harnessing this and facilitating discussion within peer groups optimises the learning of the individuals concerned and enables it to spread to others. It also provides the opportunity to challenge and reduce the risks that students will draw general and perhaps essentialised conclusions from their immersions. Many of the students felt that their experiences abroad made them aware and appreciative of their privilege in the UK, in terms of available resources and the treatment that patients were able to receive:

> There's a lot of people suffering in the hospital which is quite difficult because there weren't many beds, it made you appreciate what we have here. (Prosthetics & Orthotics, Uganda)

Unsurprisingly, the experience of observing or working in a low resource setting encouraged all students to reflect on the role that the UK's National Health Service plays in providing access to health care on a universal basis irrespective of a patient's ability to pay:

> It confirmed how privileged our life is and how precious the NHS is. It was heart-breaking to see a young mum of 20 die for the lack of an antibiotic given on time. (Nurse, Uganda)

This regard for the NHS extends to an awareness of the expertise and commitment of NHS staff – whose cadres they are soon to join – giving them confidence in their own career decision making:

> I've got a new-found appreciation for our nurses and the hard work they put in and the level of care that we provide. Everyone slags off the NHS . . . you have no idea how lucky you are to have been born in this country, receive the level of healthcare that we receive. Halfway across the world it is a very very different story, and they're so grateful for the care they receive. They don't complain in comparison to [the UK] where like everybody loves to moan. (Prosthetics & Orthotics, Uganda)

The example cited above exemplifies one of the outcomes of placements that we also discussed in our evaluation of professional voluntarism (Ackers and Ackers-Johnson 2016); namely reflection on the attitudes of

NHS users. The effect that placements in low resource settings have on reinforcing a commitment to care and compassion goes hand-in-hand with a reflection on the lack of appreciation of many patients in the UK and the demands they place on hard-pressed staff:

> It was a massive culture shock going to India, but an even bigger one coming home. I remember being on the ward and a patient was shouting at a nurse because she had given him the wrong meal and he was saying how crap the NHS was, telly wasn't working so he was discharging himself etc. And I just remember thinking, you should be thankful, you've got a bed, clean bedding, I didn't say anything but I thought it. (Nurse, India)

It is important that opportunities are given within the curriculum for students returning from placements to make sense of these sometimes conflicting feelings to understand what care and compassion means in different settings and how to handle such patients. In this way, through reflective questioning of both the challenges and assumptions of practices, students demonstrated an increased understanding of different value systems (Brookfield 1995; Elit et al. 2011; Murdoch-Eaton and Green 2011).

The sense of frustration or helplessness that students experience can extend to trauma particularly when students witness deaths. All of the child nurses working on the neonatal units in Fort Portal experienced neonatal deaths and other students experienced maternal deaths. Students were also upset by the very different approaches to death in Uganda. It is important that all parties involved in educational placements in low resource settings are prepared for the level of trauma involved and find ways of managing expectations and experiences of this from induction processes through placement supervision and during their return to study. Perhaps the most important component of this is the provision of supervision by UK professional volunteers on the ground who are able to mentor and support the students. Whilst exposure to death and to cultural differences in the treatment of dead patients can be highly traumatic, this is also an important source of learning for students that they are often insulated from in the UK. It is all too easy, faced with the immediate exposure to death, to judge patients and health workers and find them lacking in care and compassion:

> It was horrible. There was a dead baby on the floor one day. But it was kind of good that we were exposed because that can never happen here . . . there is no compassion over there; that was one of the hardest things coz when one

> of the babies died, and the doctors saw them dead, there was no grief, no compassion, no emotion, it was just really cold. So it was a learning part for me that I will never do it like that. (Nurse, Uganda)

This case takes us interesting another area of critical learning for students; typically referred to as 'cultural competence'.

Cultural Competence

The introduction to this book referred to the impact of globalisation on UK universities. The forces of globalisation and internationalisation have and continue to have a massive impact on the National Health Service both as an employer and service provider. Perhaps the most immediate example of this concerns global labour markets in terms of both exporting UK professions and importing their foreign peers. Staff shortages have been commonplace within the UK National Health Service since its creation and it has responded to these through international recruitment.[7] The NHS has a code of practice on international recruitment from low resource settings which aims to reduce the damaging effects of 'brain drain':

> Any international recruitment of healthcare professionals should not prejudice the healthcare systems of developing countries. Healthcare professionals should not be actively recruited from developing countries, unless there is a Government-to-Government agreement to support recruitment activities.[8]

In practice this code seems to have done little to prevent the leakage of large volumes of health workers from low resource settings into the NHS. Whilst these trends are common throughout the world, the UK is one of the biggest importers of foreign health workers. A report by the Organisation for Economic Co-operation and Development (OECD 2015) has shown that 35% of NHS doctors were born abroad, putting Britain ahead of every

[7] There is not scope in this book to comment on the wider ethical dynamics of these processes but for discussion.

[8] http://www.nhsemployers.org/your-workforce/recruit/employer-led-recruitment/international-recruitment/uk-code-of-practice-for-international-recruitment

other country in the European Union except Luxembourg. The same report highlighted a sharp increase in the number of foreign born nurses working in the UK NHS, rising from 15.2% in 2001/2002 to 21.7% in 2011/2012. It explains how, within this same decade, 40% of the overall growth in the number of doctors and 65% of the growth in the number nurses can be attributed to the arrival of foreign workers. Many of these foreign workers come from low- and middle-income countries; for example in England as at 30 September 2015, there were 18,096 NHS Hospital and Community Health Services staff from India, 479 from Uganda, 4,142 from Zimbabwe, 5,124 from Nigeria and 13,533 from the Philippines amongst many other countries (NHS Digital 2016)

Not only has the composition of the NHS undergone a transformation but wider society has become far more diverse and multicultural than ever before. OECD figures from 2013 estimated that 12.3% of the UK population were 'foreign born', equating to over 7.8 million people. The differing demographic, socioeconomic and cultural backgrounds lead to differing health needs which must be catered for by the National Health Service. In order for this to happen, staff require additional skill, competency and experience to deal with the less familiar and potentially more complex patient cases. Macfarlane and Dorkenoo (2015) examine the example of female genital mutilation (FGM), estimating that the number of women aged 15–49 with FGM born in countries in which FGM is practised but living in England and Wales had increased from an estimated 66,000 in 2001 to 103,000 in 2011. They attribute this increase largely to immigration to the UK from African nations where FGM is commonplace such as Somalia, Egypt, Guinea and Djibouti. The rise in cases of FGM has prompted widespread health policy review and staff guidelines and training recommendations (Topping 2015). Other similar cases can be found in terms of the prevalence of infectious diseases, such as HIV and Tuberculosis, for which rates are higher for non-UK-born people. In terms of mental health, Raphaely and O'Moore (2010) concluded that higher rates of depression and anxiety exist among refugees and asylum seekers than the national population or other categories of migrants.

These trends highlight a large and expanding international workforce and a complex, diversifying range of patients within the UK National Health Service. In many ways, professionals from all over the world are working alongside UK health staff to treat patients from all over the world. This leads to greater demands in areas such as workforce integration,

cultural awareness and sensitivity, competency and human resource management. It also requires staff to have additional skills in the areas of communication and teaching to allow for effective cooperation and the exchange of knowledge, skills and capabilities in the workplace. This is the context within which the development of ethical educational placements is taking place.

In the introduction we questioned whether it is possible for students to unproblematically become 'culturally aware' or develop 'cultural competence' through merely participating in international placements. Practically all of the students mentioned culture, usually in relation to difference, in terms of different systems, ways of working and values. Our survey suggested that 78% and 18% of students respectively believed their placement had a very strong or strong impact on their cultural awareness.

Returning to the discussion above about death, some students were able to reflect on their experiences from the perspective of cultural differences rather than concluding simplistically that Ugandans lacked compassion. In the following case, the nursing student recognised the complex relationships between human emotions and outward displays of grief:

> The women, when they are having babies and in pain, they just get on with it. There was one woman who was basically just smiling at me the whole way through her labour, she looked so beautiful as well and I just thought oh my god! But then there was one baby who was going to die and when the mum was told she didn't show a massive amount of emotion. I don't know if it's because that's so common to them it was just quite strange to see. (Nurse, Uganda)

Another nursing student describes witnessing the death of a baby in Uganda:

> One of the challenges I faced was the lack of emotion people show when they have a baby or if somebody passes away. I found this very challenging especially when somebody passed away. I could not understand how they did not cry. I overcame this by learning that it is part of their culture not to show any emotion and they often do that in private. (Nurse, Uganda)

Some students were positive about the differences they witnessed, demonstrating epistemic humility through highlighting aspects which they felt

were lacking in the UK. By way of example, many recognised the role played by the extended family and the wider community in supporting patients. This was evident across a number of disciplines and in both the observation-only (India) and hands-on (Uganda) placements. In the first case reported here the paramedic student spoke of the importance of family to patients in Uganda:

> I was able to witness how much family assistance with care is relied on, and the generosity of members of the public towards those without families to help their recovery. (Paramedic, Uganda)

Similar comments were made by a midwifery student involved in the India placement who mentioned the support provided by family members reflecting on how this would be handled in the UK:

> In India they have the whole family sleeping in the corridor waiting for them. In our hospital we don't even let them wait in the waiting room when their daughter's in labour, they have to do down stairs to Costa . . . So the difference is just mad, and like for that woman it could be completely reassuring having mum and dad there. (Midwife, India)

The student in this case is clearly considering some of the potential benefits of having family in the delivery room. She does not reflect at this point on some of the potential risks associated with this in terms of infection prevention or the privacy of other patients; these are issues that could form the basis of interesting discussion about care in context and the boundaries of individual freedom on return to the UK. Others highlighted how family members were kept informed about patients which enabled them to play a meaningful role in supporting their care once discharged from hospital. One of the mental-health students placed in Uganda explains how the family are more engaged in the care of their family members:

> I think there was a lot more family involvement in Uganda like in the mental health unit than in the UK [where] you tend to treat the person. In Uganda they connect with the family member to look after them so you got the chance to explain to the family member what condition it is and how it impacts them so that they understand better so I think some of the families in Uganda understood the conditions better than sometimes here because

> they never really get that information from a healthcare professional, so that was good. (Nurse, Uganda)

Social work students on community placements in Uganda were also very positive about the role of the wider community in supporting vulnerable members and reflected on how this approach could be beneficial to the UK:

> I did learn a lot, the community projects that are there are something that I haven't seen as much of in the UK, there seems to be a lot more community enterprise there. (Social Worker, Uganda)

The social work student in the next case talks about the 'Goats for Life' project aimed at developing social enterprise to enable families to pull themselves out of poverty. While the project itself is unlikely to take roots in the UK context, his reference to the growth of individualism in the UK is immediately relevant to his future role as a social worker:

> One of the projects was the Goats for Life project . . . So we went to the market and bought 4 or 5 goats and delivered them out to the community. Seeing the wider family network and how that goat can bring them all together was good, because everyone came round and everyone was involved, which was lovely to see. You knew that there was a bond there, and with the child there that had no parents. People would help the child get to school and things and people helped the grandmother out, and I think that's important skills to learn. Right now [in the UK] things are stuck behind doors, and we don't know problems with our own neighbours, and I think it's really important for social workers to learn that community can exist, even if that's in Africa. Were taught not to see it, and that individuality is the trump card, but it is good to see a different way, and see how it can be good to work together. This is a community coming together to help. (Social Worker, Uganda)

In the final case another social work student describes the emphasis on community in Uganda as 'progressive':

> I consider the community social work method which I have experienced in Uganda as very progressive, effective and efficient. (Social Worker, Uganda)

It may come as a shock to many to see social work in Uganda described in such positive terms. One of the social science students similarly described a local midwifery-lead health centre as fitting perfectly with her own personal commitment to natural child birth and rejection of the medicalisation of maternity services in the UK (as she saw it). It would be useful to work through these perceptions with students on return to understand what lies behind them, not as a criticism of Ugandan systems but rather to develop a deeper critique. Community social work, 'natural' childbirth and the involvement of families in mental health may be necessary responses to fundamental gaps in systems; the lack of public services as much as attention to cultural differences. Nevertheless, these observations provide the basis for critical reflection and learning.

Although we question whether just being in a different context builds culturally competence, for some students, having the experience of being in a different setting gave them knowledge of a different country, culture and environment and engender confidence about difference. In the following example a mental-health student suggests that the immersive nature of her experience in Uganda will support her future practice in what is a very multi-cultural environment:

> I felt I came back and got more understanding of the different cultures because Liverpool's really diverse; you get a lot of different patients from all around the world and I feel like I can sympathise with them a lot more and understand them a bit more. (Nurse, Uganda)

It is interesting to reflect on this case as the student is deeply embedded in a very diverse home environment; far more diverse in fact that the one she experienced in Uganda. We would argue that it is as much the students' experiences of being an outsider in Uganda or India that hones this experience as it is the exposure to cultural difference per se. The effect of the placements on students' awareness of culture was evident both in the Indian and Ugandan contexts. Echoing previous discussion about the role of family in health care the following student reflects on her placement in India:

> It's made me a better nurse because the UK is becoming more multi-cultural so I have to – not that it's a bad thing – I have to face different cultures and to be able to experience their culture and what they normally do. The patients' family come in to wash them, to feed them [in India] whereas here the healthcare systems do that, the nurses do that care. So if they felt

> more comfortable with the family, if it was appropriate, we would encourage the family to come in to offer that care. That's what I would like to do if I was running a ward. (Nurse, India)

Clearly there are many reasons why this approach is both necessary in India and Uganda as these roles are not considered a part of normal health worker roles and would present real challenges to the NHS, in terms of privacy and infection prevention control. Once again experiences such as these and the critical thinking they provoke provide fertile ground for discussion with peers on return rather than immediately transportable policy options.

In the spirit of epistemic humility, having particular concrete experiences and being able to reflect on them and conceptually abstract such experiences, gave some students the opportunity to reconsider how they would practice in the future, in terms of how they would relate to both colleagues and patients:

> I wasn't too aware of understanding people and the differences they have due to culture and religions and. I think just having a bit more knowledge . . . if I was to obviously care for a patient who was of a different religion or culture I think I would probably take the time to go away and actually learn a bit more about it and to be able to understand them a little bit better like in that sense. (Nurse, Uganda)

The midwifery student in the following case reflects on her experience of observing mothers in India and explains how this has enabled her to understand Indian women's attitudes towards breast feeding in the UK:

> We learnt a lot of cultural stuff. Now I can understand why Indian women sometimes act the way they do here. They're not rude, that's just how they are and their culture and they're not used to us being friendly. I've come across a few Indian patients here and I've just accepted this is what they want rather than saying that's just how we do it here. They tend to bottle feed the first 3 days, just because of their culture. Before I would tell them not to – now I just accept that's how they are. (Midwife, India)

Once again this raises points for discussion with her tutors and peer group; it may be that from a professional perspective simply accepting bottle feeding is deemed inappropriate or out of line with public health protocols in the UK. Witnessing cultural difference does not necessarily mean accepting all forms of behaviour but it does help to understand what lies

behind that behaviour. The following example represents similar points for discussion:

> To put it into context, I was working on a ward (back home in the UK) and there was an Indian lady having surgery and there was a lot of her family around her bed, like a lot, which you see in India because that's their culture. But I remember a few of the care staff where like 'oh no we can't have that many relatives, oh my god no they've got to go' and it was only because I had been to India and I knew that that's what happens there and that's their culture and it sounds bad but I said to my colleagues it will make it easier for you because they want to look after their relative whilst they are a patient so let them and you just be in the background if they need anything. (Nurse, India)

The nursing student in the next case talks about how the awareness she has gained in India will help her relationships with Indian health workers:

> A massive thing I gained in cultural awareness, both for patients and also there are a lot of Indian nurses coming over here and now I feel I have a better relationship with them. To be honest, I used to think they were lazy, because they didn't do personal care but now I know they don't do it and sometimes you'd ask them and they would just look at you and not do it. So now, I just don't ask them now and it's not that they are doing anything wrong it's just how they are taught and it's their culture. And I know you can say they should work within the NMC [Nursing and Midwifery Council] code of conduct but India has given me that awareness of how to deal with that stuff. (Nurse, India)

The students' conclusion that it is OK for nursing students from India not to engage in personal care is quite alarming. Certainly it is essential that foreign staff in the NHS work to the same protocols as their UK peers but understanding these cultural dynamics and global differences within the mixed economy of care is critical to encouraging individual behaviour change.

Finally, a number of students emphasised how the cultural learning they had engaged in was in fact a two-way process. Examples of sharing information, knowledge exchange and developing understanding of how different contexts and systems operate appeared to be key:

> I'd say definitely like culture-wise, they gained things because they would ask all sorts of questions about what it's like, like what we think and stuff like

> that, especially our buddie learnt loads about what it's like over here because she was asking us so many questions and stuff . . . We learnt as much as they did really, because we'd just swap the stories. (Midwife, India)

Communication

The enhancement of communication skills is identified in much of the existing research on learning outcomes (Jeffrey et al. 2011). In our survey, 40% and 43% of students respectively felt that their placement had a very strong or strong impact on their communication skills, stating they were better able to adapt the way they communicated to fit with different contexts and situations. In this way, professional skills development and acquisition (communication) could be understood to link to the development of other skills (managing difficult situations):

> I learnt so much not only to help me within my nursing career but I learnt a lot about different cultures and developed my communication skills and my ability to cope under stressful and difficult situations. (Nurse, Uganda)

Some students reported challenges in communicating with staff and patients, but were able to improvise in the way they communicated, demonstrating flexibility and adaptability, and recognised that developing communication skills was important for future practice:

> The language barrier was a massive challenge. Most of the patients I came across could not speak English and I could not speak their language. The nurses and healthcare workers also did not speak much English. This made it very difficult when communicating as I often had to use hand gestures. (Nurse, Uganda)

When talking about communication some students demonstrated humility, awareness of privilege and difference and reflected on what it is to be in the minority or perceived as 'other':

> You just sort of like get annoyed with those who don't speak English, but we got culturally aware . . . we were the only ones speaking English, and you were just more aware of how they must feel when they are somewhere [where nobody speaks their language]. (Nurse, Uganda)

The following podiatry student talks about her skills in non-verbal communication in Uganda:

> Obviously not everyone over there speaks English but you can still kind of communicate, with expressions in the way you behave. Sometimes you didn't know what they were saying but you could still get an idea of what they were saying by their body language and expression. (Podiatrist, Uganda)

Even where staff were speaking English the following nursing students showed an awareness of how miscommunication can arise:

> I haven't worked with any African patients since being in Uganda but I think I probably have more of an understanding of accepting, if you ask them to do something or you know the way they reply, I think I've had more patience and I know why they're saying what they are, and just try and approach the situation a bit differently but not be upset or angry at the fact they've turned around and said something completely out of order. (Nurse, Uganda)

In the following case the student nurse learns how to interpret a use of English in Uganda that she is unaccustomed to and accept this as a facet of cultural differences; her own language suggests that she continues to view this as 'wrong':

> At first you get on with it, like trying cursing under your breath but then you think well sometimes it's different cultures and the way they deal with things . . . sometimes people don't necessarily mean to be rude or awful, it's just how they've spoken most of their life or how they speak to people, and nobody's ever really turned around and said: you shouldn't say that to people. (Nurse, Uganda)

Other students recognised the need to modify and adapt the way they communicated to better relate to Ugandan patients. This is of particular importance in the field of mental health:

> I think it's really good . . . the cultural aspect of it, the communication. We used too much clinical language with the patient so they taught us how to speak to people. It was good like that. (Nurse, India)

The development of communication skills amongst students was also remarked upon by programme leads in the Universities and by Professional Volunteers:

> There was a big development of confidence, and being in a situation where people don't always speak the same language as you, or choose not to in some cases. I think it is using your communication skills in a different environment. People have mentioned things about their self-awareness of their inability to communicate . . . They learn more of the softer skills, like communication and working in a team and they learnt to assert themselves sometimes and come across in a certain way. (MMU University Programme Lead)

> They have really come together as a team and they are very good at supporting each other, and they have learnt to communicate with staff . . . it all links to the team working. (PV, Uganda)

Teaching and Presentation Skills

As we noted in Chapter 2 students undertaking placements in Uganda are given a range of potential teaching opportunities. These included contributing to teaching on the K4C sponsored degree programme in midwifery alongside our professional volunteers. They also had the opportunity to join local MMU students in social work and community development workshops and business students worked directly on joint project work as part of the hand hygiene project. This latter project involved some teaching in in local schools on basic infection prevention control. Perhaps less planned, EEP students found themselves working alongside quite large volumes of students from local colleges left to find their way without supervision in Ugandan health facilities. A number of students indicated that their placement provided them with the opportunity for personal growth and professional development, and developing teaching and presentation skills were key areas where this seemed to operate. It is apparent that such opportunities were felt to benefit future career prospects in terms of enhancing CVs, but students were also keen to make a contribution to the host setting. Some students were initially reluctant to put themselves forward, but were able to reflect on how the (concrete) experience helped their skills development. This 'learning through doing' occurred across a range of disciplines and student cohorts but was limited to those students who were involved in

practice-based placements in Uganda. The respondent in the first case describes her initial reluctance to get involved in teaching:

> We didn't want to do it because we hadn't done it before and at first the students laughed at some people and it ran over quite a long time but we had chance to talk to them and have a good discussion. It also helped our presentation and teaching skills. (Social work)

In another example, paramedic students were invited to develop emergency first aid training for local ambulance drivers in Uganda who receive no training at all in this area and are not accompanied on their journeys by health professionals. In this case the students jumped at the opportunity without any reservation:

> The training we did came off well, some of the nurses came and the ambulance drivers and we were very pleased with how quickly the skills were coming on; we taught CPR and how to dress wounds and deliver babies. I think we helped a lot there because they said they do have to do a lot in the community but don't really have the training for it and I think we've been a bit of an impact there. (Paramedic, Uganda)

The prosthetic and orthotic students were given opportunities to work alongside Ugandan students in co-mentoring roles. In addition, they took part in some large group teaching:

> The opportunity arose for me to conduct an anatomy lecture discussing upper limb bony anatomy, musculature, as well as blood and nerve supply to the second year students studying orthopaedic technology. I have never had the same number of students listening to a lecture before and hence it was a great experience for me to increase confidence, reinforce my ideal subject area etc. (Prosthetics & Orthotics, Uganda)

This experience had an important confidence-building effect enabling the student to reflect positively on her own knowledge and skills base; there is nothing like teaching to make you aware of how much you know! We have already pointed to the importance of 'back-to-basics' learning in low resource settings. Students' awareness of the neglect of some of these foundational systems and skills encouraged them to engage in teaching in this area:

> With a few people from my group we also did a short teaching session at Mountains of the Moon University to Nursing and Midwifery students on the importance of regular clinical observations and noticing signs of deterioration, the use of observation charts and the introduction of an Early Warning Score system. The session was quite successful and the students seemed really interested and willing to learn and change how they do things. (Nurse, Uganda)

The engagement in teaching encouraged students to see that their roles as health workers were more than simply service delivery; teaching is a core if often invisible component of everyday practice. And being aware of this supports attention to their own position as role models for other health workers:

> Up until my last module at university, I never considered myself to be someone that would be seen as a teacher, yet working in Uganda made me see that as a nurse we continue to learn and teach every single day. Whether it is showing someone a small task or helping to better someone's performance of different skills. (Nurse, Uganda)

In the final case cited here a business studies student became involved in teaching large groups of students in Ugandan schools about hand hygiene:

> I'll be more confidence in public speaking I won't be so shy now and I will feel more comfortable approaching complete strangers as this was challenging from the beginning but then it started to feel more normal. (Business, Uganda)

Student responses to the EEP survey were more varied regarding the impact that their placement had on their teaching and presentational skills. Fifty four percent believed their placement had a strong or very strong impact, 32% believed their placement had a moderate impact and 21% believed their placement had little or no impact. The reason for this variation is likely to be that not all students had the opportunity of engaging in university teaching or conducting presentations. The post-placement qualitative interviews however suggested students that did engage in these activities believed them to be highly beneficial to their learning.

The final section here concerns learning associated with leadership. 'Service improvement' is one of the areas identified in the NHS Knowledge and Skills framework. Service improvement is broader than

leadership and may imply personal skills and values as well as influencing those of others.

Service Improvement and Leadership Skills

As indicated above, Williams and Balatz (2008) identify management 'know-how' as a form of knowledge and management and leadership skills formed perhaps the most important element of learning amongst professional volunteers (Ackers et al. 2017). It is perhaps unsurprising that fewer students referred explicitly to management skills as something they had acquired or developed while on placement. This could reflect the early stage they were at in terms of their career, although some students were able to think ahead to how such skills could be deployed in the future. In the first example the nursing student felt empowered by her teaching role in Uganda reporting gains in confidence and communication:

> Some of the health professionals over there wanted to learn from us. A lot of it was about delegation and was teaching there, and it's quite useful coming back to the UK because it's made me a lot more confident really. Better communication, able to do management really of a ward which is what I was expecting. (Nurse, Uganda)

In the next case the nursing student suggests that the placement increased his ability to exercise autonomy:

> I think leadership and management is quite a big thing in nursing, and being able to manage myself in Uganda has helped massively. I went out there with an open mind. It's made me realise how lucky we are over here, and how well people can do with limited resources. . . . You are supposed to work with autonomy in nursing, and I can do that more now. (Nurse, Uganda)

Whilst relatively few students singled out management as one of the key learning outcomes, we would argue that management or leadership are composite qualities which depend heavily on other core skills embracing all of the skills discussed above. Survey responses for leadership and teamwork were very positive, with 73% of students believing their placement had a strong or very strong impact, 19% a moderate impact and 8% little impact. Responses regarding 'management skills' were weaker but still

relatively positive with 59% stating a strong or very strong impact, 23% stating moderate impact and 18% stating little or no impact.

Personal Growth

We started this chapter with a series of quotes from students indicating the transformational quality of learning on their placements. In this final section, we return to this but in the context of what can best be described as personal growth. In many cases this was not all about new learning but about increased self-awareness and confidence at having been put to the test, immersed in an environment completely outside their previous experience and comfort zone. The EEP survey revealed that 48% of students believed their placement had a strong or very strong impact on their personal commitment and motivation, 12% stated a moderate impact and only 5% stated little or no impact. The following comment is quite typical and shows the effect of the placement in terms of what we have called 'mobility capital' increasing enthusiasm for and confidence in future mobility:

> This trip was extremely relevant to my degree. It has not only benefitted me as a mental health nurse but raised my confidence as an individual. It has inspired me to challenge myself in working outside the UK later in life. (Nurse, Uganda)

Many students spoke proactively of the impact of the placements on their future plans and were actively considering future stays in low resource settings:

> Personally, I had an absolutely brilliant time. Being a part of this Ugandan placement has only strengthened my desire to continue studies and aid research/projects that can help communities. (Prosthetics & Orthotics, Uganda)

> It is an experience that will remain with me for the rest of my life and it has confirmed my desire to go back to Africa to work in similar conditions. (Nurse, Uganda)

We referred in Chapter 1 to the fact that most if not all of the students who travelled to Uganda and India with the benefit of bursaries would not, otherwise, have had access to this kind of opportunity either for purely financial reasons or because they lacked the confidence to try to

access placements. This was evident in the way many students talked about the experience of living in a foreign country with other students and away from their families for the first time:

> It's made me a different person in a sense of, because it was my first time away on my own without my family it's made me more independent, it's made me appreciate life more. (Nurse, India)

> It made you stronger as a person. It got quite emotional at times and I think being away from home as well, I've been away from home before but not for a month in a country that's completely different. Also being away from parents and family and having to make relationships with people you don't know, well you have met everyone once before but you were in that environment for 4 weeks and you kind of had to just get on. (Nurse, India)

Many students spoke of the personal journeys they had faced associated not solely with clinical exposures but with living amongst other students and outside of their comfort zones:

> It was totally different, it was like out of your comfort zone . . . I was like doing things I wouldn't normally do. Like even living with a load of people that you didn't know, you've never lived with before . . . I didn't think I'd cope well but I coped a lot better than I thought I would. (Nurse, Uganda)

> Well I've learned I'm even more emotional than what I think I've got, but then at the same time I'm a lot stronger than I thought I was. (Nurse, Uganda)

> My life has changed quite a lot since I've been back such as I am moving out because I feel more independent and I came back thinking maybe I should be doing more things such as going for more job opportunities and making the most of things. (Social Worker, Uganda)

> It was the worst and best thing I've ever done in my life that's all I can say. Worst in terms of it was hard, especially for me I'm just not used to that . . . but the best in terms of learning about culture, health care in a different world and about myself. (Nurse, India)

> It has just made me more confident, and I now know I'd be able to go elsewhere confidently . . . Definitely, it has helped with my confidence. I had an interview when I got back which I got and there were only two places so I was very pleased to get it . . . I think going to Uganda made me more confident because you get thrown into different situations I have to get on with it. (Social Worker, Uganda)

> I have learnt that I am a very strong person, I can do anything I put my mind to and it has also given me a lot more confidence as a student nurse, that I can carry forward to when I am qualified. (Nurse, Uganda)

> Even just outside the placements spending a bit of time in a different country increases your confidence . . . not sure how I'll translate it into practice but I learnt a lot about being in difficult situations and how to handle them (laughs) and a lot about emotional intelligence and how to deal with conflict and things like that and how to manage like stress as well. (Occupational Therapist, Uganda)

> When faced with the situations and experiences I did in Fort Portal, Uganda, I bloomed and I know for a fact that not only has it made me a better professional but that it has changed my life forever and will ultimately impact on my career and future planning of it. If I had the chance to go back and do it all over again I wouldn't change a thing. (Nurse, Uganda)

Employability

Although a number of students expressed concern even at being asked about the impact of their placement on their future employability, perhaps sensing that this was unethical and sounded 'selfish' it was clear that students recognised the potential career-enhancing effects of the placement experience in terms of 'giving them the edge' or 'setting them apart'. Responses to the survey were overwhelmingly positive with 95% of students believing their placement was very beneficial for their future career and employability. This applied equally to students on observational placements. The following comments are typical:

> It will show that I've got a determination expand my horizons and gain further experiences and take on challenges. (Nurse, India)

> I never really thought 'this can go in my portfolio' and 'this can be good for jobs' but everyone's telling me, even on my last (UK) placement, 'that'll be really good for interviews and jobs'. (Physiotherapist, Uganda.

> I think It puts me in a very strong position because in university they say all the time when it comes to job applications; have you done something that would make you stand out from the crowd . . . that automatically gives you a win in the interviews – you've got a really positive experience you can talk about all day – that makes you much more employable. (Nurse, Uganda)

> It will give an edge. Not a lot of nurses do it so to do it as a student shows you can manage in a different setting. You can manage in scarce resources. You can work on your own, know your limits, you're resourceful. There's loads of indications to an employer that you can work under stressful situations with new encounters and work through it in a logical way to get the most out of it for your patient. So just by saying that you've done this to an employer shows you have all these qualities and shows that you will go that extra mile to go and make a difference and improve patient care. (Nurse, Uganda)

Summary

This chapter has summarised the findings of the survey and qualitative interviews to demonstrate the impact that educational placements have on student learning. The results show that the learning outcomes are profound and directly relevant to undergraduate curricular and NHS objectives. There was an overwhelming belief that the placements contributed to their future skills and employability. Unsurprisingly clinical skills learning was much more pronounced amongst students undertaking the EEP placement and experiencing hands-on clinical work under the direct supervision by Professional Volunteers and Ugandan health workers.

CHAPTER 4

Ethical Placements? Under What Conditions Can Educational Placements Support Sustainable Development?

Introduction

Understanding the impact of human mobility on various forms of knowledge transfer and economic development has formed the subject of recent debate. Our sister book (Ackers and Ackers-Johnson 2016) is devoted to a wider discussion of the impact of the deployment of professional (i.e. qualified) volunteers on the Ugandan public health system. If there is a dearth of research on this topic and some scepticism about the impact of very highly skilled professionals undertaking extended stays in low resource settings, then it is fair to say that our understanding of the impact of short stay undergraduate electives is more or less non-existent. The literature on volunteer-tourism or 'voluntourism' has begun to raise uncomfortable questions but mainly within the frame of 'gap year' sojourns (Simpson 2004; Snee 2013). As we have noted, to the extent that there is any published research on electives it is almost exclusively focused on medical students (Coates 2006; Drain et al. 2007; Rominski et al. 2015). Some of this literature, whilst primarily focused on the (clinical) gains to the students themselves and the risks of what are quite often self-organised individual ventures, has hinted at the potential burden placed upon host locations (BMA 2009; Rominksi et al. 2015). As with all forms of 'volunteering' there is a presumption of benevolence, of altruism and inherent good or at least neutrality; of 'no harm'. But peppered within this fluffy

A. Ahmed et al., *The Ethics of Educational Healthcare Placements in Low and Middle Income Countries*, DOI 10.1007/978-3-319-48363-4_4

celebratory glow is a thorny question: in a context when the UK is itself struggling to place, train and fund its own, why should we expect low resource settings to take responsibility for training its future health workforce?

Our role in the deployment of long-term volunteers has made us very aware of the need for careful recruitment and deployment within structured, supported and managed programmes if we are to avoid becoming part of the problem and undermining health systems. Indeed, this is an unfolding story of 'unintended consequences.' The EEP model builds on eight years' experience of managing volunteers in the context of the Ugandan *public* health system. Unlike other elective placement schemes run by private companies keen to profit from the burgeoning demand for international placements, the EEP model grew out of our Sustainable Volunteering Programme and is firmly situated within an active and evidence-based partnership-based engagement. The ethics and sustainability of our engagement has formed a key component of project design and evaluation.

Building on our previous (exploratory) experience of deploying medical students alongside professional volunteers we anticipated two key dimensions of (positive and sustainable) impact. In the first instance, we knew that professional volunteers working for long periods in highly stressful circumstances and often with reluctant learners and absent colleagues were often 'refreshed' and re-energised when UK students arrived. Secondly, having witnessed some very bad practice involving payments for supervision by small poorly organised income-generating electives programmes, we were aware of the pitfalls of cash inducements to local supervisors/mentors. These payments typically failed to guarantee any supervision on the ground and contributed to systemic corruption. On the other hand, we witnessed the important contribution even quite small strategic investments could make to removing simple 'snags' that debilitate local health systems. Mdee and Emmott (2008) define the 'tension between operating a viable and commercially-sustainable enterprise and maximising social and development impacts' in the context of what they call 'pro poor tourism' (p. 191). Whilst we would distinguish undergraduate electives from gap year tourism the tension remains and lies at the heart of the EEP mission. The authors advocate the extension of a certification process based on Fair Trade Principles to kitemark organisations involved in volunteer deployment. Informed by these principles, the EEP project sought to design a model that reduced the risks of contributing to global

inequality and corruption (through the commodification of placements) or systems dependency (on consumables provision for example) and enabled us to make systems enhancing investments.

Perhaps influenced by the somewhat negative experiences of 'free mover' medical electives[1] compounded by the voluntourism debates we had rather anticipated students aiding the knowledge brokering functions of professional volunteers and seriously underestimated the role that students themselves, when appropriately placed, can play in knowledge exchange processes. Our research has evidenced the important role that students can play in actively supporting mutual learning on-the-job in health facilities but also in conjunction with undergraduate teaching programmes. And, linked to this peer mentoring role, we have found that the student placements have had a significant motivational impact on health workers in the facilities they have been based in. Finally, as the project has developed we have sought to incentivise and invest in the skills and experiences of local health workers. This is not to suggest that Ugandan health workers lack the skills and experience to supervise UK students. But we are very aware of marked differences in role delineation, training and experience. With that in mind we have encouraged bi-lateral professional exchanges supporting Ugandan health workers to apply for fellowships to spend time in the UK. With the support of British Commonwealth Professional Fellowships, we have been able to bring a number of colleagues over from both the University and the Health District to experience British professional education and placement schemes and intensify the quality of relationships.

We have noted elsewhere the externality effects associated with 'gap-filling' and labour-substitution roles. Deploying volunteers in service delivery undermines local health systems (Ackers and Ackers-Johnson 2016). It is also associated with high levels of personal risk for volunteers. This is heightened in the case of students. As a result, all of our engagement is underpinned by the 'co-presence' principle reducing to a minimum the incidence of lone working. Our objectives are system-focused and we hope that such a focus will in the medium term improve the care of all patients and not just those whose lives we personally touch. Having said that we are acutely aware that very many patients have benefited on a daily basis from their encounters with

[1] Opengart uses the concept of 'free agent learners' in the context of boundaryless careers. In the past many medical students negotiated their own placements as individual 'pioneers'.

our students. Patients comment regularly on the care and compassion shown to them by British professionals and students and we are in absolutely no doubt that our students have saved the lives of mothers and babies and improved the quality of lives for many others.

Students were invited, in the survey, to comment on the impact they believed their placement had on the individuals, facilities, organisations and health system in the country within which they were placed. This is obviously a very broad and subjective question, and the students' responses may not be indicative of their actual impact. However, responses were very positive. Fifty-four percent of students believed they had a very positive impact, 34% a slightly positive impact and 9% no impact. Three percent of students were unsure, however no students believed their placement had a negative impact. The responses for students travelling to Uganda were generally more positive than those travelling to India, which is likely to be related to the fact that the India placement were observational only whereas the Uganda placements allowed for supervised hands-on practice as mentioned previously. Additionally, the health facilities and staffing in India were more advanced than those in Uganda which left more scope for students to try to make improvements in the Ugandan health facilities.

The remainder of this chapter assesses the ethics of placing students in Uganda because, as we have explained, the placements in India were organised on a very different basis. We had no prior engagement in India and the placements were organised by other parties in a private, not-for-profit health facility. The entire programme was managed by the Indian organisation which charged a fee for every student of £850.[2] It was clear from the start that these were observation only placements and students were prohibited from any involvement with patients or wards and they included a two-week non-clinical cultural exposure designed specifically for these and many other foreign students. The India placements did not set out to support local capacity-building or systems change and took place largely outside the Indian public health system. As such we do not regard these as falling within the model of 'Ethical Educational Placements'.

Chapter 2 emphasised the importance of systems change and capacity-building to all of our work in Uganda. This implies a focus on *public*

[2] This is usual practice with companies active in the electives market. What distinguishes this placement, however, is that there was no intermediary organisation in the UK taking a slice of the profits.

health systems and we have questioned the ethics and sustainability of investing in parallel service development in the private and not-for-profit sectors.[3] In this context, the chapter examines first the 'knowledge premium' associated with placements asking whether students play a role in the transfer and exchange of useful knowledge and skills. It then moves on to discuss the role that the EEPs have played in creating new opportunities for the kinds of active knowledge mobilisation necessary to bring about sustainable systems change.

Supporting Professional Volunteer Engagement and Efficacy

Our decision to embark on the development of an ethical placements programme stemmed directly from our role in managing and evaluating the Sustainable Volunteering Program (SVP). The SVP deployed long-term highly skilled professional volunteers within the frame of the Ugandan Maternal and Newborn Hub to promote sustainable improvements in public health systems (as outlined in Chapter 2 and in Ackers and Ackers-Johnson 2016). Understanding the contribution that even these qualified volunteers can make towards sustainable system change has proved a real challenge. What we have learnt, over a period of many years, is that volunteer deployment and management is critical to mitigation of potential systems damage. Linked to this we have observed the mutual benefits of using long-term volunteers as anchors for short stays (Ackers 2015); short stays in the absence of continued project and personnel presence on the ground are rarely successful and can lapse into damaging forms of service delivery.[4] On the other hand, when there is continuity of clearly defined projects with on-going bridging relationships, short-term stays can be highly beneficial both in terms of harnessing critical skills and motivational impacts. And, having long term volunteers on the ground preparing for and creating the 'sticky branches' (Meyer 2003) that lubricate short stays enables short stay professionals to hit the

[3] Case Study 5 outlines work undertaken by a placement group focused on the development of a Public-Private-Partnership as outlined in the Ugandan Ministry of Health's Strategic Plan, 2012.

[4] It is continued presence over time rather than the length of individual stays that is of importance here.

ground running' and become effective knowledge brokers almost immediately. In this case, short stayers are most commonly very senior professionals unable to commit to longer periods away from work. However, we observed similar effects with short-stay medical electives; the Professional Volunteers were often excited to have students join them to support their own plans for audits or specific interventions. Motivation over the course of long-term placements often wanes in the face of on-going challenges (Gedde et al. 2011). At times, local health workers appear disinterested in training and long-term volunteers gain motivation from having knowledge-hungry UK students on the wards as the following volunteer suggests:

> They (group of nursing students) have been some of the best students I've ever supervised. They were always on time, keen to learn and got straight on with whatever needed to be done that day . . . It removes some of the stress having more people around to help out. (PV, Uganda)

The SVP came to an abrupt end, as with many development interventions, when our knowledge of how to mobilise and optimally place volunteers was at its peak. This is an on-going problem with Aid with many projects; jumping between funded programmes and defining themselves according to the demands of funders rather than the evidence-base and longer term strategic but iterative objectives. We realised that if we were able to mobilise an effective placement programme and generate an overhead that could fund the placement of long-term volunteers, we could achieve the kind of symbiotic sustainability capable of achieving incremental evidence-based systems impact.

Chapter 3 has discussed the benefits of long term volunteers to student support and learning. Our concern in this chapter is to explain how the model as a whole underwrites the deployment of long-term volunteers (as an outcome for host institutions and systems). It could be argued that investing in mobile expertise from the UK (in the form of professional volunteers) is in itself an example of neo-colonialism. Why not utilise local expertise to fulfil the supervisory role? Sadly, our experience of managing PVs in Uganda has exposed the fundamental weaknesses of human resource management systems in the Ugandan public health system. Elsewhere, we have argued that the failure to implement effective human resource management processes to counter endemic absenteeism and poor time-keeping lies at the heart of maternal morbidity and mortality (Ackers et al. 2016). Absenteeism is a major problem in Uganda and many staff either fail to come to work at all or,

when they do, tend to show very poor attitudes towards time-keeping. This problem is common to many low resource settings where systems of accountability are not in place and creates a specific challenge for the organisation of undergraduate placements. This is one of the key reasons why professional volunteers are so important to minimise the risks associated with lone working and ensure effective supervision in often extremely stressful circumstances. Asked whether the impact of the EEP would be the same without the presence of professional volunteers, a lecturer at Mountains of the Moon University replied:

> If you don't they (the UK students) won't get supervised – it would be dangerous to do that.

In a far more complex process, the deployment of professional volunteers in turn supports the development of training clusters that have a centrifugal effect in drawing in local health workers and students. Put more metaphorically; the professional volunteers can be characterised as the eyes of creative (and disruptive) knowledge mobilisation storms. But building and sustaining clusters is labour intensive. It requires organisation, planning, active bi-lateral communication and on-the-ground co-presence. These clusters and the benefits accruing from them cannot be achieved by simply posting large volumes of students in low resource settings and paying a cash premium. The following respondent (a member of staff at the local university) responds to the question, 'Could we have MMU and our students working alongside on placement?'

> Yes, that would be great so long as we don't have too many there at once – it depends a bit on the timing and numbers. It would be good if we communicated a bit better and tried to line it up a bit more.

As we have noted above, during the SVP it was rare to see anything other than medical students on electives. The opportunity to deploy much wider cadres of students has contributed significantly to this process creating opportunities for multi-disciplinary exchanges supporting the work of professional volunteers in a more holistic way. An example of this can be seen in the deployment of child nursing students into the neonatal units linked to maternal facilities. This has provided critical support to our obstetric and midwifery volunteers attempting to care for mothers and babies from pregnancy until they are able to go home. It provided

opportunities for students to 'spoke out' to witness birthing processes and immediate neonatal care, and then follow this through to the neonatal unit. In effect, it enables the volunteers to be in two places at once but always at hand if the students need support. In the process the UK nurses are able to work alongside, and share their skills and experience with, local staff and students. In a similar vein, students have been able to be actively involved in ante-natal or baby clinics, in laboratory-based testing of patients or in record keeping and management, all of which support the complex interventions of long-term volunteers. It is clear from our research that undergraduate students play an active role in augmenting the knowledge brokerage function of long-term volunteers.

Students as Knowledge Brokers

Having conceptualised UK professional volunteers as knowledge brokers (Ackers and Ackers-Johnson 2016) we are nevertheless aware of some tension between the needs and ability to exercise long-term mobility on the part of UK professionals, on the one hand, and the expressed needs of host institutions for the most senior clinicians. Our experience of the volunteers has challenged received wisdom on the part of UK professional bodies (such as the Royal Colleges), volunteer deployment agencies (such as VSO) and Ugandan hosts that only very senior clinicians are suitable and able to make a serious contribution. Indeed, some of the most effective volunteers have been more junior doctors willing to engage in some of the more mundane back-to-basics systems repair work. We were not expecting students, caricatured in roles as learners (inert sponges) rather than 'teachers' to assume the role of knowledge brokers. Our research indicates quite the opposite; that the students we have selected, in the positions we have placed them and with the support in place, have played very active and meaningful knowledge brokerage roles. Many interventions (such as triage, infection control or medical records audit for example) benefit from having more human resource to assist. The emphasis on 'back-to-basics' or 'neglected processes'[5] in global health lends itself well to less experienced cadres especially when they are carefully

[5] The concept of 'neglected processes' was utilised within the frame of the Ugandan Maternal and Newborn Hub interventions at the suggestion of Dr Simon Mardel.

supervised and managed. Mardel, a leading expert of ebola-preparedness work, describes the key global health challenges as follows:

> The greatest currently achievable gains in global healthcare appear dependent on solving the currently 'neglected' processes in organisation and delivery of health care and health education. These deficits, aimed at disease prevention, early diagnosis, self-care, low cost intervention, early recognition of severity, appropriate and safe use of existing resources are not sufficiently covered by existing specialties, or their redress requires unprecedented collaboration.[6]

We have reproduced Mardel's '7 pillars' in Fig. 4.1 to illustrate the potential contribution that undergraduate students can make to global health. Improving these basic processes such as patient monitoring, record keeping, IPC and access to information are precisely the areas where students have the knowledge and skills to engage effectively with local health workers and health systems in critical public and preventive health roles. This explains why, in many respects, we believe that knowledge mobilisation clusters combining undergraduate students with UK midwifery, nursing and AHP volunteers (and their Ugandan peers) deliver optimal impact.

One of the contexts within which this knowledge brokerage role has occurred most proactively has been through their engagement with Ugandan students. We had anticipated and planned to 'buddy' the students with our partner University (Mountains of the Moon) and this has created opportunities for more formal mutual learning encounters; similar to the buddy system employed in India. Many of the students have taken advantage of this opportunity and planned joint workshops and seminars with their student peers at MMU and Makerere University. One of the local supervisors made the following comment on peer learning showing its motivational impact on them as trainers and the students involved:

> It was a great opportunity to sit together and analyse; 'what do you study that we don't study and what do we study that you don't study' so it was a great opportunity for all the students. And to us, the trainers, it was very interesting to know how students from the UK think and how they look at things because that guides us on what we can also tell our students. You

[6] Cited at http://www.nhsevents.org/img/events/213/Dr%20Simon%20Mardell.pdf

Fig. 4.1 The seven pillars of neglect in global health. *Source*: Acknowledgement to come

> know we are always limited with some few things and sometimes we pick-up the perception of maybe we cannot get this far but with the interaction we had with them we realised that yes if we pick up that kind of thinking and try to initiate it into our students then we'll have the best out of this program.

This programme is continuing to evolve and we are currently hosting this respondent in the UK on a 5-month Commonwealth Professional Fellowship focused on prosthetics and robotics. The Fellowship is designed to build relationships for future undergraduate placements but

also to support capacity-building in Uganda in the development of prosthetics. This in turn represents an immediate response to a very tragic case of domestic violence (Case Study 1):

Case Study 1: Holistic Responses to Domestic Violence

In June 2016, a young mother from a very isolated rural area was brutally attacked by her partner who hacked off both of her hands and caused serious injury to her face including the loss of an ear and an eye. Ninsiima is a peasant farmer with two small children and was thirty-six weeks pregnant at the time of the attack. She was cared for, from an obstetric perspective, by a K4C professional volunteer and gave birth safely. Students on the EEP placements then supported her to care for her baby in the newly set up neo-natal unit prior to her return home. At this point a group of young pioneering engineers that had been trained by the University of Salford/K4C biomedical engineering project[7] under the leadership of Dr Ssekitoleko responded to the situation. One of these engineers (Mr Senabulya) became involved in assessing the possibility of building prosthetic hands for Ninsiima. This lead to a successful application for funding to the British Commonwealth Fellowship programme, enabling Mr Senabulya to come to Salford University for five months to work with colleagues in robotics and prosthetics. The objective of this fellowship is to build capacity in Uganda in the production of prosthetics for low resource settings, assess the possibility of building two hands for Ninsiima whilst also working alongside the UK placement team to build on our successful prosthetics and orthotics placements. One of the EEP students placed in this environment explains her experience:

> The first two weeks were based in the largest referral hospital in Uganda. We were looking at things like fractures, spinal injuries and club foot. We were helping out as much as we could and seeing patients on a daily basis and looking at the challenges they faced and trying to sort out solutions to make it easier for them by reducing the cost of things and the kind of materials they needed because the lack of resources was one of the main problems over there. The second two weeks we were with the students from the orthopaedic medical school, essentially it is just the same course as we are doing. They

[7] This project is funded by the Tropical Health and Education Trust. For details see http://www.salford.ac.uk/research/care/research-groups/knowledge-and-place

were doing prosthetics, dealing with wheelchairs and crutches. We were seeing what we could learn from them and teach them what we have learned here. (Prosthetics & Orthotics, Uganda)

EEP students have also provided considerable support to our PVs involved in the assessment of the MMU midwifery degree students in OSCI-type clinical scenarios.[8] All of the people involved in these have found them immensely valuable. One of the MMU lecturers expresses her views about the students' contribution:

Interviewer: "Do you feel the students make an active contribution to Uganda – do they have skills to give or are they too junior?"

MMU Lecturer: "I have met a few groups who have done some teaching with our students then on Saturday [the volunteer] had them come and help with a mock OSCI with the MMU students and I observed that. It's also helpful to our students in lectures – they see a student with a different capacity – with more knowledge and skills.

Interviewer: "So you feel the UK students have more knowledge and skills than MMU students?"

MMU Lecturer: "Probably like with the clinical examinations [the volunteer] is using the UK students for the actual exam; they can read an exam question and act appropriately; they know the practical side. The MMU students don't. Observing the UK students on the wards in comparison to other nursing schools in Fort Portal who send students with zero clinical skills; your students are teaching these Ugandan students on the wards. Our MMU midwives are pretty experienced but many of the other students in Fort Portal are not. The [EEP students'] clinical practice is different and at a higher standard than here so they are model clinicians in a student role. [LTV] has commented that she really thinks they add a lot to the general student population who come to the hospital for clinical placements. And with the SVP volunteers mentoring your students there is a wealth of knowledge – a real cluster which is of real benefit to the local students.

[8] An 'objective structured clinical examination' (OSCE) is a modern type of 'hands-on' examination often used in health sciences designed to test clinical skill performance and competence. (https://en.wikipedia.org/wiki/Objective_structured_clinical_examination)

EEP students have also been actively engaged in CPD-style training in health facilities and the community. Nursing and paramedic EEP students developed bespoke first aid training programmes for cadres of staff who have never had the opportunity for training; most notably these included all the local ambulance drivers and a group of potential paramedics. Wherever possible, we support opportunities for training interventions involving the students. As a project, we have a firm policy on cash per diems (we never pay them) and we endeavour to hold the training as close as possible and where we can within the clinical environment to reduce time out of work (see Ackers and Ackers-Johnson 2016). What we had perhaps underestimated was the very important knowledge brokerage role that EEP students played in relation to other (Ugandan) students and health workers. Here the benefits were mutual with active exchanges of skills and experience taking place. In the case of many Ugandan students,[9] the more advanced knowledge/experience of the UK students (most of whom are at the end of their second year and/or mature students) meant that the UK students filled the roles of the usually absent local supervisors.

We noted above the involvement of UK students in paramedic training to ambulance drivers and nurses. At first we had some anxiety about placing students from Allied Health Professions that do not (yet) exist in Ugandan public services. These concerned, in particular, paramedics and podiatrists. It proved difficult to explain to many Ugandan health workers what a podiatrist was. However, we were able to place them in a club foot and diabetic clinic in a local hospital and this precipitated a strong demand for more such students on the part of the hospital and the expression of interest in further developing work on diabetic foot ulcers (a speciality of some of the Salford tutors). Similarly, discussions with the District Health Officer about the placement of paramedics raised the possibility of working towards a policy of requiring a local health worker to accompany patients on ambulance journeys alongside the drivers (who currently travel

[9] We are referring here to the large numbers of new entrants into certificate and diploma level nursing studying at colleges in Fort Portal and not to the Diploma qualified experienced midwives on the MMU degree.

unaccompanied). How far ideas such as they progress remains to be seen; what we can say with some certainty is that the placement of students and exposure to the diverse professions has had an impact in terms of policy transfer. As a project, we make careful decisions about whether and how to invest in these project ideas that arise during placements in a very cautious and iterative fashion.

In the next case the manager of one of our partner organisations, an experienced British physiotherapist, explains how she felt the students contributed to her own reflective practice and to the mentoring of Ugandan staff within the organisation:

> It was really good for us to learn from them because they kept on asking why we do things – it makes you as a clinician think about what you are doing more. Instead of just doing what I do I have to explain it and think about it. It's what Ugandan students don't do. They're anxious about questioning. Our physios here enjoy learning from the UK students. They bring the latest research; local staff don't have the same level of education.

The point about local staff reflects in many ways the nascence of some of these allied health professions in low resource settings such as Uganda. It is not a comment about the innate abilities of local staff or students but the fact that most of them will be qualified at certificate or diploma level. In comparison, many of the UK physiotherapy students already held a first degree. The respondent (above) goes on to make a point about length of stay in the placement setting suggesting that from the perspective of her investment and the benefits of the local organisation students are best placed in one location for most of the time:

> We try to do a lot of teaching and set objectives for each student. Throughout their first week we looked at their strengths and weaknesses, and say ok let's work on your weaknesses while you are here! So, it's very individualised and that's what we can do when somebody is here for 3 weeks, but not when somebody is only here for 2 days. And also, you don't want to put so much time and effort in, I just don't have the same interest because in 2 days they're not going to learn that much from me, as opposed to three weeks, they have a huge amount of things they can learn, we can sit down and do teaching sessions and discuss cases. But

> I'm not going to do that with somebody who's only here for 2 days, because it's a lot of time and effort on my part and they don't get the same out of it. It's not fair on the parents, that you constantly have a new person working on their child.

Another Ugandan supervisor makes a similar comment suggesting he would prefer stays of two months:

Interviewer:	*"Are students too junior (not skilled enough) to be of use to Uganda – are they more of a burden than a benefit?*
Ugandan Supervisor:	*"No, I wouldn't call it a burden because learning is both sides; some things we learn from them so it is experience sharing. It isn't a burden the only challenge is the time they spend – if it is not too much time then the orientation ends when their period here is ending. In one month they get used to everything and then the second month they could perform but we do benefit".*

This is an interesting issue which reflects some creative tension between the wishes of students, in some cases, to experience a breadth of settings and exposures. The EEP placement team have tried to balance these needs and explain to the students the risks of volunteer tourism and voyeurism and the importance to their learning and impacts of relationship-building. Rominksi et al refer to this as a necessary process of 'expectation management' (2015: 3). On the other hand, some students found their placements extremely demanding. This very much depended on the context rather than the student in question. Placements on a very busy neonatal unit whilst very interesting and rewarding (and the envy of many EEP students) are exhausting. In this situation one of the students felt that a day a week in another setting was helpful:

> It was nice to have one day a week to do something that gave relief and fun. Something through which you could understand the community a bit more. Like the health clinic, that was good. (Midwife, Uganda)

The compromise we have developed is to give students a flexible half day on a Friday to enable them to negotiate visits to other settings whilst

keeping them firmly anchored in their primary location. This process in itself forms a critical part of student learning about global health.

The 'Fair Trade Premium': Local Investment Without Fostering Corruption

One of the most obvious ways to compensate or reimburse hosts in low resource settings for the work they do in supervising and mentoring UK students is via direct cash payments and, arguably, this is the mechanism that extends optimal autonomy to partners in the host setting enabling them to identify their own investment objectives. Many for-profit placement providers make cash payments directly into organisations (hospitals) as is the case in the Makerere/Mulago International Electives Programme or, often more informally, to local in-charges or senior health staff on the wards. In our experience neither of these approaches avoids the pitfalls associated with endemic corruption especially in the public sector or puts systems in place to guarantee supervision. Student placements become commodified and students are treated as 'cash cows' creating opportunities for personal gain. [10]

We have witnessed the 'institutional' approach in the National Referral Hospital where student placements have become an element of income generation, resulting not so much in a lack of supervision (in this incidence) but more in a kind of 'herding' of large volumes of students through wards in an almost voyeuristic enterprise. This process creates a serious burden for overwhelmed local staff and ward managers working in very congested facilities with few staff. One manager of a large maternity facility in Kampala told us that she felt that most of her time was spent supervising students. She was quick to point out that many of these were bussed into the hospital from local nursing and midwifery schools in large and unpredictable numbers but this was compounded by groups of visiting students from overseas. In addition to distracting local staff this herding process compounds physical congestion and existing problems of patient privacy, confidentiality and infection prevention control.

During the SVP, we also identified cases where small UK charities have engaged in student recruitment to aid their fund raising and organised, in

[10] Placements in the UK are remunerated on an inter-institutional basis but systems are in place to ensure accountability and supervision.

good faith, at a distance cash payments to local clinical leaders. We have witnessed directly these payments being taken on a personal basis by senior (and mostly absent) managers with no funds trickling down to benefit the staff working on the ground. This creates tensions, jealousies and, most critically, results in lone working. We have discussed in some detail in our sister volume (Ackers and Ackers-Johnson 2016) issues around the commodification of training in Uganda and do not have space to rehearse these issues here. What is absolutely clear from all perspectives is that student placements have been recognised as a lucrative marketable commodity by both sending[11] and receiving organisations resulting in some quite unethical outcomes.

In order to avoid these risks whilst also recognising the importance of some compensatory function we have adopted a 'Fair Trade Premium' approach. The previous section has evidenced the complexity of multilateral knowledge exchange processes associated with EEPs. Transferring knowledge in itself will fail to precipitate systems change in Ugandan public health facilities as knowledge mobilisation requires that health workers not only have knowledge but are also motivated to use that knowledge and have access to a basic modicum, of resource to facilitate behaviour change.[12] In this context the 'Fair Trade Premium' is not simply compensatory; it represents a critical investment in knowledge mobilisation processes.

In practice this has involved setting aside £150 from each placement to support critical local investments that facilitate effective placements and systems improvement. The Premium takes the form of negotiated 'in-kind' investments: we never pay cash. Working with well-established local partners we identify 'snagging' problems that a small, immediate investment could overcome. Examples include the provision of a placenta pit in a facility where the lack of such a resource was the main factor preventing patient admissions. No amount of training or knowledge transfer could have got this maternity facility functioning if there was no way of disposing of placentas. We have also repaired or installed sinks as a precursor to hand hygiene training to support our infection

[11] It is certainly true to say that the clamouring gap year companies are making the biggest financial gains here not the hosting organisations.

[12] These relationships are discussed in more detail in Ackers and Ackers-Johnson (2016) (Chapter 4).

prevention control interventions whilst also reducing risks for students. In other cases, we have constructed patient waiting areas to enable patients to wait under cover for out-patient treatment rather than congesting corridors. This also then created a visible space for students to set up a triage area and 'role model' the taking of basic observations and basic record-keeping. We have also undertaken some improvements to accommodation to enable doctors to remain on site during their duties; there was a property but it had fallen into some disrepair and needed some basic re-wiring and plumbing to connect water and power. Our intervention here was aimed at improving the medical presence to ensure 24/7 cover as audit work had shown that the lack of medical presence was responsible for high levels of inappropriate referrals (and maternal and neonatal deaths). We also know that having doctors on site at all times created a better learning environment for our students. Other 'investments' included support to the university to provide transport for their own students (an on-going problem in Uganda) which would also in theory benefit the placement students and urgent repairs to an ambulance. We had some reservations about this last investment as we do not wish to get involved in covering any routine running costs or consumables. However, at the time none of the five ambulances were on the road and we wanted to utilise the opportunity of having three UK paramedic students to encourage the development of basic first-aid training to ambulance drivers and, more symbolically, to push policy makers to begin to consider the possibility of paramedic support to ambulance drivers. In practice, we were right to have such reservations as the ambulance was out of service again a month later. We have also purchased books for the university library and supported the costs of a mobile HIV/cancer screening/family planning clinic.[13]

The following section discusses these 'investments' in more detail to illustrate their knowledge mobilisation function. The following Ugandan ward manager describes her appreciation of the investments the EEP has made in the Regional Referral Hospital (RRH), the facility in which she was based:

[13] See Case Study 4 below.

Interviewer: *"Do you think your practice has changed in any way as a result of the students being here?"*

Ward Manager (RRH): *"Maybe hand hygiene, when they gave us the hand washing gel. They gave us books; we can consult from those books. We have about four textbooks on occupational therapy and mental health; it is helping us as we didn't have any at all"*

This quote illustrates the value of these 'in-kind' contributions not as isolated donations but as part of active programs of intervention on the ground. The hand gel referred to by the respondent was manufactured as part of an on-going THET-funded project on Infection Prevention Control.[14]

Case Study 2: Reducing Maternal Mortality Through Infection Prevention Control

The ground work for this intervention commenced several years earlier as part of the SVP project in response to concerns about the lack of Ebola preparedness in Uganda. In the first instance, an SVP volunteer began local production of alcohol hand rub in a public facility in Kampala. This worked extremely well. However, when the project funding stopped, so did production of the gel despite very minimal production costs and apparent high-level stakeholder support.

K4C decided to repeat this process but with stronger sustainability elements built in including production of an accredited product (registered with the Uganda National Bureau of Standards) with potential for sales into the private sector (as a social enterprise). Having this on-going project in Kabarole provided exciting opportunities for student engagement in all aspects of the work. UK students working alongside local university (MMU) students have played an active role in all stages of this intervention including the Infrastructure Audit (a WHO instrument designed to assess the presence of sinks; running water, soap etc.); active hand hygiene training some of which was student-lead; the manufacture and marketing of the product and audit using a modified WHO Hand Hygiene Compliance Tool. This kind of managed intervention has quite a different impact to simply giving local staff bottles of hand gel.

[14] www.knowledge4change.org.uk/

One of the EEP students played a particularly important role in this project. He applied for a placement as a mature social work student. He had previously worked for over ten years in a pharmaceutical company (Apollo Scientific Research, Manchester)[15] and began to apply his skills and knowledge in this area many months prior to deployment raising funding for infrastructural investments and working with his previous employer to provide over 2000 plastic bottles to help the hand gel production process. Invited to reflect on his impact on the ground he replied:

> It is a case now of following it through because it is a long term project and I'm happy with that. I'm speaking to [local staff and UK Company] about it on a regular basis and I am happy to stay involved. Some things are worth putting energy into and this is one of them. I think seeds were sown with the hand gel.

Student placements have provided very valuable support to this intervention which has in return created a real-life experience of IPC interventions for the students. This student, who is now doing a doctorate at another university, is continuing to support the work in Uganda. His interview underlines the importance of project continuity to effective placements but also to local health systems. It also reminds us that many undergraduate students have extensive life experience and skills accrued prior to their current degree. Indeed, many of the EEP students had prior degrees and most of them have extensive work experience.

The Ugandan biomedical engineer who acted as the local supervisor of the prosthetic and orthotic EEP students commented on the value he and his University gained from the investments made in purchasing local materials for the EEP students to use in the manufacture of prosthetics for local patients. These also benefitted their Ugandan student peers and of course the patients they treated. At his request we also purchased a projector to help in the delivery of training during the placements and beyond:

> We really benefited a lot because the school of orthopaedic medicine got materials that it had not gotten before and the school of orthopaedic technology also got materials plus the projector that went to the school of orthopaedic medicine. These things they needed but they could not get

[15] Apollo Scientific Research are now underwriting the costs of providing bottles and labels for the gel.

> them from the administration because of the limited funds so when this project came in we told them we should make sure that the money should support the actual school that is involved. It's not going to the entire institution and that really so much benefited us.

This case illustrates the contribution that carefully managed investments can make in a much-grounded manner – which top-down Aid has so patently failed to achieve. They are small things that are of immediate benefit to the placement students themselves who in this case presented their work every week using the projector. There are very many cases in Uganda of students taking vocational courses who lack the raw materials to undertake practical work. We have witnessed this through our sister construction project (OBAAT)[16] where students lack access to protective clothing (including boots) basic equipment and raw materials such as cement or sand to enable them to actually practice building work.

Once the partners begin to recognise the value of these contributions and the fact that *no cash transfers will ever take place* the project began to settle. Indeed, we are rarely now asked for cash unless students are placed in the larger hospitals where there is an existing culture of such payments from local as well as international institutions. Interestingly, even when local colleges are charged a fee for placements we are not asked to follow suit. We believe that this reflects two things: firstly, that the UK students are often more highly trained and able to contribute more immediately than their Ugandan peers (or at least those cohorts who come straight from school). And, secondly, linked to that, the presence of the professional volunteers who in effect supervise/mentor their own staff plus the Ugandan students are in effect making their own non-pecuniary contribution. It is not so much that we are passing the responsibility for student supervision onto already hard pressed Ugandan staff: rather that, as a project, we are contributing to multi-disciplinary training and mentoring clusters.

Context is all important and in the environment within which the students are placed in Uganda we believe this is an effective, ethical and sustainable way of organising student placements. Notwithstanding the care taken to prevent the cash nexus fostering corruption and jealousy, we have had several experiences of Ugandan health workers trying to

[16] http://www.vmminternational.org/one-brick-at-a-time-obaat/

exhort cash from students. In one case a student (who incidentally came herself from Kenya and was black) was immediately pressurised to take bribes from patients as the doctor clearly did on a daily basis. He advised her that she would not survive long in Kenya if she did not engage in this practice (assuming she was going to be working in Kenya). In this case, despite talking to the doctor concerned, we decided to move the student to another location. In another and more common case, staff asked students to purchase drugs ostensibly to treat sick patients. We are aware that whilst this may be legitimate in some cases, this is also a mechanism to fund drugs for sale or for use in their private practices. On that basis, the project has adopted a firm stance on all donations urging students to report any such requests and resist the temptation to donate even small items, such as sweets and toys as this in itself distorts the objectives of the placements and the wider project and generates unintended consequences.

From 'Ninja Medicine' to 'Neglected Processes'

We talked above about the unintended consequences of service delivery and gap-filling. This is a major risk with professional volunteers and especially more senior cadres many of whom are attracted by the lure of 'ninja medicine'.[17] Interestingly it has been less of a challenge with students perhaps because the students themselves respect the fact that they are primarily there to learn and more acutely aware of the risks of lone working. We have found this to be particularly the case with nursing, midwifery and allied health students who tend to show a higher level of humility, and perhaps a little less confidence (hubris) than medical students. The most pressing need in the Ugandan public health system is to attend to 'neglected processes' and get the basics right; if the basics could be improved we would be far less likely to see the kinds of emergencies that congest the main hospitals. EEP students played a very important role in supporting the back-to-basics orientation. In this capacity, they are supporting and working alongside local staff in critical role modelling

[17] This is a phrase used by a junior doctor in the SVP excited by the opportunities to save lives in emergency situations on a daily basis in the National Referral Hospital.

positions and, in the process, relieving the burden on them as the following Ugandan midwife explains:

> When a patient comes it is much quicker because everything is done on time when they are here. All the observations are done before we even touch the mother and the mothers do appreciate by the way. They come and tell us because they can't communicate with the students because of the language problem so they tell us. They say where did you get these doctors and nurses I wish you could keep bringing them because they are helping us a lot spending a lot of time on the mother so we wait less hours. Even in the late hours if we get a case they will come and help us. They ask questions when they don't understand because some of them are nurses and they also want to learn. For us here it is fantastic I may say.
>
> [Does it make more work for you?]
>
> No it is very easy it makes our work simpler. They were even very happy helping us with deliveries.

Involving students in preventive public health roles such as these can play a very important role in improving patient management, reducing congestion in overwhelmed referral hospitals and preventing damaging delays. Having said, that unless the students are placed in an environment of planned and active partnership founded on trust relationships these outcomes may not be realised. The respondent in the case above is a midwife in a health centre that we have been actively building links with for some years. Case Study 3 provides some background:

Case Study 3: Sustainable Capacity-Building at Kagote Health Centre, Kabarole District

The midwife in the case above is based at Kagote Health Centre III, a midwifery-led unit based in Kabarole District. The first project visit to Kagote Health Centre took place in May, 2014. At this time the facility had not delivered a mother for 16 years and the maternity unit was closed. In June 2014 K4C organised a visit involving four self-funded students. Working alongside an SVP midwife volunteer and the wider project team the facility was opened for business within a month. We have continued to support this location through the deployment of professional volunteers and it became the first 'training site' for undergraduate placements.

A combination of our Fair-Trade contributions, working in close partnership with OBAAT, resulted in the relocation of the laboratory, the construction of two patient waiting areas; the refurbishment and extension of the delivery and post-natal wards and the relocation and refurbishment of the Out Patients Department. We have also been awarded Commonwealth Professional Fellowships for three of the five midwives based in Kagote to undertake further midwifery training at Salford University. This Health Centre was recently pronounced by the District Health Officer to be a model for Kabarole District. We are now using this site as a training site placement for MMU midwifery students who are supervised by both the local midwives and the SVP volunteers. The benefits for patients of this intervention can be seen in the graph shown in Fig. 4.2 produced during an audit undertaken by a recent placement trainee (in this case a Graduate Trainee from the Central Manchester Foundation Trust):

The very positive experience referred to above, and echoed by all midwives we interviewed, was not always shared by other cadres and in other contexts where our engagement as a project was less well-established or supported by long-term volunteers. We noted above the problems of motivation in the Ugandan public health workforce. The impact of poor motivation and a local culture[18] of absenteeism extends beyond the student's own learning to seriously reduce the potential impact of their presence. An on-going problem we face in placing students in Ugandan public health facilities is that we can only rarely rely on local staff to be present with any predictability or reliability. We are using the word 'culture' here to refer not in an essentialist way to Ugandan ethnicities but

[18] We are using the word 'culture' here to refer not in an essentialist way to Ugandan ethnicities but rather to specific occupational sub-cultures within the public health sector. Corruption and absenteeism are a case in point. Interestingly we have found that absenteeism and poor time-keeping is less of a problem in midwifery in comparison to nursing, however, perhaps due to the fact that there is much greater pressure on midwives to be present on a 24/7 service. Many are not and many facilities operate a very limited week-day only service bit where this does take place mothers vote with their feet and either fail to access services at all or go directly to higher level referral facilities. On the whole midwives are far more likely to be present over the working day and to undertake night shifts than nursing staff working in Out Patient Departments who typically leave by 1 pm to engage in other forms of employment and supplement subsistence wages.

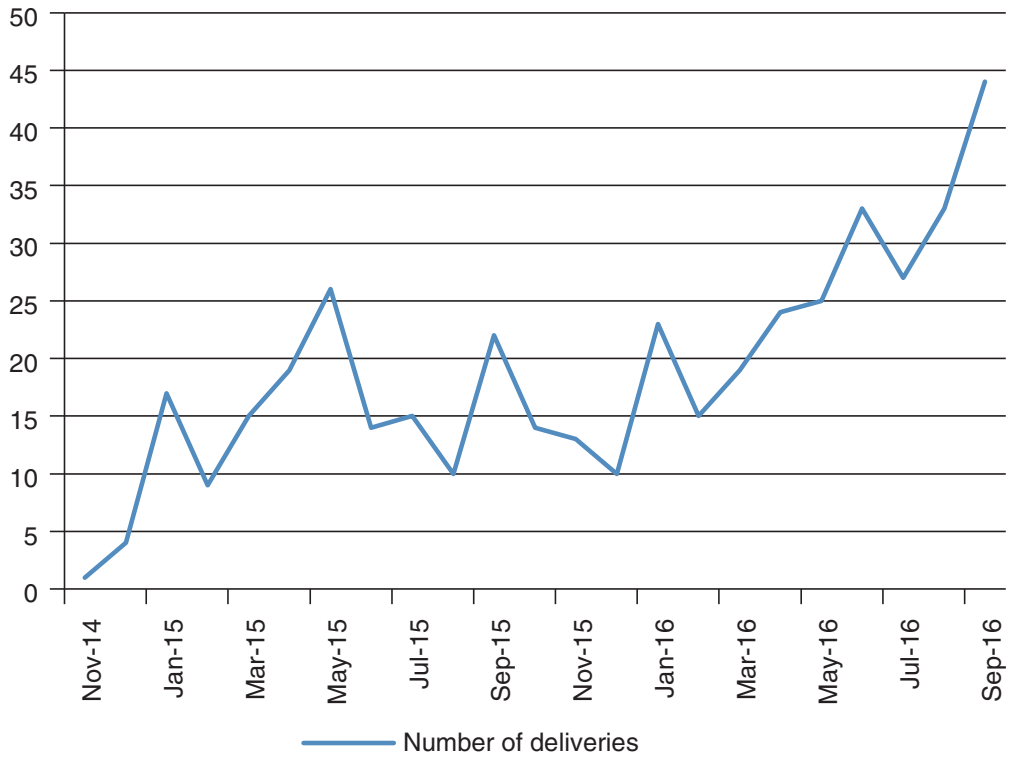

Fig. 4.2 Deliveries at Kagote health centre, Kabarole district. *Source*: Created by the authors based on data collected on site by an EEP Placement Trainee, working alongside local midwives

rather to specific occupational sub-cultures within the public health sector. Corruption and absenteeism are a case in point. Interestingly we have found that absenteeism and poor time-keeping is less of a problem in midwifery in comparison to nursing, however, perhaps due to the fact that there is much greater pressure on midwives to be present on a 24/7 service. Many are not and many facilities operate a very limited week-day only service bit where this does take place mothers vote with their feet and either fail to access services at all or go directly to higher level referral facilities. On the whole midwives are far more likely to be present over the working day and to undertake night shifts than nursing staff working in Out Patient Departments who typically leave by 1 pm to engage in other forms of employment and supplement subsistence wages.

At most health centres there is strong pressure on nursing staff to 'clear the lines' (of patients) before 1 pm. This encourages staff to rush and is a

major factor explaining the lack of effective patient monitoring and triage. In this environment, local staff may find having students around doing monitoring and triage effectively actually slows them down and this can generate some resentment to the presence of both students and professional volunteers. Patients are fully aware of this culture. As a result, many facilities (and potential placement locations) empty after 1 pm. This situation is reflected in the following responses:

> She only worked from 9 until 1 and then she'd go home. To begin with I would stay until one and then she sends me home. (Occupational Therapist, Uganda)
>
> I think they're just lazy because it always finishes by lunchtime: they can arrive late, see their patients quickly and then go home for lunch and then not turn up for the rest of the day. (Podiatrist, Uganda)

Where projects are actively engaged on the ground and where professional volunteers are in place this is much easier to predict and manage but nevertheless remains a major challenge for placement managers. An obvious response to this tension for placement managers is to place students in private and mission (not-for profit) facilities where occupational cultures (and human resource management) is quite different and supports a full working day and potentially more effective supervision. Our (ethical) commitment to health systems change could not support this approach and students would gain very little exposure to the challenges facing health systems in low resource settings if we took the easy option. Our commitment to co-presence further exacerbates this problem and the challenge of achieving active clinical engagement across the working day. If we allowed professional volunteers to engage in service delivery roles in the absence of local staff we could provide the supervision necessary to enable students to engage in clinical work. We have witnessed this type of situation on many occasions during visits to health centres. It is not at all unusual to see a quite junior overseas volunteer working with a small group of foreign students (often from different countries) on their own in a health facility. We would not regard this type of activity as either safe or ethically acceptable encouraging as it does systems damaging practices of absenteeism and moonlighting (Ackers et al. 2016).

The student in the following case explains how this situation affected his placement and the impacts associated with it. He experienced absenteeism in the hospital but also when the students had

agreed to organise First Aid training for local ambulance staff and MMU students. Fortunately, he reflected on this as part of his own learning:

> There was a lot of absenteeism from Ugandan staff – some days I'd be going to the operating theatres and you would be all ready to go but no staff there so theatre would be cancelled. This obviously affects your entire day. With the staff absenteeism, that could affect our time because we could have prepared way in advance to go to do something and people don't turn up and then it is cancelled so that can be frustrating. It appears that even if they didn't come to work, they would still get paid, and then they questioned why there was such an issue with attendance. It's more about the situation in Uganda as opposed to us, but I don't know how we could possibly get it changed as it is outside our control. It was just interesting to see. (Adult Nurse, Uganda)

In another case the student suggested that local staff tried to 'put them out of their way'; they also observed that when the UK obstetrician volunteer was around local staff took the opportunity not to come to work (something we try hard to prevent):

> I think they just wanted us out of the way, so they put us in a room triaging, but they didn't listen to anything we said. When [professional volunteer] came the doctors stopped turning up because she was there to do the work. (Adult Nurse, Uganda)

In another context, students noted that when the Project Managers were around staff behaved quite differently towards them:

> It was really laid back. Have you heard that if it's raining people don't go to work they just stay indoors? The impression that we got is that when yourself and [X] go over, it's like the CQC (Care Quality Commission) coming to the hospitals over here, so there were certain staff that weren't very friendly towards us, or motivated. But when [X] was here she was saying that they were absolutely lovely they did everything but we had seen a completely different side of that. (Nurse, Uganda)

As a project, we learnt that placing some cadres of students presented more challenges than others and mental health was a case in point. In the

first instance, we placed these students in the Mental Health Unit at the regional referral hospital aware that there was no community mental health in the Ugandan public system. This placement proved a serious challenge as the demands on language were much higher (most patients not speaking English and language being a much more important component of diagnosis and treatment). The Unit also managed the most serious cases with very few staff. This facility also completed its work around lunchtime each day and our interview with a local health worker expressed concerns at the lack of opportunity for active student engagement and the pressure this put on her:

> There are days here where I don't know what to do with these students when I am not busy and you have to make them busy so that was a very big challenge. (Health Worker, Uganda)

In this and other similar situations the potential for effective knowledge mobilisation and systems impact was limited. This did not imply that knowledge was being exchanged but the resource and cultural environment restricted its benefit:

Response: *"They shared knowledge especially when we asked them how they do it in their country. Comparing approaches and how they handle things".*

Interviewer: *"Do you think that knowledge could be applied here?"*

Response: *"Not really, maybe. What is practical we can't do here. Here the patient comes and what we normally do is say what we think is right for them; which is wrong. Here patients don't even know their rights, they don't know what they are supposed to expect. There (in the UK) they say the patient has to be told all their options and they make a choice and if they don't want it that is ok; maybe that is a difference I saw. Here it may not be very practical for us because our patients don't even know what they are suffering from when they come. They don't know where to get information from so if we leave them to decide they may not do it; that is a limitation. The doctor will decide which medicine to give them and they take it; we convince them to take it but they really don't know what they are taking and sometimes they don't know the side effects but the patient should surely know before taking a drug they should expect the side effects."*

(Nurse, Uganda)

As this was a new placement group and we did not have long-term volunteers in this field we monitored this carefully and subsequently placed mental-health students with a mental-health specialist who runs a local NGO. We have noted above our reasons for not placing students outside of the public-health system. In some situations, where services are barely in existence or professions not yet developed this was the only option and the NGOs involved were actively interfacing with local public health facilities. This is certainly the case with the Youth and Women Foundation (YAWE).

Case Study 4: The Youth and Women Foundation (YAWE) Mobile Clinic

For the reasons described above, K4C has partnered with the Youth and Women Foundation (YAWE).[19] YAWE focus on youth and gender empowerment with a particular emphasis on 'living positively' (with HIV). The Director of YAWE is a mental-health specialist. YAWE had been donated a mobile clinic to undertake community outreach work in rural villages and refugee camps. When we visited YAWE to discuss potential placements for mental-health nurses we found that the vehicle was not being used due to a lack of resource (fuel and manpower). We felt that the mobile clinic would offer unique opportunities for students and also critical complementary services in hard-to-reach areas. On that basis, we agreed to fund the costs of using the vehicle once or twice a month. During the outreach visits, local staff and the EEP students work alongside village health teams who mobilise the local community providing cervical screening, family planning, HIV diagnosis, care and treatment and diabetes screening alongside other public health services. The Director describes the value of these visits to his project and the local community:

> They do home visits – nursing care, malaria – wounds – those who need medication and also our mobile clinic they join the team when we go to the field – we provide fully fledged healthcare services including screening for HIV, diabetes because most people in the villages don't get the chance to get diagnoses because the equipment isn't there. The students from your program are very good – they do that – we provide them with strips – they

[19] www.yawefoundation.webs.com

> also check BPs and cervical cancer screening but most of them have learnt that here because they come when they are not so skilled but they participate. They participate in the actual procedures.

When the team go out one of the professional volunteers usually accompanies them. The outreach clinics have proved particular attractive to placement students. As project managers, we were concerned that placing mental-health students at YAWE may put a burden on local staff. Whilst the supervisor admitted that hosting the students does imply an investment on his part he said he enjoys this and recognises the wider reciprocity involved:

Interviewer: *"I was just trying to work out if you are making special plans distracting you from your normal work – are we making extra work for you?"*

Response: *"It is true sometimes I feel they need attention especially the mental health students so I feel they benefit from having a person like me (a mental health specialist) with them so this week I have set up a program for them".*

Interviewer: *"So you are doing extra work for the students?"*

Response: *"Yes but they had a week of supervision and I wanted the students to see how mental health counsellors here work and what tools they use – how they diagnose here. Your project supports our outreaches (mobile clinic) so we are happy to help. I enjoy working with students and so long as it is planned it is OK".*

The final case study presented below is included as an example of project development and how students (in this case NHS Management Trainees) can be involved in quite strategic planning roles focused on some of the most serious obstacles to health systems change. This also illustrates the potential for multi-disciplinary integrated interventions engaging the kinds of knowledge clusters we referred to earlier on.

Case Study 5: Building the Case for Public-Private-Partnerships in Kabarole District

As noted in Chapter 2, the EEP project was designed to provide placements for students. Most of the EEP participants have been studying at undergraduate level although many of them will already hold first degrees. Some of the students were also studying at Masters Level and several were involved in

data collection for their doctorates.[20] Towards the end of the Health Education England project we were presented with an opportunity to organise a placement for NHS Management Trainees. These trainees are all graduates undertaking a fast-track management training with a view to becoming managers in the UK NHS. As a project, we were at the point of making a critical decision of whether to embark on a new project to restore functionality to a Health Centre IV facility that was failing to deliver effective maternity services.

Given our knowledge of this process and the very serious concerns we had about trying to get emergency obstetric services going in the absence of a doctor and our experience of trying to mobilise Ugandan doctors in these environments (Ackers et al. 2016) we mooted the idea of a Public-Private-Partnership drawing on a model explicitly advocated in the Ministry of Health Strategic Plan (2012). The success of this intervention, in our experience, rested on the ability to devolve the budget and responsibility for human and physical resource management to a PPP Management team. This represented an ambitious and entirely untested idea. The four NHS Management Trainees from the Central Manchester Foundation Trust were tasked to work alongside one of the project managers spending a month in Uganda to conduct a thorough scoping analysis and audit and prepare a proposal for a PPP intervention. The Trainees conducted some very high-quality work engaging in active negotiation and audit-related activity combined with interactions with local health workers to create the first steps in this potentially exciting new venture.[21]

Relationship and Capacity-building in Partner Universities

The EEP model involves another element of capacity-building that has been of great value to the local University and health system. The professional volunteers funded through the EEPs each co-teach one module on a new BSc Midwifery programme at Mountains of the Moon University (MMU). The programme was planned with considerable support from K4C and

[20] These students received funding from Santander.

[21] The outcome of this venture will not be clear for some time.

three professional volunteers and welcomed its first cohort of students in August 2015. It would have proved very difficult to get this programme off the ground in Uganda in the absence of professional volunteers as there are so few people qualified to teach the programme at degree level.[22] This model is focused on sustainability and capacity-building and co-presence in the teaching environment has been insisted upon in order to ensure that institutional memory and resources are built up for the future. The programme has also involved the active encouragement of MMU and diploma level midwives in selected local facilities to come to the UK to undertake recognised training programmes at Masters Level in order to build capacity in Uganda but also support mutual understanding of educational programmes and training systems. We have planned the whole process to focus on a small number of health centres which we are developing as established training sites both for UK and Ugandan students on placement (including Kagote). Whilst ensuring optimal learning outcomes for UK students this process has ensured that Ugandan students can begin to be supervised in fully functioning health facilities.

In some cases, the Ugandan fellows have been trained in research methods (rather than clinical areas) in order to build research capacity at MMU but also invest in the evaluation potential of our Ugandan colleagues. This will enable us in future to engage in genuine co-research activity. Asked to reflect on the contribution of the student placements to this area of activity the academic lead of Health Sciences responded;

> [Is there anything we can do to improve to improve impact?]
>
> I've been very impressed with the quality of the students' teaching – of course they were mature students – but they did a really beautiful job teaching our students and our students really appreciate someone coming in and teaching them from outside (even if they are also students) they are teaching something appropriate to our student's environment and something practical too. I think it would be good to keep that in mind and plan ahead and make sure topics are needed to be covered – if

[22] Uganda faced a 'catch22' situation as the rules required that a degree programme in midwifery is taught by staff with a degree in midwifery. At the present time the number of midwives in Uganda with a degree can be counted on one hand.

we can think about it and plan ahead and the students are interested in teaching and it is good for them.

Conclusions

The results of the EEP evaluation suggest that undergraduate placements can form the basis of valuable capacity-building work in low resource settings. We have been somewhat surprised at these results building as they do on several years' evaluation of the impact of far more experienced volunteers and the demand from host settings for the most senior and experienced professionals. Reflecting upon this apparent contradiction and the sense that student placements when organised in structured and deeply grounded 'knowledge clusters' may facilitate a higher level of sustainable systems change than the isolated deployment of highly qualified volunteers the logic is clear. The human resource environment in Uganda is such that for most of the time there are no doctors in situ and facilities are run by nurses, midwives and clinical/anaesthetic officers. The majority of staff in many facilities will be students themselves often at an early stage in their training with little concrete knowledge or experience and typically no effective supervision.

Referral systems are structurally damaged in the overwhelming majority of lower-level health facilities and basic neglected processes (patient monitoring; record keeping; audit; infection prevention control; and prescribing behaviour) are rarely in place. In these circumstances, we may question the merits of deploying highly qualified physicians to Uganda as they will rarely work in sustained co-present relationships with their peers. Deploying cadres of staff such as midwives and nurses facilities a more immediate engagement and the formation of highly effective training clusters supporting bi-lateral mentoring and knowledge exchange. This, coupled with the ability to identify and remove minor 'snagging' problems and leverage some conditionality within the local health system wherever possible through the fair-trade premium arguably constitutes the most efficient and effective intervention whilst also reducing the system destabilising effects associated with labour substitution UK students are far less likely to create the kinds of 'malignancy' referred to by Moyo (2009). The overall impact of EEPs is dampened by systems features and, most notably, staff absence and poor time-keeping. If staff are not presents and systems effectively

close down in the afternoons then opportunities for knowledge mobilisation close down too. Responsibility here rests with the Uganda authorities to manage their human resource more effectively to improve motivation and reduce the need for moonlighting. An easy solution for placement providers would be to place students in better managed and remunerated private and mission facilities. As a project we do not believe that this 'solution' complies with ethical principles or gives the UK students the best understanding of global health.

CHAPTER 5

Managing Reciprocity: No Harm Approaches to International Educational Placements

The idea of 'win-win' outcomes from international mobility is not new. Critiques of the 'brain drain' concept presented new hopes of mutually beneficial knowledge mobilisation referring to the returns to 'sending' countries via circulatory processes and virtual mobilities (Meyer 2003; Regets 2003). Our own work on scientific mobility concluded that brain drain as a concept was far too narrow and failed to capture the relationship between human mobility and knowledge mobilisation processes and the fact that mobility is the lifeblood of science in many resource starved regions (Ackers and Gill 2007). But these relationships are highly complex and there is no effective way of (quantitatively) 'measuring' losses and gains. To speak of win-win is to fail to capture these complexities and the critical importance of context to any evaluation of impact (Bate 2014). Our action-research study of ethical educational placements concludes that such exposures create transformational learning opportunities for the UK students involved. And these opportunities have the potential to make a significant contribution to the learning outcomes of direct relevance to curricula in their home universities. From the perspective of student learning we have no doubts that spending a period in a low resource setting is uniquely valuable. The learning premium and its specific relationship with core learning outcomes associated with academic study programmes will vary quite significantly depending on the structure and organisation of placements.

Placements organised through private sector companies capitalising on the swelling demand for volunteer-tourism, fuelled by university

A. Ahmed et al., *The Ethics of Educational Healthcare Placements in Low and Middle Income Countries*, DOI 10.1007/978-3-319-48363-4_5

internationalisation processes, will generate some forms of useful learning. Taking students outside of their own country and the health systems they are accustomed to will necessarily develop systems thinking. It will push students out of their comfort zones and create opportunities for exposure to and reflection on cultural difference and global inequalities with the potential to build competence in global citizenship. Having said, that we have serious concerns that, unless placements are framed appropriately and adequate systems are in place to manage this process of intense engagement in a foreign environment there is a high risk that the 'shock' effects of what some authors have termed 'poverty tourism' (Dowell and Merrylees 2009)[1] could reinforce stereotypes. Simply being immersed in a low resource setting for four weeks and observing poverty does not necessarily translate into cultural competence. It may have quite the opposite effect. An important concern for placement providers here is to ensure a level of cultural awareness and understanding that goes beyond the potentially damaging effects of what Simpson calls the 'essentialized concepts of 'other' (2004: 682).

To the extent that international educational placements are just that: namely 'electives' (implying optional choices out with the core curriculum)[2] participation in forms of gap-year voluntourism provided by private companies may deliver valuable learning opportunities. And universities will (hopefully) pick up and challenge incidences of cultural 'mislearning' in reflective components of emerging global health curricula. We have serious doubts that such encounters generate the kind of curriculum-relevant learning that we have evidenced in the EEP project. Achieving this requires a much higher level of engagement that goes beyond quite voyeuristic 'observation-only' placements captured by Wearing and McGehee as a form of 'shallow volunteering' (2013: 123) and guards against the arrogance and risks associated with 'free mover'

[1] A shocking example of this has been described as 'orphanage tourism.' We have direct experience of the ways in which orphanages have been developed in Uganda as commodified 'honey pots' to attract gap-year students and the income associated with this 'market' creating new partnerships in corruption and opportunities for child abuse. For details, see http://www.thinkchildsafe.org/thinkbeforevisiting/

[2] Wikipedia defines 'An elective course is one chosen by a student from a number of optional subjects or courses in a curriculum, as opposed to a required course which the student must take' https://en.wikipedia.org/wiki/Course_(education)

medical electives. Achieving optimal curriculum and practice-relevant learning requires direct engagement with university programmes and effective supervision. When these structures are in place and embedded in active partnership working, international placements in low resource settings have the potential to become part of the core curriculum. This process of moving from 'out-of-program' electives to 'within–program' educational placements is important for a number of reasons. Firstly, because the learning returns in carefully planned and funded placements justify full recognition within education programmes. Secondly, because electives are inherently and increasingly associated with profound inequalities of opportunity. Notre Dame University defines electives as 'optional' but that does not imply free choice; the ability to access them has in the main reflected students' financial status (or that of their parents). As Wearing and McGehee note, most participants in international elective schemes have come from middle-class backgrounds (2013: 121).

Raymond and Hall go further suggesting that volunteer tourism exists in a highly commodified environment and serves as a 'stronghold for the privileged' (Raymond and Hall 2008). Social class and attitudes towards mobility are not a simple reflection of financial resource; they also reflect cultural or mobility 'capital'. Students who have been exposed to foreign travel at a younger age or for whom it has been a cultural expectation or rite of passage (as the medical elective often is) are far more likely to seek out elective placements and to process and manage the perceived risks involved. Most of the students who have taken part in the funded components of the EEPs are not in that situation and the EEP represents the first opportunity they have ever had to travel to a low resource setting. Certainly, most would not have taken this step without the encouragement and support of the project.

The funding provided by Health Education England coupled with the institutional support offered through the University of Salford-Knowledge for Change partnership facilitated these mobilities. The growing 'expectation of mobility' and the tendency for this to influence student opportunities and life chances at ever earlier stages in their education places pressure on education providers to recognise and respond to the inherent inequalities this presents. One of the major providers of placements, 'Work the World' advertises its dentistry placements with the strapline: 'A specialist dentistry placement with us will set you apart from anyone who chose to play it safe and

stay in the UK'.[3] The website advertises placements at a basic cost of £1390 for four weeks (plus £300 registration fee) excluding international flights making a placement cost in the region of £2300. Another provider (Projects Abroad)[4] provide a price list depending on the location and type of placements to around £1,800 (for four weeks) taking the price including flights and visas to over £2500. These are far cheaper than many other providers with students reporting costs of over £4000 for elective placements often with an additional expectation of donations attached. As Hartman et al. describe, higher education and volunteering represent the largest growth sectors in the youth and tourism industry in a market which they estimate to be worth over 2 billion dollars globally. Wearing and McGehee in their review of the burgeoning literature on 'volunteer tourism' cite figures suggesting that volunteer tourists spend between £838m and £1.3b per year (2013: 120).

An international placement is not an 'elective' if a student cannot afford to access it or lacks the confidence to engage. Bringing placements in-programme renders the inequalities explicit and forces key actors in universities and the NHS to recognise and respond to them. The process will also put pressure on private providers engaged in the commodification of placements to show value-for-money. It will also expose the genuine costs of this form of activity to universities enabling them to consider their role in the new fees structure for nursing, midwifery and allied health professions and the possibility of developing equitable ways of managing these to an increasingly diverse student body.

So far, we have discussed the benefits of international placements to the students in 'sending' countries and the potential costs involved raising issues of equity and quality. When ethics are raised in the context of placements the discussion is usually with the impacts on 'host' settings. Most of the private providers offering placements pay at least lip service to the development impacts of placements typically referring to either cash payments or donations as forms of compensatory 'payments' in this commodified environment. By way of example 'Work the World'[5] advertise

[3] http://www.worktheworld.co.uk/dentistry-electives

[4] http://projects-abroad.co.uk/

[5] See note 3.

the 'support for partners' offered through their schemes stating that, 'we make a point of recognising [our supervising staff] by financially rewarding them, personally, for their efforts'. Furthermore, 'a fixed sum is given to each and every hospital for every student we send'. They go on to show photographs of huge volumes of consumables donated to facilities and to list equipment donations. Whilst it is important not to underplay the potential value of these forms of compensation each component of this raises serious concerns to anyone with a knowledge and understanding of working in low resource settings.

Reciprocity and Fair Trade Learning

In 2016, FK Norway[6] commissioned an international expert Benjamin Lough to draft a report setting out the Norwegian model of 'international volunteer service' recasting volunteers as agents of change working in more equitable and balanced relationships with their partners in host countries. The report identifies reciprocity as the core value guiding the ethics of these exchanges. In line with the critiques of more traditional donor-recipient models of 'volunteering' it acknowledges the fundamental asymmetry responsible for the dependencies and harms associated with professional voluntarism. Citing Polonijo-King (2004) Lough refers to concerns that 'unidirectional aid relationships ultimately rob recipients of self-respect using altruism as a form of social oppression' (p.109). He goes on to propose that 'reciprocal learning is one expression of strategic reciprocity [. . .] disrupting the helping narrative' (p10). This resonates with our own experience of managing EEPs. The concept of 'student' is far more balanced than that of 'volunteer' and enables local hosts to conceptualise themselves as active participants in an exchange relationship rather than as the passive recipients of foreign 'expertise'. These forms of symbiosis are most evident in engagements involving not only academic partners (as traditional student exchanges) but also service or non-academic partners. Sharpe and Dear (2013) use the concept of 'International Service-Learning' or 'ISL' to describe

[6] FK Norway is a part of the Norwegian national developmental policy. It was established in 1963 to send people from Norway, and was reorganised in 2000 to do mutual exchange: http://www.fredskorpset.no/en/about-us/

university programmes in the US that 'combine academic instruction and community service in an international context' (2013: 49). The ISL approach has more in common with our concept of Ethical Educational Placements than the commodified products offered to consumers of volunteer tourism. In addition to the kinds of 'person-to-person' reciprocity evident in the relationships that mobile students have with their peers and health workers, Lough underlines the role of organisational reciprocity in supporting effective and balanced interventions.

A critical component of the success of the EEP model lies in the partnerships that underpin and operationalise it. According to Wearing and McGehee the organisations that engage in the operation of volunteer tourism are a key factor in maximising good practice (2013: 124). Knowledge for Change (K4C) as a social enterprise plays a critical brokerage function linking key stakeholders including the University of Salford, Mountains of the Moon University, Uganda and Kabarole Health District. Hartman et al. argue that the 'unique mission, research, and evaluation capacities of higher education' places universities centre stage in the university-community nexus facilitating opportunities for 'best practice' maximising the benefits and minimising the negative impacts for host communities and volunteers. Whilst we would prefer to see the EEP model as conveying ethical standards for educational placements (as opposed to volunteer tourism) we would concur with their view that universities have institutional characteristics which make them 'ideal catalysts' (p. 109) for change. These typically include a not-for profit foundation; public serving missions with a focus on education, academic expertise in research, a research-based understanding of international development and an inherent commitment to challenging inequality, dependency and injustice. Wearing and McGehee refer in their review of the literature on volunteer tourism, a shift towards a more 'scientific' critique of the phenomenon involving more structured, interdisciplinary, transnational and mixed-methods studies (2013: 122).[7] All of the organisations involved must also commit to principals of *good governance* and the

[7] They couch this discussion as lying at the intersection of tourism and volunteering research; we would argue that there are other perhaps more insightful theoretical insights to be had here from studies of mobility and internationalisation in higher education and careers.

promotion of transparency and accountability.[8] This is the cornerstone of trust and trust lies at the heart of partnership relationships.

The University partners in the EEP pilot provide important support and credibility to educational placements. Salford University, by way of example, underwrites the risk assessment process drawing on significant expertise in placement management. As a not-for-profit organisation committed to education and training it provides a level of credibility for potential students seeking out placement opportunities that is not found amongst private sector companies. The EEP secretariat is firmly based in Salford's prestigious Knowledge and Place Research Group ensuring a firm grounding in research on internationalisation processes, global health and research/evaluation methodology. As such EEPs represent a prime example of evidence-based policy. The University also supports high level dissemination of the EEP model encouraging other placement providers to reflect on their programmes and consider whether they can improve on the learning environment and ensure that they comply with ethical principles. The Universities in Uganda provide a similar assurance of support for students when on placement and a focus on learning and knowledge exchange. Working with these partners opens unique opportunities for peer-peer co-working but also harnesses and facilitates the role that Community Universities (such as MMU) play in delivering training to health workers in their hinterland. The link with Kabarole District is also essential to ensure that proper systems are in place and senior managers are aware of the presence and activities of volunteers and students. Also that they are given the opportunity to discuss and negotiate those interventions creating new opportunities and minimising the potential for unintended consequences. Once these relationships are established and respected K4C can then operate at a more detailed level in the negotiation of specific tailored placements linked into active on-going project interventions with key actors within the District including health facilities and collaborating partners. An effective and respected intermediary with the capacity to manage relationships and maintain a close understanding of context is critical to this process. The intermediary also plays an essential role in managing and mitigating risk and operationalising the risk assessment process which is necessarily fluid and reactive.

[8] Governance is identified as one of the cornerstone principles of Fair Trade: http://www.fairtrade.org.uk/en/what-is-fairtrade/the-impact-of-our-work/our-theory-of-change

On another level the intermediary organisation has a fundamental role to play in ensuring compliance with ethical principles. As with risk, ethical compliance is an on-going process involving constant negotiation and mediation. The issues are complex and confounded by the innovative dynamics of global inequalities and corruption. Every intervention generates externality effects (unintended consequences) many of which are difficult to predict.

The Multiplier Effects of Student Consumption

Chapter 4 identified a number of ways in which EEPs have made a sustainable impact on local health systems in Uganda through the 'Fair Trade Premium'. We did not include in that discussion the wider economic impacts associated with students as consumers in local economies. However, anyone who has been involved in touristic activities in Uganda will see how important students and volunteers are to local tourism; the majority of participants in touristic visits in Uganda are volunteers or students often undertaking tourism alongside other activities. Hartman et al. extend their concept of Fair Trade Learning to consumption behaviour suggesting that programmes should take care to use 'local eateries' and source local products including local guides. We would support that assertion and have taken strides to discourage donations of equipment from the UK preferring wherever possible to source medical equipment in-country. We have been fortunate to have the intelligence and connections of our sister bio-medical engineering project to support us in this work. An example of this can be seen in the endeavours of a group of returned students actively wishing to continue their involvement in Uganda and respond to an identified need (for cervical cancer treatment). The students had taken part in the YAWE cervical screening work (Case Study 4) but were concerned that many women who were tested positive then had to make a 5–6-hour journey to Kampala for (potential) treatment. They therefore decided on return to raise funds for a cryotherapy machine to co-develop a local service. K4C became involved in this taking advice from the biomedical engineering project and seeking in the first instance to procure equipment from Uganda providers. Having researched the situation, we have decided to source an alternative machine not yet available in Uganda but less reliant upon expensive consumables. K4C have since agreed to support this service providing the engineering and clinical training with the support of our long-term volunteers to ensure the equipment functions effectively for a minimum of three years.

Hartman et al. also advocate the use of host families in the host setting to accommodate students. This is something we have chosen as a project not to engage in for a number of reasons. The students on EEPs are first and foremost professionals and not tourists and, on that basis, we feel it is important that they do not live with local families. From a risk perspective, we have preferred to organise our own premises and ensure that students have access to the facilities they need to maintain contact with their home universities and families. Many of the EEP students are mature students with partners and children and many continue to engage in elements of coursework during their placements. We also ask them to prepare teaching materials and weekly reports and prefer to provide them with the facilities to do that. Students on placement in the UK would not live with local families and we do not feel this contributes to their professional identity and external perceptions of them as students on educational placements. We have also found that students faced with quite challenging placements need to connect together in the evenings to debrief and share experiences with their peers, placement managers and supervisors. Having said that we have engaged our sister project (OBAAT)[9] to undertake all of the building and repairs work using local builders engaged in capacity-building construction projects.

Sharpe and Dear's evaluation of 'International Service-Learning' (2013) echoes our own experiences and the importance of understanding the messiness of these kinds of interventions and the constant contradictions and unintended consequences muddying relationships between project rhetoric and practical reality. We present the EEP model in this book not as a static and perfectly formed 'model' but as a work in progress representing at least a commitment to progressive practice if not its complete realisation. The journey continues as we constantly try new things and reflect upon them. What is of utmost importance is that we continue to build upon our evidence base to improve the quality of the concept and its execution and, as Hartman et al. advocate, 'move forward in a sector increasingly dominated by a noxious combination of slick marketing and under-informed consumers'.

The emphasis on community-engagement and multi-disciplinarity in Hartman's 'Fair Trade Learning' has been taken a step further in our current plans to develop a series of integrated multi-disciplinary group

[9] See note 53.

projects in line with Salford University's employability agenda.[10] The plans for these placements follows similar lines to the existing EEP model but with greater emphasis on the identification of a specific need or project by local stakeholders and the recruitment of explicitly multi-disciplinary student teams to support an intervention. By way of illustration, one of the projects we are currently recruiting to involves a planned relationship between the Ugandan and UK Blood Transfusion Services designed to reduce mortality and morbidities associated with poor access to blood. The supply of blood in Uganda is constrained by a whole range of factors including donor awareness and behaviour, the lack of capacity in equipment management and repair, lack of capacity in laboratory management and skills and problems with power (to supply cold chain networks) and transportation. There is also no capacity in Uganda at the present time for cell salvage to enable patients to receive their own blood during operations taking the pressure off donor blood supplies, reducing costs and improving safety. The problems call for multi-disciplinary complex interventions involving many different stakeholders and all kinds of knowledge. We hope that the kinds of knowledge clusters generated within the EEP programme will enable us to mount an effective if incremental approach to such challenges.

Early Career Mobility and Global Citizenship

All studies of student mobility concur on one thing; that early stage mobility is an important precursor of subsequent mobility. We have expressed some concerns (above) that the kinds of mobility associated with 'electives' has been largely restricted, until recent years, to the mobilities of the privileged and noted that this reflects not solely income differentials but also differences in life experiences and exposure to mobility in their lives. One of the key findings of the EEP study has been the confidence and thirst the opportunity has given to young people with little previous experience or perhaps even interest in global health to consider future visits. It is interesting to see how cadres of students who would have had little opportunity to spend time in a low resource setting subsequently talk about their futures. We have referred to the specific challenges of

[10] We have received funding to develop and pilot these through Salford University's Higher Education Innovation Fund (HEIF).

placing students in cadres that do not even exist in Uganda. This hasn't stopped one of the podiatry students planning to work abroad in future. Interestingly she also talks very positively about the attractiveness of multi-disciplinary working:

> I'm so glad I did it, and it's helped me realise what I want to do future and I know that I want to work abroad. It's made it a lot clearer. It's helped me realise what type of thing I want to go into. I want to work with high-risk things and with multidisciplinary areas.

Another student, this time in prosthetics also expresses a desire to plan a longer stay in a low resource setting in future:

> Even though we weren't there for too long, we felt like we made a big difference in people's lives. It has definitely given me the motivation to do something like this again. I have always wanted to do some care relief work in developing countries, and I definitely will now, even if it's just for a couple of years.

The final section summarises the key ingredients of the Ethical Educational Placement Model.

EEP Model

Infrastructure Investment Through Partnership-Building

Sending Organisations

Phase 1 requires the establishment of 'Fit-For-Purpose' Sending Organisations.

Ideally these would involve a combination of a Registered Charity (NGO)[11] working in partnership with a Higher Education Institution (with not-for-profit and explicit educational objectives).

Identification of key managerial roles in sending and receiving locations (to include an overall Project Manager and Placement Leads in both locations). Individuals in these roles need a firm grounding in the

[11] We note in Ackers and Ackers Johnson (2016) the importance of these organisations operating within the spirit and letter of UK equality law.

context and capacity-building objectives. It is essential not to underestimate the level of commitment and investment required to ensure that individuals with the right level of knowledge and skills are employed in these positions. **Financial Planning and Transparency** is essential.

Host Organisations

This includes the identification and formation of firm trust and governance relationships with partners[12] in the hosting setting established through continuous collaboration. Ideally these would involve local HEIs partnership with relevant local stakeholders. From an ethical perspective we would advocate working only within the frame of public services and those NGOs committed to supporting pubic services.

Where appropriate objective setting processes and objectives should be formalised through a Memorandum of Understanding or similar agreement. This needs to be a 'living' document responsive to the outcomes of evaluation (below) with periodic review built in.

Professional Volunteers

Deployment of Professional Volunteers to support Partnership capacity-building objectives. The EEP Volunteer Agreement combines capacity-building roles in PUBLIC facilities with co-teaching in HEIs and placement supervision (of UK and Local students in knowledge clusters).[13]

Placement Operationalisation

Once infrastructure and active partnership working with established goals are in place planning can commence for placements.

Where possible ethical educational placements should be **Integrated within Undergraduate Curricula** rather than sitting outside of them in the form of 'electives'. This should expose them to full interrogation from

[12] This could be a Health Partnership or a partnership with local schools, for example.

[13] Further details of Professional Volunteer deployment and Volunteer Agreements are provided in Ackers et al. (2016) and Ackers and Ackers-Johnson (2016).

equality and ethical perspectives and ensure that curriculum-relevant learning is actively validated.

This requires attention to undergraduate curricula to ensure a firm grounding in **Ethics and Global Health /International Development in Undergraduate Curricula** (including cultural competence) for ALL students.[14]

Comprehensive and Fair Recruitment processes complying with best practice in equal opportunities including maximum exposure to opportunities available, open advertisement of opportunities and rigorous selection criteria (where bursaries are involved). Clear procedures re disclosure of health and other conditions to ensure that all students have the necessary resilience to cope with a placement and team-working.

Comprehensive and tailored approach to **Pre-departure Training and Induction**; ideally combining provision of regularly up-dated Induction and Orientation materials with opportunities for one-on-one email and face-to-face communication. To include expectations management. Where possible, engagement of host partners in this process.

The Induction Pack should contain links to full **Risk Assessment** and a bespoke and comprehensive **Insurance Policy.** Wherever possible students (and Professional Volunteers) should be covered by a Common Policy to ensure rapid and effective response to crises and ensure there are no gaps in cover.

Centrally planned and clearly communicated logistical arrangements need to be in place to ensure the management of student journeys from initial expression of interest to final post-return reporting/reflection. Particular attention to in-country travel, provision of risk-assessed accommodation with amenities necessary for completion of an effective and professional *educational* placement (this will vary according the local context). Provision of services of a **Local Placement Manager** actively engaged within the overall Partnership activity (as above). The local placement manager will work alongside Professional Volunteers and project managers to ensure effective debriefing and pastoral care.

[14] This is an area that we are currently working on and was not fully established prior to deployment of EEP students. The research has suggested this is necessary to prepare students and promote optimal learning and guard against the concerns expressed about 'essentialized concepts of 'other' (Simpson cited in Chapter 5).

Establishment of a **Placement Agreement** providing generic clarity on student roles on placement, codes of conduct (including disciplinary procedures), co-presence and supervision/mentoring with an additional tailored component specific to each individual student. This should be seen as an iterative agreement established prior to departure but subject to negotiated revision during the placement in response to changing needs and contexts.

Financial planning and governance requirements (above) extend to the relationships with local hosts and the management of the **Fair Trade Premium**. Serious consideration should be given to any cash payments and avoided wherever possible. Local stakeholders should be actively involved at the appropriate level where possible involving local health workers in decisions about local investments to support joint decision-making and effective outcomes.

Evaluation and Iterative Review

Integrated Evaluation of the wider capacity-building initiative and within that, the Placement Review. This is as an on-going requirement to ensure that all of the above are adhered to and optimal outcomes achieved (including attention to 'no harm' principles). Placement review and reporting should include written weekly reports and focus group meetings supported, where necessary, by opportunities for personal discussions with the Local Placement Manager.

Appendix 1

Ethical Educational Placement Student Agreement

This agreement contains placement details, a code of conduct and outlines project evaluation requirements. Please read through fully and carefully before signing and returning to the project manager. No student/volunteer will be allowed to begin their placement until the agreement has been signed and returned.

Usual Placement Hours and Leave

- Students are expected to 'work' for an average of 37 hours per week whilst on placement.
- Students are expected to 'work' regular hours each day. The timing of these hours can be discussed with the project manager and may be subject to flexibility. They may include night placements or weekends if necessary, provided that the co-presence principle is always respected.
- Students may spend their evenings and weekends as they please (within certain limitations).
- Students will be required to advise the Project Manager of where they are travelling to if moving outside of Fort Portal during the placement. No student will be allowed to travel outside of Uganda during their placements without prior written consent from the Project Manager.

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Student Conduct

Students are reminded that whilst they are in Uganda they are representing Knowledge for Change, the University of Salford and their own University and/or professional body. Students are required to behave in a manner that reflects the professional standing of both the UK institutions and the host organisations in Uganda.

Students are required to adhere to the risk assessment guidance. Any deviation from the risk assessment guidance may imply a breach of the terms of their insurance. Students should be aware that if they do deviate from the assessment/guidance that they do so at their own risk.

Any behaviour that brings Knowledge for Change, the University of Salford, or any of our partner organisations into disrepute will be dealt with through the University of Salford Disciplinary Policy.

Policies and rules relating to student conduct are necessary to support the efficient and smooth running of the Educational Placement Project. It is acknowledged that the majority of students consistently behave appropriately. However, it is necessary that a disciplinary procedure is available which is understood by all and outlines the rights and obligations of students and managers to ensure that fairness and equity are applied in all circumstances.

This document applies to all students and/or volunteers participating in either short or long stay programmes. The guidelines within this document also apply to medical students and short-term volunteers participating in the link during their placement module and any medical staff volunteering in Uganda as part of the Educational Placement Project.

The following are examples of offences that, having given due consideration to all of the circumstances, may be regarded by the University of Salford as ***Gross Misconduct***. It is possible that a student could be dismissed without previous warnings. This list is indicative. It is not to be regarded as exclusive or exhaustive:

- Misuse of drugs, for example through misappropriation of drugs or being under the influence of illicit drugs.
- Criminal conduct while participating in the Educational Placement Project.
- Sexual offences or sexual misconduct while participating in the Educational Placement Project.

- Conduct likely to offend decency (employees need to be aware and observe cultural differences).
- Violence or other exceptionally offensive behaviour.
- Discrimination against a member of staff or public on the grounds of sex, race, colour, nationality, marital status, sexual orientation, religion, disability or social background.
- Breaches of safety regulations endangering oneself or other people including deliberate damage to, neglect of, or misappropriation of safety equipment. Reckless behaviour which constitutes a danger to health or safety of any person.
- Breaches of confidentiality relating to patients, staff or other persons.

Listed below are examples of offences of **Misconduct**, other than gross misconduct, which may result in disciplinary action and/or counselling in the light of the circumstances of each case. This list is to be regarded neither as exclusive nor exhaustive. Other forms of misconduct may give rise to disciplinary action.

- When a member of the team fails to observe, without sufficient cause, operational regulations while participating in the Educational Placement Project.
- Where any member of the team renders himself/herself unfit, through the use of alcohol or illicit drugs, for duties which he/she is, or will be required to perform, or which he/she may reasonably foresee having to perform. For example, unfit to conduct project work due to use of drink/drugs on the previous day/night.
- Smoking within the work place or in public areas or while in the company of community officials, local workers and patients (this can cause offence in Africa). This also includes smoking within student accommodation and surrounding areas.
- Failure by any member of the team to adhere to the risk assessment guidelines without good reason.

Project Evaluation and Review

Evaluation of individual progress is a process designed to form a rolling record of your experience and learning in Uganda. It is also an essential component of Project Evaluation. All students /volunteers must comply

with the Project Evaluation processes designed by Knowledge for Change and the University of Salford which may include interviews, focus groups and written reports/blogs. You may also wish to develop a personal or public blog detailing the activity on your placements, but please be aware of ethical aspects and confidentiality.

Declaration

In signing the Placement Agreement; you are acknowledging that you have read and understood the content within the Agreement, the Induction Pack, the Risk Assessment document and Travel/Medical Insurance documentation. You are also agreeing that you have undergone any necessary health checks, are up to date on all required inoculations, have made arrangements to ensure you have a supply of anti-malarials for the duration of your placement, and will comply with the University of Salford's project evaluation activities.

Student name:

Student number:

University:

Date:

Signature:

Appendix 2

The Ethical Elective Placement Project – Post-Placement Student Survey

The post-placement survey was created using SurveyMonkey software and was sent to all students who completed placements as part of the Ethical Elective Placement project. The survey was circulated by WhatsApp using a web link in October 2016. Of the 111 students it was sent to, it was only received by 104, suggesting that 7 of the students had either did not have access to WhatsApp or had changed their contact details in the time between completing their placements and being sent the survey. WhatsApp was used as a medium for dissemination of the survey link as many of the students had graduated by the time the survey was circulated and would be unlikely to still have access to their university emails accounts. It was also expected to provide a higher response rate due to the nature of the technology and the age range of the students.

Sixty-five students completed the survey in total, representing a response rate of 59% of all the students who completed a placement, or 63% of those students who received the link. It comprised seven primary questions, the results for which are listed below (Fig. A.1):

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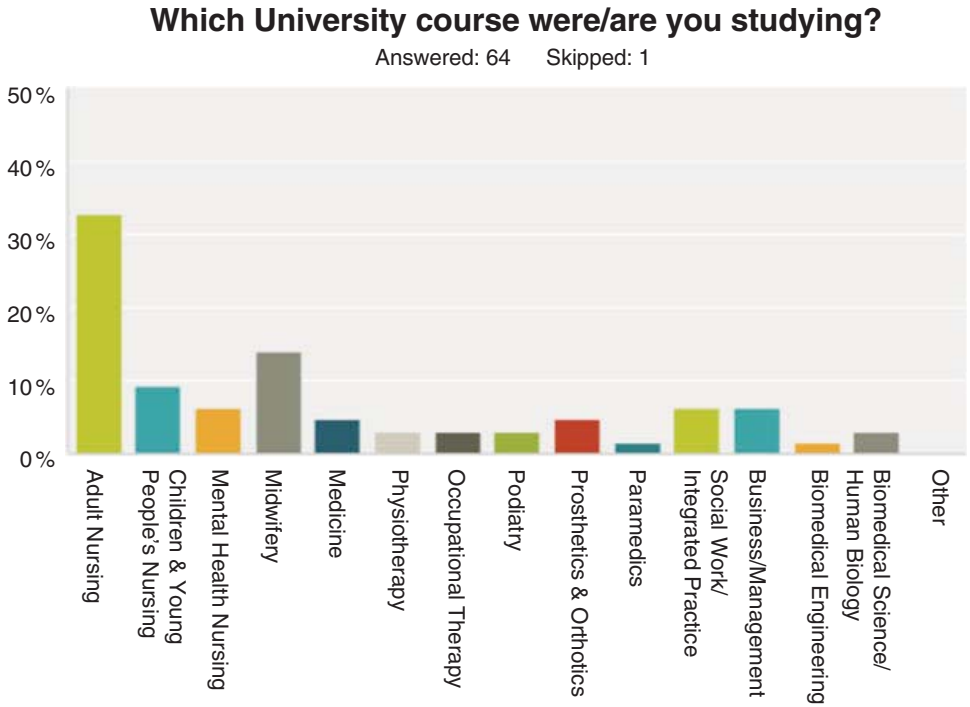
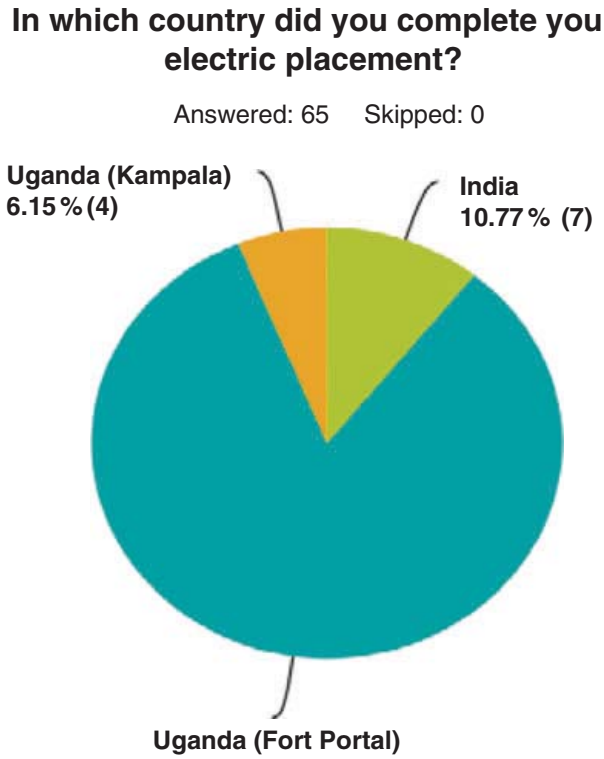


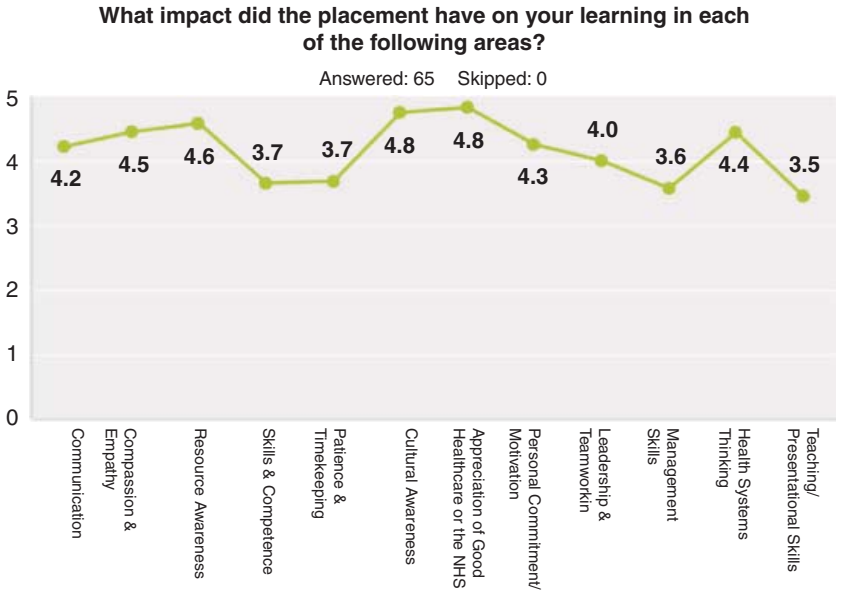
Answer Choices	Responses	
Adult Nursing	32.81 %	21
Children & Young People's Nursing	9.38 %	6
Mental Health Nursing	6.25 %	4
Midwifery	14.06 %	9
Medicine	4.69 %	3
Physiotherapy	3.13 %	2
Occupational Therapy	3.13 %	2
Podiatry	3.13 %	2
Prosthetics & Orthotics	4.69 %	3
Paramedics	1.56 %	1
Social Work/Integrated Practice	6.25 %	4
Business/Management	6.25 %	4
Biomedical Engineering	1.56 %	1
Biomedical Science/Human Biology	3.13 %	2
Other (Please Specify)	0.00 %	0
Total		**64**

Fig. A.1 Questions 1–5



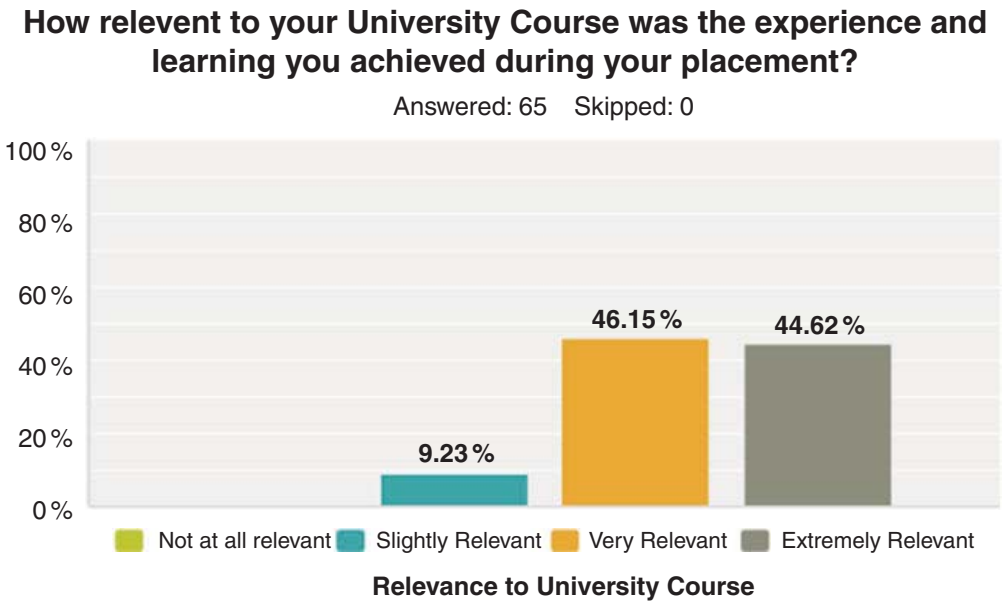
Answer Choices	Responses	
India	10.77%	7
Uganda (Fort Portal)	83.08%	54
Uganda (Kampala)	6.15%	4
Total		**65**

Fig. A.1 (continued)



	1 - No Impact	2 - Little Impact	3 - Morderate Impact	4 - Strong Impact	5 - Very Strong Impact	N/A	Total	Weighted Average
Communication	0.00% 0	1.54% 1	15.38% 10	43.08% 28	40.00% 26	0.00% 0	65	4.22
Compassion and the Importance of Empathy	0.00% 0	1.54% 1	9.23% 6	32.31% 21	56.92% 37	0.00% 0	65	4.45
Resource Awareness (improving resource efficiency and reducing waste)	0.00% 0	3.08% 2	9.23% 6	13.85% 9	73.85% 48	0.00% 0	65	4.58
Skills and Competence	3.08% 2	10.77% 7	32.31% 21	26.15% 17	27.69% 18	0.00% 0	65	3.65
Patience and Time Keeping	3.08% 2	10.77% 7	33.85% 22	20.00% 13	32.31% 21	0.00% 0	65	3.68
Cultural Awareness	0.00% 0	0.00% 0	3.08% 2	18.46% 12	78.46% 51	0.00% 0	65	4.75
Appreciation of Good Healthcare and the UK NHS	0.00% 0	0.00% 0	4.62% 3	7.69% 5	87.69% 57	0.00% 0	65	4.83
Personal Commitment & Motivation	1.54% 1	3.08% 2	12.31% 8	35.38% 23	47.69% 31	0.00% 0	65	4.25
Leadership and Teamwork	0.00% 0	7.81% 5	18.75% 12	39.06% 25	34.38% 22	0.00% 0	64	4.00
Management Skills (Ward/Hospital/Time Management)	4.62% 3	13.85% 9	23.08% 15	36.92% 24	21.54% 14	0.00% 0	65	3.57
Health Systems Thinking (appreciation of how different health systems work and how different health systems compare and contrast with one another)	0.00% 0	3.08% 2	7.69% 5	29.23% 19	56.92% 37	3.08% 2	65	4.44
Teaching and Presentational Skills	9.23% 6	12.31% 8	24.62% 16	32.31% 21	21.54% 14	0.00% 0	65	3.45

Fig. A.1 (continued)

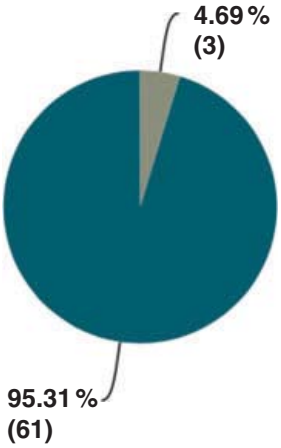


Answer Choices	Responses	
Not at all Relevant	0.00 %	0
Slightly Relevant	9.23 %	6
Very Relevant	46.15 %	30
Extremely Relevant	44.62 %	29
Total		**65**

Fig. A.1 (continued)

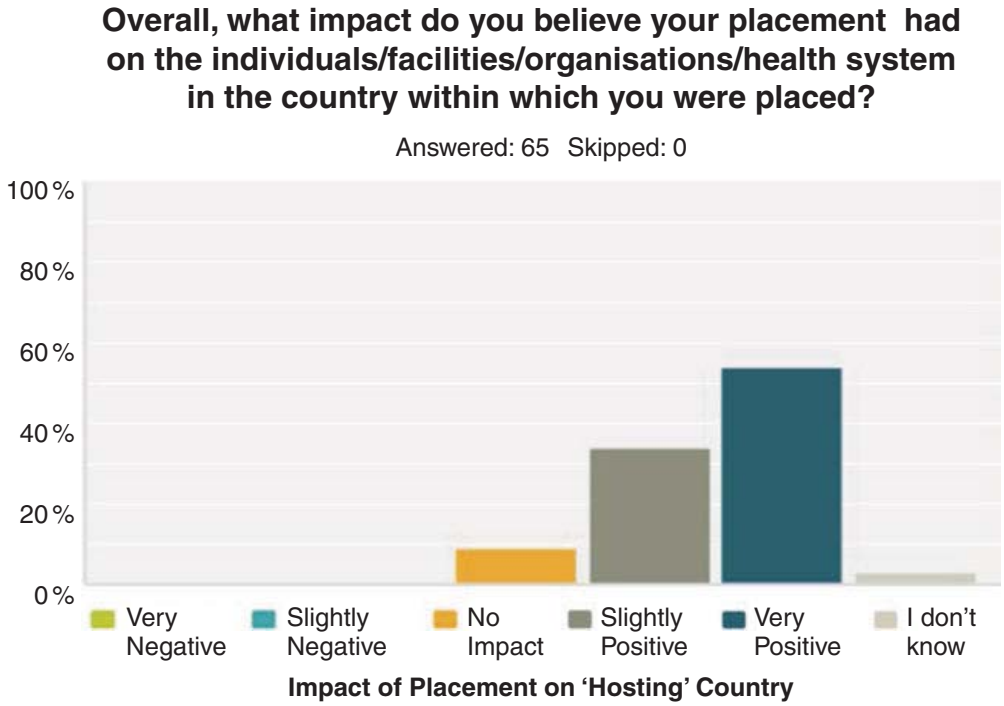
What do you think impact of completing the placement will be on your future career and employability?

Answered: 64 Skipped: 1



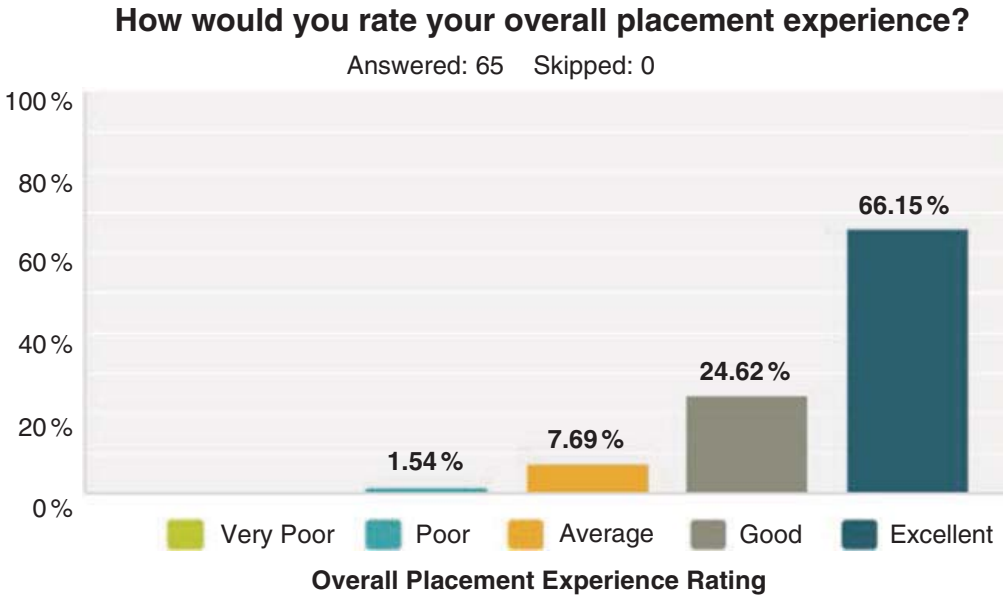
Answer Choices	Responses	
Very Negative	0.00%	0
Slightly Negative	0.00%	0
No Impact	0.00%	0
Slightly Positive	4.69%	3
Very Positive	95.31%	61
Total		**64**

Fig. A.1 (continued)



Answer Choices	Responses	
Very Negative	0.00 %	0
Slightly Negative	0.00 %	0
No Impact	9.23 %	6
Slightly Positive	33.85 %	22
Very Positive	53.85 %	35
I Don't Know	3.08 %	2
Total		**65**

Fig. A.1 (continued)



Answer Choices	Responses	
Very Poor	0.00 %	0
Poor	1.54 %	1
Average	7.69 %	5
Good	24.62 %	16
Excellent	66.15 %	43
Total		**65**

Fig. A.1 (continued)

Appendix 3

Interview Schedule

International Placements, Uganda. Pre-departure interview schedule: students

Preamble: Purpose of interview, confidentiality, anonymity (Fig. A.2).

1. Placement Experience

    a. Can you describe/tell me a little bit about what you did on your placement?
    b. What specifically did you gain from the placement in terms of your study and work? What skills and knowledge did you learn/apply in your study and work?
    c. What specifically did you gain/learn from the placement beyond study and work?
    d. What do you think you contributed to your placement hosts?
    e. What were the main challenges for you on the placement, if any? (personal, social, academic/professional)

2. The Placement: Structure and Support

    a. Looking back, do you feel you were prepared for your placement? What did you find most/least helpful?
    b. What kind of information or training (or support) do you think volunteers or students might benefit from that you haven't had?

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Biographical/study background data (if not previously collected during pre-interview)	
Name (interviewee)	
Year of birth	
Sex	*Male* ☐ *Female* ☐
Ethnicity	
Nationality	
Relationship status	*Single* ☐ *Relationship (not co-habiting)* ☐ *Live-in partner/spouse* ☐
Caring responsibilities	*Children* ☐ *Other* ☐
Work outside study	*No* ☐ *Yes part time* ☐ *Yes full time* ☐
Volunteering activities	*Yes* ☐ *No* ☐
Course level	*undergraduate* ☐ *postgraduate* ☐
Course name	
Course year	*1* ☐ *2* ☐ *3* ☐ *4* ☐ *(Is this the final year? Yes* ☐ *No* ☐*)*
Funding for placement	*Self* ☐ *HEE* ☐ *Bursary* ☐ *Other* ☐ *Please specify* _____*)*

Fig. A.2 Questionnaire

c. How easy/difficult was it for you to take part in the placement? How did you manage/cope in the context of other aspects of your life? (work, study, family etc.)?
d. How do you feel about the supervision of your placement?
e. What about accommodation /travel/food etc.?
f. Length of stay?

3. Final Question

   a. In terms of your learning, can you tell me a bit about how it relates to your course and the learning outcomes associated with that?
   b. How do you feel this may add to your CV/future employability?
   c. Could you in a few words sum up how you are feeling about the placement now?

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Healthcare, Frugal Innovation, and Professional Voluntarism: A Cost-Benefit Analysis

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HEALTHCARE, FRUGAL INNOVATION, AND PROFESSIONAL VOLUNTARISM

A Cost-Benefit Analysis

Helen Louise Ackers
James Ackers-Johnson
John Chatwin and
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ISBN 978-3-319-48365-8
ISBN 978-3-319-48366-5 (eBook)
DOI 10.1007/978-3-319-48366-5

Library of Congress Control Number: 2017933688

Printed on acid-free paper

This Palgrave Macmillan imprint is published by Springer Nature
The registered company is Springer International Publishing AG
The registered company address is: Gewerbestrasse 11, 6330 Cham, Switzerland

Acknowledgements

We would like to acknowledge the support, both financial and personal, that we have received from the Tropical Health and Education Trust which made the Sustainable Volunteering Project (SVP) possible. We would also like to thank Health Education England (HEE) for supporting the MOVE project, which provided the resource to broaden the research and further explore the returns to professional volunteers from placements in low resource settings.[1]

Our gratitude extends to all of the professional volunteers who have so generously engaged with the SVP evaluation and MOVE study and played such an active role as co-researchers in project development and evaluation.

Note

1. The Sustainable Volunteering Project (SVP) is funded by the Tropical Health and Education Trust (THET) as part of the Health Partnership Scheme, which is itself supported by the UK Department for International Development (DFID). The views expressed are those of the authors and do not necessarily reflect the views of THET or HEE.

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CHAPTER 1

International Mobility and Learning in the UK National Health Service

Abstract This chapter sets the study of international placements for healthcare professionals in the wider context of knowledge mobilisation characterising mobile health workers as knowledge brokers. It then discusses the concept of 'volunteer' and how appropriate this term is to the study of placement learning. The term 'professional volunteer' is proposed as a compromise. Two key contextual dimensions are then outlined: first, global health and the needs of low-resource settings. Secondly, the challenges facing a resource constrained UK National Health Service.

Keywords International mobility · Training · UK National Health Service

Internationalisation has become a feature of many, if not most, careers. It can be achieved through a variety of mechanisms, including, perhaps most obviously, the recruitment of staff from other countries. Certainly, international mobility has come to play an important role both in terms of attracting the 'brightest and best' across global labour markets (Iredale 2001; Mahroum 2000; Smetherham et al. 2010) and in terms of fostering mechanisms to provide international exposure to locally recruited staff. Mobilities of various forms involving shorter or longer stays at different stages in careers and to diverse locations are widely acknowledged to play an important role in the generation and exploitation of knowledge and

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innovation. Whilst the 'mobility imperative' (Ackers 2010; Cox 2008) has received greatest attention in those careers specifically associated with knowledge generation (such as research), there is increasing recognition that all professionals are inherently engaged in knowledge creation and mobilisation (Baruch and Hall 2004; Baruch and Reis 2015; DeFillippi and Arthur 1994).

Healthcare professionals are not simply the consumers or users of knowledge but through their daily lives actively engage in its co-creation. The concept of 'lifelong learning' bridges archaic boundaries by distinguishing early career phases of intense knowledge acquisition (through formal 'learning') with subsequent knowledge utilisation (through professional practice or 'doing'). Set within this wider context, the growth in professional mobilities involving healthcare professionals will come as no surprise. In some cases, these mobilities may themselves represent 'migrations' as healthcare professionals identify opportunities for longer term relocation abroad (Buchan 2001). Recent years have seen a growing interest amongst British healthcare professionals in Australia and New Zealand contributing to what is often referred to, somewhat simplistically, as the 'brain drain' (Lumley 2011). In many other cases, mobilities take the form of shorter stays to gain exposure, respite or adventure in foreign climes (Hudson and Inkson 2006).

This book and the studies on which it is based focuses on one component of these complex mobility flows, namely temporary stays undertaken by National Health Service (NHS) employees in low- and middle-income countries (LMICs). The individuals and groups involved in these forms of movement are by no means homogenous, either in terms of personal characteristics or motivations (Bussell and Forbes 2002; Lewis 2006; Strachan 2009). The nature of their deployment, their roles in the receiving country and the objectives and quality of the placement organisation all vary enormously. Collectively, these forms of mobility are historically associated with voluntarism largely because the periods of time spent in the low-resource setting are not remunerated by the hosting organisation. (So, objectively, they are volunteers in the receiving country and organisation.) This does not mean that the individuals involved receive no financial support. The (quite contentious) concept of 'compensation' has been utilised to distinguish contributions to maintenance and travel and so on, from remuneration (as pay). In many respects, this tells us little about the motivations or roles of those involved and more about attempts to negotiate legal parameters on the part of deploying organisations.[1]

Whilst most 'volunteers' will not be remunerated as employees of the deploying or host organisation and therefore are technically unpaid (so 'volunteering'), the concept of 'volunteer' has various connotations and infers motivations associated with altruism. Many of the organisations involved in the deployment of NHS professionals and creating opportunities for these forms of mobility do have charitable objectives. The British Red Cross, for example, has been actively recruiting volunteers since the beginning of the Voluntary Aid Detachment Scheme, which deployed volunteers to treat wounded soldiers during the First World War. Fifty years later in 1958, Voluntary Services Overseas (VSO) began linking international volunteers to projects. There are now many smaller charities offering international volunteering placements, including the much-publicised response of volunteers to the Ebola crisis in West Africa. Altruism of one form or another, often linked to forms of religiosity, may stimulate interest in placements in low-resource settings but this is by no means the sole factor.

In reality it is extremely difficult to characterise any form of human mobility in terms of one or two key motivations. Migration (or mobility) decision-making almost always involves a complex range of interacting factors combining lifestyle with career and sometimes adventure or escape. And motivational factors may combine genuine free choice with increasing elements of what we have called the 'expectation of mobility' (Ackers and Gill 2008; Cox 2008), as early career mobility becomes a rite of passage shaping entry into highly prized careers such as medicine. In the context of gap year mobilities, Heath (2007) points to a rise in numbers and argues that the socio-demographic profile of those involved is changing because of the increasing cost of university education. The act of being mobile (irrespective of learning) and displaying that on CVs becomes an important means of 'gaining the edge' in the competition for entry to elite institutions and subsequent career progression. This form of CV-enhancement has become an increasing expectation amongst junior doctors and perhaps lies behind the remarkable growth in the percentage of doctors 'choosing' to work and travel after foundation year, which almost doubled from 2011 to 2013 (UKFPO 2013).

The emergence of the 'global health' concept and the connections it has forged between International Development and Health policies in the UK has added new dynamics and actors. The Tropical Health and Education Trust (THET) itself funded through UK Aid has actively sought to recruit 'volunteers' to support its Health Partnership Scheme

(HPS). Two of the authors of this book (Ackers and Ackers-Johnson) have managed the THET-funded Sustainable Volunteering Project (SVP)[2] which sought to harness volunteers in knowledge mobilisation projects in support of maternal and new-born health in Uganda. The SVP developed the concept of 'professional volunteer' in an attempt to capture the fact that the NHS staff deployed were first and foremost highly skilled professionals, and it was their knowledge and professionalism that were fostered and mobilised as much as any altruistic motivation. This conceptualisation of the people involved in international placements in low-resource settings as 'knowledge brokers' captures their roles perfectly but fails to engage with popular terminology. In our recent work in Uganda, we have tried to substitute the very loaded concept of 'volunteer' with the more familiar concept of 'international faculty' but this tends to work better for those individuals and organisations engaging with university actors. In this book, we have decided to stick with the concept of 'professional volunteer' (PV).

Recruiting PVs to knowledge mobilisation interventions involves a range of considerations. In reality recruiting and deploying organisations will be balancing the expressed needs (wants) of host organisations with the needs (and supply) of potential professional volunteers and a degree of 'tension' often exists between those demanding (seeking) professional volunteers and those supplying them. Hosting organisations will often articulate a need for very highly qualified and experienced faculty even privileging the more prestigious professions (such as surgery or obstetrics) over nursing, midwifery and allied health professions – and they will express a strong preference for long stays. Put simply, they are looking for knowledge rich 'teachers'. On the other hand, the supply of potential faculty available to deploying organisations is skewed in the direction of early career individuals often seeking shorter stays that fit within training programmes and life course decisions (Ackers 2015). These forms of shorter stay mobility of more junior cadres of staff may be what offer the greatest return to the NHS. From the perspective of the NHS then, they may be looking at exporting knowledge-hungry 'learners'. What is clear from our work is that this simple binary characterising teachers at one end of a continuum and 'learners' at the other fails entirely to capture the complexity of knowledge mobilisation and lifelong learning.

Notwithstanding the motivations behind the professional volunteering or the cadres involved, there is a general consensus in the literature that relevant and valuable learning happens as a result of this activity (Crisp

2014; Jones et al. 2013; Kiernan et al. 2014; Lumb and Murdoch-Eaton 2014). And, that learning is often described as 'transformational' or life-changing (Fee and Gray 2013). Banatvala and Macklow-Smith (1997) suggest that the experience doctors gain overseas contributes significantly towards their professional development and that their clinical, organisational and managerial skills are improved when they return to the UK. In practice, much of the existing research on professional voluntarism focuses on impacts on host settings (Ackers and Ackers-Johnson 2016) and undergraduate electives (Ahmed et al. 2016). To the extent that studies address the returns to professionals and their employing organisations, these often take the form of opinion pieces or small-scale case studies, with a significant emphasis on medical electives. Just as we know relatively little about the more specific learning outcomes associated with professional volunteering in general, we also need more detailed understanding of the contextual and organisational variables that facilitate or inhibit these different forms of learning.

Healthcare professionals on international placements will undertake a diverse range of activities reflecting the objectives and structure of the deploying agencies and projects. Some, especially if they are taking time out of their careers or towards the end of their careers, may actively select placements outside of formal health systems, in orphanages, religious or environmental projects (Bhatta et al. 2009). Whilst most early career professionals will seek out placements in healthcare settings, these will involve quite different organisational and professional settings to those they are accustomed to in the NHS. Disciplinary boundaries are often dissolved, and a doctor may find herself doing the work of a nurse and vice versa (Button and Green 2005; Longstaff 2012). They will often work at the boundaries of their specialities, undertaking activities they would not engage in in the UK, or working with different populations (Kiernan et al. 2014; Lumb and Murdoch-Eaton 2014). The objectives of the deploying organisations will also impact learning; placements focused on service delivery in humanitarian emergency relief work may play a bigger role in supporting explicit clinical skills than capacity-building projects such as the SVP with its focus on systems change and capacity-building. The level of supervision is also likely to shape learning in interesting and perhaps surprising ways. The emphasis on 'co-presence' in the SVP project (Ackers and Ackers-Johnson 2014) and resistance to lone working and gap-filling may enhance some forms of learning whilst potentially detracting from others.

Supporting Career Mobility in Resource Constrained Environments: The UK NHS

The Global Financial Crisis and ensuing financial (austerity) constraints have adversely affected healthcare systems in most developed nations. In turn, this has put pressure on public healthcare systems to increase efficiency and reduce waste by adopting approaches used in private enterprise to promote 'lean healthcare'. There is growing concern that importing organisational systems from private companies may fail to achieve the goals of large public sector not-for-profit organisations. Gover et al. point to some of the potential barriers and political resistance to the imposition of 'lean' business models in public service environments and introduce a parallel concept of 'frugal innovation'. They define frugal innovation as the search for 'efficient, low costs solutions to everyday problems' capable of containing or reducing public healthcare spending, whilst simultaneously assuring levels of service and extending provision to marginalised groups. Frugal innovation, they suggest, demands a 'reconfiguration of capabilities, resources and competencies' (p. 3). Of central importance to this book, the concept of frugal or 'reverse' innovation (Zedtwitz et al. 2015) implies that low-resource settings characterised by stark resource constraints may stimulate relevant learning or knowledge mobilisation (Petrick and Juntiwasarakij 2011). Crisp captures this concept in his book *Turning the World Upside Down: The search for global health in the 21st century*. Put simply, he argues that his book, 'explores what richer countries can learn from poorer ones' through processes of co-development. Whilst frugal innovation is often described by reference to physical devices such as low cost, 'no-frills' equipment or prosthetics, the concept also extends in interesting ways to aspects of human resource management such as 'task-shifting'[3] (Schneeberger and Mathai 2015).

The UK National Health Service, as a universal service providing free healthcare at the point of use, and in the context of increasing dependency and medical advances, inevitably faces ongoing funding challenges. It is in this specific context that the case for expanding resource on professional mobility needs to be fully justified to NHS managers, employees and patients. Increasing numbers of NHS providers are in financial difficulties. In 2011–12 only 24% of NHS Trusts[4] reported overspending (The Kings Fund 2015). The projected figures for the end of 2016 suggest it is likely to be in the region of 67%, with 89% of acute hospitals projecting a deficit

(Appleby et al. 2016). For the first time since the Kings Trust Quarterly Monthly Report began in 2011, more than half of the trust directors believe that the quality of care in their local area has worsened in the past year (Appleby et al. 2016).

The NHS financial crisis is progressively worsening despite government initiatives to reduce spending (Appleby et al. 2016), and it would seem that human resource deficits lie at the heart of the current funding crisis. Addicott et al. (2015), for example, argue that 70% of costs incurred by NHS trusts are workforce related. This human resource crisis has left NHS managers increasingly reliant on a very expensive locum or agency staff. Figures suggest that 80% of hospital trusts spend more than £1,000 per shift on medical cover for doctors. This equates to more than £2 billion in two years, which could have paid the wages of 48,000 nurses or 33,000 junior doctors over the same period (Donnelly and Mulhern 2012). Migration trends lie at the heart of the problem, and the potential solution. In order to fill the vacancies, 69% of trusts are actively recruiting doctors and nurses from overseas (Hughes and Clarke 2016); 11% of NHS staff and 26% of doctors are non-British (Sidduique 2014). Professional migration is not unidirectional; the number of doctors seeking to emigrate from the UK has increased by 20% in the past five years (Boffey 2014).

The pressure on human resource budgets is also manifest in demands for workforce efficiency and productivity; the NHS requires more from current staff than ever before, resulting in an emphasis on resourcefulness, cost efficiency, flexibility and inter-professional working (Health Education England 2016a; 2016b).

These demands for improved productivity imply further investment in staff through continuing professional development (CPD). Health Education England (HEE) has organisational responsibility for the commissioning of training and the professional development of NHS professionals. It aims 'to support the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place' (Health Education England 2016C).

Health Education England's 15-year Strategic Plan focuses on the skills and competencies needed for the future workforce (HEE 2014). The emergence of new infections and antimicrobial resistances underlines an emphasis on cross-professional training to support generic competencies. The plan is based on core characteristics of the future workforce and

includes the need for adaptable skills that are responsive to evidence and innovation. It also proposes that finite resources need to be invested more wisely and healthcare facilities should focus on coordinated care delivered by multidisciplinary teams. The NHS *5 year Forward View* is a similar, more short-term, focused document outlining what the NHS plans to achieve in the next five years (NHS England 2014). It also places an emphasis on training to equip staff with skills and flexibilities to deliver new models of care with a focus on innovation and an investment in improving leadership.

In this environment, it is hardly surprising that many NHS employers are reluctant to agree to requests for leave to undertake international placements even when they involve a high level of self-funding. 'Back-fill' (funding staff to cover the work of those who are not on duty) represents a major and very expensive challenge to line managers on the ground (Longstaff 2012). And, in the current environment back-fill will often have to be provided by agency or locum staff who are in turn significantly more expensive (Donnelly and Mulhern 2012). Smith et al. (2012) suggest that this situation leads to reluctance to release staff for international placements.

In addition to political and economic pressures on NHS budgets, government spending on International Development has also been called into question. In reality, the UK Aid budget has been successfully ring-fenced and insulated from public sector cuts. However, this has come with increasing pressure for public accountability reflected in an explicit policy emphasis on the UK 'national interest' (UK Aid 2015). In future, all spending on aid will have to demonstrate that it either responds to a direct threat to British interests (such as terrorism or climate change) or has spill-over components that present a simultaneous challenge to the UK; global health features in this group with specific reference to epidemics and anti-microbial resistance. Whilst there is no specific reference in this chapter to professional volunteering amongst NHS employees, the case remains to be made that this form of UK investment falls squarely in the 'national interest'. Crisp (2010) suggests that in the brave new world of global health we are all increasingly connected and interdependent. It is not only health systems in low-resource settings that are challenged by issues of sustainability and funding, but high-resource settings now face the same problems, and so the growing mobility of the international labour force plays a key role in the mutual cross-fertilisation of knowledge and ideas.

To summarise, the UK NHS faces a serious human resource crisis; this is manifest in two ways of direct relevance to our research. In the first instance, we are dealing with an immediate shortage of staff. In this context, international placements represent an additional and immediate burden on the already pressed systems. Secondly, the pressure for efficiency and productivity increasingly places an emphasis on improved continuing professional development, and in this context, international placements present potentially fruitful and highly efficient opportunities for lesson learning and 'frugal innovation'.

Whilst there is strong evidence to support the view that international placements present valuable and enjoyable opportunities for healthcare professionals, there is insufficient evidence at the present to justify and lend public credibility to NHS expenditure in this area of activity. The quality of the learning and potential for effective knowledge mobilisation and innovation requires a higher level of specification aligning, wherever possible, to identified staff development priorities and costing accordingly. Every international placement is distinct in terms of its context, the activities that the professional volunteer engages in, and the learning opportunities that they present. We need to understand more about the conditions under which mutual learning is optimised and opportunities for translational impact (for the NHS) generated. What exactly this learning entails and how it is facilitated within an international context or how it maps onto CPD needs in the NHS is less well known (Jones et al. 2013).

What interests us in this book and the *Measuring the Outcomes of Volunteering for Education* (MOVE) study[5] is the collective impact of these disparate processes on the National Health Service as an employer with responsibility for the delivery of universal public healthcare in the UK.

The MOVE study was a collaborative project conducted by the research teams based at the School of Nursing, Midwifery, Social Work & Social Sciences, University of Salford and Manchester University Medical School. It ran for two years from 2014 until 2016 and was commissioned and funded by Health Education England (Department of Health). The key objectives were as follows:

Objectives

1. What forms of mobility are present within the current NHS workforce?
2. What forms of knowledge are effectively mobilised during these mobility episodes?

3. How does knowledge gain map onto strategic training objectives in the NHS? (How relevant is the knowledge?)
4. What organisational and contextual variables facilitate the optimal acquisition of these forms of knowledge?
5. What barriers exist to international placements and to the mobilisation of the knowledge gained from them on return to the NHS (is the NHS receptive to new knowledge?)
6. Can the evidence base derived from this research support the development of a psychometric tool capable of measuring quantitatively the outcomes associated with professional volunteering in LMICs?

The MOVE Study: Methods

The MOVE study built on extensive previous action-research on professional voluntarism within the frame of the THET-funded Sustainable Volunteering Project (SVP). Further details of this are contained in Appendix 2 and reported on in Ackers et al. (2016) and Ackers and Ackers-Johnson (2016). Building on many years' experience of research on highly skilled mobilities and knowledge transfer processes, the evaluation strategy included a range of methods complementing and balancing each other through a process of triangulation. The study adopted a multi-method approach designed to capture as accurately as possible the complexity of learning that takes place during international placements. We utilised the following data sources:

- A review of available research and literature on professional volunteering.[6]
- A face-to-face electronic survey of staff in a selection of NHS facilities in the North West of England.
- Semi-structured interviews with key informants and returned professional volunteers (both within the frame of the SVP (n = 150[7]) and drawing on the survey population (n = 51))
- Analysis of documentary evidence collated as part of the SVP including volunteers' monthly reports
- Ethnographic observation and fieldwork with professional volunteers deployed via the SVP to Uganda.

In addition to this, members of the MOVE team (headed by Dr. Byrne-Davis) have utilised a Delphi approach for assessing the possibility of developing a psychometric tool to measure the core outcomes associated with professional volunteering. The tool is not reported in this book.

Notes

1. For details see https://www.gov.uk/volunteering/pay-and-expenses
2. A summary of the SVP is contained in Appendix 2.
3. Defined as the 'systematic delegation of tasks to less-specialised cadres' or 'optimising health worker roles'.
4. A National Health Service trust is an organisation within the English NHS generally serving either a geographical area or a specialised function (such as an ambulance service). In any particular location, there may be several trusts involved in the different aspects of healthcare for a resident.
5. Companion volumes focus on the impact on the host (LMIC) settings (Ackers et al. 2016) and undergraduate mobilities (Ackers et al. 2016).
6. This included a systematic review undertaken by Tyler and explained in detail in her doctoral thesis (unpublished).
7. The numbers cited here are constantly increasing as we continue to deploy volunteers and assess impacts.

CHAPTER 2

Internationalisation and Placement Activity in the UK National Health Service

Abstract This chapter presents and discusses the findings from a survey conducted in the North West of England designed to gauge overall patterns of international exposure amongst all cadres of staff in the UK's National Health Service.

Keywords Internationalisation · Overseas placements · Current usage levels (in NHS)

Introduction

Very little is known about the prevalence of international exposure across the NHS. In contrast to the highly accurate and detailed NHS workforce summaries which are available from central government sources, information specifically concerned with professional volunteering placements is often piecemeal and deals only with discrete settings or departments. Organisations responsible for volunteer deployments, such as Voluntary Service Overseas or the Tropical Health and Education Trust, have conducted some small-scale surveys of their own volunteers, but this gives little impression of the overall propensity to engage in international placements and may give the impression that the phenomenon is far more common than it really is.

We thought it would be useful to contextualise the findings on learning outcomes derived from the qualitative interviews with professional

H.L. Ackers et al., *Healthcare, Frugal Innovation, and Professional Voluntarism*, DOI 10.1007/978-3-319-48366-5_2

volunteers within an overall understanding of prevalence and patterns of this form of mobility. Chapter 1 raised concerns about the growing expectation of mobility in healthcare professions. It also positioned the study in the context of the evolving skills agenda in the NHS and the emphasis on soft skills and multidisciplinary team working. Both of these issues raise the issue of inclusivity and the importance of opening up opportunities for all staff across cadres and over the life course. Chapter 1 also raised concerns about the financial implications that these forms of mobility generate in terms of providing staff cover. The survey findings provide an important context for these discussions.

The NHS Staff Survey

Survey research is often hampered by non-response skewing findings. (See, for example, Bhatta 2009; Baruch Y and Holtom 2008; Evans and Mathur 2005; Barclay et al. 2002.) We anticipated a greater response rate to an online survey from those staff who had experienced international placements than those who had not. Pilot work supported this assertion as staff in technical areas or laboratory work who had not experienced international mobility immediately interpreted the survey, despite assurances, as implying that they were not eligible to respond. We were particularly keen to sample a wide range of staff, including those whom we may expect to have had less opportunity to engage in international placements. With this objective in mind we decided not to opt for a blanket email/online survey but rather to attempt to gather results on a face-to-face basis to optimise completion rates.

Attempting to sample the whole population of (1.3 million) NHS employees could only have been achieved with great difficulty and probably only through an online survey tool administrated via Trusts. Our relationships with institutions in the North West enabled us to target a subpopulation that we consider to be broadly representative of the wider NHS. We therefore decided to focus our recruitment on a small number of hospitals and community medical centres within a single NHS region in the North West of England. These included two large regional teaching hospitals: Salford Royal Infirmary, Salford, and Wythenshawe Hospital (the University Hospital of South Manchester NHS Foundation Trust). We also undertook recruitment at Liverpool Women's Hospital, which is a major obstetrics, gynaecology and neonatology research hospital; and Liverpool Community Health Trust, which is a large regional hub for the administration of over 3000 NHS staff in the North West. Data from these institutions were supplemented with findings gathered from the

2015 Royal College of Nursing Research Conference, and a large Community-Based Medical Education training event held in April 2015.

Following a successful pilot survey conducted at Liverpool Women's Hospital, we decided it would be most effective to target our activity on busy public areas within each site, such as main entrances, cafeterias and arterial thoroughfares. We reasoned that such areas would be used by the whole range of hospital employees, and there would be the best chance of accessing a broad sample. The research team worked in groups of three or four, identifying potential respondents as those with NHS identification badges. At the Wythenshawe site, we were also able to attend three large staff orientation events organised by the hospital's HR department. These events, which were essentially held to welcome new starters at the hospital, attracted a wide range of people from different staff groups.

The survey was designed to be conducted on a one-to-one basis by researchers using an iPad running *eForms* software (University of Manchester 2015). It was deliberately framed to be very quick to complete – around two minutes – and was anonymous. Using *eForms* streamlined the process of participant engagement and meant that the survey could be conducted wholly electronically. Once a member of staff had been approached and agreed to take part, they were given the iPad and worked through the various simple sections of the survey (see below). Respondents were automatically assigned a code number by the *eForms* system, and their anonymous responses were stored offline on the iPad. Data were downloaded to a central online database at the end of each fieldwork session. Field work was conducted in the various settings between January and August 2015. The survey consisted of seven sections.

Cadre

The categorisations we listed were derived from eight standard employment cadres currently utilised by human resource departments across the NHS:

1. Allied health professionals
2. Healthcare scientists
3. Medical and dental
4. NHS infrastructure
5. Scientific and technical
6. Ambulance staff
7. Nursing midwifery and health visitors
8. Clinical support staff

Career Stage

1. Pre-university
2. Student
3. Early-career
4. Mid-career
5. Experienced /senior
6. Post retirement

Subsequent sections were related to age, gender and nationality. Those who indicated that they had spent time in another country, either as an employee or volunteer, proceeded to a final section (6), which focused on specific details for each time of stay abroad. This section included questions on the economic status of the country (high, middle or low income), and the career stage they were at when abroad: *pre-university; student; early-career; mid-career; experienced /senior; post retirement*. We also collected basic qualitative information at this point relating to length of stay and the type of placement if this was relevant. At the conclusion of the survey respondents who indicated that they would like to be sent information on the outcome of the study were asked to share an email address or phone number. A copy of the survey is given in Appendix 2.

Results

SPSS software was used to provide basic descriptive statistics and isolate the key features of the data. Overall, a total of 911 NHS employees completed the survey.

Sample Characteristics

Table 2.1 shows the relative proportions of different staff cadres currently employed in the NHS as a whole (column **A**), along with the relative percentages of staff specifically employed in the North-West region where the staff survey was conducted (NHS-ESR 2013) (column **B**). Column **C** shows the proportion of respondents from different staff groups who actually took part in the survey. Column **D** gives the proportion of staff by cadre who were interviewed for the qualitative arm of the MOVE study.

It can be seen that in line with our broad hypothesis, the relative *proportion* of staff that go to make up the NHS workforce nationally

Table 2.1 The survey population compared to the NHS workforce and interview sample

Staff group	*(A) Relative percentages of staff in the total NHS workforce (%)*	*(B) Relative percentages of staff in the North West region. (NHS-ESR 2013) (%)*	*(C) Survey respondents (%)*	*(D) Interviewees (%)*
Nurse/ midwife/ health visitor	30	31	31	32
Allied health professionals	8	6	14	13
Medical and dental	10	10	32	35
Clinical support staff	29	27	10	4
NHS infrastructure	16	20	7	14
Ambulance staff	2	2	2	0
Health scientist	5	4	4	2

Source: Created by the authors.

(column **A**) is very closely matched to the proportion of staff employed in the North-West Region (column **B**). This supports our contention that the survey data obtained in the context of a single region could be reasonably expected to reflect the situation across the entire organisation – at least in relation to the kind of non-regionally specific issues we are concerned with. The only staff cadre with any significant variation between regional and national levels is *infrastructure*, and even with this group, there is only a 4% difference. The slightly higher proportion of infrastructure staff relative to the national figure may be due to a variety of factors but is likely to reflect the particular organisation and management idiosyncrasies which have evolved in the North West. In the context of this survey (and indeed the wider MOVE project), these kinds of variation are unlikely to have a significant impact. Although our sampling process was largely opportunistic (see above), the sampling process achieved the level of diversity that we had planned for (column **C**). Significantly, the percentage of *nurse /midwife /health visitor* staff we engaged with accurately

reflects both the national and regional figures. However, *medical and dental* were over-represented and clinical support staff and infrastructure staff were underrepresented.

International Placements

Table 2.2 provides the relative percentages of staff from the various cadres who had engaged in overseas activity at some stage in their educational career. It can be seen that overall, 42% of those in our survey (389) reported at least one overseas placement experience.

The three highest responding groups were medical and dental with 140 respondents (36%); nursing/midwifery and health visitor (21%); and allied health professionals (18%). The remaining groups were composed of clinical support staff (15%); NHS infrastructure (4%); health scientists (4%); and ambulance staff (2%)

It is no great surprise that in line with the focus of much of the literature on volunteering and placements within health and medical contexts the highest proportion of staff with overseas experience were *medical and dental* (see, for example, BMA 2009; RCN 2010). This is likely to be a reflection of the way in which medical training in the UK has traditionally valued the experience that students gain from time abroad. The option is to participate in an overseas placement often being built into, or at least available through UK-based clinical training programmes (Gedde et al. 2011; Tooke 2009).

It is significant in the context of current policy initiatives that, although the next most populous group in terms of placement activity were *nurses, midwives and health visitors* (21.1% of volunteers), the

Table 2.2 Volunteering experiences by cadre

Professional group	*Proportion of sample*
Nurse/midwife/health visitor	(21%) 82
Allied healthcare professionals	(18%) 71
Medical and dental	(36%) 140
Support to clinical staff	(15%) 58
NHS infrastructure	(4%) 15
Ambulance staff	(2%) 8
Health scientist	(4%) 5
Total	389

Source: Created by the authors.

third group, *allied health professionals*, was of a similar size (18.3%). This group as a whole has not traditionally engaged in overseas activity as part of NHS-based training, although particular sub-groups including physiotherapists and speech and language therapists do have a more active tradition of incorporating international placements and training (Rodger et al. 2008). The relatively high percentage of staff in this group as a whole may indicate that there are a large number of individuals who have managed to navigate their way through the process of organising and undertaking an overseas outing within the demands of their everyday roles, and not necessarily with the structural support enjoyed by some of their colleagues. The detailed makeup of such a group would be usefully analysed in further work, as they will have a first-hand experience of just where systemic and organisational barriers can develop.

It is interesting to reflect on the perceptions of one survey respondent (a theatre technician) who had not experienced an international placement himself but had views about their relative contribution to learning:

> It doesn't seem to be offered to people [theatre assistants] in the operating theatres cos we're on the coal face doing the important work [laughs]... Value? Possibly, possibly not. I'd love to go abroad and see how other people work but value – possibly not. I've spoken to people who've gone abroad and they've come back and they don't seem to bring very much back with them to be quite honest. They tell you how – people who have been to Africa, for example, or India – they come back and they say it's been great for them to help, to see how other people work. But the only thing they seem to bring back is that they're really happy to be back and they're not working in those conditions anymore. You know, the NHS, seems to be a good place to work really and they realise that when they come back and they see how the rest of the world works.

Placement Location

Table 2.3 shows the broad socio-economic status of the countries where staff reported having gained overseas experience. 20% (77) had worked in a high-income location; 22% (86) in a middle-income location; and 58% (226) in a low-income location.

Over half of the respondents reported an experience in a low-resource setting. The clear tendency for professional volunteering to be focused on low-income locations such as sub-Saharan Africa and India is borne out in

Table 2.3 Economic status of locations where staff reported overseas experience

Location	*% of staff*
High-income	20
Middle-income	22
Low-income	58

Source: Created by the authors.

the literature. As early as the late 1980s Graitcer et al. (1989) were suggesting that 100,000 non-governmental sponsored volunteers worked in developing countries, with much smaller numbers choosing to go to more wealthy locations. More recent estimates by the Department of Health have supported this (Department of Health 2010a), and at a broader corporate level, a recent survey by internet placement brokers *Go Overseas* noted that the top five most searched-for locations for voluntary work and placement opportunities in 2014 were the Philippines, Thailand, India, Nepal and Cambodia (Go Overseas 2014). Interestingly, the Philippines headed the list at the time of their survey due to people specifically wishing to help with the response to typhoon Haiyan, which struck the area in late 2013. From a more functional perspective Bhatta et al. (2009) have outlined how the tendency for low-income locations to be favoured over high-income ones can also be influenced by placement providers. Well-established organisations such as VSO concentrate their efforts exclusively on low-income areas, and contextually too, the idea of 'overseas volunteering' is rarely associated with locations such as America or Western Europe unless the activities undertaken are concerned with low-income or deprived sectors. Volunteering in high-income settings can evoke a slightly different kind of motivations, and there can be a shift from the purely altruistic to something with a more personal focus; activities, while still essentially 'voluntary', can become labelled more as internships, with a more overt focus on work experience and career development.

Gender

The overall sample included more females than males (519 females compared to 392 males). This echoes the gender balance in the NHS. A recent report by the National Health Service Employers (NHSE 2016) indicates

that around 77% NHS employees are female. Figures from NHS Digital (NHSD 2016) note that it is only in the cadre represented by ambulance staff that male employees predominate (62% are male).

Our sample indicated that 217 females and 172 males had voluntary or overseas experience. Table 2.4 shows the overall gender balance among volunteers across the different staff grades.

In terms of females, nurses, midwives and health visitors reported the most experience of international placements (34%), followed by medical/dental (27%). Amongst males, medical/dental cadres represented the largest group; (48%), followed by Allied Health Professionals (25%) (Table 2.5).

Within the individual staff group, it can be seen that the balance between male and female volunteers broadly reflects the gender balance

Table 2.4 Overall proportion of staff by gender volunteering in another country

Professional group	*Female*	*Male*	*Totals (M &FM)*
Nurse/midwife/health visitor	34% (74)	5% (8)	82
Medical and dental	27% (58)	48% (82)	140
Support to clinical staff	17% (38)	11% (20)	58
NHS infrastructure	6% (13)	1% (2)	15
Health scientist	2% (5)	6% (10)	15
Allied healthcare professionals	1% (28)	25% (43)	71
Ambulance staff	1% (1)	4% (7)	8
Totals	100%/217	100%/172	389

Source: Created by the authors.

Table 2.5 Gender breakdown by cadre (international volunteering)

Professional group	*Female*	*Male*	*Total (M & FM)*
Nurse/midwife/health visitor	90% (74)	10% (8)	82
NHS infrastructure	87% (13)	13% (2)	15
Support to clinical staff	66% (38)	34% (20)	58
Medical and dental	41% (58)	59% (82)	140
Allied healthcare professionals	40% (28)	60% (43)	71
Health scientist	34% (5)	66% (10)	15
Ambulance staff	12% (1)	88% (7)	8
Total	217	172	389

Source: Created by the authors.

of the overall NHS workforce (National Health Service England 2014). The heavy bias towards females in the organisation as a whole is matched by the predominance of female volunteers in most staff cadres. For example, only 10% of nurses, midwives and health visitors in the NHS are male (NHS 2016), and this proportion is reproduced in our volunteer sample – 10% of male nurses and midwives had volunteered or worked overseas. Similarly, the overall proportions of male and female doctors in the NHS are currently relatively balanced, with 55% male and 45% female (National Health Service 2016). Our sample revealed that the numbers of male and female volunteers in this cadre also broadly followed this trend (59% male and 41% female). What this appears to suggest is that the predominance of female healthcare workers noted in many locations may be due more to the fact that there are proportionately more women working in this field (e.g. nurses). It is not that women per se are more inclined to become involved, or that it is seen as a particularly 'female' activity (Fig. 2.1).

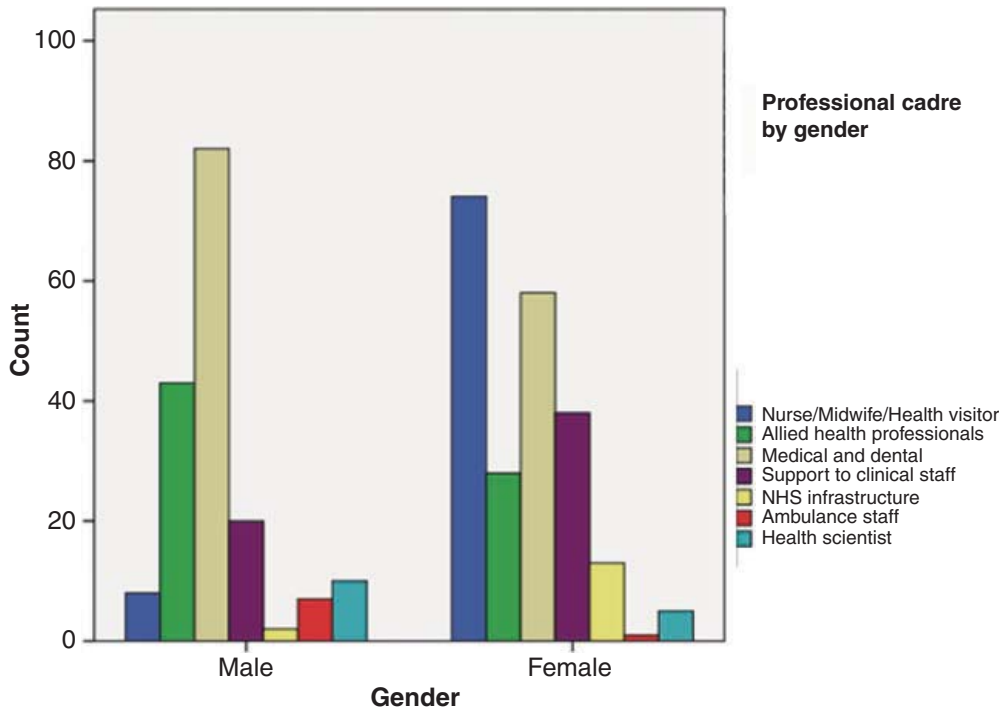

Fig. 2.1 Professional cadre by gender

Source: Created by the authors.

Nationality

Although nationality data for the NHS workforce is officially collected (NHS digital 2016), it is currently categorised by the country of origin, rather than under the socio-demographic headings we required (i.e. *British, European, Non-EU National*). We derived approximate equivalent proportions by manually assigning the 212 countries in the official workforce data to our nationality categories. We acknowledge that this is only likely to give a broad approximation of current levels as there is a degree of ambiguity over where many locations might be categorised, and further bias will be introduced by the high number of staff who are officially listed as 'nationality unknown' (22%). However, even with these caveats, the proportion of staff in our survey sample (column **B,** Table 2.6) does appear to reflect the levels found in the workforce overall (column **A,** Table 2.6). The major difference is the number of Europeans listed. Staff from European countries accounted for around 2% of the total NHS workforce, whereas our sample included just over 12%. Given that it is limited to a single category, this difference may reflect local socio-demographic conditions and is also likely to be influenced by the significant number of 'unknowns' (22%) in the national data. Significantly, the proportion of staff in our sample who had volunteered (column **C**, Table 2.6/Fig. 2.2) is closely matched by the makeup of the entire sample (column **B**, Table 2.6). This appears to indicate that in the healthcare sector the propensity to volunteer or work overseas is not dependent on country of origin.

Table 2.6 Nationality of NHS staff and survey respondents compared

Nationality	*(A) Approximate proportion of NHS workforce**	*(B) Proportion of overall sample*	*(C) Proportion of staff who had volunteered*
British	(70%) 850000	(80.6%) 734	(78.4 %) 305
European	(2%) 24500	(11.7%) 107	(12.1%) 47
Non-EU national (developing country)	(5%) 62000	(6.5%) 59	(6.7%) 26
Non-EU national (developed country)	(1%) 9000	(1.1%) 10	(2.6%) 10
Other/unknown	(22%) 264000	(0.1%) 1	(0.3) 1
Total	1.2 M	911	389

Source: Created by the authors.

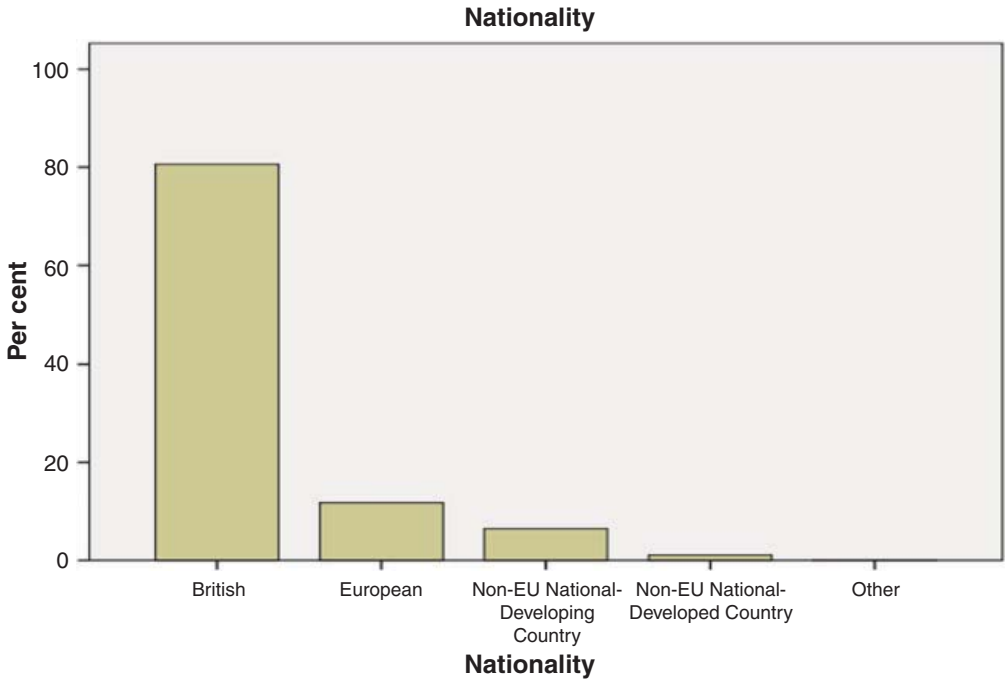

Fig. 2.2 Proportion of surveyed staff who had volunteered (column C)

Source: Created by the authors.

Career Stage

Table 2.7 illustrates the gender split within the survey, cross-tabulated by career stage. It can be seen that most males took an international placement while they were students (33% of male volunteers) followed by early career (26%) and mid-career (22%). The remaining 19% were split between pre-university (6%), experienced (11%) and post-retirement (2%). Women also tended to favour international placements while they were students (41%), with 31% going during their early career, and 14% at mid-career stage (Fig. 2.3):

Overall then, the survey indicated that the majority of overseas work or volunteering activity takes place during the early stages of people's careers, particularly during *student* and *early career* phases. For clinical staff, who may to some extent have opportunities to do this kind of activity built into their training, this is to be expected. For other staff cadres too, the period during which people traditionally have more freedom (i.e. time removed from the inevitable build-up of commitments such as starting a family) to

Table 2.7 Career stage while working or volunteering in another country

Career stage while abroad	*Male*	*Female*
Pre-university	(6%) 11	(6%) 13
Student	(33%) 56	(41%) 88
Early career	(26%) 46	(31%) 68
Mid-career	(22%)38	(14%) 31
Experienced	(11%) 18	(7%) 15
Post-retirement	(2%) 3	(1%) 2
Totals	172	217

Source: Created by the authors.

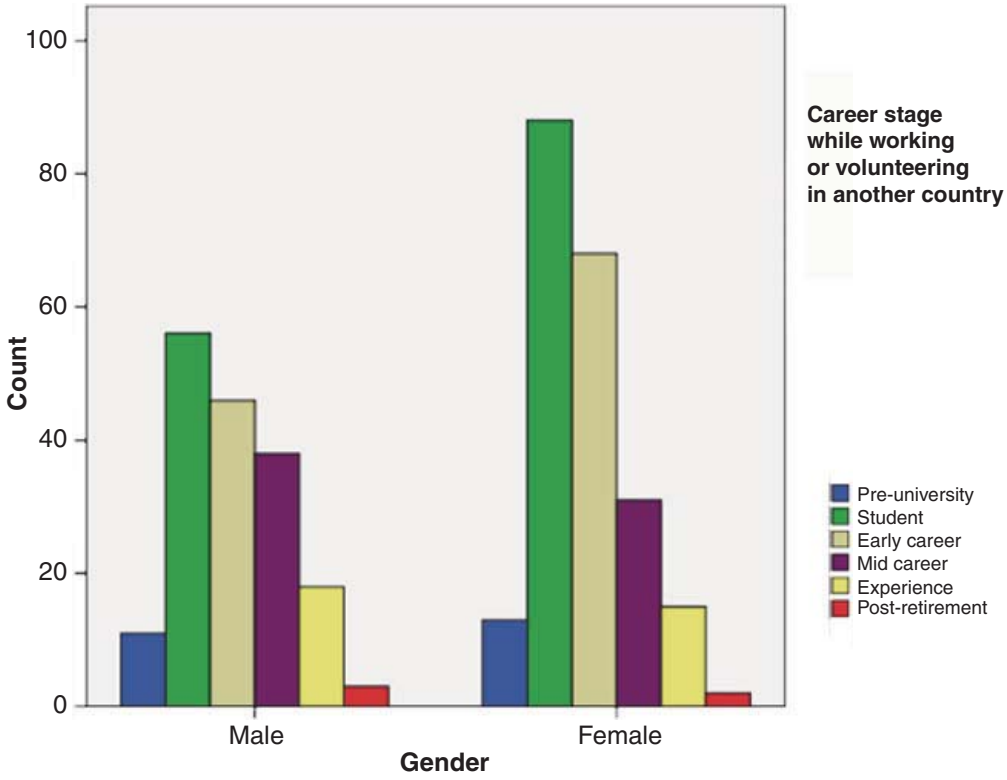

Fig. 2.3 Career stage while working or volunteering in another country

Source: Created by the authors.

engage with a spell abroad often coincides with these early career stages. Of course, not all staff follow the conventional route straight from education into training, and whereas this direct path may be the norm for medics, for other cadres, the process can be much more circuitous. Many people come to nursing, for example, after working in other careers for a period, and this obviously has implications in terms of how they may be able to deal with their other commitments. Others, like some of the midwives we interviewed for the qualitative strand of the study, had reached a point in their careers where their personal commitments had lessened and they were able to consider some time away. Kelly told us:

> I'd been a midwife for a long time and I wanted a year out. So I applied to join VSO and got in. I was just doing all that sort of stuff and then I saw [a project in Uganda] so I came out here instead. I've got two grown up boys. I think you either come before you've got children/family, so there's a lot of young people. Or like me, our kids are grown up and we can just walk out.

Sandra, an experienced midwife with grown-up children, found herself in a similar position:

> I have always thought about doing something with my career or profession. Take some time out and do something with it. And I had been a midwife for a very long time, and I was thinking I have to do development, something in developing countries with it. It was just a thought really. I thought if I did this, my CV would look a lot different and I might get out of working nights and delivering babies.

Length of Stay

For the purpose of the survey, we defined length of stay as *short-term* (under a week); *medium-term* (over two weeks); *long-term* (over three months) and *extended* or *settlement* (over one year). On average, the most popular length of stay for an overseas placement or voluntary work was *medium-term*, with 50% of respondents indicating that they stayed for up to three months.

It was much less usual for staff to report stays of over one year; only 8% indicated that they had been away for over a year. In terms of the gender breakdown, males tended to favour medium-term placements (46%) followed by long-term stays (24%). Eighteen per cent of males reported a short-term stay. In comparison, just over half (52%) females took a

Table 2.8 Length of placement stay by gender

Length of time abroad	*Male*	*Female*	*Overall proportion (M and FM)*
Short term	(18%) 31	(15%) 33	(16%) 64
Medium term	(46%) 80	(52%) 114	(50%) 194
Long term	(24%) 41	(19%) 42	(21%) 83
Extended	(8%) 13	(9%) 18	(8%) 31
Other	(4%) 7	(5%) 10	(5%) 17
Totals	172	217	389

Source: Created by the authors.

medium-term placement; 19%, a long-term and 15%, a short-term placement. Respondents who chose to make an extended stay were similarly matched in terms of gender: 8% were male and 9% were female. Overall, gender does not appear to have a great deal of impact on length of stay. The proportion of males and females in each time frame closely matches the percentages in the overall sample (Table 2.8).

Age Group and Length of Stay

Table 2.9 and Fig. 2.4 provide the age group of staff cross-tabulated against length of stay. It can be seen that the majority of respondents engaged in international placement were from the age group 'below 25' to '41–50', which equates to 288 out of a total of 389 respondents (74%). 94 respondents, or 50%, engaged in medium-term placements. Overall, medium-term placements were the most popular, with a total of 49% of respondents across all age groups. Settlement/extended stays represented the smallest discrete group, with 8% respondents.

In many ways, the data relating to the age groups within which staff routinely fall when they work abroad appear to reflect socio-demographic conventions. The majority of staff with overseas experience, for example, come from the below 25 age group, and those who were 41–50. Almost half of these (49.9%) reported taking a medium-term placement. Medium-term placements were defined as over two weeks, but less than three months, and as such represent a period away which may be incorporated into the ongoing training and employment, without necessarily causing too much disruption. It is also a time frame that meshes conveniently with commercially available, medically focused, student placement schemes. In fact, many such schemes are clearly market driven and are designed to be

Table 2.9 Length of stay by age group

Age group	*Short term*	*Medium term*	*Long term*	*Extended*	*Other*
Below 25	(22%) 14	(21%) 41	(11%) 9	(10%) 3	(12%) 2
26–30	(8%) 5	(10%) 19	(12%) 10	(3%) 1	(17%) 3
31–40	(17%) 11	(23%) 44	(22%) 18	(29%) 9	(29%) 5
41–50	(25%) 16	(18%) 36	(31%) 26	(35%) 11	(30%) 5
51–60	(9%) 6	(11%) 22	(11%) 9	(13%) 4	(0%) 0
61–70	(14%) 9	(14%) 27	(9%) 8	(10%) 3	(12%) 2
71+	(5%) 3	(3%) 5	(4%) 3	(0%) 0	(0%) 0
Totals	64	194	83	31	17

Source: Created by the authors.

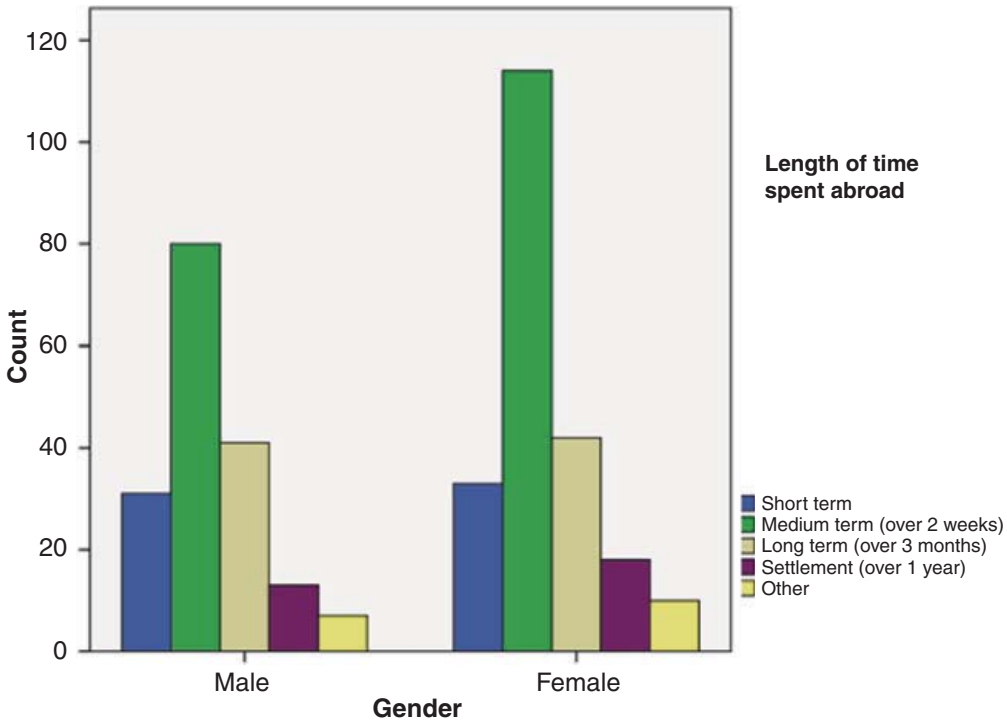

Fig. 2.4 Length of time abroad

Source: Created by the authors.

as attractive as possible to their potential customers. In terms of cadres, for example, it tends to be doctors who are able to take longer periods abroad. However, as this anaesthetist told us, the pathway to taking a placement is not always straightforward, even for this group:

> I wanted to do volunteering for a long time. I wanted to do it in an early stage of my life but I never quite did it, and although the GMC and the Royal College of Anaesthetists, and the various bodies say yeah, we support volunteering, we support working in developing countries, my individual deanery, my individual school was dead-set against it. I think they've been dead-set against it for about two years. So now I've been trying to build it in to a training placement by taking time out unrecognised for training. I've just been hitting brick walls to a point where they just kept on changing the goal posts. This is something I've got an email chain about going back about two years. When I actually asked them about wanting to do something like this, I got so frustrated that I ended up just making a decision to do my own thing. I did have a volunteer placement in Ethiopia. So I resigned my NHS job because I felt so disenfranchised and I thought well if I don't do it now, then when am I going to do it? I can always re-join registrar training, I can always get my accreditation another way.

Multiple Placement Experience

In our sample, multiple placement experiences tended to be relatively unusual. Only 10 respondents reported three periods of overseas activity, and only six of those with overseas experience reported four. All of those with multiple placement experiences came from the three staff groups incorporating *midwife /nurse /health visitor* (3 with 3 placements, and 3 with 4 placements); *allied HCP* (2 with 3 placements and 1 with 4 placements), and *medical and dental* (5 with 3 placements and 2 with 4 placements), respectively.

The issue of staff who engage in multiple placements, or periods of voluntary work abroad, is revealing. Again, in our sample, it was the *medical and dental, nursing*, and *allied healthcare professional* cadres where activity was focused. None of the other staff groupings were represented. This skewing of multiple placements towards these groups – and by extension, the employment and socio-demographic conditions which underpin them – may again be a reflection of the way in which medical training and career structuring within the NHS allow these cadres the freedom to engage in such activity.

Summary

In this chapter, we have outlined the findings from our NHS staff volunteering and overseas placement survey. This formed a discrete component of the MOVE study. The survey was primarily intended to capture a snapshot of current levels of volunteering and overseas placement activity across NHS staff grades in the North West, and we would argue that we achieved this. We are also confident that our broader aim of being able to use our findings to give a rough indication of the position across the whole of the NHS has been fulfilled. Like any large national organisation, the NHS is fairly homogenous in terms of the way its local structures are organised. The relative staffing levels we were able to capture are therefore likely to be reproduced across the organisation as a whole. By extension, levels of volunteering and overseas placement activity amongst these staff at a regional level are likely to be reproduced nationally. In the context of the NHS, it has traditionally been trainee doctors who were most likely to engage with a period of work, or placement overseas, and our survey reflects this trend. Nurses and midwives too have more recently begun to take advantage of slightly more flexible employment arrangements which have given them easier access to such placements within their career structure, and this is also reflected in our sample. In line with established NHS management and training models, our survey showed that although some degree of overseas placement activity is undertaken by a relatively high proportion of NHS staff, such activity is heavily skewed towards higher clinical staff grades. However, significant numbers of allied health professionals and equivalent non-clinical cadres also report overseas experience, and if current initiatives gain momentum, we would anticipate that these numbers will continue to rise.

CHAPTER 3

What Do Health Workers Learn on International Placements?

Abstract Chapter 3 reviews existing research and the findings from qualitative interviews with returned professional volunteers to identify core learning outcomes associated with International Placements.

Keywords Learning outcomes · Interviews · Continuing professional development (CPD)

Introduction

Drawing on the literature reviewed and our qualitative work with returned professional volunteers, Chapter 3 summarises what is known about the forms of learning that can take place on international placements. It is extremely difficult to isolate or specify key skills or competences gained from professional voluntarism. First, the phenomenon is itself incredibly broad encompassing an overwhelming diversity of experience and learning across professional cadres and career stages. Secondly, the most common response when interviewing returned volunteers about placement learning is for them to refer to the transformational or life-changing impact it has had. Mezirow (1997) argues that significant 'life transitions' or crises create a disequilibrium that may then trigger 'transformational learning'. Fee and Gray use similar language to contextualise the learning that takes place on international placements describing it as following a, 'social, non-linear process, punctuated by a series of triggers that result in evolutionary

H.L. Ackers et al., *Healthcare, Frugal Innovation, and Professional Voluntarism*, DOI 10.1007/978-3-319-48366-5_3

and revolutionary change' (Fee and Gray 2013). Other authors argue that the challenging and shocking nature of international placements in low-resource settings stimulates problem-solving, decision-making and coping skills (Kiernan et al. 2014; Longstaff 2012; Marçal-Grilo 2014). In the context of nursing education, Stephens describes the difficulty of trying to change student nurses' attitudes, values and behaviours. Using a meta-ethnography approach, she concludes that international placements constitute one of the most effective learning environments enabling nurses to move from 'compliance' through 'identification' to active 'internalisation' and behaviour change (2015: 1). Her analysis indicates that this is due to the combined dynamics of 'solving real problems', managing 'cultural encounters' and being forced out of one's 'comfort zone' (p. 7).

These sentiments are certainly echoed in the reports of respondents:

> You go there and you're different and you hope that you're different when you come back. You can dress it up for other stuff but it's a whole different set of tasks and skills that I wanted to develop as a human being. [Nurse]

> Staff come back motivated and inspired. They are more content in their own work, they feel very privileged and honoured to work in the NHS. [Line Manager]

> I know why I became a doctor which I'd actually forgotten in the NHS. I'm going to go back to the NHS, I wasn't sure if I would go back to the NHS.

It takes some persistence and probing in interviews with returned volunteers to draw out specific competences and experiences. Before attempting to respond to this challenge, it is perhaps worth emphasising the fact that all learning is by nature difficult to capture, characterise and 'measure'.[1] This is particularly true of higher and more complex forms of knowledge or knowledge combinations blending explicit (perhaps clinical or engineering) skills with more tacit learning. Whilst we, as researchers, recognise the political and economic importance of specifying learning and its relevance and translational potential, we are also acutely aware that in trying to hold it fast and 'measure' it, we may understate its transformational qualities. Before examining the learning experiences of professional volunteers in more detail, we first consider the context within which this learning needs to evaluated, namely lifelong learning or continuing professional development systems within the NHS.

Continuing Professional Development in the National Health Service

Training and professional development within the NHS, in common with most UK organisations, is managed and evaluated within the framework of *continuing professional development* (CPD). CPD is an important strategic tool for improving the effectiveness of the NHS workforce. The current annual allocation for Multi Professional Education and Training (MPET) in the NHS amounts to a staggering £4.9 billion (Health Education England 2016A). CPD in the NHS is not limited to the enhancement of individual clinical skill sets or career prospects; it is also a key mechanism to improve organisational effectiveness and patient outcomes. Sadler-Smith et al. (2000) identified three core functions of CPD. The *maintenance role*, which implies a generally passive and ongoing engagement with new workplace practices as they develop; the *survival role*, which enables practitioners to demonstrate their continued competence to work at an appropriate level; and the *mobility role*, which is essentially tied into an individual's aims and aspirations. This includes enhanced employability and career progression – potentially beyond their current employer. The Department of Health has long recognised the importance of CPD to NHS effectiveness, and all three strands of CPD are likely to be encountered within an arena as diverse as the NHS workforce. However, there is an acknowledgement that, in contrast to many other fields of employment, the rate of technological advancement and policy change in medicine and health care can be extremely rapid. This rapidity has a direct impact on working practices and means that there is an ever-present demand for healthcare professionals to review their knowledge and skills, and constantly engage with developments in their fields (i.e. an emphasis on *survival mode*).

As early as 2001, the framework for lifelong learning for the NHS was identifying how mandatory re-registration, post-registration and inter-professional education should focus on developing workforce skill sets (Department. of Health 2001). Until recently these types of initiative tended to have a clear clinical bias, focusing on developing and maintaining explicit, practical skills. In 2016, with the release of *Health Fit for the Future – Public Health People: A review of the public health workforce* (Public Health England 2016) the remit widened, and staff at all levels are now encouraged to engage with aspects of CPD that will 'enhance

personal effectiveness skills, negotiating, influencing and co-production approaches' (Public Health England 2016), alongside specific technical skills. The Francis Report (2013) emphasised the importance of care and compassion at all levels of the NHS workforce. This stimulated a drive toward a 'value-based' strategy (Waugh et al. 2014) which has placed the '6 Cs'; Care, Compassion, Competence, Communication, Courage and Commitment (NHS 2016) at the heart of the NHS' skills enhancement agenda. As the NHS has attempted to utilise continuing professional development as a means of promoting productivity, innovation and efficiency so too has the emphasis shifted from more readily codified and measurable explicit skills to more complex and tacit transferable skills. The problems of codifying and measuring knowledge acquisition are as much a problem within the NHS environment as they are in sub-Saharan Africa.

Knowledge Mobilisation through Professional Voluntarism

So, what kinds of knowledge and skills are enhanced through professional voluntarism? A recent report by the All-Party Parliamentary Group on Global Health, *Improving Health at Home and Abroad: How overseas volunteering from the NHS benefits the UK and the world* (APPG 2013), highlighted the scale and potential contribution of overseas volunteering to improving health globally and in the UK. The report is mainly concerned with the impact that NHS staff have on host settings but a degree of attention was also given to the advantages that staff themselves might derive, and the impact these will subsequently have on the organisation as a whole. The four primary areas of benefit outlined include the following:

1. Improving health in low-resource settings: volunteers are able to strengthen the capacity of health systems, institutions and professionals in these countries, where weaker training structures mean the chance to be supported by UK professionals is highly valued.
2. Leadership development: volunteers develop strong leadership skills and return with a greater understanding of how to enact change and communicate across professional cultures.
3. Sharing innovation: NHS staff are brought into direct contact with novel approaches to healthcare delivery, returning with greater confidence to challenge and change established practice in their Trust.

4. International relationships: a valuable asset to 'soft power' and international influence, giving Trusts a competitive advantage in recruitment and retention at home, and generating new opportunities for partnerships, research and revenue generation abroad. (APPG 2013)

Research on the experiences of healthcare professionals taking international placements suggests that a wealth of intense and valuable learning takes place. Many professionals describe developing a new perspective as a result of international placements (Jones et al. 2013; Wright et al. 2005). Others describe the development of specific skill sets such as communication, leadership and cultural awareness (Hockey et al. 2009; Lee et al. 2011; Norton and Marks-Maran 2014). A number of themes emerged from our literature review and empirical work with regard to 'what' learning happens and how this learning is facilitated. Before exploring these themes in more detail, it is important to emphasise that the majority of respondents cite a whole range of skills. The following response is typical:

> I have come back with teaching skills, leadership skills, management, we have also done service development which the NHS want and I have been physically involved in the project and I think these are the skills that they want. I have achieved much more out here than I ever would at home. Not just a personal way, those hard skills are there. Clinically, if I was going to stay in paediatrics it has improved my neonatal examination skills. [In the UK] you can just order a test, they definitely improved and trying to think about language barriers and communication. And a realisation of how important building relationships is. [Junior Doctor]

This case illustrates the combination of explicit skills and the emphasis on core 'back-to-basics' clinical skills with transferable 'soft skills' in areas such as management and communication. This respondent also illustrates the quite common experience of using 'time out' on placement to help them make decisions about their future career development deciding to apply for general practitioner (community physician) positions on her return.

Clinical Skills

Perhaps the most obvious (and potentially measurable) area of skills enhancement concerns explicit clinical skills (Kiernan et al. 2014). When asked about their motivations for applying for placements professional

volunteers, especially doctors, refer immediately to the potential for clinical skills enhancement. And, post placement, professional volunteers report gains in clinical skills achieved through the sheer volume of cases they encounter; their exposure to diseases that are unusual in the UK; conditions that are rarely seen due to early or preventive intervention (the outcomes of delays) or, quite commonly, scenarios that they would have limited direct (hands-on) access to due to their status (in terms of seniority or cadre).

One of the most tangible and obvious benefits of spending time in a low-resource setting concerns the large volume of cases and the access that clinicians are likely to have, even at a relatively junior stage in their careers, to these. The idea that learning is gained through repetition (case volume) is captured by theories of learning focused on 'deliberative practice' which suggest that individuals acquire or hone skills through practice (Ericsson et al. 1993). Skills enhancement here relies on an assumption that the learner has been taught the skill in the first place, and it is use of that skill that perfects the skill and builds confidence in its utilisation; similarly, lack of practice may result in skills wastage or more likely in waning confidence. This form of learning, through repeated use of pre-existing skills, could arguably happen in the absence of supervision but may be significantly enhanced when the learner has access to a 'more knowledgeable person' (Kolb 1983; Nonaka and Takeuchi 1995).

An experienced midwife volunteer described the gains she feels she made in terms of clinical skills:

> Some of my clinical examination skills are ten times better than before we came out. In the UK we lose our basic skills and midwifery skills of how to palpate a uterus and to say which position the baby is lying in because if there's any doubt we just send for a scan. I had a woman who came and I felt her abdomen and she saw it on my face – she said, 'you think I've got two babies don't you?' I said, 'I really do think you've got two babies in there'. She laughed, she said she had a scan the week before and it said single baby but there were too many poles and too many limbs for it to be one baby. I said I'm not happy with that scan result I want you to go to [hospital] and have another scan and ring me. In the evening I got a telephone call. She said 'I have twins'! How fabulous that?

We have cited her at length here as the language she uses indicates not only the actual learning but also her sense of achievement and the confidence this has given her. A core clinical skill frequently mentioned by many volunteers from various cadres' concerns neonatal resuscitation:

> I have resuscitated more babies in a few weeks here than in my whole career at home. There are times (in the UK) when the paediatrician is stuck in theatre or you're at a home birth and actually what do you do? Well you keep going (Midwife).

The midwife in this case points out the potential value of this on her return to the NHS either when staff are committed elsewhere or when she is at a home delivery. The effect of skills shortages combined with patient volume generates important opportunities to gain exposure in areas tangential to clinician's roles in the UK. We have noted a similar experience in relation to undergraduate electives (Ahmed, Ackers-Johnson and Ackers 2016) where students refer to opportunities for 'exposures' or 'spoking-out' from their main area of specialism. The following case involves a junior obstetrician:

> I had not done any neonatal resuscitation until I came out here – obstetricians don't do neonatal resuscitation in the UK.

The opportunities for learning through repetition not only improve clinical skills but also enhance confidence in using those skills:

> From a professional point of view, I've always had a gap . . . well not a gap . . . I'm not very confident and I should be more confident with neonatal resuscitation and care of the new-born.
>
> Do you feel that you'll go back with confidence in neonatal resus?
>
> Yeah, definitely, yeah.

This case illustrates the close relationships between actual skills and confidence in using those skills. In practice, it is hard to disentangle the two. The following anaesthetist makes a similar point about her exposure to working with children:

> I have done a lot more paediatrics than I've ever done [in the UK] without supervision, so that is a clinical skill. I was anesthetising neonates.

The following doctor realised the benefits of this confidence when she returned to work in the NHS:

> I have noticed that when I am on call at night – I know when I go to theatre there is pretty much nothing that can faze me; if I open for c/section I am pretty sure that whatever is there is not as bad as what I've done [in LMIC]. From a practical point of view that makes a big difference to your confidence.

One anaesthetic volunteer describes the patients he has encountered in a low-resource setting as 'sicker' than those he meets in the UK:

> The patients are generally sicker so it's a combination of factors. In certain clinical areas, you will de-skill, yes, but in other clinical areas it's a form of crash course, six months and then all your acute care skills as a physician you're just practicing them more commonly. You're less reliant on the high-tech stuff and you become more reliant on your clinical acumen.

These cases also illustrate the importance of volunteer learning in situations of emergency. The sheer volume of emergencies in these settings certainly provides critical learning across all specialities and a preparedness to think out of the box and react. One key informant referred specifically to this experience and the confidence it spawns:

> Their knowledge and skills are enhanced by what they've seen and they're more confident in responding to emergencies.

The volume of patients by definition implies a diversity of conditions and, sadly, in a low-resource setting characterised by extensive delays and poor patient management, exposure to conditions that are rarely witnessed in the UK. Kiernan et al. contend that the breadth and depth of conditions seen in low-resource settings provide exposure to a variety of illness allowing health workers to tap into a wider range of diagnoses. In the following case, a midwife refers to her experience with breech deliveries but also tropical diseases complicating normal pregnancies:

> From a purely medical point of view there is the opportunity to see a lot of conditions. I can do breech deliveries to get more skilled up in that – diseases in maternity so HIV, hepatitis in pregnancy, malaria, TB and that kind of stuff. . . . These things will be useful when I return in the UK.

A very experienced volunteer midwife who had spent time in a number of African countries returning to the UK in between argues that these skills could be very useful in the UK where the medicalisation of childbirth has (in her view) reduced patient choice:

> Can I just talk about clinical skills because I think that is really important – having been back and forth to Africa for a few years now, I have certainly

> found that clinical skills say with breech and twins in the UK are really going downhill because everything goes to section. In the UK I see very often the obstetric distress where the person on call actually has not dealt with a breech or hasn't had much experience with twin deliveries. And they're the one who is getting really upset and stressed because the woman wants a vaginal delivery and that causes problems. To come here is actually an opportunity to witness and deliver twins where there is not that feeling that this woman must go for section or because you have a breech you must go to section. It is very much regarded as normal here.

Linking into the 'global health' discourse, the following volunteer notes that, although many of the conditions volunteers encounter are not common in the UK, they are increasingly relevant given high levels of immigration:

> I have increased my knowledge of tropical diseases and malaria. I know it is not common in the UK but they do come up sometimes with people coming from other countries so it is nice to have that.

Obstetricians almost always report their experiences of serious complications that are either rarely seen in the UK (and they have only come across in textbooks) or that they would have limited direct access to in the UK due to their seniority:

> I have had the opportunity to do complex cases here which are far different from the UK . . . there were plenty of uterine ruptures this week, multiple pregnancies and I had never done an ectopic pregnancy but I have now done that as well.
>
> I will go home having done breach deliveries and lots of uterine rupture repairs. That will be two things on my obstetric CV that you won't have unless you do something like this.

One respondent expressed some concerns about the value of her new-found skills on return to the NHS where such complications were highly unusual:

> I am not sure how these skills are transferable to my UK practice because I have been dealing with uterine rupture and some more obscure things and I'm not likely to see them for a long time in my practice in the UK if I ever do. I have been exposed to all sorts of clinical scenarios.

A leading representative of the Royal College of Obstetricians responded to these concerns in an SVP workshop re-assuring volunteers that these skills are relevant and, furthermore, often lacking among NHS consultants:

> The skills you are learning are fantastic and actually the majority of UK consultants could not do any of these things you have just mentioned because they have never seen them and that is a huge risk to the mothers in the UK. We are seeing maternal deaths occurring because the people just don't have that experience which the previous consultants may never have seen before. That demonstrates something in you – that your experience allows you to confidently say, 'well somebody has to do it' while in the UK people don't seem to have that and they are frightened of doing that. So if you are given that confidence to actually deal with the situation which you are presented with this is hugely valuable. You may not use it in ten years but that 1 in 10 years – that is very important.

The opportunities for clinical learning will vary by cadre and placements may not provide opportunities for all people or in all skills. And, from that point of view, it may be difficult for them to map neatly and comprehensively onto a comprehensive CPD framework. Anaesthetists, for example, often report fewer opportunities for the kinds of clinical skills enhancement that is immediately relevant to their practice in the UK. This reflects the fact that the equipment and gases used are so different:

> Clinically it won't be cutting edge things that I've learned but I've learned how to use drugs that I haven't used before, like ketamine which I've never used in the UK.

Other anaesthetic volunteers immediately identify skills applications in the UK:

> The clinical skills I've learnt? I don't normally use ketamine back in the UK; I've never used the anaesthetic agent ether or halothane before and so you're using all these drugs but some of them are available in the UK. Some are not but the ones that are you'll be so much more skilled in using them. I'll even go as far as saying I know people that are so much more senior than me at consultant level that have never used drugs that I've used that I could make useful in settings back in the UK. They've gone on to become established consultants and they may have only seen one or zero cases. Some of the cases you see out here as a registrar level anaesthetist sure

> you won't see those commonly again in the UK, and if you do, something has seriously gone wrong but the skills you learn are very transferable, very transferable to other conditions and you're incredibly more confident.

In the following example, a junior doctor distinguishes learning in surgical skills from internal medicine:

> I think the people who learn the most from this experience will be internal medicine which is not surgery, just because of the array of things they see over there, people usually present very advanced malaria and how to treat it, I mean I don't know how you would apply that [in the UK] but it increases infectious disease knowledge. They would see more advanced TB that could be applied over here now. They can see very advanced things. From the anaesthetic and surgery point of view, we see things like very advanced cancer, someone with a huge tumour, something that could have been solved earlier. Things are more scary and exciting, you don't have as much modern equipment, you have to make do and adapt to your patient. You learn so much.

In such cases, skills enhancement may be constrained by the lack of access to essential equipment, consumables or cultures of practice. Indeed, in many situations, clinical intervention may simply be impossible due to these environmental factors. The prevalence of these kinds of situation led to the development of the THET-funded bio medical engineering project designed specifically to reduce the occasions on which interventions are limited by lack of usable equipment.[2] As well as improving local health systems this project has enhanced opportunities for volunteer learning by keeping theatres, neonatal units and high dependency units operational. Equipment is not always the main factor. One mid-career obstetrician suggested that, from a narrow clinical perspective, his skills were not being enhanced because 'here there is nothing between a normal delivery and a c-section – they don't do assisted deliveries and that is where a lot of the skill lies'.

This in part (and at face value) reflected a lack of equipment but in fact reflects a much deeper seated cultural[3] opposition to the use of forceps or vacuum for assisted delivery. In another case an ophthalmologist suggested that in his specialism, experiencing new diseases was a less significant component of overall learning:

> In ophthalmology, I don't think the primary benefit for medical staff is that you will see unusual things because most blindness in [LMICs] is cataracts and squints and we've plenty of those ourselves. So I don't think seeing new

> diseases – that's not a big issue. You might see a more advanced case of something you already know but that in itself is neither here nor there.

Certainly, as managers of professional volunteers, we were aware that placing some cadres presented greater immediate challenges that would affect clinical learning. Where a specialism is underdeveloped or even non-existent, it is more difficult to relate clinical skills learning directly to CPD frameworks at home. Mental health is a case in point. One mental health nurse suggested that her learning was less focused on improving clinical skills and much more focused on 'soft' skills.[4]

We have referred (above) to 'exposures' outside health workers' disciplinary specialisms. In many cases these exposures have played quite an influential role in helping volunteers to make decisions about their future careers – or adding to their CVs to make those decisions possible. The following junior doctor used the opportunity to gain experience in midwifery as the basis for a planned specialism in obstetrics:

> I'm almost certainly going to go into obstetrics training when I get back so for now I'm still quite a general doctor. It's good experience for me, practically it's a lot of hands on stuff, I'm doing a lot of midwifery work – it's useful to have that basic background isn't it? When I say basic that's a bit rude really, I just mean it will be useful to know how things should work normally compared to when things go wrong so that's really useful. Already I'm much better at delivering babies than I was two months ago so that's brilliant, that's really fun and satisfying.

The SVP social science volunteer, involved in evaluation, later decided to train as a nurse in the UK. In another case, a more experienced midwife used the opportunity to gain access to management experience which she felt would help her to make the next step in her career:

> It depends what stage in your career you are as well, I don't need to go and learn clinically really. I'm looking to stop working totally clinically (to work) in management.

Sadly, the exposure to acute situations also results in very immediate experiences of mortality:

> I have looked after ladies with more still births in the six months I have been here than I have ever in my whole career. In the UK, people are absolutely

> mortified even if they have a late miscarriage. It's so upsetting. If they have a stillborn it's devastating. You know huge counselling and just horrendous.

The immediate and repeated experience of mortality constitutes a key component of risk in volunteer management and must be managed accordingly. However, it does also present opportunities for skills development in terms of counselling skills and resilience; these are often also linked to elements of cultural awareness (see below).

Whilst the opportunities generated through patient volume or disease complexity will doubtless generate novel exposures for UK health professionals, the quality of the training environment may reduce the potential for knowledge gains. A key factor here is supervision. Where junior or non-specialist staff are exposed to situations without access to adequate mentoring or supervision skills enhancement will not be optimised. Indeed, the level of absenteeism of staff and especially doctors in low-resource settings (Ackers et al. 2016) can significantly reduce the clinical exposure of professional volunteers as theatres remain closed for extensive periods. The following junior doctor refers to the need for clinical supervision in low-resource settings and the importance of having a UK mentor to compensate for the lack of immediate supervision:

> It becomes a challenge when you have a baby that you don't know what to do and you don't, at the health centre, have someone to discuss that baby with and I've emailed my mentor about a couple of babies and have had to rely on a senior doctor from the UK rather than having a senior doctor here. So in terms of co-presence I mentioned that I am not always working with a doctor but I am always working in co-presence with the nurse in charge of that unit. I do think for junior doctors, you do need a doctor that you can talk to about cases.

Literature on learning theories describes the importance of a 'more knowledgeable other' to some forms of learning (Vygotsky 1988) which enables the learner to move from the 'zone of current development' to the 'zone of proximal development' (Harland 2003). According to this theory, the 'more knowledgeable other' could be someone from other professional cadre; what is significant is that they have a higher skill set on that specific aspect of knowledge.

This is a point we pick up in Chapter 4 and reflect the potential tensions between optimising the skills of volunteers and minimising the damage to

health systems caused by unintended consequences (Ackers and Ackers-Johnson 2016). In the absence of effective safeguards, professional volunteers may also be exposed to unacceptable levels of risk through lone working in such circumstance, a point we return to later.

Leadership

Leadership is notoriously difficult to pin down both as a discrete skill and as an element in self-reported assessment. The lack of clarity around the concept was pointed out over 40 years ago (Sales 1966), and many attempts have been made to disaggregate its components (see, for example, Tourangeau and McGilton 2004; Rohs and Langone 1997). In terms of professional placements and international volunteering, the hypothetical construct of leadership is often referred to as if it were a homogeneous concept. Even the Chartered Institute of Personnel Development brackets elements as diverse as time management and creativity under the rubric of 'leadership skills' (CIPD 2014). At policy level, there is also ambiguity. The 2010 framework for NHS involvement in international development (NHS and DoH 2010), for example, singles out the development of 'leadership' as a key strategic priority. The 2013 All-Parliamentary Group on Global Health similarly refers to volunteers developing 'strong leadership skills', and returning from their overseas encounters with 'a greater understanding of how to enact change and communicate across professional cultures' (APGGH 2013). So, in this case, there is a conflation of leadership skills with cultural competency.

Many NHS policy documents outline the requirement of NHS staff to demonstrate leadership skills. The NHS '5 Year Forward View' document has a focus on leadership (NHS England 2014). Additionally, the '2022 GP' has a focus on co-ordinating complex care and the role that general practitioners play in coordinating multidisciplinary skills. The Health and Care Professionals Council (HCPC) standards of proficiency suggests physiotherapists, psychologists and radiologists should understand the concept of leadership and be able to apply it to practice. Furthermore, leadership is named as one of eight principles of nursing practice by the Royal College of Nursing (2015).

Clearly leadership is recognised as a core skill across the NHS and an ability to demonstrate leadership is necessary and desirable in staff of all professions and all career stages. If it were well-evidenced that

international placements develop these skills, then it could provide a way to increase human resource capital, at a time when maximising staff skills is increasingly important.

Furthermore, the NHS Leadership academy has created numerous frameworks to help assess leadership in healthcare professionals. The medical leadership competency framework (MLCF) was devised in 2008 and aims to identify competencies that need to be developed and can be used by any NHS professional (Hockey et al. 2009). The model includes five domains: personal qualities, setting direction, working with others, improving services and managing services. It has been argued that this framework, along with others, can be applied to work in low-resource settings to develop leadership. In a specific project involving UK professionals working in Cambodia with a purpose of leadership development, authors argue that having complete ownership of a healthcare improvement project enables professionals to engage in processes of planning, management, critical evaluation, systematic enquiry and encouraging innovation (Hockey et al. 2009).

Available literature suggests that professional volunteers based in low-resource settings are presented with opportunities to lead that they would otherwise not have in the NHS (Baguley et al. 2006; Banatvala and Macklow-Smith 1997; Jones et al. 2013; Kiernan et al. 2014). Many of our respondents describe being in a low-resource environment as a catalyst for them to acquire leadership skills, out of necessity. As noted above, the kinds of skills or experiences they identify are quite diverse ranging from elements of project management, health systems thinking, quality improvement, audit and cross-cultural, inter-professional communication within teams frequently involving conflict management. Some volunteers, often at a more advanced stage in their careers, identify this as a specific objective of their placement to gain management experience to support career development on their return. Others become involved in high-level project management initiatives. The first case presented below involves a registrar who was in part motivated to volunteer in order to gain management skills. She identifies the difficulty she has had in the UK in gaining this kind of experience, even though, according to her, this forms an explicit component of her training:

> It is difficult as a registrar in the UK to really get involved in management . . . there is management stuff in my training; there are specific things that I have to do. You don't really get a lot of say in how things

> are running and should happen.... and I mean that is the way forward to try and get the team we were working with to think about new ideas. I think that would be good to try and do that before I become a consultant rather than after.

In this case, the doctor developed a large triage area in the national referral hospital. Whilst this may sound relatively straightforward from a UK perspective, triage is one of the most difficult concepts to introduce in LMIC settings (see Ackers et al. 2016, for a case study of this process). The next respondent refers specifically to the emphasis on managing 'dysfunctional teams' in her training and the experience she has gained:

> Lots of management, I'm sure it will make me better at managing a team where all is not going as it should do. That's one thing that's on my advanced training modules 'how to manage a dysfunctional team'.

As noted above, many quite junior volunteers engaged directly in managing complex interventions. Arguably this type of experience is likely to be more prevalent in volunteering positions that are focused on capacity-building rather than service delivery per se as these often encourage volunteers to develop or work within multi-professional teams. In such cases and especially where projects are funded, placements will have an emphasis on evaluation and audit. The SVP evaluation identified many situations in which early career health workers became actively involved in management and leadership for the first time in their careers. The respondent in the next case immediately linked her own experience of project management as an early career obstetrician to evidence of personal qualities such as initiative and responsibility:

> It shows initiative. How you can cope in such situations. I got a level of responsibility that I would never have got in the UK working in project management and leadership. It shows that I have more skills.

In the two following cases, quite junior doctors (pre-specialisation) achieved a high level of engagement with staff and very senior managers setting them apart from their peers at home:

> From the professional point of view it's benefitted me. Obviously something I've never done before and it's really more on the coordination and

> management of people. I feel like I am actually benefitting a great deal from coordinating different people. We are meeting people even up to directorship level who are inputting lots of quite useful ideas and I'm meeting guys who are meeting at a technical level within a low-resource setting which is something that I was never used to, so this is also quite beneficial to me professionally. I think I'll be stronger from here, professionally.
>
> I am much more experienced than my grading as a doctor. I spent time on wards to train a great many staff and I am much more comfortable in different settings and difficult situations. Now, I have seen it before and have done it before in different circumstances. I got different skills in leadership and in people management. [But] communication was the main place where I learned lots of extra skills.

Volunteers were acutely aware that these are the kinds of skills that are highly prized in the NHS or at least in NHS rhetoric and believed that their ability to concretely evidence them is likely to accelerate their career progression. In the following case the doctor refers to the systems thinking components of this experience and the link to organisational innovation:

> Things like managing people, leadership, quality improvement projects especially as you get more senior. That's what consultants want to see when you are applying for a job, they don't need to know that you can hold an airway because that's competency, they want to see that you can see a health system and innovate, how you can improve something, and I think that's something that I would say to my Deanery when they ask what I learned from this.

She also uses the language of 'quality Improvement' as a component of management. Quality improvement emerged in other volunteer accounts. In the next case the respondent links this closely to inter-personal and inter-cultural skills. She also makes direct reference to the value of learning from failure:

> I've done a few quality improvement projects which have been a real obstacle and I've come to learn how you have to strategize, deal with different personalities, when to move forward, when to stop and observe so a lot of inter personal and inter cultural skills that I've had to learn. I've also learned about myself, to understand myself more, ask myself why I am frustrated.

Some volunteers talk of leadership in a more routine way in terms of managing difficult trainees and the use of diplomacy to instil behaviour change:

> Its leadership, service development and communication where I've learned a lot. I think my people handling skills; I've got an intern who is particularly difficult to manage. I'm trying to get the best out of him, those kinds of skills have come on a lot.
>
> Interpersonal skills that you're drawing on every minute of the day; trying to get things done in a diplomatic fashion.

The following respondent suggests that her experience of managing change will be of direct value to the NHS and impress her managers far more than gains in clinical skills that may arise from placements in high-resource settings:

> What they will be very interested in, what they will see in me is an individual who is very motivated to try to change things in spite of a very difficult environment, and if she is able to do that, if she comes to our Trust and we give her a project/protocol to start to improve things, she would be the one. I think they will appreciate that more than say if I went to America and learned a new fancy skill.

This area of learning, especially for those cadres with little previous exposure to leadership, could be interpreted as an example of 'experiential learning' which Ng et al. (2009) characterise as a 'holistic process of adapting to the world'. Patrick describes experiential learning as, 'learning through reflection on doing' (Patrick 2011). Arguably, this kind of learning can continue to happen effectively in the absence of co-present supervision (Kolb 1983), although this learning process will vary according to the environment and qualities of the learner.

Whilst many respondents talk about leadership and management in terms of people management skills, others referred to the experience they had gained in resource management more generally. Low-resource settings are characterised by major problems in terms of consumables and medicine management. This by no means only concerns the lack of resources per se but very poor systems resulting in regular stock-outs further compounded by endemic and highly innovative corruption. It is by no means unusual to see theatre lists closed due to a lack of surgical

gloves, theatre linen or basic equipment or triage halted due to the lack of blood pressure machines. Inevitably professional volunteers become involved in these processes on a daily basis:

> I've gained skills and expertise related to logistics, resources and stores, stocks and supplies and all those kind of things that really could be useful.

As Crisp (2010) notes, managing resources is as much a problem for high income settings and the NHS as it is for low-income settings such as Bangladesh, and there are great opportunities for knowledge transfer and frugal innovation. The NHS' '5 year Forward View' suggests innovative ideas for cost saving are important and that these should be implemented more quickly in the future (National Health Service England 2014). Evidence suggests that placements in low-resource settings improve awareness of the relative costs of interventions and the damaging effects of resource misuse (Kiernan et al. 2014; Leather et al. 2010). The phrase 'problem-solving' is used throughout the reviewed literature to describe a skill set that develops as a result of international placements (Baguley et al. 2006; Horton 2009; Longstaff 2012). The interviews link this financial awareness to 'back to basics' clinical skills and problem solving:

> I Had to Use My Eyes, My Ears and My Stethoscope like I've Never Done Before.

> We're so used to ordering investigations, we've forgotten some of those basic skills.

The development of soft skills can be seen as a key facilitator in the various stages of clinical skill development. For example, planning, concentration, repetition and revision (a tendency to practice), study style and reflection (a tendency to self-regulate learning). The next two cases show how a resource constrained environment improves the ability to plan and solve problems:

> I've become more resourceful because of the lack of resources and equipment that works. I've learned to anticipate what's ahead and what might go wrong and get myself ready for it, whereas back home I have an assistant so I don't have to worry. So it makes me prepare and not rely on anyone else. [Anaesthetic volunteer]

> I learned to be more resourceful, clinically, because if something bad happens, there's no one else. It taught me to how to monitor patients even with the most minimal equipment especially with kids and I think that's quite a useful skill. [F2 doctor]

The next case is very typical and refers to the awareness that volunteers gain from their core skills. We have used the word awareness here as in many cases this is not about developing new skills but remembering and revitalising skills. In this example the bio medical engineer volunteer is talking about the fundamental science that lies at the heart of his profession but lies dormant in the UK:

> It's made me think about things completely differently. About the way I work in the NHS particularly in times of resource constraints and trying to think laterally about the way you do things. It makes you go back and think about things in their fundamentals . . . of course physics and that kind of thing. UK degrees are fantastic but they are so theoretical.

The MOVE project did not set out to capture the views of line managers as such. However, some returned volunteers had themselves become line managers as in the following case:

> Low-resource settings give people the ability to think on their feet and be quicker and I think they become people who can solve things; people who are used to working in high resource setting, I don't think they are very flexible – especially when you have worked somewhere like Australia or New Zealand where health care is very prescriptive and very defined (Midwifery Lead)

One of the line managers interviewed was involved with the recruitment of Army reservists and their deployment to low-resource settings usually in crisis situations. He was very clear about the skills they were offering potential recruits and the NHS:

> The organisational skills are gonna be first and foremost. These people will have to stretch themselves clinically with the things they are dealing with and bring this clinical practice back to the UK. So we've seen catastrophic traumatic situations that are influencing how we deliver care back in the NHS. We'll offer you leadership, we'll give you confidence in presenting and all that sort of stuff cos you've got to be quite credible, so all of these things will give you an edge. When we're dealing with the NHS we find that senior

> managers straight away see the benefits of reserve service. You send us someone with clinical ability and we'll enhance that ability in a wider field than you do. We'll give you back somebody who's very comfortable with sorting order from chaos, being in a stressful situation and able to manage people and lead teams. That's quite an ambitious statement to make, but that's what we deliver.

This statement echoes the literature on highly skilled mobility generally and scientific mobility, in particular. In this context mobility is often seen as a way of recruiting the 'brightest and the best' or those individuals more willing to take risk and innovate. Nevertheless, we must allow for the fact that those individuals who put themselves forward for professional placements in low-resource settings (all else being equal) may be a self-selecting group. And, added to that, recruitment and deployment processes may identify individuals with a high degree of resilience and ethical commitment. The following volunteer hints at such:

> I don't know if you have to be a tough person already to some degree?

Another volunteer talks of how she is no longer afraid of 'risky situations' – the question is whether organisations recruit people who are less risk averse or whether the process itself develops this quality. Certainly, the recruitment processes that volunteer deployment organisations are involved in will actively valorise resilience.

Leadership and management are necessarily linked to team working. The NHS and its training arm (Health Education England) have recently placed significant emphasis on the development of multidisciplinary teams and the dissolution of counter-productive professional boundaries (HEE 2016C). Kiernan et al. (2014) suggest that international placements provide unique opportunities to work with people from other professions. This finding is echoed by professional volunteers who describe the skills they gain through team working with other cadres. This arises in a number of ways. First, deploying organisations may actively mobilise multi-professional teams in complex interventions. This is the case both in systems-focused capacity-building environments and humanitarian crisis situations. Secondly, volunteers witness the stark absence of team-working in hosting organisations which heightens their awareness of its value. And, thirdly, the act of simply living in proximity to other volunteers from diverse

backgrounds undermines professional boundaries as the following case illustrates:

> It's great that teams go out there that are multi-disciplinary because you see your colleagues in a different way and appreciate their roles more. You are all in it together when you're out in a difficult situation. I mean it's so resource poor that it is actually a hard thing to go and live in an environment where it's not a guarantee that water will come out of a tap or you plug something in and it will work. That's quite difficult really, so I think you see people rather than colleagues.

We have made the point on several occasions that active learning in low-resource settings often comes about as a direct result of observing or experiencing failure. This is also the case with regard to team-working where the challenge of solving immediate problems precipitates a team dynamic:

> When they go and realise the absence of team work [there] it makes them aware that they do do team working (in the UK) and they realise how important team working is. [Line Manager]

Team working was also specifically emphasised in the interviews with army reservists:

> Certainly one thing about the military is team work, because everybody just works as a team and just does it. There is no premadonnas. And that team work, if you could bring that team work back that is what you would want to bring back. [to the NHS]

Volunteers often report positive experiences while working in local teams. Key among these was a heightened appreciation of the damaging effects of professional hierarchies and boundaries. This was not because such boundaries are any less evident in low-resource settings which are often more hierarchical (Briscoe 2013). It was more closely related to dimensions of positionality[5] and the uniquely privileged status that volunteers acquire – as supernumerary foreigners – which positions even quite junior health workers in critical leadership roles.

Many volunteers become involved in aspects of audit, protocol development and related training (Ackers et al. 2016). This broad area of skills

could be categorised as a component of teaching or research (see below) but also forms a key component of leadership in the NHS. The 'Trainee Doctor' underlines the importance of accurate and clear clinical records and understanding the principles and practice of infection control (General Medical Council 2009). Working in low-resource settings exposes professionals to the stark reality and consequences of lack of compliance with clinical guidelines and protocols, especially in areas such as patient management and infection prevention control. Standage and Randall (2014) argue that working overseas provides nurses with a greater understanding of why it is necessary to do things that are required in the NHS such as gaining a child's consent by experiencing an environment in which such systems are not in place. Nurses on international placements become critical observers of the difference in the implementation of safety procedures such as infection control (Button et al. 2005). Some returned individuals reported that experiencing a world without NHS standards, allowed them to appreciate their importance (Greatrex-White 2008). Certainly the ethnographic work with SVP volunteers shows that almost every volunteer when confronted with the chaos that is present in most public health facilities immediately jumps to advocate interventions focused on patient management, record-keeping, audit, infection prevention control and surgical safety (Ackers et al. 2016). The stimulus for this comes from the immediate and stark reality of outcomes associated with its absence. Patient safety is an ongoing theme in most interventions and the spectre of Ebola/Marburg pushes this home:

> It just made me think in terms of patient safety in this environment.

Learning from Failure

At a pragmatic level, it is argued that learning experiences embedded in the context of a developing country provide invaluable opportunities for staff to see the consequences of poor healthcare system management. The senior manager of a charity providing volunteer placements in Africa told us:

> I was talking recently to some returned mental health nurses who were learning about the side effects of the drugs that are given to schizophrenics. But when they went to Africa they actually saw the side effects of these drugs that they never see here – patients foaming at the mouth

> and whatever. And they saw the end stage of things that would've been dealt with much earlier her. And that's very dramatic, but on a different level, I think that a lot of people in the NHS get sick to the back teeth of paper pushing. Then as soon as they get to a developing country, and see really chaotic health care and the first thing they want to do is paper push because they understand the real value of audit and basic patient management, of basic triage. They get to see how badly things go wrong if those systems aren't in place, that I guess on a routine day to day over here might seem a bit boring – maybe even unnecessary. But they see the lack of audit and the consequences of basic patient observations and patient notes. They see the value of interventions that they take for granted here, and they see the consequences of stuff that doesn't work.

The absence of the highly ordered societal and organisational structures that we are so used to in the West was mentioned by many people who had worked in low-resource settings. A fundamental lack of basic administration systems in many settings could be difficult to come to terms with. This appeared to be especially frustrating for nursing staff who tend to be known for their reliance on securely structured protocols, and were used to working in the 'protocol heavy' environment of the HNS. A placement provider told us how she had noticed that while there was a general culture of negativity towards the opaque layers of bureaucracy which tend to characterise the NHS, when staff returned from locations that did not have even the basics of such systems they often found a renewed appreciation for them and: '*. . . the first thing they want to do is an audit*.'

Barbara was a senior clinical manager and part of a team who regularly travelled to Central Africa to provide training courses in emergency obstetric care. She told us how the complete lack of structure in many of the health centres she had encountered still shocked her, even after many trips. This lack of structure could extend well beyond the clinical environments that she and her team needed to engage with:

> They don't register births, deaths, marriages. It just happens. Which is such an alien thing to us in a country where I think we have an image of who's here – we know how many are here – you know with all the information that we gather when we do a census we've got a good grasp on what we think our population is, whereas in Africa that doesn't exist. Patient records are hit and miss. They may have a record, they may not. So it's very difficult because

> when somebody dies there's a process that we have to go through of reporting it and making sure the right forms are filled in. It just doesn't happen there. It's just give them back to the relative and off they go. Without it [medical bureaucracy], although it feels like a lot of red tape and it feels like a barrier to giving the care that we want to give, but it actually gives us so much more than that, just on that level of a process, although it is sort of a name and a number, it gives that person some value. And I think it's different when you go to Africa, it makes you feel a bit vulnerable because you could just disappear. Nobody would look, and nobody would even know that you existed.

The absence of good teamwork in some settings was also reported, but even this could be seen as an important learning opportunity:

> It's learning through the observation of failure. I don't think they're going there and seeing wonderfully good practice or team working or patient safety. When people learn over here [in the UK] and when people prepare learning materials, they show them best practice, and all the examples are best practice. That's not what they see in developing countries. They see dreadful practice, but it shocks them into very simple back to basics thinking. Things like 'no one took that patient's temperature' or 'no one made a note of that'. And I think 98 per cent of what they're doing is learning from and reacting to bad practice. [Placement charity worker]

Many volunteers comment on the level of bureaucracy in the NHS and its impact on clinical time; but at the same time most engage in some form of protocol development and audit. In the following case the respondent is planning to use her new skills as soon as she returns home to a new role:

> I've just got a new job doing audit which will be really interesting. I'm hopefully going to use some of that here as well.

Witnessing the outcomes of bad practice and lack of clinical guidelines also makes volunteers aware of the role that these processes play in promoting justice for patients:

> I try to look at things from another positive perspective, it makes me much more tolerant of a lot of bureaucracy because I think well at least we do have that level of protection somebody will pay attention if reported something in

> the UK and that I think is right – somebody will listen and there is some system that to try and get some justice in some way

Having said that there is often a sense among volunteers that returning to the NHS will undermine their new found autonomy and weigh them down with what they view as excessive administration:

> How are you feeling about returning to the NHS?
>
> To be honest it fills me with a bit of dread, as much as things are tough here and frustrating, sometimes when you save lives here it really hits home and its more rewarding but I do miss the efficiency, but I don't want to go back to administrative paper work and that's what the NHS is heading towards. And over here I have more freedom with my ideas and back home it's a lot more structured and there's so many levels of authority and administration for someone to ok you.

The empirical data generated as part of the MOVE project supports existing literature to suggest significant and accelerated (intense) exposure to managerial and leadership skills on placement in low-resource settings. Unfortunately, the paucity of research that exists suggests that these competencies may fail to support effective knowledge mobilisation in the NHS on their return due to a lack of leadership options or systems closure. The engagement of often very early career professionals (and even students) in leadership roles often reflects the fact that volunteers find themselves to be the most senior person in the facility, or are perceived by local staff to be in such a position. This carries both opportunities and risks and raises questions about supervision and responsibility (Dowell and Merrylees 2009).

Communication

The ability to communicate is a key skill in any and every workplace especially when dealing with customers and patients. Guidance from the Nursing and Midwifery Council (2012) identifies 'poor communication skills' as a common area of concern with regard to fitness to practice and the General Medical Council (2009) emphasises the need for 'Tomorrows Doctors' to communicate appropriately in different circumstances. These concerns are echoed in the Health Professions Council assertion that physiotherapists and psychologists should be able to communicate

effectively using both verbal and non-verbal methods and understanding the impact of culture on these. Communication is also one of the '6C's' (NHS England 2014). This document focuses on the centrality of communication in care, specifically that decisions should not be made about the patient without their consent; it also has a focus on the importance of listening.

Much of the literature describes how communication skills are enhanced during international placements (Kiernan et al. 2014). This argument centres around the development of skills to communicate with people from a different culture/country, such as overcoming language barriers, developing non-verbal communication and communicating in a culturally sensitive manner. Furthermore, the development of a generic 'communication' skills set is stated throughout many of the articles found in the systematic review (Jones et al. 2013; Kiernan et al. 2014; Lee et al. 2011; Norton and Marks-Maran 2014). Whilst most literature talks in general terms, some break this down into more specific learning. Norton and Marks-Maran (2014), for example, refer to the development of 'interpersonal skills to live and work together with people of all nationalities and cultures' and Duffy et al. suggest that simply being in a foreign culture is the most important facilitator of learning in an international environment. Clampin (2008) argues that being in another environment and outside your comfort zone forces individuals to reconsider their existing methods of communication and this results in novel approaches.

The majority of professional volunteers interviewed identified 'communication' amongst the key areas of learning. This embraced a range of skills including verbal and non-verbal skills and involving patients and/or colleagues. Many of the respondents had worked in countries where English is the language used at work (amongst professionals). In these cases, their learning often reflected a heightened awareness of how, even when using English, communication presents a challenge. This may reflect the type of English used or its combination with other forms of non-verbal communication. Volunteers become acutely aware of how problematic communication can be even when they share a common language:

> You are developing different communication skills – different people, different cultural norms. They speak very good English but you have got to communicate in a different way to make yourself clearly understood so communication is a big thing. The knowledge and skills framework is about communication, equality and diversity – all those kind of things.

Although much of the literature emphasises communication from a health worker-patient interface, volunteers speak more about communication with other health workers in multidisciplinary and often international environments. The following volunteer uses the language of diplomacy to characterise these skills:

> The non-technical skills are the most prominent thing; the interpersonal skills that you're drawing on every minute of the day trying to get things done in a diplomatic fashion.

In other cases respondents spoke of the challenges of communicating with patients through the use of translators; an experience that will be of great value on their return to the UK. In other contexts communication skills were closely aligned with leadership and negotiation skills and networking with key stakeholders outside of their disciplinary specialisms:

> I've learnt about the networking thing really; approaching people in different ways, like someone who is political, you also meet him as a politician. To break that ice.

The cases above suggest an emphasis not so much on communication with patients but more on the role that professional volunteers play as knowledge intermediaries or brokers (Ackers et al. 2016) spanning the boundaries between different cadres of staff or levels of seniority or the interface between health workers and health planners and stakeholders. Peate (2008) similarly identifies the importance of communication skills for negotiation whilst Banatvala and Macklow-Smith (1997) refer to communication as affecting the ability to liaise between diverse groups. The following example illustrates these boundary spanning skills and their value to a hierarchical NHS:

> I often didn't ask the name of the scrub nurse because I never thought it would be relevant to me, I never thought I'd want to know the name of the guy who's pushing the trolley in and out of corridors. But you come here and realise actually just by getting to know the cleaner which you may not do back in the UK so just building those personal, professional relationships with people can make a big difference to your outcome. I'm starting a job in a new hospital now [in the NHS] and I'm going to make a lot more effort to get to know the people I'm working with.

The relative lack of reference to their communication skills with patients may reflect the overwhelming emphasis on inter-professional relationships in many international placements rather than the fact that volunteers do not experience or learn about communicating with patients. Our ethnographic experience of working with professional volunteers suggests that the stark absence of attention to communication with patients in low-resource settings is in itself a huge learning process. In the Ugandan public health context (which needs to be differentiated from the private sector), for example, it is very usual to see no verbal communication taking place between health workers and patients or to witness verbal abuse. In that respect, volunteers are learning through the observation of bad practice and often find this aspect of learning quite stressful.

Cultural Awareness

In an increasingly diverse British society, much of the literature stresses the increasing importance of adapting to the needs of individuals from other cultures. Between 1993 and 2014 the number of foreign-born individuals living in the UK almost doubled from 7% to 13%, suggesting there is an increasing need for NHS staff to be able to best serve the needs of migrant populations. The General Medical Council's 'Tomorrows Doctors' suggests that doctors should understand the sociological factors that contribute to illness, course of disease and treatment success, including the effect of poverty (GMC 2009). The Royal College of Surgeons' 'Good Surgical Practice' suggests that encounters with patients and colleagues should be culturally sensitive and non-discriminatory. Similar commitments are expressed by the Nursing and Midwifery Council (NMC 2015). International placements provide an excellent opportunity for staff to experience other cultures and develop cultural awareness (Leather et al. 2010).

Respondents also emphasised this area of learning and its relationship with personal qualities such as patience and tolerance:

> The value of working with the team, managing other people, looking at your own expectations and how you view patients and other members of staff. Taking into account other cultures, other perspectives. It broadens you as a person and it makes you more tolerant.

The reference here to patience and tolerance is very common. In the next case the volunteer nurse suggests that being out of her 'immediate comfort zone' will improve her empathy on return:

> You come back and you are a bit more generous with your time, a bit more understanding, a bit more empathetic with people from different backgrounds. We see everybody in all walks of life in the NHS and sometimes despite all our training in equality and diversity let's face it y'know we can have some inbuilt kind of prejudice against whatever it is and I think that it helps break those down. It makes you broader minded.

It is clear from the above that cultural knowledge, skills and attitudes are extremely important to team working and service delivery in the National Health Service. It is interesting to reflect at this juncture on the issue of cosmopolitanism and heterogeneity. The UK is in many respects far more cosmopolitan and diverse than many of the locations professional volunteers will find themselves in especially if they have experience of working in the larger multi-ethnic urban areas. Our experience as researchers on the ground would suggest that it is not so much the exposure to new cultures that precipitates the acute learning that takes place but the profound sense and experience of being an outsider themselves and reflecting on their own identity and people's perceptions of them:

> The soft skills you learn are huge and valuable because you are doing it in a different culture as the outsider, and constantly working at five different ways of asking something silly. I think those kinds of skills you don't find [in your own culture] I can't imagine getting them at that level in such a short period of time.

Norton and Marks-Maran (2014) describe 'cultural awareness' as the exploration of one's own cultural and professional background, including recognising one's biases, prejudices and assumptions about individuals who are different. Briscoe (2013) similarly argues that cultural sensitivity develops out of self-awareness and an ability to critically reflect; immersion in an international context may encourage a growth in self-awareness and critical thinking that underpins genuine cultural awareness. This point is illustrated in the next two cases both of which refer to communication with peers rather than patients as such. In the first case the respondent

explains how her training and experience in the UK failed to prepare her for her own experience of being an 'outsider':

> The first half of the placement was an eye opener. Certainly in the UK you're kind of aware of all the cultural differences and you 'do' equal opportunities but until you're actually in a place where you're the outsider, you don't realise how much it impacts, so I've gained non clinical skills such as communication and cultural awareness.

In the next example the volunteer is herself a third country national employed in the NHS. She suggests that whilst her own experience as an outsider in the NHS has increased her awareness of cultural difference, she has gained in communication skills:

> I am from Thailand so for me I am used to it and can integrate but I think it's a very useful skill for people. It's really important, in any job communication is so important and in the UK there are so many different cultures, it does help for communication.

In the next example the respondent talks about her experiences as a 'mzungu' (white person) in sub-Saharan Africa:

> Personal skills, how to deal with the frustration. In the end it made me understand the other person more, why are they behaving like this, putting it in perspective and taking it at a pace that is more realistic and not in a 'muzungo' time frame instead of being upset.

Respondents' comments about cultural awareness suggest a far deeper process than one simply of observing and learning about different cultures. Indeed, what many volunteers learn, particularly if they are able to spend some time in one location and build relationships effectively with their peers, is that cultural awareness is more than about observing difference; it is fundamentally about trying (as a privileged outsider) to understand behaviour and engage with the contextual underpinnings of that. Greatrex-White (2008) argues that the experience of being a 'foreigner' is underrated, and that this 'disturbance' affects cultural knowledge and perspectives. The following volunteer explains that she has learnt that cultural awareness involves '*making less assumptions about what someone's behaviour says about their thoughts and feelings*'. This is where the

distinction between shallow forms of 'voluntourism' (observation of difference) which may reinforce cultural stereotypes and actually working alongside colleagues in a very different environment lies. The final case cited here recounts the experience of a British Muslim doctor:

> I am more in tune with how cultural differences affect you professionally; you can't go in there and start shouting and screaming, you need to build relationships. I always knew they were important but maybe didn't appreciate how important. I will be a lot more in tune about how I'm making people feel because I've been in situations where all of a sudden I'm the foreigner.

The respondent goes on to identify some very specific scenarios where these skills could be actioned:

> The way I do consent will change. I will understand when an 80-year-old grandmother who's broken her hip and says, 'I want to wait for my son to arrive before I sign'. Oh gosh there's going to be a delay, why can't this 80-year-old just say yes? We are here for her benefit and she's delaying her own treatment. But now I think, 'actually you know what, you should wait for your son because it's important for you, whilst it's important for me to give you the right treatment as soon as possible, I can see that your priority is to wait here for your son to arrive'. So I think it will influence a whole area of things; cultural awareness, family awareness, how important family is to patients.

Teaching, Research and Presentational Skills

There is some reference in existing research to the role that international placements play in terms of developing teaching, presentational and research skills (Banatvala and Macklow-Smith 1997; Lovett and Gidman 2011). Much of the literature regarding development of teaching skills refers to the experience of adapting existing skills to new environments, or having the opportunity to practice already established teaching skills (Jones et al. 2013). This is one component of learning that is very much a reflection of placement structure and volunteer roles and will be more evident in capacity-building interventions. Health Partnership projects, such as the SVP, funded by the Tropical Health Education Trust (THET) are focused on systems change through capacity-building. This has implied a heavy emphasis on knowledge transfer through CPD-style

interventions (Ackers et al. 2016). The SVP has attempted to shift this emphasis from formal classroom style teaching/training to encourage mentoring on the job through co-working as our research indicates greater impact on behaviour change. In this respect SVP volunteers have been explicitly characterised as knowledge intermediaries and co-researchers/teachers. In practice this thrusts volunteers into a wide variety of (co) teaching roles and research activities including

- The development of classroom teaching skills including teaching to large and diverse multi-professional audiences
- Active engagement in the development of continuing professional development often involving protocol/guidance adaptation to local circumstances and associated training to promote implementation and behaviour change
- On-the-job mentoring and supervision, often across diverse multi-professional teams
- Presentation of their work to other volunteers, professionals and policy-makers/stakeholders
- Applying for grants and designing/costing projects.

The following nurse volunteer talked about her teaching experiences:

> I was asked to teach medical students – formal teaching on the special care unit on respiratory management etc. Your confidence just goes up because these are people who are training to be doctors and save people's lives and they are seeking to learn from you. Now I know I have something to give; it gives me satisfaction.

In this case the volunteer engaged in a wide variety of knowledge transfer activities ranging from active mentoring of midwives and nurses on-the-job in a health facility, through organisation of intense CPD programmes in conjunction with a British paediatrician volunteer. She also organised the rotation of staff between facilities to optimise opportunities for learning and became involved in the formal class room teaching of medical students. It is clear from her narrative that she gained huge confidence from this. However, her interview in the UK suggested an immediate frustration as she was very aware that she would be unable to engage in these activities in her role in the NHS.

In the next case a UK obstetrician explains how the teaching components of her work stretched her previous teaching skills developing new areas of competency. It is important to note that in this context most of the clinical work in the hospital she was based in was undertaken by undergraduate nursing students on placement and medical interns (trainee doctors). In that sense she was working with health workers who are at a very active stage in their own learning:

> I've used some of my teaching skills, but I've realized teaching out here is so different to the UK and a lot of the skills I have for teaching in the UK aren't applicable here. It's quite hard to engage students out here in that way because they are not used to being taught in the way I do in the UK. So I've had to adapt a lot of my teaching skills. Practically, I've done quite a lot of operating, mostly with the interns (trainee doctors) and it's really helped me with my practical tutoring, most of the time in the UK I've been teaching relatively simply operations whereas here none of the operations are simple so I've been letting them do it and that means that when they get stuck they might have made a difficult situation very difficult so then its stretched my skills to get them out of that situation.

In another case involving a team of UK midwifery and nursing volunteers, the teaching roles formed a new and exciting component of their work that motivated her to explore new career directions:

> Teaching – I guess that's been the biggest part of my four months. And I just feel really positive about that. One thing that I have got out of the teaching in terms of my own career development is that I think I would really like to go in to teaching. I really really enjoyed the teaching and we ended up teaching over 200 midwifery students. They just want to know absolutely everything that they can get from you and you feel like they really listen and engage. So from my own perspective, I think that might be something I would consider further down the line. I know I won't be a midwife for the rest of my life, I wanna do other stuff within midwifery and I didn't know I'd want to do teaching. I always thought it was something I'd never ever want to do.

Depending on a range of factors, professional volunteers will also have unique opportunities to develop as researchers engaged in evidence-based interventions (Jones et al. 2013). In the SVP context this has involved multi-lateral processes of; harnessing volunteers to support research-based interventions (two volunteers were deployed as programme evaluators);

supporting volunteers' suggestions for research-based interventions and finally working in terms to develop research initiatives proposed by Ugandan colleagues. Of course teaching and research go hand-in-hand and all those volunteers engaged in teaching will have researched the topics they are working on:

> I have read up on things a lot. You have to read up well before you teach – you must know your topic. I was not doing formal teaching (in the UK) at all.

Summary

This chapter has reviewed the available research and empirical data collected during the SVP and MOVE projects to summarise the key areas of learning gained from professional volunteering in low-resource settings. There can be little dispute that such placements provide fertile and unique environments for professional development in areas that are of key concern to organisations such as the UK's National Health Service and explicitly recognised in current NHS training objectives. An important theme running through the learning theories literature and echoed in respondents' experiences suggests that the learning that happens in such international contexts is informal by nature with a much greater emphasis on tacit knowledge. Marsick and Watkins describe the '*incidental learning which occurs in institutions, as not typically classroom-based or highly structured, and where control of learning rests primarily in the hands of the learner*'. Learning in these environments becomes integrated with daily routines, is triggered by internal or external jolts; a haphazard, and inductive process of reflection and action linked to the learning of others (Marsick and Volpe 1999). Of course this is precisely what makes it difficult to measure. The following chapter moves on to consider some of the costs and potential risks associated with placements and approaches to mitigating risks and structuring placements so as to optimise relevant learning.

Notes

1. The second component of the MOVE project is focused on developing a psychometric tool to measure learning outcomes and will be reported separately.
2. www.knowledge4change.org.uk/our-projects
3. We are using the word culture here to refer to occupational culture.

4. This can be contrasted to the experiences of undergraduate mental health nurses who identified important areas of learning in relation to the side effects of drugs (Ahmed et al. 2016).
5. Positionality is defined by the Oxford English Dictionary as, 'The occupation or adoption of a particular position in relation to others, usually with reference to issues of culture, ethnicity, or gender'.

CHAPTER 4

Managing Costs and Risks

Abstract This chapter identifies some of the 'costs' associated with health worker placements in low-resource settings; it begins with a discussion of the costs of covering staff time during placements and some of the fears surrounding skills 'wastage' before highlighting risk areas associated with such placements.

Keywords Costs · Risks · Skills wastage · Measurement

Background: the NHS in Fiscal Crisis?

On the basis of the research we have conducted and our experiential learning as managers of professional volunteering projects, we have no doubt that placements in low-resource settings both identify and invest in entrepreneurial knowledge and innovation. We also know that the remodelling of care in the current NHS environment in response to rising levels of chronic and complex conditions requires new forms of critical connective knowledge. Addicott et al. (2015) express the need for, 'closer attention to the role of generalists [in an environment] where care is delivered in teams based around the patient rather than in professional silos' (2015: 34). International placements deliver precisely this form of knowledge. But this learning, however valuable in its own right, is taking place in a specific economic, political and temporal context. The NHS is facing a financial crisis. And this is best characterised as a human resource crisis, as 70% of

H.L. Ackers et al., *Healthcare, Frugal Innovation, and Professional Voluntarism*, DOI 10.1007/978-3-319-48366-5_4

recurring costs relate to staffing (Addicott et al. 2015: 2). The 'crisis' is specifically manifest in an alarming growth in reliance upon temporary and agency staff. According to a recent document, NHS spending on agency staff has 'increased to the extent that it is one of the most significant causes of deteriorating Trust finances' (NHS Improvement Agency Rules 2016: 4). New rules designed to control this spend have introduced a cap (ceiling) on the level of pay that NHS employers can offer agency staff; in the case of junior doctors and other medical/clinical staff the cap is set at 55% above basic pay rates. The document explains how to cost agency staff using specified hourly rates and provides illustrative costs for a consultant doctor at £652.96 for an eight-hour shift. Based on these figures, providing staff cover or 'back-fill' for a junior doctor on an international placement for 12 months could cost around £66,760 (p. 20).[1] The Royal College of Nursing also produced a report on the 'unprecedented' reliance on agency nurses in the current 'perilous' financial crisis and projected an annual NHS spend of at least £980 million on agency nursing by the end of 2015 (RCN 2015: 3). This is the environment within which the MOVE project was tasked to weigh up the costs and benefits associated with professional volunteering.

The costs identified above concern only replacement salaries. What if the placements themselves generate new costs in relation to the individuals involved? Sherraden et al. (2008) suggest that the overwhelming majority of studies focus on the positive returns on professional volunteering with little attention paid to costs. In some ways, even personal experiences which are ostensibly (or actually) negative at the time can be regarded as having a positive effect in the long run. As we have noted, experiencing failure can stimulate innovation. However, there are, largely unsubstantiated, concerns that long periods overseas can result in elements of skills wastage, absorption within cultures of bad practice or desensitisation to risk. More specifically, there is a genuine risk that personnel may be exposed to infectious disease, terrorism, road traffic accidents and other forms of stress or trauma which generate new costs for the NHS. The systematic review conducted as part of the MOVE project identified a number of perceived 'externality' effects. These can be loosely grouped as follows:

1. Financial costs of staff replacement (as above)
2. Potential career risks (re-integration, negative attitudes of colleagues, professional revalidation)
3. Risk components (insurance, health and safety and security issues, personal trauma).

4. Cultural awareness
5. Personal impacts (loneliness, relationship tensions, fears of becoming judgemental on return)
6. Environmental impacts associated with air travel.

These concerns map onto the findings from the interviews with returned volunteers, although it must be said that the balance tips very strongly in the direction of benefits and these issues are typically mentioned only when respondents are encouraged to think in those terms. The following section discusses some of the issues raised.

Professional Voluntarism and 'Brain Drain'

The most tangible and immediate risk to the NHS is for the placement experience to stimulate a desire for future mobility or eventual emigration. It is well established that early career or early life mobility tends to foster a desire or the confidence to engage in future mobilities (Ackers 2003; King and Ruiz-Gelices 2003). We have also identified a number of cases where individuals were motivated in the first instance to engage in professional voluntarism as an active decision to develop a career in global health. The following case is illustrative:

> I had an ulterior motive, I applied for MSF (Médecins Sans Frontières) a while ago and I didn't have enough management skills. I've worked in the humanitarian sector before but not with front line stuff.

The line manager in the following case suggests that some volunteers may find it difficult to return to the NHS and take the decision to engage in further international work once they return. She does suggest that it may not be the placement as such but the personality involved that precipitates this more 'footloose' approach to career planning:

> I think it is hard coz sometimes when they come back I think they don't fit here anymore and they leave again. Those with certain types of personality probably would have – its gonna happen anyway, but maybe it happens earlier [Line Manager]

In this and several other cases, the applicant was already planning to leave the NHS, at least temporarily, for a career in a low-resource setting or in

global health more generally. In such situations, international placements provide important opportunities to take the first steps for leaving the NHS. In one case, the volunteer later signed up for a master's programme in global health; in another, a midwife left her position in the UK prior to departure with no intention to return immediately after her placement. Of course, these plans subsequently change and individuals may actually return to the NHS either immediately or in the future. In one case, a volunteer who took up a placement immediately after completion of a master's programme in global health and actively planned a career in global health at that stage in their career later returned to the UK to commence nurse training. Further down the line, he may elect to spend some time in a nursing capacity in a low-resource setting.

Having said that, in most cases where mobility creates an appetite for future work in low-resource settings this takes the form of an interest, often transformed into action, in getting involved in subsequent short stays (typically two weeks taken during vacations or study leave) perhaps to deliver specific training or 'virtual' engagement through mentoring of colleagues. The opportunities for individuals undertaking placements in low-resource settings to up and leave the NHS are very limited and restricted to those specifically interested in global health. On that basis, there is far less risk that they will leave to take more attractive positions or transition into long-term or settled forms of migration as the labour markets are simply not conducive to that. It would be rare to find professional employment in a low-resource setting that could even begin to sustain an employee let alone a family. In that respect, international placements in high-resource settings pose a much greater 'brain drain' risk. Recent interviews with British doctors and nurses in New Zealand identified a strong relationship between early career placements and future career decision-making facilitating the longer-term emigration of UK junior doctors.[2]

Career decision-making is increasingly boundaryless (Arthur 1994, 2014; Arthur and Rousseau 1996) and less likely to follow simple linear pathways and individuals change their perspectives over time. Whilst placement experiences may provide an opportunity to test the waters and potentially leave the NHS, they may also provide the impetus for a decision to return to it with renewed motivation:

> I was getting frustrated with the NHS cos I couldn't get away to volunteer. My Deanery were like, sorry [name]. Where I wanted to go wasn't recognised as a training placement as there were no senior medics there. I was

> seeing colleagues who were going away for what was effectively a year in Australia and places like that. It's supposed to be training, but half the time it's sitting on Bondi Beach. Or they were doing management fellowships where they sit in an office for a year. But I was feeling like I wanted to do something that was actually useful to other people. I got very frustrated, so I decided I needed to resign and once I'd decided, it all sort of fell into place. I'm now back in the NHS, working as a locum registrar, but my intention is to get back into the NHS as a permanent registrar. I think I'm more committed now than before I left, but if I hadn't have left when I did, I might not have come back.

Skills Wastage

The next issue raised with some regularity (but once again by a minority) concerns potential skills wastage. There is no hard evidence in existing research or in our own empirical work of actual skills waste on return. However, prior to return, many volunteers do experience some anxiety about their ability to slot back into the NHS environment with its rigid protocols, hierarchical structures and high-tech equipment. Once they have returned and reintegrated into the NHS workforce, they typically reflect on this as a momentary confidence issue due to the gap in their use of specific types of equipment. This concern links nicely to the ideas of deliberative practice discussed earlier suggesting that anyone who is not regularly using a skill may experience some decline in confidence. Anaesthetists were most likely to raise this issue:

> I'm definitely de-skilled in the high-tech side of things, which is what I expected beforehand. All this high-tech equipment like fibre optic intubations. Even Epidurals. But that doesn't worry me because once you get back into your normal practice we quickly pick that up. At home working fulltime two or three weeks you'll be back to normal.

The first comment, '*I'm definitely de-skilled*' is a little alarming but is immediately followed by the reassurance that this de-skilling is very short lived and may be more about confidence and perception than explicit skills. In another case, a midwife expressed some anxiety about water births:

> I've gone back to post-natal first, so I'm not going straight back into labour suite yet. I'm scared of water births strangely, but I know if I call for help it will be there.

In other cases, respondents talked about doing some prior reading to prepare themselves, perhaps building on research skills and a 'can do' attitude honed during their placement:

> There are things I will have to go back and read up like patient monitoring – we would never use that here because it's just too modern, but I think it will just take a day or so.

Chapter 3 discussed the benefits of multi-professional working and working at the boundaries of one's own profession. This was viewed as an important benefit by most volunteers and a key locus of new learning. However, a small number of volunteers also expressed some concerns about the impact of this on their subject-specific knowledge. In one case, a nurse who had been working in paediatrics in the UK applied for a placement involving work with neonates. Although she enjoyed the challenge of working in this rather new environment on a neonatal unit, she did begin to express a desire to work with older children which fell outside the scope of the project and articulated this in terms of a decline in her specialist skills:

> This was always going to be a bit of a challenge because I've not worked with neonates before and I feel like we're [now] going in more of a midwifery direction. I'm actually quite happy to do that for a week or so but I wouldn't fancy for long term.

The study also identified isolated perceptions of what can best be described as a lapse into bad practice or 'cutting corners'; interestingly these are always reported 'second-hand' about a third party. One volunteer described a situation she had observed where a nurse who had been away from the UK for two years (deployed through another organisation) had begun to adopt some of the bad practices of local staff in relation to routine patient monitoring and recording. Another British nurse expressed concern that her volunteer colleagues were lapsing into bad practice rather than encouraging best practice amongst their peers:

> It's ended up that even the white people are doing that now. You were talking about de-skilling – what we're doing is changing our ways to cope with theirs, to fit in with them and suit theirs. We're seeing more of that from the white people rather than the other way around.

This respondent was one of very few cases of volunteers who requested to return to the UK prematurely after four months of a six-month placement. She had found leaving her teenage children, as a single parent, very challenging and found it hard to cope with the level of what she saw as negligence on an overwhelmingly busy maternity unit. It is difficult to know whether the practices she refers to concern professional volunteers making some necessary adjustments to their working practices to meet the needs of the resource-constrained local environment and 'make do' but without any de-skilling taking place as such, or whether they were simply taking the easy option and losing their sense of professionalism. Our observational research would certainly indicate the former and suggest that there is little risk that staff would not adhere to protocols on their return, although many did not relish a return to the level of bureaucracy and form-filling associated with the NHS. The following doctor explains how he had to 'make do' but this represented a conscious and necessary response to the situation and not a preference or indication of laziness:

> In this country we're highly specialised and we have to learn how to use a lot of equipment. When people go over there that's stripped away and you're just working with the bare bones. It's your responsibility to make do with what you've got, and that's an eye opener for people but I don't think people like to work that way. They like the security of working within the NHS and having skilled people around them. It's a lot safer.

In the following case, an anaesthetist had only allowed herself one week on her return home to relocate to a new position. This situation is quite common amongst junior doctors who rotate annually and will be commencing an entirely new position on return. Nurses and midwives more usually return to their old position reducing overall dislocation. It is interesting to see how this doctor talks about her communication skills:

> How are you feeling about returning to the NHS?
>
> Nervous, I haven't got any downtime between coming back and starting my job. I'm working in a brand new city, a brand new hospital, new doctors and I don't have a car or a house. I only have a week from arriving home to starting my job. I feel like I'm out of practice in a lot of things; I haven't done any gynaecology out here, I'm out of sync with all the good normal

> practice that we should be using. Even communicating, I had a friend come out to stay and she asked me why I was talking in a ridiculous voice; she said I was talking really slowly. You realise you adopt a way of speaking so people understand you better, so to go back it's going to be really hard to kick out of it and speak normally.

There was some concern that extended stays could result in disengagement with the latest evidence-based practice and technological advances. In the following case, the respondent refers to an American colleague who has organised periods of repatriation to enable her to keep up to the speed of the latest research and advances:

> One of the clinicians from the [US] group is going to be there for three to five years. Obviously that is going to have a huge impact on her clinical practice where you cannot do basic investigations and things are moving on, there are papers being published every week that she is missing out on so they have set it up for her that every three or four months she goes back and gets updated.

This may well be a matter of confidence and clinical practice rather than knowledge as such as most volunteers will be able to access published papers and gain quite significant research skills during placements. Indeed, from an ethnographic perspective, the volunteer house in Kampala had an atmosphere of research – of constantly discussing and researching conditions and potential interventions. This discussion took place on a 24/7 basis so much so that visitors and on rare occasions volunteers themselves had to extricate themselves to gain some reprieve.

The interviews, unsurprisingly, suggested a close relationship between the loss of confidence and length of stay. Longer stays tend to be associated with a greater decline in confidence in certain skills. On the other hand, this has to be balanced with the potential for skills gains in other areas which may derive from longer stays and, importantly, as this respondent points out, the relative benefits of the host setting:

> If you're coming for a month it's not worth it; you're only going to take. You won't be able to give that much in the space of a month – I've learnt and got so much out of it and really enjoyed it and just thought . . . the time has flown and that's the sign of a really positive experience. If people wanted to really do a lot of work I would struggle not to say, 'go for six months minimum.. a year or even better, two?

> Do you think the longer the better?
>
> I do but there is a thing in that if you're out of the UK working or the US or the Western world of medicine are you deskilling yourself and are you as up to date and providing as good an obstetric advice as you could be? I've only been out four months, but I'm when I go back, I have a week of working with another midwife reorienting myself because I'm so out of the practice with writing notes and doing what we consider to be really top obstetric care . . . I need to re-familiarise myself with the speed at which I have to work at so I think if you're out for longer than a year you might lose a few skills . . .

One volunteer was faced with limited career options on return as her line managers had assumed a level of deskilling. Without any explicit consultation or communication, the decision was made to require her to work in the teaching hospital on her next rotation. At the time of interview this doctor was a little perplexed at the attitude of her employers and their implicit assumption that she posed something of risk especially as she had prepared herself for precisely that situation:

> I didn't do foetal monitoring there. I think that is why they were concerned about me coming back so before I came back I made sure I refreshed my skills and stuff.

Asked whether she felt she had suffered from skills wastage and this had affected her practice on return, she replied: '*For me no, because I just think Uganda is different to the UK, I just adapt. You work to your environment. I just know it's a different system.*'

An optional period of reintegration was subsequently built into the SVP program allowing one month on return when the volunteer could continue to receive their stipend and work on an unpaid basis. Experienced clinicians linked to the health partnerships and based in UK hospitals actively offered to mentor returned volunteers during this period. In practice, not one volunteer took up the offer.

In Chapter 3, we referred to the distinction between explicit and tacit skills and the growing emphasis on what can perhaps best be called 'qualities' or professional attributes rather than skills. Tolerance is frequently cited as an example of attitudinal change brought about through placements in low-resource settings. However, respondents on some (relatively few) occasions suggested that their experiences of working in resource-constrained environments and witnessing the stoicism of these

patients may make them less tolerant of the more privileged patients in the UK. An experienced nurse with extensive experience in low-income settings highlighted an issue that many of our respondents mentioned:

> [when I came back] I had to be careful that I didn't judge people too much who chuntered about petty things. Because, you know, these complaints that patients and staff will make . . . I just stood there and I just thought, I really wanted to say this really isn't anything for you to complain about. You know, you want to be where I've just been and seen what I've seen.

Exposure to Risk and Vicarious Liability

Risk is a major driver of policy and practice in large organisations such as the UK National Health Service. The systematic review identified a number of potentially negative impacts of international placements linked to risk, including insurance, litigation, health and safety, and security issues and personal trauma. As managers, our experience of managing and evaluating risk responsible for volunteer deployment, and more recently, the Ethical Electives Project, has emphasised the importance of distinguishing genuine and tangible risks from perceptions of risk. International placements in low-resource settings expose individuals and organisations to risk. Inflated, generalised or misguided perceptions of risks amongst potential volunteers, their families, line managers and policy makers add a further dimension generating obstacles to mobility (Ackers et al. 2014). Aversion to risk may damage learning and reduce opportunities for innovation.

The SVP commissioned a professional risk assessment undertaken by the Chief Risk Officer at the University Hospital of South Manchester NHS Foundation Trust (Paul Moore). In addition to his background in risk management within the NHS, Moore had also completed risk assessment on the ground in Uganda for the Man-Gulu Health Partnership. The risk assessment report describes risk management proactively as a process of anticipating the effect of uncertainty on the achievement of programme objectives and building resilience to mitigate that uncertainty (Moore et al. 2015). It distinguishes 'inherent' from 'residual' risk which is defined as 'the estimated level of risk exposure after taking additional steps to control (or mitigate) risk' (p. 8). Figure 4.1 presents the *inherent risks* identified, and Fig. 4.2 identifies the *residual risks* at the time of the

Risk	Mean Score
Personal accident or injury including road traffic accident	15.00
Terrorist attack targeted at volunteers or project (suicide bomb, false imprisonment, kidnap or hostage)	15.00
Exposure to infection/tropical disease	12.00
Assault (verbal, physical, sexual)	10.00
Access to safe supply of food and drinking water at location	10.00
Lost (in unfamiliar and/or dark surroundings)	10.00
Needle stick injury (including provision of emergency HIV post-exposure prophylaxis)	10.00
Civil unrest/violent public disorder	10.00
Lone working	6.25
Slips, trips or falls on uneven, wet and/or muddy ground	5.77
Unsafe or unsupervised clinical activities	5.25
Sun exposure	4.00

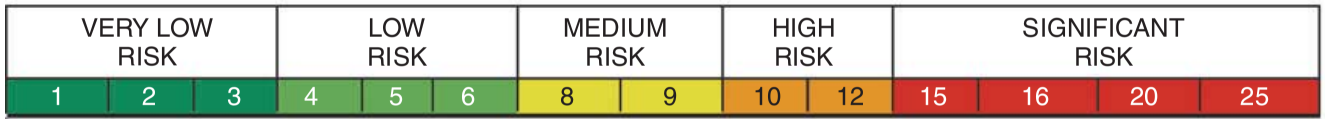

Fig. 4.1 Risks associated with professional voluntarism in clinical settings in Uganda

Source: Moore, Surgenor, Ackers-Johnson and Kakulgulu. (2015). SVP Risk Assessment. Available at: www.knowledge4change.org.uk/

Hazard Profile	Overall Residual Risk Exposure (Taking Control Into Consideration)								
	Kabubbu	Kasangati	Mulago	Fort Portal	Mbale	Hoima	Kisizi	Mbarara	Gulu
Access to safe supply of food and drinking water at location	10	10	10	10	10	10	10	10	10
Assault (verbal, physical, sexual)	10	10	10	10	10	10	10	10	10
Unsafe or unsupervised clinical activities	3	9	15	3	3	3	3	Unable to Evaluate	3
Civil unrest/violent public disorder	10	10	10	10	10	10	10	10	10
Exposure to infection/tropical disease	12	12	12	12	12	12	12	12	12
Lone working	5	5	15	5	5	5	5	Unable to Evaluate	5
Lost (in unfamiliar and/or dark surroundings)	10	10	10	10	10	10	10	10	10
Needle stick injury (including provision of emergency HIV post-exposure prophylaxis)	10	10	10	10	10	10	10	Unable to Evaluate	10
Personal accident or injury including road traffic accident	15	15	15	15	15	15	15	15	15
Slips, trips or falls on uneven, wet and/or muddy ground	6	6	6	8	6	6	6	6	4
Sun exposure	4	4	4	4	4	4	4	4	4
Terrorist attack targeted at volunteers or project (suicide bomb, false imprisonment, kidnap or hostage)	15	15	15	15	15	15	15	15	15
Are all risks acceptable (i.e. controlled as low as reasonably practicable (Y/N)?	Y	Y	N Co-presence & Lone working	Y	Y	Y	Y	N Unable to complete assessment	Y

Fig. 4.2 Residual risk exposure in placement locations

Source: Moore, Surgenor, Ackers-Johnson and Kakulgulu. (2015). SVP risk assessment. Available at: www.knowledge4change.org.uk/

initial risk assessment visit that was conducted prior to project commencement:

The judgement about whether identified risks are 'acceptable' or not in a particular context requires the relative balancing of risk 'severity' with risk 'likelihood.' On that basis risks associated with road traffic accidents or terrorism are graded as severe, although their likelihood may be low and mitigated by effective behaviour management. This process stimulated and informed the development of SVP volunteer management systems largely reflected in an evolving induction process and associated induction pack.[3] Over the past five years, the SVP has encountered most of the risks identified above. At the more alarming and less 'likely' end of the spectrum, there have been outbreaks of terrorism and civil disobedience (typically quite isolated and around election periods or involving tribal disputes). Road traffic accidents remain one of the greatest risks to volunteers in all low-resource settings (Gedde et al. 2011: 186). Bhatta et al. (2009) confirm the importance of road traffic accidents as a major cause of volunteer morbidity and mortality. In a survey of VSO volunteers, diarrhoea was the most prevalent heath risk reported (by 79.9%) with highest levels found amongst short stays and younger volunteers. This is followed by skin and dental problems and 17.5% reported some form of road traffic injury. The authors are clear to point out that the response rate to their survey was small (36%) and that this response rate may be skewed in favour of those who had experienced problems (and had something interesting to report). The situation is exacerbated in the Ugandan context by the use of 'boda bodas' (motorcycle taxis) and a study of Peace Corps volunteers in Africa found that 60% of road accidents were related to motorcycle use (Bernard et al. 1989). These risks to individuals also present a risk to the NHS potentially affecting the subsequent safe return of work-fit employees.

Exposure to infectious disease presents more direct potential impacts on return and these are risks that the wider public may become aware of and sensitised to.[4] Since the commencement of the SVP, Uganda has experienced at least three localised outbreaks of Ebola and Marburg haemorrhagic fever. We have also witnessed several instances of needlestick injury. Both of these were responded to immediately triggering expert advice and a constant iteration of the induction pack.

Whilst NHS employers may be interested in the well-being of employees on placement, they are also anxious about the liabilities associated with that and the impact that any local incidents may have on volunteer's fitness

to practice on return. This raises issues around clinical registration on placement and professional indemnity insurance.

All of these risks can be mitigated to some extent through attentive volunteer management supported by active relationships on the ground. It may provide some reassurance to readers to point out that over the past five years we have deployed well over 60 long-term professional volunteers and 110 undergraduate students in Uganda without any serious adverse outcomes.

One area highlighted in the risk assessment that is often overlooked and compounds all of the risks referred to above is that of lone or unsupervised working. We have discussed some of the implications of supervision in relation to optimal learning outcomes (Chapter 3). In some situations it could be argued that lone working or working without close supervision generates profound opportunities for innovative learning especially for more senior volunteers. International placements certainly attract individual clinicians keen to work outside the perceived constraints of NHS structures. The risk assessor described volunteering in low-resource settings as a 'magnet for mavericks' during initial discussions about risk and this is certainly confirmed by our experiences of recruiting and subsequently managing volunteers, especially doctors and more senior doctors some of whom actively seek out opportunities for what one junior doctor termed 'ninja medicine'.

Managing volunteer–health worker relationships has formed a major focus of the SVP process leading to the operationalisation of rigorous systems to prevent lone working for all cadres of staff. Drawing on previous research on highly skilled migration and knowledge mobilisation we have imported and operationalised the concept of 'co-presence.'[5] Co-presence is a necessary (but not sufficient) condition for mutual learning and reduces the risks associated with gap-filling and labour substitution (Ackers and Ackers-Johnson 2014). It is also a key component of risk mitigation. At one level, it links to other health risks, such as needle stick injury where policy requires that the individual must seek immediate HIV prophylaxis. It is also a key component of managing litigation or more commonly in many low-resource settings, the impact of blame cultures. In this environment, having witnesses is of critical importance. At another, more complex level, it requires and assists professional volunteers to manage the daily pressures on them to perform out with their competency.

Many medical and nursing students and junior doctors in low-resource settings are required to work without supervision often running services

on their own (Ackers et al. 2016). This environment puts huge pressure on UK volunteers to do likewise. This 'expectation' and peer pressure is further compounded by irresponsible international organisations that place volunteers in gap-filling roles without adequate supervision or support. The risk assessment visit identified a shocking example of this, involving British medical students encouraged by their 'virtual' UK clinical supervisor to work at nights for data collection purposes:

> Medical students explained how they were often goaded into carrying out clinical examination or diagnostic procedures they did not feel competent to perform, and whilst they declined to carry out the procedures, they explained how this created some tension with Ugandan medical students also working at the Hospital (Moore et al. 2015: 15)

Concerns about lone working and the complexities of establishing rules that were suitable to a wide range of volunteers from different professions, levels of seniority and personal competence/confidence led to the co-development of the 'SVP Competency Algorithm.'[6] This was developed as a flexible working guide to empower volunteer decision-making when confronted with lone working or lack of effective supervision.

The case cited above involved students and UK volunteers who were working at night. The risks associated with lone working are elevated during night time and weekend working. A simple response to this is to prevent volunteers from working during these times and ensure that local staff are aware that this 'rule' is imposed by the deploying organisation rather than a simple volunteer preference. The issue of working hours is also present in some volunteer interviews. In keeping with the spirit of UK law the SVP instituted strict policies on working hours to prevent over working and the risks of exhaustion and trauma arising from that. The general lack of adherence to timetables in Uganda and many other low-resource settings can place pressure on those staff who are committed to their work to work extremely long hours to cover for absenteeism and poor time management. In most cases it is concerns about patients and leaving wards unattended that encourages long working hours. However, some volunteers based in mission hospital facilities faced undue pressure from British managers to commit to arduous working schedules that would not be permitted in the UK and subjected to humiliation if they questioned this. Weekly reporting mechanisms and close relationships with volunteer managers enabled us to support volunteers in these

circumstances and to relocate volunteer to other Health Partnerships if situations did not improve.[7]

The research has identified a number of other areas of concern which have the potential to cause stress to professional volunteers. In many ways these sit hand-in-hand with key areas of learning underlining our contention that some of the most acute learning arises from discomfort. Whilst positive learning may indeed accrue, it is important that professional volunteers are protected and supported. The first of the areas concerns experiences of overt discrimination. The most prevalent form of discrimination identified involves attitudes towards women. A mid-career anaesthetist describes her experience:

> I have come up against fairly misogynistic attitudes and several misunderstandings about whether or not I am actually a doctor. In fact, I am fairly certain on one occasion my ability or qualifications for teaching on the neo natal resuscitation course were questioned.

The following volunteer had six years specialist experience:

> People here think that I am younger than I am definitely, but my personal perception of the relationship that I have with [in-charge doctor] is that he does not take me particularly seriously. I thought maybe that was gender. I constantly had to prove myself but at the same time when the department had no doctors he was more than happy for me to go on the rota [alone] and do ward rounds.

Gender emerges with some regularity in volunteer narratives in the SVP. This reflects the feminised nature of employment in maternal health and the stronger tendency for women to volunteer (Hudson and Inkson 2006: Bhatta et al. 2009). The strongly hierarchical nature of professions and organisations in many low-resource settings generates a high potential for gender-based discrimination. This should not be confused with the more composite concept of 'culture/religion' that often conveniently obscures gender/human rights dynamics. The SVP project with its emphasis on maternal and new-born health was strongly skewed in favour of female volunteers (Table 4.1).

Most of the female doctors deployed within the frame of the SVP reported experiencing patronising behaviour from senior peers and managers. In many cases this manifests itself in stereotypical assumptions

Table 4.1 VP volunteers by gender

Anaesthetists	10 (6 female)	71
Obstetricians	9 (7 female)	60
Midwives	8 (8 female)	60
Nurses	6 (6 female)	48
Foundation year 2 doctors	4 (2 female)	30
Paediatricians	3 (0 female)	33
Social scientists	2 (1 female)	24
Biomedical engineers	1 (0 female)	26
General practitioners	1 (1 female)	6
Total	**44 (31 female)**	**358**

Source: SVP Final Report, 2014.

about their appearance and how 'young' (read inexperienced) they looked. In one case, where the author herself was present in a meeting with a representative of the Ministry of Health, the (male) turned to the obstetrician and asked her if she was a medical student. In response to a gentle assertion that she was a qualified obstetrician he replied that she 'looked much younger'. Another volunteer refers to the difficult relationship she had with her Ugandan line manager whom she felt did not treat her as an equal and take her seriously. Concerned about this she spoke to her predecessor (a male volunteer at the same level of seniority and discipline), '*he said the head of department was always fine with him. It sounded like it was much easier for him. I did not feel being a woman [was easy] in an environment like Uganda, even though women are able to be doctors*'.

Two anaesthetic volunteers at the same level of seniority discussed the impact of gender on their relationships with local staff:

> [Female volunteer] I think it's harder, harder for women.
>
> [Male volunteer] Yep, definitely.
>
> [Female] Without a shadow of a doubt. I think you've got to understand the society you work in, so I think being female, I wouldn't say being male is an advantage, but I would say being female is a disadvantage. Traditionally their culture in some of the tribes. You're coming into that, and then you're asking men in their fifties and sixties to listen to a young, white female (volunteer) that's a tall order in a hierarchical patriarchal society. My very first day, and I don't harp on about this, the principal [clinician] physically pushed me out of his way. Not in any forceful way, but it was definite.

A mid-career obstetrician illustrates the inter-section of different dimensions of 'positionality' and the impact on learning and behaviour change:

> Over the last week alone I must have said at least 40 times, 'don't suction the baby when it's breathing and crying', 'stop suctioning', 'please stop', 'can you put the suction down'. It's just really hard, when it's so engrained in what they do for some white person to come along and say 'no'. The working relationships I have with most of the midwives are good. They often just see me as another pair of hands, as marginally more competent than their junior doctors. They don't completely believe me in certain things but they tolerate me because they know I'll come in and do some c sections. The interns (doctors in training), I did have quite good relationships with. But one of them I'm not getting on with, he's being directly challenging towards me. He will challenge me on pretty much everything I say, and I'm sure it's because I'm white and female and he doesn't understand me.

Attitudes about gender are often intertwined with professional boundaries and hierarchies compounded by gender segregation; all midwives and nearly all nurses are female in Uganda. Another 'twist' on the disciplinary aspects of positionality emerges in multidisciplinary interventions. An experienced volunteer midwife explains her treatment by a local doctor during a multidisciplinary 'Well Woman' intervention:

> We had a local doctor that spoke to me absolutely appallingly like, 'get this', 'do this', 'do the other'.

Professional hierarchies are by no means a feature only of Ugandan health systems. Indeed, some of the most valuable transferable skills gained by professional volunteers are connected to experiences of multidisciplinary team working. These hierarchies are often rarefied in low-resource contexts with firm boundaries obstructing effective cross-professional cooperation and team working. Another area that poses a challenge to professional volunteers concerns their treatment as 'outsiders'. We have noted above how this may stimulate active and effective learning around cultural awareness. On the other hand, it can amount to forms of quite explicit and distressing stereotyping.

Culture and 'Racial' Stereotyping

Although translated strictly to mean 'white', the concept of 'mzungu' in Africa[8] refers in more complex ways to 'wealthy' foreigners. It is also linked to an historic association of professional voluntarism with missionary-style, 'donor-recipient' voluntarism. An example of this can be seen in the nickname given to one volunteer as 'Dr Donor'. In many instances volunteers are viewed as 'cash cows' rather than co-workers. This perception of volunteer roles reinforces the expectation that volunteers come to low-resource settings as locums and donors challenging the commitment to knowledge exchange and co-presence. A good example of this is the caricature of clinicians in low-resource settings as the passive recipients of training at the opposite pole on a linear knowledge gradient; as individuals lacking capabilities and collectively, the system lacking experienced personnel.[9] These myths continue to shape development interventions damaging relationships and limiting impact. They create obstacles to the achievement of the kinds of balanced professional relationships experienced in other international contexts based on collegiality.

The stereotypes associated with the 'mzungu' concept are tainted with misunderstandings about experience, skills, seniority and relative wealth. We noted above how female volunteers tend to be viewed as 'young' by senior Ugandans. In other situations, 'mzungus' are perceived by their peers as more experienced and possessing higher skills. This can place British trainees in positions where their competency is stretched (as noted above). It can also cause distress to professional volunteers.

The 'fluffy' concept of culture tends to gloss over or even excuse discriminatory and unprofessional behaviour. This narrative from an early career obstetrician shows how this stereotyping of UK volunteers can put them at risk especially when, as in this case, they are working in isolation at night:

> We arrived at 8 pm. From the start midwives were sleeping in the office. The doctors worked until 3am when they all went to sleep and said that they would be up at 6am. The theatre staff all stopped work at 3am and went to sleep, despite there being women waiting for caesareans. During this time anything could have happened. I was delivering one baby after another often on the floor in the waiting area and dealing with complex obstetric emergencies. A woman died which was emotionally draining. There was an off-duty security guard taking bribes off patients and moving them to the labour ward. Then I had the doctor go mad at me for documenting in the notes

> that the reason I couldn't take a woman to theatre was because they were all asleep (despite waking them all up and informing them). He shouted at me in front of patients and staff. He showed them the notes I had written and accused me of trying to get them sacked justifying it by saying 'this is what happens in Uganda every night shift. We aren't in the UK now'. I felt vulnerable and didn't know how to get senior help. Being a mzungu in these working environments can be hard as no one really wants to help you if it interferes with their routine.

Avoiding Risks through International Placements in High-Resource Settings?

The discussion above has identified a range of potential costs, risks or 'disbenefits' associated with placing NHS employees in low-resource settings. It is important to reiterate that, from the perspectives of respondents and our experiences as volunteer managers, the gains far outweigh the costs. In practice, we have seen very few examples of these risks converting into serious outcomes. It could be argued that people do not need to travel to such extreme locations, with all the expense and general upheaval that this involves, in order to be exposed to difficult working conditions. Apart from activities that might be specifically tied to the location, the UK could arguably provide plenty of environments in which to develop the skills that are claimed to be uniquely fostered in low-income settings (McCulloch and Mishra 2009; Yule et al. 2006). However, although the UK, or any high-income country, may have some extremely deprived socio-cultural areas, anyone who has travelled or worked in low-resource settings will acknowledge that what can be experienced in such places is fundamentally different. Poverty and systemic dislocation in the UK in no way approach the levels that can be found in parts of the developing world. We asked the managers of volunteering organisations that currently provide overseas placement opportunities to comment on the difference between sending staff to high- and low-income countries. A senior coordinator with several years' experience of organising long term placements for health professionals was clear about the situation as she saw it:

> I'm not absolutely sure they get that much out of going to high resource settings. I think it's completely different. I think that clinical staff may get a bit of training in comparative systems, but they'll have the same restrictions

> that affect them here. The problem in the UK is that they don't get their hands on any complex cases, like twin or breech deliveries, because of litigation and defensive practice. Because of the sheer weight of trainees, I guess, they will see so few of the cases that they need to see to progress. So when they go to a developing country they get so much more hands on. They might do observation – they might be able to observe over here, but they'll see things that they've read about in text books that over here aren't allowed to mature onto real problems – like ruptured uteruses, or diabetic foot ulcers.

Volunteers themselves who had experienced working in both high- and low-income settings highlighted similar issues. There was a general feeling that working in any foreign setting, be it low- or high-income, would be valuable and support a degree of 'systems thinking'. Even comparatively similar high-resource settings such as America or Australia, where elements such as a shared language helped to mitigate excessive culture shock, were seen as worthwhile, although it was usually acknowledged that they tended not to offer the experiential onslaught that is a feature of low-resource settings. Bethany, a recently qualified nurse who had already undertaken long-term placements in Central Africa, Tanzania and Australia, explained how the differences between the Australian and the UK high-income settings were largely administrative. The Australian healthcare system is a form of hybrid public/private arrangement which she found very easy to adjust to. It engendered none of the shock value which characterised her low-resource placements:

> I think it's always good to go to somewhere different to experience something else. I think as much as it's a nice idea to stay in one job once you've qualified, I don't necessarily think it's a good idea because you don't know anything different. [In Australia] it was the same sort of culture, pretty much. Some things I'd be like, 'do you not do it like this?', and they'd say 'no' but it's just little differences. Main procedures and stuff pretty much all the same. The hospital set-ups and the hierarchies are very much the same.

A meeting with UK midwives in Australia suggested that, from a midwifery perspective, the work in Australia was less challenging than their previous work in the UK, as midwives had less autonomy in that setting. This can be contrasted with the situation described by midwives in New Zealand which has witnessed a marked policy shift in

favour of independent midwives practicing with a very high degree of autonomy.[10]

Disengaging with the system one is familiar with facilitates a level of (comparative) systems-thinking that health professionals are less likely to engage in in the absence of mobility. The MOVE project did not set out to explicitly compare experiences in high- and low-resource settings and future research may prove highly valuable particularly if it is able to address experiences in areas such as the remote Australian outback. For now, we can conclude that placements in high-resource settings are less likely to present the opportunities for clinical practice or leadership that are associated with low-resource settings, and they are far more likely to act as a precursor to longer-term stays and potential settlement given the relative attractiveness of positions.

Summary

This chapter has rehearsed some of the potential externality effects of international placements in low-resource settings. The most important of these concerns the financial costs of providing staff cover for NHS employees in the current human resource crisis. In addition to this, there are risks associated with such placements and it is essential that they are exposed and discussed. In practice, the perception of risk is a far greater barrier to placements than actual or inherent risks often exacerbated by forms of moral panic and lack of contextual knowledge. Risk mitigation through effective project organisation and volunteer management can significantly reduce residual risks and balance the relationship between risk management and optimal learning.

The final chapter summarises the discussion presented so far and concludes with a presentation of the Volunteer Deployment Model developed and continually refined in the course of the Sustainable Volunteering Project.

Notes

1. This is without taking into account any costs associated with the volunteer such as pensions.
2. A pilot study was completed in August 2015 and further work is planned.
3. The SVP also provides every volunteer with 'Working in International Health' (Gedde et al. 2011).

4. https://www.theguardian.com/world/2016/aug/18/pauline-cafferkey-ebola-nurse-accused-concealing-high-temperature
5. Understanding 'Co-Presence' in the Sustainable Volunteering Project, Policy Report 2014 available at www.knowledgeforchange.org.uk/
6. The tool was designed by Drs Kim McCloud and Helen Schofield and is reproduced in Ackers, Lewis and Ackers-Johnson (2014).
7. Our sister book (Ackers-Johnson 2014) has a specific recommendation aimed at such organisations to make registration with UK Charities Commission contingent upon compliance with mainstream UK policy and practice in employment and equality matters.
8. According to Wikipedia, 'mzungu' is a Bantu language term used in the African Great Lakes region to refer to people of European descent. It is a commonly used expression among Bantu peoples in Kenya, Tanzania, Malawi, Rwanda, Burundi, Uganda, Democratic Republic of Congo and Zambia, dating back to the eighteenth century. Strictly defined as an 'aimless wanderer', the term is used in Uganda to refer generically to non-African 'outsiders' – usually but not always white people.
9. A point we discuss in our sister volume (Ackers-Johnson 2014).
10. These interviews were organised as part of a scoping visit to New Zealand and a conference visit to Perth, Australia; see note 2 above.

CHAPTER 5

Conclusions: Towards a Model for Sustainable Professional Volunteering

Abstract Chapter 5 presents a brief summary of key issues. Returning to the conceptualisation of professional volunteers as knowledge intermediaries, it emphasises the critical learning opportunities associated with placements in low-resource settings. It then cautions against equating mobility metrics with notions of excellence per se, arguing that any experience must be judged on its outcomes if we are to preserve principles of equality of opportunity in National Health Service (NHS) careers. It then presents the Sustainable Volunteering Model as the basis for future evidence-based up-scaling that complies with highest ethical principles whilst respecting the duty of care to professional volunteers.

Keywords Sustainability · Ethical deployment · Volunteer placements model

Introduction: Professional Volunteers as Knowledge Brokers

Our previous work has characterised professional volunteers on international placements as 'knowledge brokers' engaged in forms of collaborative knowledge generation and mobilisation (Ackers 2015). Ongoing evaluation substantiated through the MOVE project has underlined the resonance of this conceptualisation. Extracting individuals from this process and attempting to distinguish volunteer learning and the returns to sending organisations such

H.L. Ackers et al., *Healthcare, Frugal Innovation, and Professional Voluntarism*, DOI 10.1007/978-3-319-48366-5_5

as the NHS, whilst necessary, is also highly problematic both from a 'measurement' and an ethical perspective. The introduction to this book made a somewhat arbitrary distinction between explicit clinical skills and tacit knowledge. We identified the growing emphasis attached to tacit knowledge and 'transferable' or soft skills in NHS staff development priorities and, in Chapter 3, evidenced the impact that international placements have on these areas of learning. In reality, hard and fast distinctions between explicit and tacit knowledge break down as tacit knowledge is increasingly associated with all skills implementation. Williams and Baláž contend that these diverse forms of learning operate in combinations to bring about innovative thinking and behaviour change criticising the tendency to view skills in isolation as technical competences or, 'something that can be taught and assessed'. Meusberger (2009) makes a similar point, distinguishing knowledge from 'information'. The work of these authors recognises the importance of more socially situated and socially constructed forms of tacit knowledge to knowledge translation process. When it comes to understanding not simply whether new knowledge or skills are generated but more importantly whether these can be utilised in either the low-resource setting or the NHS on return, the distinction between forms of explicit and tacit knowledge loses significance; they are 'essentially complementary . . . because all forms of codified knowledge require tacit knowledge in order to be useful' (Meusberger 2009: 31).

We have seen how repetition of clinical skills on international placements not only hones skills but also builds the confidence required for skills utilisation. Similarly, whilst triage, audit or management skills can be taught, in theory, it is the experience of actioning these skills in dynamic cultural and political contexts that generates higher-level experiential learning and opportunities for knowledge translation and implementation in future environments. The UKs Medical Research Council highlights the increasing importance of 'complex interventions' to the contemporary NHS (MRC 2008; Richards et al. 2015). The multi-professional experiential learning that takes place on international placements provides opportunities for the kind of systems thinking so important to complex interventions. It enables individuals to step outside of their immediate position and view organisations more holistically from the outside.

Chapter 1 discussed the use of the word 'volunteer' in global health research and policy arguing that although the term captures a factual legal situation (that they are not employees in the host locations), it fails to convey the reality of individual motivations and learning. The

prefix 'professional' was added to emphasise the essentially professional quality of these forms of highly skilled mobility as 'embodied knowledge' (Williams and Baláž 2008). We used the language of lifelong learning to break away from conventional stereotypes tying knowledge transfer processes to career stages; learning and teaching occur simultaneously across all stages of a professional career and life-course. This approach enables us to understand the contribution of even very early career health workers (or students) to low-resource settings and the learning opportunities for even the most senior of cadres. The concept of knowledge brokerage captures these processes perfectly by placing health workers as critical knowledge intermediaries both during their placements and on their return to the NHS. Exposure to new learning combined with existing knowledge creates significant innovation potential. Sadly, host organisations and systems in low resource settings often fail to create environments receptive to this new knowledge. We have discussed these processes and the unintended consequences of professional voluntarism elsewhere (Ackers and Ackers-Johnson 2016). The MOVE project was tasked to capture the volunteer learning associated with international placements and the conditions for its optimisation. As a project, we were not instructed to assess the impact of that knowledge premium or the potential for knowledge translation and behaviour change within the NHS. Our interviews with returned volunteers would suggest that further work needs to be done to ensure that the NHS is more receptive to this knowledge if we are to realise the potential benefits associated with frugal innovation.

The knowledge, networking and mobility capital that professional volunteers gain as a result of their sojourns represents huge potential for the NHS. It also augments individuals' CVs in a way that adds to their 'employability security' (Opengart 2002) insuring them against the risk of dependency on any one employer and opening up opportunities across diverse sectors and countries. The growth of 'portfolio careers' increases opportunities for creativity and agency. The interviews have identified a number of cases where individuals have used their placements to re-imagine their careers and perhaps move out of the NHS into other health systems or other forms of work. Some actively chose professions such as medicine and nursing to pursue careers in global health; others became interested in global health or development work as a direct result of their exposure. The majority renewed their motivation to return to the NHS and use their new skills

and confidence to stimulate innovation. Ultimately it is for the NHS to find ways of harnessing these qualities and energies to enhance the UKs National Health Service.

The remaining section of this chapter addresses some of the more operational aspects that need to be addressed if international placements are to be developed as a wider lifelong learning 'offer' accessible to all NHS employees rather than simply providing enhancements to the CVs of more privileged doctors.

Mobility 'Metrics' and Equality Issues

In Chapter 1 we referred to the notion that professional mobility is a selective process and that mobile professionals are often identified as sitting amongst the 'brightest and the best'. Ferro (2006) suggests that mobility can take on a symbolic quality (or rite of passage) reflecting social norms as much as genuine ability or potential. Mobility, she argues, contributes to a 'self-actualisation process' that could be achieved through other mechanisms including forms of virtual connectedness. This work is of importance to the MOVE objectives (of presenting an evidence-based model for professional voluntarism) for two reasons. First, whilst mobility is clearly one means of achieving accelerated and enhanced learning, it is not the only way and it is critically important that health workers who have experienced international placements are evaluated according to the experiences and learning they have gained and not from the 'fact' of their involvement alone. International placements in low-resource settings are unlikely to generate consistent and comprehensive skills sets as such as every context and deployment is quite distinct. A study of doctoral mobility in the social sciences warned of the consequences of treating mobility as an indicator (or metric) of 'excellence' and concluded that 'mobility is not an outcome in its own right and must not be treated as such (as an implicit indicator of internationalisation). To do so contributes to differential opportunity in scientific labour markets reducing both efficiency and equality. Mobility is one means of achieving international research collaboration and knowledge transfer. It is not an end in itself' (Ackers 2008).[1] We would argue that the same applies to international placements and their role in the development of health professionals. Any automatic association (or presumed correlation) between placement mobility and notions of excellence could generate forms of discrimination privileging those in a position to access opportunities. Secondly, and linked to this, it is of utmost importance that we acknowledge

the fact that health workers are not equally footloose and able to respond to mobility opportunities. Family and caring responsibilities and financial status as well as the attitudes of employers and line managers will have a significant effect on their ability to action any aspirations they have towards mobility (Ackers 2008, 2010; Boyd 1989). These processes are gendered and impact differently across the life course. Lifelong learning and its counterpart, the 'boundaryless career', will shape in important ways individuals' abilities to engage in international placements. Whilst finance alone will rarely be the only factor impeding mobility, the Sustainable Volunteering Project (SVP) certainly found that less well-remunerated cadres of staff such as nurses and midwives were more reliant upon compensatory payments to facilitate their engagement in international placements in comparison to doctors most of whom either have access to immediate resource or the ability to forgo income in the expectation of deferred gratification.

This issue of equality of opportunity will grow in significance if international placements become more of an expectation across all cadres of staff. At the present time it is primarily evident in relation to medical trainees where the expectation of mobility has existed for some time. Widening participation programmes will increase the potential for inequity in medicine as will the introduction of tuition fees for nursing, midwifery and allied health professions.[2] The survey results presented in Chapter 2 suggest that women are less likely to exercise these forms of mobility during the years associated with child bearing and rearing. These will often coincide with periods of accelerated career progression for their male counterparts. Consideration needs to be given to the barriers to engagement in international placements and the implications of these in terms of equality of opportunity. Promoting the view that international placements provide unique and career-enhancing opportunities will necessarily increase the demand for such placements and the kudos attached to this experience. The potential for opportunities to generate inequalities will be linked to, amongst other factors, length of stay and the perceptions of learning outcomes associated with this variable.

Length of Stay on International Placements

The general consensus, at least among theorists of highly skilled migration, would seem to be that the distinction between short- and long-term stays holds little validity and may indeed constrain our understanding of learning (Ackers and Gill 2008; Iredale 2001). When discussing potential

stays with professional volunteers, the issue of length of stay usually forms the basis of the first enquiry; 'How long do I have to stay for?' Length of stay is also identified as a key issue for the host setting where conventional wisdom and the practices of dominant deploying organisations (such as VSO) have favoured extended stays (of over two years).[3] Our own evaluation of the relationship between length of stay and host impact informed by contemporary research on highly skilled mobilities and business travel provides a powerful critique of this perspective arguing that length of stay is only one of a number of key variables impacting knowledge mobilisation processes (Ackers 2015). Length of stay in isolation tells us nothing about learning or impact.

In considering optimal models, we start from the premise that some element of co-presence (physical meeting) is critical to relationship-building and the formation of effective inter-organisational interventions (Williams and Baláž 2008; Meusberger 2009). The Tropical Health and Education Trust (THET) recognise this in their scoping visit funding stream enabling interested parties to meet and develop plans. The formation of strong relationships is critical not only to host impact but also to all forms of bi-lateral learning, including volunteer placements. Stays for the purpose of project initiation and development can be quite short and intense and need to involve those individuals central to programme organisation.[4] The continued development of inter-institutional links can be maintained through regular short stays; indeed, repeated (return) or cyclical stays have a powerful symbolic and practical impact in maintaining relationships and an up-to-date understanding of contextual dynamics. Shrum et al. made a similar point in the context of understanding project failure and corruption in Ghana arguing that strong and effective relationships are 'built through repeated visits over time' (2010: 161). Our paper describes another type of stay focused specifically on knowledge mobilisation objectives at organisational as well as individual level. 'Long-term volunteers' (defined by THET as stays involving a minimum of six months) play a critical 'anchoring' function (Ackers 2015: 140) providing continuity and communication in environments where virtual methods (email etc.) are rarely optimal. These long-term volunteers play a key role in maintaining organisational relationships and communication channels; they also support those volunteers who are unable to stay for longer periods to engage effectively in knowledge mobilisation roles and bi-lateral learning. In the context of established and active health partnerships stimulated and reinvigorated through repeat short stays and underpinned

by long-term anchoring volunteers, short stays focused on targeted interventions can prove to be highly effective. Although our own survey did not identify a high incidence of repeat stays, our experience of working within the frame of the Ugandan Maternal and Newborn Hub provides numerous examples of repeat short stay visits especially amongst more senior clinicians. This is borne out by Smith et al.'s study (2012) which found that 33% of doctors on international placements of less than a month had returned on at least five occasions. Other literature supports the contention that short stays are conducive to volunteer learning (Dean 2013; Dowell et al. 2014; Dowell and Merrylees 2009; Smith 2012).

Long stays in the absence of active health partnerships run the risk of lapsing into service delivery often involving lone working and 'fly-in-fly-out' random short stays deliver little for host settings or volunteers. The exception to this may be emergency relief work, although even in these circumstances this must take place within the frame of credible and effective organisational relationships. Organisations like the 'Mercy Ships'[5], for example, may provide effective opportunities for intense clinical learning on the part of short term and relatively junior health workers.

From the perspective of volunteer learning, length of stay is fundamentally about personal objectives and tailored volunteer deployment. Ackers (2015) argues that there is no ideal length of stay:

> The experience of short-term clinical exchanges in Health Partnerships suggests that where the visits are well organised, prepared for in advance and form an integrated component of a mutually planned and coordinated project, they can play a very important role in promoting knowledge transfer. The existence of clear (negotiated) project objectives (and annual priorities) tightens the focus, promoting continuity of the knowledge transfer activity. (Ackers 2015: 143)

On the basis of our contextualised experience we would disagree with Williams and Baláž's assertion that three-month stays represent a 'minimum for significant and effective learning' (2008: 1927). However, short stays have cost and management implications. A consultant anaesthetist volunteer describes the importance of having effective management systems in place particularly for short-term volunteers:

> They've got to be managed very well. Any placement has got to be managed well but I think it's more important with a short-term placement. You need to make sure that you don't force in someone who's used to having a lot of

> support. Here in the UK we have a very hierarchical structure – even a consultant can always get a second opinion on something. Even if people [criticise] the NHS, you'll never be on your own, even as a consultant. You can always ring up your director and say 'I'm really in [trouble] here, what would you do?' But then you've got to make sure that if you're a relatively junior person and you're going into an environment where you're not supported, then you've got to make sure that it's not going to be catastrophic. I mean, you get disasters [overseas] that you don't see in the UK, so you've got to make sure that there's some kind of network, some kind of infrastructure in place that's able to rescue them, protect them, whatever you want to call it. Which is going to be difficult. It'd be dreadful if a young doctor went out there who was really eager, really keen, and they end up in a situation where they want to go for help, but no help arrives cos there is no help there.

We have presented this quote in some detail as it leads naturally into the final section of the book which sets out the Sustainable Volunteering Model. We present this model here not as an example of 'best practice' but rather as guidance to aid potential policy transfer. Policy transfer is a complex process and it is never possible to pluck one model out of its context and attempt to transpose it into another quite different environment (Park et al. 2014, 2016). To echo the language of learning theories, the translation and operationalisation of this 'model' to another setting requires a further layer of knowledge brokerage by a 'knowledgeable other' (individuals or organisations with deeply contextualised knowledge of the local hosting environment). Strachan et al. make a similar point:

> Placement structures may not transfer appropriately, and there will certainly be new patterns of negotiation, organisation, strategy and management to learn, as well as new relationships to build and new needs to engage with. (2009: 12)

Towards a Model for Sustainable Professional Volunteering

Sustainable and Ethical Deployment

First and foremost, professional volunteering needs to comply with ethical standards; the primary concern here is commitment to reciprocity and mutual benefit. This balance can be illustrated by reference to the original

SVP objectives which themselves echo the objectives of our funding body the Tropical Health and Education Trust and its funding, body, UK Aid:

1. To support evidence-based, holistic and sustainable systems change through improved knowledge transfer, translation and impact.
2. To promote a more effective, *sustainable and mutually beneficial* approach to international professional volunteering (as the key vector of change).

Arguably, we could have added a new dimension to capture more fully the bi-lateral learning processes and expanded the expectation of system change to cover not only the Ugandan health system but also the NHS.[6] However, at this stage our concern with health systems was primarily with the low-resource setting (Objective 1), the reciprocal component emerging only in individual-level analysis (Objective 2). With these thoughts in mind, the SVP intervention and its evaluation was framed around three potential 'scenarios:'

Scenario 1: Partial Improvement (Positive Change)

Under this scenario, evidence will indicate that the professional volunteering interventions we are engaging in are at least ***partially effective*** in promoting systems change. It is important that even this 'partial effect' relates to incremental long-term progress and is not short-lived. Moyo suggests that project evaluations often identify the 'erroneous' impression of AID's success in the shorter term – whilst failing to assess long-term sustainability' (2009: 45).

Policy Implications: Any positive collateral benefits to individual service recipients (Ugandan patients), UK volunteers/health systems are to be identified and encouraged.

Scenario 2: Neutral Impact (No Change)

Under this scenario, evidence will indicate that the professional volunteering interventions we are engaging are generally ***neutral*** in terms of systems impact. They neither facilitate nor undermine systems change.

Policy Implications: Positive outcomes for individual service recipients (patients), volunteers (and the UK), free of unintended consequences, may be identified and supported.

Scenario 3: Negative Impact (Collateral Damage)

Under this scenario, evidence will indicate that the professional volunteering interventions we are engaging are generally ***counter-productive/*** damaging in terms of promoting long-term (sustainable) improvements in public health systems.

Policy Implications: Any positive gains to individuals (including Ugandan patients) or systems in the UK are tainted with unintended consequences and, on that basis, are unethical and should not be supported.

In this framework, volunteer deployment can be justified provided it meets either Scenario 1 or 2. In Scenario 3 volunteer learning as a goal in its own right cannot be justified and it would be unethical to deploy NHS volunteers to low resource settings in that kind of environment.[7]

This generates important challenges for international placements in the NHS and these have cost implications. First and foremost, to even begin to achieve the outcomes above, volunteer deployment must take place in organisational settings grounded in strong and meaningful relationships and a deep understanding of and commitment to local context. This implies some form of intervention focused on the needs of the host setting. It is not ethical or effective to randomly deploy UK health workers to facilities in low-resource settings as has been the case in the past with medical electives and many missionary style outfits. Investment in the host setting need not and arguably should not imply major financial donations; indeed, we have argued in our sister volume that these are in most cases damaging and counter-productive (Ackers et al. 2016). The major contribution the UK is providing is skilled and willing personnel although carefully planned 'in-kind' contributions may optimise volunteer safety, volunteer learning and host benefits.[8] But it does imply investment in a global health infrastructure and intelligence.

A serious consideration for the NHS and deployment agencies are the operational costs associated with effective volunteer management. These will include a lean but efficient organisational set up in the UK working in close relationship with a lean and efficient receiving organisational team in the host location. In addition to building and investing in relationships with key stakeholder communities in both locations, the team will have an active presence and understand the ever-changing dynamics of context. At present organisations such as THET have relied heavily upon a volunteering ethic to support this

infrastructure and many, if not most, health partnerships are managed on a pro bono basis. Unfortunately, this cannot ensure that the most effective and sustained skill base is in place to manage potentially growing volumes of quality-assured international placements.

Volunteer Management[9]

Once this environment and the relationships that connect it are developed to an adequate level, perhaps through short stay exchanges, volunteer selection processes can be developed in compliance with best practice in UK employment policy. 'Volunteers' by definition are not employees but this should not be seen as a rationale for avoiding or evading sound employment principles. The SVP Model invested considerable effort in advertising/dissemination to raise awareness of opportunities throughout the target community paying particular attention to non-medical cadres who are often neglected in these processes. We then generated a comprehensive recruitment system.

Transparent and Equitable Recruitment Process

At present, the supply of placements is managed by a disparate range of largely unregulated providers motivated by quite diverse goals. Some of the larger organisations, such as VSO, may be committed to providing equality of opportunity to prospective volunteers. Others may have no interest or experience in this aspect of their work or may utilise quite discriminatory selection criteria. At present, providers operate their own selection systems. A number of SVP volunteers spoke of being rejected by VSO, for example, on the grounds that they were not legally married or, in one case, was a single parent. In another situation, a hosting organisation explicitly discriminated against any volunteers who were not practicing Christians (and requested the insertion of a question in the SVP application form asking for details of the church they currently worshipped at). They also refused to accept volunteers who were not legally married in a heterosexual relationship and made it clear that volunteers were required to attend chapel daily during their placement. These organisations filtering applicants with overt religious 'rules' that fail to comply with UK equality law and policy should not be allowed to provide placements that are affiliated to UK public or charitable organisations.

Age and Seniority

Another area of potential tension between the needs of individual volunteers, employing organisations such as the NHS and deploying/hosting organisations concerns age and seniority. Whilst the latter may explicitly prefer more senior or experienced individuals (as noted above) or more mature people perhaps around retirement age who can stay much longer and have fewer pressing family or financial commitments, there is relatively little 'knowledge premium' for the NHS to be made from sending very senior (and expensive) staff towards the end of their career. Interviews with the Army Reservists who play an important, if specific, role in volunteer deployment indicated a strong preference for mid-career individuals who are already highly skilled in their chosen field; primarily clinicians in the 40–45 age group. The interviews suggest that this strategy may prove quite fruitful in identifying and investing in future leaders.

Overall our research would suggest that international exposure at early career level has the sharpest impact on learning; also that early career exposures tend to stimulate ongoing engagement in global health. From an equality perspective sending organisations should see this in the round, balancing the net gains from facilitating early career mobility with the motivational and project-related benefits of mid- and later career engagement. Experienced volunteers with extensive clinical and life experience, particularly if they have worked in low-resource settings offer considerable stability and resilience to composite international teams.

Volunteer 'Matching'

Once a candidate satisfies the deployment criteria, a 'volunteer matching process' ensues in full consultation and with deference to the Health Partnerships engaged on the ground. Unlike organisations such as VSO, the SVP does not advertise detailed positions/roles. Once potential volunteers come forward, it seeks to identify where and how they could contribute to project objectives (including their own learning objectives). Whilst the placement of professional volunteers cannot be supply lead (and focused solely on the needs of prospective volunteers), neither should it be solely demand lead. The articulation of demands from low-resource settings typically places an emphasis on long stays of the most highly qualified staff often with the intention of substituting for local staff. Our research would suggest that this is rarely the most effective form of

deployment in capacity-building projects such as the SVP,[10] in terms of the needs of either their volunteers or their employers (the NHS); it does not deliver optimal benefit to the low-resource setting and can be positively detrimental. This is a negotiation process that demands a high level of contextual knowledge of volunteer supply, intervention dynamics and resilient trust relationships. Strachan points to the critical role of relationship building and trust to effective volunteer deployment (2009: 3).

Having identified a potential 'match' the SVP then provides details of the volunteer to the hosting organisation/s. In the SVP case, these organisations are individual health partnerships linking hospitals/universities in the UK with hospitals/universities in Uganda. Wherever possible we link only with public health facilities and strongly advocate that approach in order to support system strengthening rather than the development of parallel systems. One of the unique qualities of the SVP was its basis in a consortium of Health Partnerships known as the Ugandan Maternal and Newborn Hub (the HUB). The HUB was a response to the perceived need for very grounded cooperation and mutual support within the Ugandan HP community; working together in this way enabled us to develop an efficient secretariat that assumed many of the core roles of volunteer management in a democratic environment and wherever possible and appropriate respecting the subsidiarity principle (that individual HPs were primarily responsible for managing their own interventions on the ground).[11] Having this infrastructure and bi-annual volunteer workshops aimed at building relationships and supporting team working gave us the opportunity to support short and longer stay volunteer mobility within Uganda (volunteers could be based across two sites, for example, or teams could get together at certain times for multi-professional interventions).

In theory, other organisations could become involved in this process without undermining the emphasis on deeply contextualised relationships. Health partnerships could act as effective intermediaries linked to commissioning organisations, for example, which is in effect how THET have managed their 'long-term volunteering programme.'[12] Strachan et al. point to the fact that most placements are organised in response to a demand from a deploying or host organisation and most 'sending' organisations do not run placements themselves but use intermediaries for this process (2009: 6/9). However, the more intermediaries become involved the more complex the relationships will be and the greater the potential for poor-quality communication.

The next stage in the SVP process is to set out an initial volunteer role description which then forms the basis of a signed volunteer agreement. The volunteer role description involves direct negotiation between the SVP management team, HP leads and the volunteer in question and seeks to balance the needs of the intervention/s they were contributing to; their own defined learning/career/personal needs, the overall objectives of the SVP and any concerns about risk. The volunteer agreement is in all cases an iterative document[13], and we explain to volunteers that this will go through a process of constant evolution in response to the changing environment and project objectives as well as their own learning and ambitions. In addition to regular email and face-to-face and telephone communication, a monthly reporting mechanism is used to assess progress and identify any concerns/opportunities.

Supervision, Risk and the Co-Presence Principle

The principle of 'co-presence' lies at the heart of the SVP volunteer agreement setting out the expectation that every professional volunteer will be working alongside a Ugandan counterpart.[14] As noted in Chapter 4, co-presence is the single most important principle underpinning a risk mitigated and ethical placement. Mechanisms must be in place to enforce and monitor adherence to co-presence and respond accordingly to breaches of this principle. Individual volunteers and host locations are required to sign up to this commitment. In practice, the long history of breach of conditionality principles in Aid (Moyo 2009) has encouraged a tendency to ignore such principles without reprisal. As such, co-presence takes a long time to embed within a programme and every new volunteer will be faced with the expectation that they will go on rotas and engage directly in service delivery. As noted above many professional volunteers, especially doctors, will be tempted to ignore the commitment to co-presence, especially if they interpret this as a challenge to their primary commitment to individual patient care (for a discussion see Ackers et al. 2016). This underlines the need to impress on every volunteer that they are one member of a complex intervention and must comply with project objectives and principles; managing volunteers in this way demands an investment in infrastructure both in the UK and on the ground. Volunteer induction is a critical component of the 'volunteer journey'.

Building Relationships with Professional Volunteers: Induction through to Debriefing

Much of the international placement literature argues that adequate support before, during and after international placements optimises learning and impact. Certainly volunteer induction is critical to effective deployment (Gedde et al. 2011). Induction is commonly associated with a physical 'induction pack'. In the SVP we assessed existing products and on the basis of our risk assessment developed a 'pack' tailored to the local context. In practice this is a living document continually adapted over time as new challenges or opportunities/resources emerge. Some discussion has taken place over the relative merits of formal induction meetings either in the UK or in the host setting. However, the original plan of holding group meetings either in-country or in the UK has been amended to provide more individual-based approaches largely not only because volunteers are coming and going at all times of year (and not in blocks as originally anticipated) but also because many were unable to commit to week long programmes prior to departure. In practice, the SVP has combined interviews and face-to-face meetings with measures to connect new volunteers to the wider volunteer and project community.

As important as preparation, the literature on placement learning not only emphasises the importance of reflection both in terms of translating and applying knowledge but also mitigating trauma or culture shock on return (Briscoe 2013; Clampin 2008). According to Kolb (1983), reflection is a key component of experiential learning and much of this reflection continues to happen post return (Murdoch-Eaton 2014). Protagonists of 'transformational learning theory' emphasise the longitudinal quality of volunteer learning as individuals consolidate their new knowledge into existing schemas (Fee and Gray 2013). In the SVP model, we have tended not to view this as before-and-after events but rather as a continuous relationship-building process linking volunteers not only into project management teams but also and perhaps most importantly with previous, existing and future volunteers to build volunteer communities. From a volunteer deployment perspective, our strong preference now is to locate volunteers in clusters encouraging cross-professional and inter-generational mentoring and support. We have found that both optimise impacts in host settings and opportunities for volunteer learning, creating active co-supervision and co-learning contexts. Importantly this is also a cornerstone of risk mitigation.

These processes are labour intensive and rest on the quality of personal relationships and active knowledge of project interventions on the ground. Whilst larger organisations may have the volume of volunteers to support and require intense pre-placement induction and de-briefing, we would argue that it is detailed knowledge of activity on the ground that is most important in supporting volunteer deployment.

Responsibility for volunteer induction in the SVP context was shared throughout the management team with HP leads contributing to the induction pack and playing a critical role in in-country volunteer induction. Wherever possible new volunteers accompany or join one of the HP leads. We also encourage volunteers to 'overlap' so that they can support each other and encourage continuity in project interventions (whilst being cautious about labour substitution[15]).

Risk Mitigation and Administrative Issues

Once a volunteer placement has been planned and the volunteer agreement set out our in-country support manager sets processes in motion to ensure that every volunteer has the necessary clinical registration and visa/work permits. We have referred (above) to the importance of conditionality and reciprocity. In practice, receiving countries are accustomed to behave as the passive 'recipients' of Aid with little interest in or attention to the risks involved. The Ugandan Maternal and New-born HUB with the assistance of the UK-Uganda Health Workforce Alliance[16] has established a smoother system so that volunteers now obtain their clinical registration prior to arrival and work permits within the first three months of their stay (when entry visas expire). Following ongoing lobbying by the SVP we have managed to secure work permits at no cost; we are currently pushing to reduce the costs associated with clinical registration.

The SVP purchased a bespoke health insurance plan suitable for volunteers engaged in hands-on clinical work; most existing off the peg insurance policies are not suitable for professional volunteers. As managers we felt it was important to have all the volunteers covered by one policy so that all volunteers are aware of procedures and emergency contact details (included in the induction pack). This process is relatively expensive.

Despite considerable effort and lobbying over the last five years, it has become even more difficult to provide professional indemnity insurance cover for professional volunteers. For the first three years of the SVP, doctors could receive cover from the Medical Protection Society (MPS)

or the Medical Defence Union (MDU). Since then, both organisations have tightened up and are giving it only on a case-by-case basis. In the case of the MDU they require details that adequate supervision is in place. The Royal College of Nursing (RCN) covers all its members including students and this extends to midwives registered with the RCN. However, the Royal College of Midwives refuses to extend professional indemnity cover to any of its members leaving a significant loophole in cover. More detail on risk management including protocols on HIV prophylaxis and Ebola are contained in the SVP Volunteer induction pack on the Knowledge for Change Charity website (www.knowledgeforchange.org.uk/).

Notes

1. This has been explicitly recognised in the MOVE project through the assessment of the potential for a psychometric tool to assess the learning outcomes deriving from international placements.
2. From 2017/18, new students on nursing, midwifery and allied health professional pre-registration courses (which lead on to qualification with one of the health professional regulators) in England will take out maintenance and tuition loans like other students rather than getting an NHS grant (Council of Deans of Health 2016)
3. VSO are currently reviewing this policy and encouraging shorter stays.
4. Valuable learning also takes place at this level and many of the actors will be senior UK clinicians (and evaluators) but the primary objective of these visits will be to enable the learning of others.
5. www.mercyships.org.uk/
6. We paid some lip service to the NHS as a system in the scenarios but this was not a focus of our intervention at that point in time. Our current work involving undergraduates is more explicitly holistic.
7. We assume that similar assumptions will be made by NHS facilities hosting undergraduate students.
8. A simple example here would be the work SVP volunteers undertook in a multidisciplinary team to effect the opening of a large facility which then became a valuable placement site (Ackers 2014).
9. Strachan (2009) and Comhlamh (2016) provide excellent guidelines on ethical volunteering.
10. We would expect this to be different in emergency relief organisations.
11. An area of considerable tension concerned delegation of principles of equality and fair deployment which were challenged repeatedly by the UK lead of a mission hospital.
12. http://www.thet.org/our-work/what-we-do

13. Strachan et al. emphasise the importance of volunteer 'flexibility' ad a willingness to respond to changing demands and circumstances (2009: 10).
14. This is discussed in Chapter 4 and in footnote 6.
15. In some cases we deliberately planned gaps in volunteer deployment to assess where interventions had led to behaviour change on the ground and reduce the risks associated with dependency. Continuity of project does not necessarily imply continuous presence in a particular health facility.
16. The 'Alliance' was established in 2013 By Lord Crisps following a high-level meeting with the Ugandan Ministry of health. In practice its activity has been quite minimal until it was recently received support from THET and the Global Health Exchange (GHE): http://www.globalhealthexchange.co.uk/projects/uukha/

Appendix 1

Data Collection and Methods

This was a qualitative, interview-based study which broadly utilised the principles of grounded theory (Glaser and Strauss 1967). Therefore, rather than basing out explorations on a firm hypothesis, we attempted to develop a plausible representation of the worldview in which our participants were embedded and engaged in a research strategy which incorporated the ongoing analysis, comparison and theorising. The purpose of utilising semi-structured interviews was to achieve an understanding of varying conceptualisations of professional volunteering, the different meanings it had for people and its place in their lives and career planning. We also wanted to explore more mundane issues such as how professional placements worked for people on a practical level; how and why they undertook them; what people thought they got out of them; and how these experiences impacted their work and career once they returned to the NHS.

Interviews

Our primary corpus of in-depth semi-structured interviews comprised a wide range of returned volunteers and other stakeholders ($n = 51$). These data were collected during 2014 and 2015 and included a representative sample of NHS employees which was designed to broadly reflect the current spread of staff across all grades.[1] The sample comprised 11 qualified or trainee doctors 16 nurses and midwives; 6 clinical support staff; 10

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managerial and administrative staff; and 8 'others', which included ambulance and maintenance staff, cleaners and caterers etc. Of the entire sample, 8 respondents (15%) had not been on a placement or had no overseas experience. We initially recruited participants via our existing NHS contacts based at the University of Salford, and the University of Manchester Medical School. A significant proportion of volunteer or ex-volunteer respondents were contacted via established links with organisations that provided overseas placements.

We were fortunate in that half of the research team had extensive experience working in the field of overseas development and professional placement provision, and the other half in NHS training evaluation and healthcare research. This gave us a broad base of primary contacts connected and whom we were able to access. We placed only broad restrictions on which individuals we approached, and recruitment of participants was routinely snowballed from an initial contact with a key player, for example, a returned professional volunteer or a charity administrator volunteer. This person provided an all-important level of legitimisation to other potential interviewees. Connections and subsequent interview opportunities tended to develop organically from here. This approach was informed by an understanding of professional volunteering charities and how they are embedded in a web of other groups and networks that intersect with the NHS. Interview recruitment was continued until saturation was achieved. That is, until the process was adding nothing new to our understanding of a given theme.

We used qualitative and semi-structured interviews, and these were always conducted informally. This enabled us to adapt to the variety of positions and perspectives that were in evidence. Our interview schedules (i.e. the questions we asked and the themes we chose to explore) were continually reviewed and revised as necessary on the basis of emerging evidence, and we individually tailored the interviews of each interviewee. We explicitly pursued negative cases as a means of enhancing the validity of our propositions as they developed. In the context of this study, this particularly meant talking to staff and stakeholders who were not actively engaged in professional volunteering, as well as those who were, to those who had experienced barriers to involvement and so forth. There were, however, a number of thematic elements which were addressed in every case. These were as follows: (1) their basic demographic information; (2) their relationship to, or role within the NHS (doctor, nurse, placement provider etc.); (3) their experiences of being on a professional placement

abroad; (4) the way these experiences had affected or changed them; (5) the processes they had gone through to get a placement; (6) barriers or enabling influences they had encountered and barriers they could see being an issue for other people; (7) finally – particularly in the case of returned volunteers who were back in their NHS roles – we wanted to explore the impact of their experience on their everyday work, and on their relationships with the colleagues and patients, now that they were back in the UK.

These themes formed the basis for the majority of interviews, although again the specifics of individual cases and their particular relation to a given group often meant that the interview format we actually used differed quite widely between participants. Interviews were audio-recorded where possible and transcribed verbatim. Analysis of transcription data was conducted alongside ongoing analysis of data from our other main sources.

Documentary Analysis

During the course of the MOVE project, we collected a very wide range of documents and other media. This material helped us contextualise the findings that we generated from our other sources, but also often provided useful tangential trigger points for our analysis. We looked at publicity material and formal documentation from a range of relevant organisation; official and unofficial policy documentation; information and marketing material from placement providers; internal auditing and evaluation material (SVP project); NHS and DOH statistical data; personal diaries and blogs written by participants; and photo, video and audio material. Our selection of material was informed both by our initial research questions and by themes that were emerging during the course of the study. The importance of documents and media varied. However, we were deliberately eclectic in our definition of what we considered to be relevant, and as a result, only a proportion of the large corpus we amassed were actually incorporated into our analysis.

Ethnographic and Observational Work

Ethnography was not initially intended to be one of our primary methods. However, in the course of the study, the research team, many of whom had other roles organising volunteer work (see Ackers and Johnson 2016) had the opportunity to undertake several field trips to sub-Saharan Africa.

There, they were able to conduct participant and non-participant observation with long-term professional volunteers in the field. We were also able to undertake background ethnographic observation while accompanying groups of student doctors and nurses on shorter-term elective placement trips to Uganda and Central Southern India during 2015–2016. Subsequently, this observational material made a very useful addition to our primary corpus and our appreciation of the context in which professional volunteers – in a developing country at least – are required to work.

The actual observational work carried out was therefore quite varied and opportunistic. It ranged from spending time with professional volunteers in the field, primarily doctors, anaesthetists, nurses and midwives, but also biomedical engineers and administrators. We were able to observe them as they worked and saw how the environments they engaged with influenced what they did. We were also able to obtain data from 'around' these environments to enable everyday detail of the setting to emerge. These included 'satellite' encounters, such as those which might occur between UK volunteers and local staff or between local staff and patients when UK staff were not present. Observations like this helped clarify and flesh out some of the more subtle cultural interrelations that were reported and allowed us to compare the reported perspectives of volunteers (as relayed in interviews etc.), with direct observations of ongoing behavioural dynamics.

Data from the Sustainable Volunteering Project (SVP)

We were fortunate to have full access to a large corpus of the interview and ethnographic data collected as part of the *Sustainable Volunteering Project*. This was a separate action-based researchstudy that pre-dated MOVE, and which provided us with some significant data – particularly relating to narrative accounts and interviews with current and returning (NHS) professional volunteers engaged in work in sub-Saharan Africa. A full outline of the *Sustainable Volunteering Project* (SVP) is given in Appendix 2, but broadly, the data we were able to access were originally collected as part of an extensive internal evaluation programme which was carried out for the duration of the project. These data included the following:

1. Pre-, mid-, and post-placement interviews with long-term volunteers
2. Monthly reports (containing qualitative and quantitative data)

3. Interviews with the Ugandan Health Facility management and staff
4. Interviews with UMNH partnership coordinators
5. Interviews with mentors
6. Recorded workshops and focus groups
7. Site visits and observations made by the LMP evaluation team

We were also able to gain access to a large collection of email correspondence between volunteers in the field and SVP staff. This corpus is particularly interesting, as it is composed mainly of material relating to long-term volunteers. Most of the SVP volunteers, for example, were in a country for at least three months, and personnel frequently stay for over a year. This length of stay is relatively uncommon for NHS-based professional volunteers taking time out for work-related or ongoing training placements (the average stay being around a month), but could be argued to be most impactful – in the context of both the volunteers themselves and the country they are working in. In the context of this book, we are not specifically concerned with arguments over the benefits or otherwise that professional volunteering has on local populations, but with these types of extended stay, a whole raft of subtle, in-depth, contextual knowledge becomes available to an in-country person who would not necessarily be apparent to those engaged for shorter periods.

Ethical Approval

Ethical approval for the MOVE study was obtained from the University of Manchester Research Ethics Committee and the University of Salford Research Ethics Committee in 2014. As an independent evaluation-based enterprise, the SVP project was not subject to formal academic or NHS ethical approval. Permission to use these data on a case-by-case basis was obtained from the Tropical Health Education Trust (which funded the SVP) and the appropriate project steering groups.

Note

1. In recruiting to the study, we aimed to broadly match the proportions of respondents from each staff cadre with current actual staffing levels within the NHS.

Appendix 2

The Sustainable Volunteering Project

Background and Objectives

The Sustainable Volunteering Project (SVP) is managed by the Liverpool-Mulago Partnership (LMP) and was initially funded by the UK Department for International Development via the Tropical Health Education Trust's Health Partnership Scheme. Financial support has also been received from the Royal College of Obstetricians and Gynaecologists (RCOG) and the Association of Anaesthetists of Great Britain and Ireland (AAGBI). The THET-funded project began in April 2012 and ran for a three-year period, ending March 2015. The SVP continues and is now funded in association with our partner charity Knowledge for Change (www.knowlege4change.org.uk/)

The LMP had been placing professional volunteers in Kampala for over four years before applying for funding for the SVP. The SVP, however, marked a substantial increase in the scale and scope of this activity, widening the LMP's focus outside of Kampala to support other Health Partnerships involved within the Ugandan Maternal & Newborn Hub (UMNH) and also broadening the cadres of Health Professionals supported to include not only obstetricians but also paediatricians, anaesthetists, midwives, nurses and biomedical engineers.

UMNH is a consortium of UK-Uganda Health Partnerships established by the LMP in 2011 and encompassing the LMP, the Basingstoke-Hoima Partnership for Health, the Gulu-Manchester Health Partnership, the PONT-Mbale Partnership, the Bristol-Mbarara

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Link, the Kisiizi-Chester Partnership, the Kisiizi-Reading Partnership and a partnership between Salford University, Mountains of the Moon University and the Kabarole Health District.

The professional volunteers complete placements of varying lengths (between 6 and 24 months) and engage in a variety of initiatives, training programmes and on-the-job mentoring schemes which aim to increase capacity and improve the skills of the health workers, both in Uganda and in the UK. The SVP's focus is on capacity building, and systems change and its objectives are twofold:

1. To support evidence-based, holistic and sustainable systems change through improved knowledge transfer, translation and impact
2. To promote a more effective, sustainable and mutually beneficial approach to international professional volunteering (as the key vector of change)

The SVP does not have a focus on service delivery or workforce substitution as this activity is not judged to be sustainable.

Volunteer Management and Support

All SVP volunteers are recruited, selected and managed by the LMP (and more recently also K4C). The main organisations targeted during the initial LTV recruitment were the Royal Colleges of Obstetrics and Gynaecology, Anaesthetists, Nursing and Midwives. The Royal Colleges either circulated an advertisement by email or posted it on their websites. The advertisements were also circulated by UMNH members to their local deaneries and hospitals. This initial advertisement process was successful in raising sufficient interest from prospective LTVs, the key to the success being the LMP's ability to utilise the existing links and networks established over previous years. As the project matured, an increasing number of LTVs were recruited through word-of-mouth advertisement by previous SVP LTV's and during project dissemination events, national and international conferences and workshops. Examples of such events include the British Maternal and Foetal Medicine Society's 'Annual Conference' (2013), the AAGBI's 'World Anaesthesia Society Conference' (2013), the Global Women's Research Society Conference (2012) and the Development Studies Association's 'Annual Conference' (2013).

Selection

Following an initial expression of interest, two processes are run simultaneously before a candidate can be recruited to the SVP. The first process involves prospective LTVs completing an application form and attending an interview (usually face-to-face) in order to ascertain, for example, whether a candidate would be suitable, when and why they wish to undertake a placement, what support they might require, what they hope to achieve and what skills they possess which would be of benefit to the health system in Uganda. Two references are required to objectively verify a candidate's suitability and identify any additional support they may require.

The second process involves circulating the candidates' details to UMNH partnerships to assess which of them would be interested in hosting the candidate should they be recruited to the SVP. This process was designed to align the supply of LTVs with demand on the ground in Uganda and the ability of the local UMNH partnerships to host them. An LTV is only recruited if both of the selection processes yielded positive results.

Placement Logistics

The subsequent stage following an LTV's recruitment is their pre-placement induction. Each LTV is provided with a comprehensive induction pack containing useful information on UMNH placement locations, what to expect in Uganda, placement logistics and travel, insurance and emergency contact details, health and safety and advice on pensions and other personal finances. LTVs receive a 'volunteer agreement' to sign and return to LMP management which outlines the LMP's organisational expectations, a code of conduct, a statement on co-presence, potential disciplinary procedures and a personalised role description. Volunteer agreements are drawn up in conjunction with the LTV, the relevant UMNH partner organisation and the in-country counterparts to maximise stakeholder involvement and ensure all parties remain informed and satisfied.

Each placement location/facility and all LTV accommodation were professionally risk assessed at the beginning of the SVP. This risk assessment is shared with LTVs in advance of their placement, advising them of the potential risks of placements in Uganda, how the risks can be mitigated and what to do in the case that the risk materialises. The LMP also purchased a bespoke and comprehensive travel and medical insurance policy at the beginning of the SVP to cover all LTVs, ensuring each of

them had adequate and sufficient cover throughout their placements. Having one familiar and reliable insurance policy and emergency contact number for all LTVs is beneficial in terms of project management and reduces individual LTVs and organisational risk.

In addition to insurance, the LMP also arranges LTV flights, clinical registration, visa/work permit, accommodation, airport transfers and the majority of placement related travel in line with the recommendations of the risk assessment. The risk and logistical burden put on LTVs is reduced by, for example, using safe and reliable drivers for travel, only selecting flights that arrive at suitable times and only using safe and risk assessed accommodation. Controlling these processes centrally allows for better coordination and achieves some economies of scale in terms of the procurement.

Placement Support

LTVs have access to a wide range of support during their placements. In terms of financial support, LTVs receive a monthly stipend to assist them in covering their costs at home and in Uganda. The stipend is paid directly into their bank account, with the initial payment being made on the date of their outbound flight and consecutive recurrent payments made at monthly intervals. The Tropical Health Education Trust's Health Partnership Scheme is able to fund the employer and employee pension contributions of those LTVs previously employed by the UK NHS for the duration of their placements, marking a less direct yet potentially hugely beneficial provision of financial support for LTVs.

Each LTV is assigned a UK and a Ugandan mentor to provide clinical, mental and pastoral support and advice during their placement. Suitable mentors are selected by the LMP in collaboration with UMNH partners and in-country stakeholders, and usually come from the same disciplinary background as the LTV, as well as having previous experience of working/volunteering in Uganda. Many of the UK mentors selected are themselves former SVP LTVs that have returned to the UK but are keen to retain links with the project. The mentors serve as the first point of contact for LTVs; however, frequent communication with LMP management is also encouraged in case any problems arise that the mentors cannot deal with. LTVs provide written reports to LMP management on a monthly basis so their health and well-being can be monitored.

SVP workshops are held every six months. All SVP LTVs and stakeholders are invited to attend along with other LTVs working on similar projects, for example, the 'Global Links' project run by the Royal College

of Paediatrics and Children's Health. Each LTV conducts a short presentation detailing their placement activity, successes and any challenges faced. The events stimulate useful discussion and learning and enable the LTVs to build networks which provide platforms for effective peer-to-peer support, partnership and co-working.

Project Evaluation

An extensive and comprehensive evaluation programme has been carried out for the duration of the SVP. Data is collected by LMP management and evaluation teams, PhD students and the LTVs themselves for evaluation purposes and includes the following:

1. Pre-, mid- and post-placement interviews with LTVs
2. LTV written monthly reports (containing qualitative and quantitative data)
3. Interviews with Ugandan Health Facility management and staff
4. Interviews with UMNH partnership coordinators
5. Interviews with LTV mentors
6. Recorded workshops and focus groups
7. Site visits and observations made by the LMP evaluation team
8. Logging of stakeholder email communication
9. Reviews of new and existing literature relating to professional volunteering
10. Publications and presentations conducted by the LTVs at conferences and other dissemination events

All data is collected, anonymised, coded and analysed using Nvivo software. The SVP has evolved and strengthened on an iterative basis since its beginning in April 2012, based on the outcomes of the project evaluation and the growing experience of the project managers.

Volunteer Deployment in the SVP

The SVP placed 44 professional volunteers across the UMNH partnership locations over the course of the initial three-year period between April 2012 and March 2015, achieving a combined total of 358 'volunteer months'. The total number of volunteer months spent at each UMNH location is illustrated below in Fig. A.1. The average (mean) placement

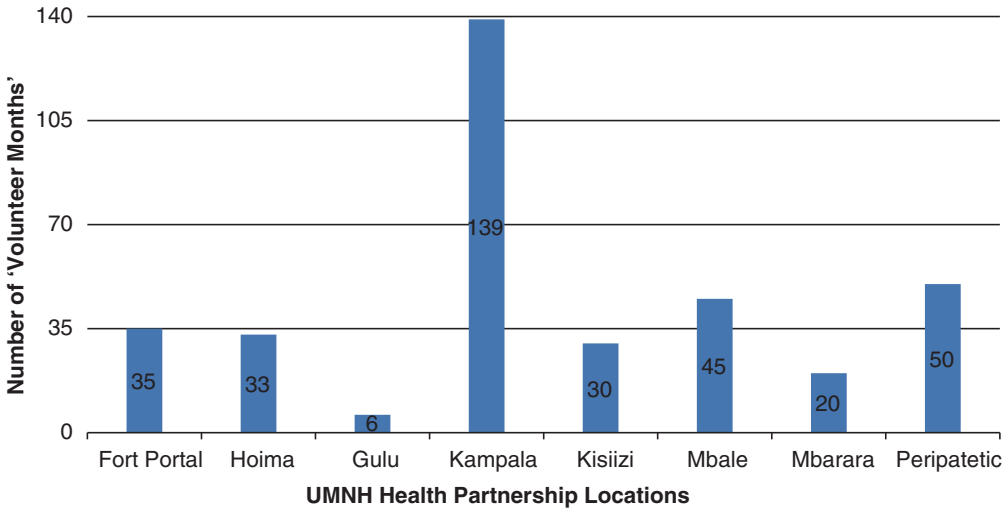

Fig. A.1 Number of 'volunteer months' spent at each UMNH health partnership location

duration across all disciplines was 8.1 months; however, the most common placement duration (modal average) was six months. The shortest placement duration was one month (the volunteer ended their six months placement early) and the longest placement was 26 months.

The professional volunteers came from nine broad professional backgrounds; the highest number coming from Anaesthesiology (10) and

Table A.1 SVP volunteers by professional background

Health professional disciplinary background	*Number deployed during the SVP*	*Total combined number of volunteer months*
Anaesthetists	10	71
Obstetricians	9	60
Midwives	8	60
Nurses	6	48
Foundation year 2 doctors	4	30
Paediatricians	3	33
Social scientists	2	24
Biomedical engineers	1	26
General practitioners	1	6
Total:	**44**	**358**

Source: Created by the authors.

the lowest number coming from General Practice (1) and Biomedical Engineering (1). Table A.1 details the number of volunteers deployed from each of the disciplinary backgrounds and the total number of volunteer placement months completed. Multidisciplinary team working was a key feature within the SVP and was believed to be the most effective way of achieving the desired outcomes of the project.

Appendix 3

The Move Survey

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Measuring the Outcomes of Volunteering for Education

1) Staff Group

- ☐ Allied health professionals
- ☐ Healthcare scientists
- ☐ Medical and dental
- ☐ NHS Infrastructure
- ☐ Scientific and technical
- ☐ Qualified Ambulance staff
- ☐ Nursing, midwifery and health vis
- ☐ Support to clinical staff

2) Career stage

- Pre-University
- Student
- Early career
- Mid career
- Experienced
- Post retirement

3) Age

- ☐ Below 25
- ☐ 26-30
- ☐ 31-40
- ☐ 42-50
- ☐ 51-60
- ☐ 61-70
- ☐ 71 or over

4) Gender

- ☐ Male
- ☐ Female
- ☐ Other

5) Nationality

- ☐ British
- ☐ European
- ☐ Non-EU National – High income Country
- ☐ Non-EU National – Low income Country
- ☐ Other

6) Have you had **any periods in another country, either as an employee or volunteer**?

- ☐ Yes
- ☐ No

Placement 1 (form included space for multiple placements)

What kind of placement was it?

- ☐ Healthcare
- ☐ Other

Economic status of country:

- ☐ High income
- ☐ Mid income
- ☐ Low income

What stage of your career were you at?

- ☐ Pre-degree
- ☐ Degree / training
- ☐ Early career
- ☐ Mid career
- ☐ Senior
- ☐ Retirement

7) Would you be happy to be interviewed about your experience as a volunteer abroad?

Name

Email / phone number

Fig. A.2 Measuring the outcomes of volunteering for education

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H.L. Ackers et al., *Healthcare, Frugal Innovation, and Professional Voluntarism*, DOI 10.1007/978-3-319-48366-5

The Impact of Delays on Maternal and Neonatal Outcomes in Ugandan Public Health Facilities: the Role of Absenteeism

Health Policy and Planning Advance Access published May 3, 2016

Health Policy and Planning, 2016, 1–10
doi: 10.1093/heapol/czw046
Original Article

OXFORD

The impact of delays on maternal and neonatal outcomes in Ugandan public health facilities: the role of absenteeism

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Accepted on 28 March 2016

Abstract

Maternal mortality in low- and middle-income countries continues to remain high. The Ugandan Ministry of Health's Strategic Plan suggests that little, if any, progress has been made in Uganda in terms of improvements in Maternal Health [Millennium Development Goal (MDG) 5] and, more specifically, in reducing maternal mortality. Furthermore, the UNDP report on the MDGs describes Uganda's progress as 'stagnant'. The importance of understanding the impact of delays on maternal and neonatal outcomes in low resource settings has been established for some time. Indeed, the '3-delays' model has exposed the need for holistic multi-disciplinary approaches focused on systems change as much as clinical input. The model exposes the contribution of social factors shaping individual agency and care-seeking behaviour. It also identifies complex access issues which, when combined with the lack of timely and adequate care at referral facilities, contributes to extensive and damaging delays. It would be hard to find a piece of research on this topic that does not reference human resource factors or 'staff shortages' as a key component of this 'puzzle'. Having said that, it is rare indeed to see these human resource factors explored in any detail. In the absence of detailed critique (implicit) 'common sense' presumptions prevail: namely that the economic conditions at national level lead to inadequacies in the supply of suitably qualified health professionals exacerbated by losses to international emigration. Eight years' experience of action-research interventions in Uganda combining a range of methods has lead us to a rather stark conclusion: the single most important factor contributing to delays and associated adverse outcomes for mothers and babies in Uganda is the failure of doctors to be present at work during contracted hours. Failure to acknowledge and respond to this sensitive problem will ultimately undermine all other interventions including professional voluntarism which relies on local 'co-presence' to be effective. Important steps forward could be achieved within the current resource framework, if the political will existed. International NGOs have exacerbated this problem encouraging forms of internal 'brain drain' particularly among doctors. Arguably the system as it is rewards doctors for non-compliance resulting in massive resource inefficiencies.

Key words: Absenteeism, human resource management, low resource setting, maternal delays, maternal health, Uganda

Key Messages

- Human resource dynamics are the key to understanding maternal delays in low resource settings.
- Health worker absenteeism is a major contributory factor.
- Absenteeism is a particular concern amongst doctors.
- The failure of doctors to be present during their contracted hours directly contributes to delays and poor maternal and neonatal outcomes.
- Human resource management lies at the heart of this problem; policy attention to motivational factors and enforcement would significantly improve health system efficiency.

Introduction

This article draws on research conducted within the frame of international health partnership interventions in the field of maternal and newborn health. The Liverpool–Mulago Partnership (LMP[1]) is one of many health partnerships twinning hospitals and universities in the UK with their counterparts in Uganda. Health Partnerships are often quite small, often charitable, organizations relying on individual volunteers (Ackers and Porter, 2011). In 2011 and with support from the Tropical Health Education Trust (THET), the authors set up an umbrella organization known as the Ugandan Maternal and Newborn Hub (the 'HUB') linking 10 health partnerships across Uganda.[2] The HUB provided opportunities for improved coordination, team-working and evidence-based intervention. In 2012, the HUB received funding from THET's Health Partnership Scheme (HPS) for a major intervention known as the 'Sustainable Volunteering Project' or 'SVP'. The HPS is seen by THET as a mechanism to 'harness UK health institutions and professionals in partnerships with developing country counterparts, and strengthen health systems through skills transfer and capacity development.'[3] UK volunteers play a key role in this scheme which is designed to 'leverage the knowledge and expertise of UK health professionals'. Echoing these objectives, the SVP identified two linked objectives:

1. To support evidence-based, holistic and sustainable 'systems change' through improved knowledge transfer, translation and impact.
2. To promote a more effective, sustainable and mutually beneficial approach to international professional volunteering (as the key 'vector of change').

Building on 4 years' experience of volunteer deployment, the SVP has focused its energy on systems-changing interventions restoring functionality to referral health facilities with the aim of reducing congestion in referral hospitals and associated maternal delays. Since 2012 the SVP has deployed over 50 UK volunteers throughout the HUB in a diverse range of activities.[4] The SVP and all related work in Uganda has been conceptualized first and foremost as 'action-research' supporting evidence-based policy development. In the context of exceptionally high and often increasing levels of maternal and newborn mortality, the work is part of a wider attempt to understand why 'international development' and particularly volunteering initiatives are failing to impact systems and how they may be improved.[5]

Methods

The emphasis on process in a programme such as the SVP coupled with the paucity of reliable secondary data demanded an innovative and iterative multi-method approach. Building on many years' experience of research on highly skilled mobilities and knowledge transfer processes, the evaluation strategy included a range of methods complementing and balancing each other through the process of triangulation (Iyer *et al.* 2013). As researchers we were acutely aware at the outset of the limitations of facility-generated secondary data. Accurate, reliable data on maternal and newborn health simply do not exist in Uganda. We therefore conducted a major benchmarking exercise across the 10 HUB facilities (including health centres and hospitals). This was an interactive process in itself and was as much about improving data collection and record keeping as it was about data capture; indeed the process included training of record keeping staff. These data should be regarded with caution (see below).[6] As Gilson *et al.* note (2011) even in this 'hard data' context there is no single reality, no simple set of undisturbed facts and the data that we do see are essentially socially constructs.

The project has also used simple before-and-after testing schemes using Likert scales to assess learning and skills enhancement during formal training programmes. Capturing the impacts of volunteer engagement on health workers—and more specifically on behaviour change—is far more complex. We have utilized a range of measures including qualitative interviewing of volunteers, structured monthly reporting schedule for all volunteers and bi-annual workshops. Wherever possible volunteers have been interviewed at least three times (depending on their length of stay with interviews prior to, during and post-return). We have over 150[7] verbatim transcripts drawn from all 10 HUB locations. Most of these have been conducted face-to-face in Uganda or the UK with some taking place via Skype. Where appropriate, email has also been used to discuss issues.

The research has also involved interviews and focus groups with Ugandan health workers, line managers and policy makers (about 50 to date). The authors have also spent many months in Ugandan health facilities and working with Uganda health workers in the UK. The project coordinator and manager each make regular visits (around 4 per year) ranging from 2 weeks to 5 months in duration. This intense observational research is recorded in project notes and diaries and is perhaps the most insightful of all of our methods. The qualitative material has been coded into a software package for qualitative analysis (NVIVO10) and subjected to inductive thematic analysis.[8]

In addition to this, volunteers have been encouraged, where appropriate, to develop specific audits to support contextualization and highly focused interventions. This has included audits on, for example, triage and early warning scoring systems, anti-biotic use and C-section rates. Building on detailed audit conducted by a Ugandan doctor on the causes and impact of delays or 'decision-operation-intervals' in the National Referral Hospital (Balikuddembe *et al.* 2009), a number of clinical volunteers have developed similar small scale studies focused on referring health centres. One of these studies conducted by a volunteer obstetrician

is discussed in some detail in this paper. These audits are small scale and necessarily inherit the same problems with the accuracy of data and of medical records as the wider study.[9]

We have described the study as an example of action-research. It is necessarily iterative and as such we did not set out to achieve a specific sample size but have continued to spend time in Uganda interviewing and observing work in public health facilities and facilitating active workshops to encourage discussion around key issues. Indeed, it is through this iterative process that we have come to identify a key challenge that we believe is central to understanding both resistance to change in Ugandan health systems and the efficacy of professional voluntarism in low resource settings.

The article draws on this database with specific attention to research on human resource management informed by the work with Ugandan Health Workers and the audit of referrals conducted by the obstetric volunteer. It is interesting to note at this point that all of this research has attempted to go beyond narrow clinical assessments of individual obstetric cases to develop a deeper understanding of health systems and factors affecting health worker behaviour. Prolonged engagement with Ugandan health workers has enabled us to understand how, as Schaaf and Freedman suggest, 'those who work on the ground, within struggling health systems, see and experience challenges that are all but ignored in the health literature' (2013, p. 1).

The article is structured rather differently to many traditional papers with findings and discussion blended throughout in a more narrative style. This enables us to move from the general (figures on maternal mortality and its causes) through to more specific discussion of human resource factors.

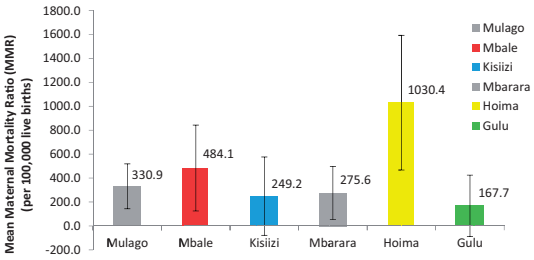
Maternal mortality in Uganda

Figures on maternal mortality in Uganda vary considerably depending on the source. The World Health Organisation reports maternal mortality ratios (MMRs) in Uganda of 550 per 100 000 live births (WHO, 2010, P.26). The SVP benchmarking exercise (McKay and Ackers 2013) indicated wide variation between facilities in levels reported to the Ministry of Health. Perhaps of greater significance, it reiterated the very poor quality of reporting and records management in facilities resulting in significant underreporting. The figures for Hoima Regional Referral Hospital (figure 1) likely reflect improvements in records management following the intervention of a UK Health Partnership (the Hoima–Basingstoke Health Partnership) rather than a greater prevalence of mortality. Indeed, more detailed audit of case files by an SVP volunteer indicated levels in Mbale regional referral hospital of over 1000 (more than double reported levels).[10]

Maternal mortality in Uganda remains a serious and apparently intractable challenge despite the significant volume of international development investment. The key focus of the SVP has been to understand this challenge and identify ways of improving efficacy of volunteer interventions. This requires an in-depth understanding of causal factors.

Understanding the underlying causes of maternal and neonatal mortality

Although the clinical conditions responsible for the final ending of a mother's life remain all too consistent across low resource settings (haemorrhage, infection, eclampsia, obstructed labour, HIV/AIDS and unsafe abortion),[11] the underlying causes demand more holistic



Source: McKay and Ackers (2013)

Figure 1. Mean maternal mortality ratios in referral hospitals 2011–12.

and systems-focused analyses. The '3 delays model' first espoused by Thaddeus and Maine (1990) emphasizes the temporal dimension of a complex sequence of individual decision-making and service failure marking the hazardous journeys women make along the 'road to death' (Filippi *et al.* 2005).

This emphasis on delays and the context within which women die helps to support evidence-based interventions focused on prevention and targeting the appropriate level of service delivery (Pacagnella *et al.* 2012). This certainly echoes our ethnographic experiences of working in the National Referral Hospital enabling us to make sense of the overwhelming congestion and atmosphere of 'crisis management' as women are admitted already near to death.[12] Research conducted by Filippi *et al.* on near miss events in three African countries found that 83% of such cases were in a critical condition on arrival at the hospital (2005, p. 11). Similar findings are reported in studies of maternal mortality in rural Uganda (Kaye *et al.* 2011) and newborn deaths in Eastern Uganda (Waiswa *et al.* 2010).

According to the 3-delays model, the key to understanding the 'maternal death puzzle' lies in capturing the causes and outcomes associated with delays (Thorsen *et al.* 2012). It identifies a relatively linear continuum, 'marking the interval between the onset of obstetric complication and its outcome' (Thaddeus and Maine 1990, p. 1091). The first delay is associated with individual agency and the socio-economic factors shaping mothers' care-seeking behaviour; the second, delays in reaching the facility and the third, delays in the provision of adequate care at the facility. Whilst the second delay is linked to delays associated with transport and access, in reality there may be a series of fraught journeys taking place as patients are (literally) bumped along dysfunctional referral systems. In that respect the second and third delays effectively merge as the lack of effective care at health centres results in further transport delays compounded by extensive waits in overwhelmed hospitals.

Iyer *et al.* (2013) present an alternative 'missed opportunity' approach to the 3-delays model critiquing the implied linearity and embracing more effectively the power dynamics involved. More specifically, they propose the use of social autopsy to capture the multiple and often conflicting narratives of actors to challenge the 'bio medical 'causes of death. We would very much subscribe to this approach. The well-being of mothers ultimately stems from their status in the family and community and the most effective interventions lie in female empowerment and improved family planning. However, clinical interventions by expatriate volunteers have tended to focus on the large referral facilities, perhaps reflecting the interests and the 'knowledge paradigms' (Gilson *et al.* 2011, p. 1) of the clinicians involved. Indeed, a central focus of much HP activity has been on emergency obstetric care rather than preventive interventions. The

deployment of volunteer doctors through the SVP has sought to take a step back from this and address referrals into these large hospitals from those health centres [Health Centre IV (HCIVs)] in Uganda that are, in theory at least, designated to provide comprehensive maternity services including emergency obstetric care.[13]

The Ugandan Ministry of Health's Strategic Plan identifies the lack of health centre facilities providing emergency obstetric care as a key challenge. This problem is linked specifically in the report to the 'weakness of referral systems' (2010, p. 36). The objective of the previous Health Strategy (HSSPII) was to 'ensure a network of functional, efficient and sustainable health infrastructure for effective health service delivery closer to the population' (p. 19). This included the construction and refurbishment of operating theatres and maternity wards. However the Annual Health Sector Performance report suggests that 'most facilities and equipment are in a state of disrepair' (p. 19) and calls for the Government to, 'mobilise resources in order to increase the functionality of HCIVs from 5 to 50% and create a fully functional national referral system' (p. 20). In the Ugandan health system, HCIV facilities should be the closest facility to mothers providing 24-h emergency obstetric care (including caesarean sections). However, a national assessment found that only 3% of these facilities did so (UNDP 2013, p. 25).

This situation reflects weaknesses in physical infrastructure and resource (equipment, consumables, power or blood) combined with a ubiquitous 'human resource crisis'. This 'crisis' remains under specified with vague references to an overall lack of personnel and/or lack of necessary training and skills (Thorsen *et al.* 2012). Indeed, it is hard to find a study that does not refer to the lack of skilled personnel in facilities across low- and middle-income countries (LMICs) as a major factor. However, the reader is often left wondering what lies behind this situation.

Generic reference to 'staff shortages' tells us very little about the situation on the ground and the reasons behind shortages. It is easy to assume that the problem is simply down to an overall lack of qualified personnel perhaps due to inadequate training capacity and/or international brain drain (emigration). Both of these are important contributory factors. Certainly recruitment, especially in lower level facilities and rural areas, is an immense challenge: in 2008, Ministry of Health (MOH) figures suggested that only 51% of approved positions at national level were filled with more rural/peripheral locations faring worst.

Research conducted by three Ugandan specialists (Balikuddembe *et al.* 2009) assessed the length, impacts and causes of delays in conducting emergency caesareans in Mulago National Referral Hospital. Although the lack of theatre space was listed as a factor contributing to delay in nearly all cases, the study highlighted major problems in human resources and the presence of staff (see table 1):

Asked to explain the reasons for the human resource crisis, an experienced Ugandan health professional replies:

> To start with really they don't have enough people trained to fill all the possible positions. I know that almost all the big hospitals are advertising positions for doctors and nurses. I also know lots of doctors who don't want to practice as doctors because they can work as consultants in an NGO. They usually go to American funders, they basically look around everywhere for anyone interested in funding their opportunities. People are now trying to go for project jobs. One good thing that people have realised now is you can work in a government institution because there you are guaranteed more like a lifetime job, at the same time there are so many projects that come into the government institutions and help people kind of top up their salaries in one way or another'. [UHP10]

Table 1. Common factors determining the decision-operation-interval (Mulago Hospital, Uganda)

Rank	Factor	Mean time lost (minutes), $n = 351$[a]	% Mothers affected
1	No theatre space	366.5	94.0
2	Shift change-over period	26.1	22.2
3	Instruments not ready	15.1	21.4
4	Surgeon on a break	13.7	24.5
5	Anaesthetist on a break	11.7	6.8
6	Theatre staff on a break	6.4	13.7
7	Some theatre staff not arrived	5.1	12.5
8	Linen not ready	3.7	7.7
9	Irregular patient drug dosing	3.3	1.1
10	Anaesthetist not arrived	2.8	4.0
11	No theatre sundries	2.1	5.7
12	Patient unstable	1.7	2.3
13	Patient not seen on ward	1.6	0.6
14	Lack of i.v. fluids	0.5	2.0
15	Patient not consented	0.4	0.6
16	Surgeon not arrived	0.3	0.6

Source: Balikuddembe et al. (2009).
[a]Assume all 351 participants' DOI could be affected by all the factors.

The respondent identifies a number of contributory factors. In the first instance, he indicates problems in initial supply exacerbated by the haemorrhaging of doctors from clinical work into (usually non-clinical) positions in NGOs. Others strategically seek to combine 'project' work with their full-time public roles (contributing to absenteeism).

The respondent later refers to the problems of international brain drain suggesting that many Uganda doctors are looking for better paid work across the border in Rwanda, for example. But this is compounded by the often more damaging effects of 'internal brain drain' (Ackers and Gill (2008)). In Uganda, this manifests itself in many doctors studying for Masters Degrees in either Business Administration (MBA) or Public Health (MPH) positioning themselves to work in NGOs in managerial positions.

Linked to the above, remuneration is a key factor affecting the presence of doctors in public health facilities. At the present time private work ('moonlighting') is, in theory, illegal and banned. In practice, it is endemic. To some extent, this represents a natural and entirely logical response to low pay. The following Ugandan health worker explains both the need for salary augmentation and the importance of holding a position in the public sector to this process:

> Most doctors working in the private sector are working for themselves simply because they need to make a bit of extra money and that way they can even negotiate to take some of the patients from the public hospital to their private hospitals. [UHP21]

In addition to the low level of pay, serious administrative problems in many districts mean that healthcare staff are not paid at all for months:

> Right now they are not paying them enough and it doesn't come on time. I know people who don't get paid for six months and they expect them to carry on smiling, offering the best services they can when their landlords are chucking them out because they don't have money to pay. [V39]

The respondent had personal experience having waited for over 6 months to be paid (in this case by a university).

Remuneration remains a major problem but it is never the only factor (Dieleman *et al.* 2006; Garcia-Prado and Chawla 2006;

Mathauer and Imhoff 2006; Mangham and Hanson 2008; Willis-Shattuck et al. 2008; Mbindyo et al. 2009; Stringhini *et al.* 2009). And, it is not at all clear that a recent MOH initiative to significantly increase the pay of doctors in HCIVs (to 2.4 million per month—around £500) has translated into (any) increased presence on the ground (for further discussion, see Ackers and Ackers-Johnson 2016).

According to the MOH, staff shortages are compounded by 'high rates of absenteeism and rampant dualism' (Ministry of Health 2010, p. 20).[14] In a rare study focused specifically on the absenteeism of health workers Garcia-Prado and Chawla (2006, p. 92) cite WHO statistics indicating absenteeism rates of 35% in Uganda. A senior manager of a Ugandan Health District reported (UHP49) much higher genuine rates of absenteeism suggesting that during a recent personal visit over 65% of his staff were 'on "offs" ' at any point in time. This certainly confirms our experiences as ethnographic researchers and is likely to significantly over-estimate the presence of doctors. In the following focus group with Ugandan mid-wives and doctors, respondents were asked about health worker absenteeism. They talked at length about mid-wives and nurses but did not mention doctors:

> Interviewer: You haven't mentioned doctors at all?
>
> (Laughter between everyone)
>
> Respondent 1 (midwife): Oh, sometimes we forget about them because most of the time we are on our own. You can take a week without seeing a doctor so we end up not counting them among our staff.
>
> Respondent 2 (doctor): Especially on a night, you never see them there (at the health centre).
>
> Respondent 1: Even during the day like most of the time.
>
> Interviewer: How often would you say a doctor would come to the facility in a typical month?
>
> Respondent 1: The medical officers have the rest of this centre to cover too so maternity will see them only if there is any problem. So they come for two hours three times a week but that's for the whole centre, the other wards as well.
>
> Respondent 2: Yes, like two times a week, sometimes once but most of that time even when they're on [duty] someone will not come to review the mothers.
>
> Interviewer: What would happen if a mother needs a caesarean? Would you call the doctor?
>
> Respondent 1: Initially they told us we should call before [referring] but every time you call that doctor he is going to tell the same thing: 'I'm not around, you refer'. And you use your own judgement but sometimes you follow protocol, because if anything happens . . . you call that doctor for the sake of calling.
>
> Interviewer: Just going through the process?
>
> Respondent 2: But you know he's not going to come [FGUK04]

Whilst physical infrastructure and supplies of consumables continue to contribute to facility down-time, it is clear that human resource factors are a major contributing factor. And, in many respects the former are used as excuses to conceal the latter. One facility manager explains that, at the time of interview, there were few other factors restricting the use of theatre:

> Now we have constant power—the power is there. We had issues of water now they've stabilized. Now water is flowing; the issue of drugs we have sourced drugs.
>
> Interviewer: But the doctors are still not here?
>
> No, they don't even come and you have to keep calling. You will call the whole day and some will even leave their phone off. [Referring to a list of referrals] Take this [referral] is for a 'big baby' but this is a doctor, an obstetrician. [I asked] when you referred this case, why wouldn't you enter into theatre? We are making many referrals to [the Hospital] and they are complaining. [The doctors] are very jumpy, they work here and there. So, we had a meeting and one doctor was very furious about [the decision to question referrals]. I said, no this is what is on the ground; we want people to work. And the reason [they give] is there's no resting room. There may be issues of transport (i.e. the doctors' personal transport), but there's also negligence. [UHP32]

It is not simply that doctors work very few hours but the unpredictability of their presence and the absolute unwillingness to commit to any set hours that impacts services. In several HCIV facilities, we have attempted to institute elective C-section lists in the hopes that this would enable us to be sure that UK volunteers could work alongside Ugandan doctors but also to prevent emergencies arising. This has proved absolutely impossible. It is no surprise, in this situation, that the overwhelming majority of caesarean sections in Uganda is undertaken as emergencies allowing complications to develop and outcomes to worsen. A recent audit in Mulago Hospital (Acen 2015) found that of 200 C-sections undertaken in September–November 2014, 184 (92%) were emergency sections. This stands in stark contrast to the UK where emergency caesareans are reducing in proportion (NHS 2014).

Most of the 15 or so obstetric volunteers have attempted at some point to introduce elective lists: all have failed. Asked about the prevalence of elective C-sections an experienced British mid-wife (SVP volunteer) who worked for 4 years across a number of health centres remarked:

> What is an elective? I haven't seen any here at HCIVs—possibly a few private ones.[15] [V31]

Accommodation is a serious issue (as noted above) but it is not a panacea especially when it comes to doctors. The LMP funded a doctor's overnight room in one facility but it has yet to be utilized. Where we have provided an overnight room for mid-wives (in another facility) we have achieved and sustained 24/7 working. However, in one of the health centres we are involved with where doctors benefit from the provision of dedicated (family) housing on site, this has not improved their presence:

> Caesarean section mothers operated on Thursday or Friday are generally not reviewed by a doctor over the weekend. One mother operated on for obstructed labour whose baby died during delivery had a serious wound infection, pyrexia and tachycardia and pleaded (4 days later) for me to help her. (SVP volunteer V31 report to District)[16]

Whilst absenteeism and poor time-keeping is an endemic problem amongst all cadres in Uganda, the situation is most acute when it comes to doctors. 'In-charge' doctors (senior medical officers appointed as facility managers) are often the worst offenders setting a very poor example to medical officers in their facilities and failing to observe and enforce contractual terms.[17] As the following respondent suggests, many if not most of the doctors in these leadership positions do not do any clinical work in the public facility they preside over:

> Most of the (in-charge doctors), if you really look at them, want to do administrative work actually, they want to sit in the office—they sign out the PHC (primary health care) fund. It's at their discretion to spend it so. . .. And of course sometimes there's corruption, outright corruption.

> Interviewer: So really what they're doing is administration but not leadership.
>
> Leadership requires you to be around, you can't let people run the place when you're not there. Leadership needs your presence, so you know the fact that [the in-charge doctors] are not always there, it's difficult. [UHP29]

Where in-charges are nurses, mid-wives or administrators, they have very limited ability to hold doctors to rotas:

> [Enforcement] is a problem. Doctors don't want to be accountable to someone 'below' them. They don't want someone, even if someone has a degree but they're not a doctor, to keep instructing them. [UHP29]

This problem of enforcement seems to stem from higher levels with District Health Officers seemingly powerless to sanction poor behaviour:

> I think particularly in the health department they are still intimidated by doctors which is a bit surprising. It goes hand in hand with accountability because if I know I am accountable for something going missing and if it goes missing then something will be done to me, in terms of discipline then of course I will behave differently. I wouldn't want to be found doing something on the wrong side of the law because I know that there is action that is going to be taken against me. But because here people don't see anything being done then they can do lots of things. [V39]

Interestingly he goes on to contrast the quite severe enforcement of anti-theft measures recently instituted during building works at Mulago hospital with the 'blind eye' approach to absenteeism suggesting that this is not a general problem of enforcement in Uganda but one connected specifically with human resource management culture:

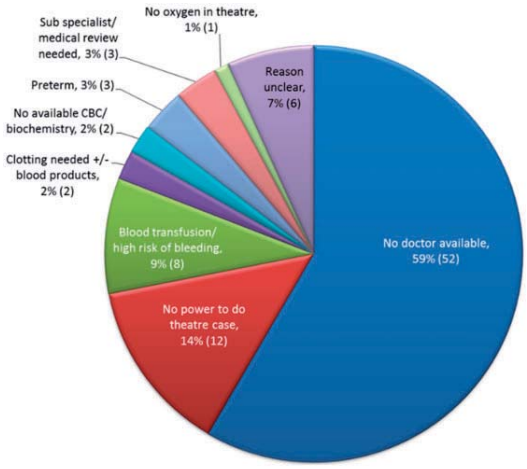
> I can give an example, in Mulago they are renovating and if you are caught taking something out of the hospital without proper papers you will be dismissed indefinitely. You can steal something worth 10,000 shillings (£2) and in the newspapers you will be regarded as a thief. Now people know where they stand: they can choose to disobey the law but they know that if you walk on the grass verge (in Kampala) they will get fined 100,000 shillings.

The following section reports on an audit conducted by an SVP volunteer as part of an intervention designed to reduce referrals to the national referral hospital.

Auditing referrals—a case study

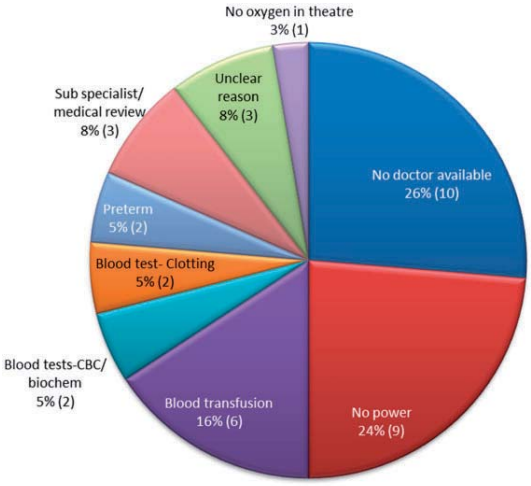
Whilst the research on maternal delays points to the human resource crisis in public healthcare, the relationship between absenteeism and maternal outcomes is rarely studied explicitly. On-going engagement of SVP volunteers with health workers in one health Centre indicated serious concerns. It was in this context that [the obstetric volunteer] undertook an audit focused on the impact of absenteeism.

In 2014, at the specific request of Kampala City Council Authority and with the involvement of a multi-disciplinary team of SVP volunteers working with local staff we were able to commence deliveries in a facility that had never been operational since its construction in 2008. Deliveries commenced within a week and have risen to over 600 per month (Ackers 2014b). However, large numbers of referrals continue to be made to Mulago hospital contributing to congestion (in a facility delivering 33 000 babies a year) and significant delays. Many of these referrals are due to the failure of doctors on rotas to be present. The Health Centre is different to



Source: Ioannou et al, 2015:8

Figure 2. Primary reasons for referral ($n = 89$).

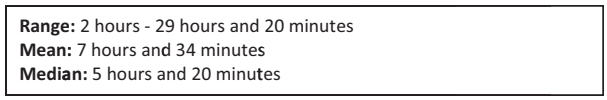


Source: Ioannou et al, 2015:7. CBC= Complete Blood Count.

Figure 3. Reasons for referrals between the hours of 08:00 and 17:00.

many other HCIVs in that it is purpose built, has good general infrastructure, benefits from the quite unusual presence of a dedicated ambulance and is only about 4 km from Mulago Hospital. As a project we were delighted at the rapid growth in deliveries over the first year. However, we found it exceptionally difficult to get theatre functioning due to the failure of the four doctors employed there to report for work with any degree of consistency or predictability. This meant that, in practice, the facility has been functioning more as a Health Centre III (mid-wifery lead unit).

During her placement the obstetrician observed that, 'when [the Health Centre] runs well patients are normally seen and treated within a few hours of a problem arising'; however, referring women increases time delays to their treatment especially when referring to an already congested facility. Minimizing such referrals and delays



Source: Ioannou et al, 2015:14. Of the 39 cases only 13 had specific times documented.

Figure 4. Time from decision to transfer to caesarean section at Mulago Hospital.

should improve maternal and neonatal outcomes. The audit took place over a 2-month period (December 2014–31 January 2015) and attempted to audit all obstetric and gynaecological referrals during that time frame. One of the major limitations of the study was the poor quality of patient records and failure in many cases to accurately record times and reasons for referral. The results are presented in detail in Ackers (2015). This article will focus on obstetric referrals. Figure 2 presents data on the primary reasons for referrals: 59% of referrals were due to the failure of local doctors to be present during their contracted hours:

Figure 3 presents the timing of referrals; whilst many of these referrals were made in the evenings and at night the problem was also present during the day:

Bharmal and Bell-Webb's audit in another region (2015) identified similar patterns. Here, over 78% of referrals to the Regional Referral Hospital were not reviewed by the resident doctors; many of these were during the day and at weekends. It is relevant to point out here that two doctors are accommodated on site in this facility.

Figure 4 reviews the delays associated with referrals in 39 obstetric cases for which data were available. Patients at the Kampala Health Centre are fortunate to benefit from the presence of a fully functioning (new) ambulance which is highly unusual in an HCIV facility in Uganda. Although records are very poor in this area, where times are recorded the time taken for the ambulance to arrive at the Health Centre was on average 40 min and the journey took, on average, 45 min.[18]

Bharmal and Bell-Webb (2015) also report extensive delays. In this context, the distance between facilities is about 33 km with the average (mean) time between referral decision and arrival at the referral hospital being 6 h.[19] Taking delays incurred following arrival at the hospital, mothers faced a mean delay of just under 21 h between the original referral decision and actual delivery (with a median of 23 h). If we take only those mothers who went on to have a caesarean section, the mean delivery interval time was over 22 h.

The volunteer obstetrician presented detailed notes focusing on cases with poor outcomes. As expected in some cases the assessment supports the decision to refer and/or the lack of a causal relationship between the presence of doctors and patient outcomes. However, in nine cases the absence of a doctor appears to contribute directly to poor outcomes for mothers and babies. For brevity, we present two of these cases to illustrate the relationship between medical presence and maternal/neonatal outcomes:

Case 1: Maternal death and macerated still birth

This 19-year-old woman with a twin pregnancy was referred for caesarean section at 16.30 on a Saturday due to slow progress. It is unclear why she was referred at this time as a doctor should have been on site. There was no evidence that a doctor had seen the patient prior to referral. She was subsequently seen by a doctor in Mulago Hospital at 17.55 and the decision was made for caesarean section. At 11.00 the next day she was fully dilated and membranes were felt and ruptured. At this point, the liquor was foul smelling and there were signs of obstruction. The operation was not performed until 21.50, 29 h and 20 min after referral. The first twin was born alive. However, the second twin was a macerated still birth and pus was found in the uterus. The mother became very unwell and 2 days later was admitted to the high dependency unit with severe sepsis. She died 2 days later.

Clearly, the long delay, which is not uncommon in Mulago (for reasons discussed above), contributed to this woman's death. However, had a doctor been present and her case managed effectively at the Health Centre this could have been avoided.

There is no reason why this patient could not have been delivered 29 h earlier at the health centre. The delay is very likely to have contributed to the degree of sepsis and hence the final outcome. This was an avoidable referral resulting in long delays.

Case 2: Fresh still birth

This 28-year-old woman was referred at 21.35 with a diagnosis of cord prolapse. There was no doctor on site to review the case. She was referred to Mulago (no timings available) and seen by a doctor at 23.25 when she was 6 cm dilated and a foetal heart documented to be present and a normal rate. The plan was for caesarean section but there were no theatre linens available. At mid-night she was scanned and an intrauterine foetal death confirmed.

Could this referral have been avoided?

This outcome could have been avoided if a caesarean had taken place in the facility within 2 h.

Ioannou *et al.* conclude, 'on the basis of this audit that 9 cases (10% of total) resulted in significant negative outcomes: at least 4 of these outcomes were very likely to have been avoided if doctors were present between the hours of 17.00 and 08.00 am and the patient was delivered earlier at the health centre' (2015, p. 21).

As well as echoing serious concerns about record keeping (documentation) that made the audits very difficult, Bharmal and Bell-Webb identify the problem of 'self-referrals' with many patients deliberately by-passing referral units that they know are not functioning adequately and referring themselves directly to the Regional Referral Hospital. If patients are aware that staff are not present on a reliable and 24-h basis, many will literally vote with their feet. It is hard to gauge with any accuracy the prevalence of this phenomenon. Analysis of 10 000 cases mapping the villages mothers came from in Mulago Hospital provided some indication of self-referrals (Ackers *et al.* 2010). The same report showed that of the 211 maternal deaths recorded in Mulago Hospital between April 2006 and November 2009, 19.4% were self-referrals.

As noted above, this audit illustrates not only the serious impact of delays but also the paucity of accurate facility-based data in Uganda and the difficulties in tracking cases. And this is not simply a technical/capacity issue. Data are often deliberately interfered with by doctors involved in corrupt practices.[20] The audit is presented here as indicative of the situation in all of the HUB public health facilities. It is by no means unique. A volunteer obstetrician reported a very similar sequence of events over the space of 1 week affecting referrals from a HCIV facility (in another region) into a regional referral hospital. This case highlights the impact of absenteeism of senior doctors not only on UK volunteers (who, according to our co-presence model,

should withdraw from clinical practice in such scenarios)[21] but also on junior Ugandan doctors many of whom are receiving little if any supervision and working dangerously long hours:

> The obstetric department at [referral hospital] is overwhelmed with the patient load. The interns currently staffing the unit are working 100–150 hours a week. The interns I have encountered are without exception highly professional and enthusiastic about patient care and quality improvement. [...] However, I know personally of three occasions where consultants were contacted for help with complex cases and did not attend. On XXX (a Sunday) I was called by one of the intern doctors requesting help with a complex ruptured uterus. Unfortunately I was in [another town] so I could not attend. He informed me that he had attempted to contact all the (4) consultants but that none of them responded. In the end one of the interns who previously worked in obstetrics and gynaecology and is now working in surgery came to assist with the repair.
>
> [One week later] I attended a Caesarean section in the afternoon to receive the baby while awaiting theatre space to begin one of three Caesarean sections waiting to be done. The intern performing the section found that the uterus inverted when he attempted controlled cord traction delivery of the placenta due to placenta accreta. Together with the medical officer, the three of us proceeded to perform a subtotal hysterectomy. On this occasion the consultant on duty was contacted and asked to attend but informed us to proceed without him.
>
> [The following day] a patient was transferred from [HCIV] with a ruptured uterus and arrived just after 6 am. The patient was in theatre at 8.30, however due to the anaesthetist arriving late the procedure was not commenced until 10 am. The foetus was stillborn and a significant rupture extending into the left broad ligament and down towards the cervix was identified. Two consultants were contacted and asked for help, however neither attended. The procedure was performed by the intern and the medical officer.
>
> I have observed that a high number of the referrals into [the regional referral hospital] are coming from [a particular HCIV] which is a source of great frustration to the staff at FPRRH. [Over the past month another HCIV facility] referred half as many patients as the previous month. I believe this reflects the presence of a doctor at the centre on a daily basis. [V52]

This case illustrates the kind of scenarios that are experienced on a daily basis by UK volunteers working in Uganda public health facilities across the HUB and the effects this has on patients, peer workers and UK volunteers.

Conclusions

This article has presented research evidencing the impact of absenteeism on services and patient outcomes in Uganda. As such it represents a highly contextualized 'thick description'. Whilst the results of such a study cannot be said to be statistically generalizable, the HUB environment enables us to combine and compare case studies within the Ugandan national context presenting opportunities for important theoretical insights that we believe apply across the Ugandan 'public' health system and, potentially, other low resource settings. Gilson *et al.* suggest that this type of work with a strong and essential emphasis on the dynamics of context and triangulation 'challenge the HPSR community to think more deeply about how to support policy and system change through the generation of "middle range" theories'. (2011, p. 4)

The failure to develop an effective human resource management system in Uganda capable of both incentivizing and enforcing adherence to contractual terms is responsible for serious resource inefficiencies. Whilst this problem is evident across all cadres from cleaners to specialists, doctors possess a degree of autonomy that enables them to avoid compliance with impunity. As doctors are also, in most cases, in leadership (management) positions this removes the opportunity for effective role modelling for other cadres. Where the overwhelming majority of doctors fails to present themselves for work with any degree of regularity or predictability, the costs to the public purse are enormous. Improved human resource management could release significant funds to augment the salaries of those staff that do present for work as well as creating the environment for the development of effective team-working.

The planned decentralization of health systems management giving greater autonomy to Health Districts and potentially devolving power to in-charges has the potential to iron out some of the serious delays in paying health workers and also to increase accountability in human resource management and enforcement of employment contracts. At the present time, salary augmentation through private working is essential to persuade doctors to work in the public sector. We would urge the Ministry of Health to consider the possibility of openly permitting a degree of private working within the frame of existing contracts and subject to stringent accountability and enforcement mechanisms. International NGOs and development organizations should also attend to the externality effects associated with interventions in particular the distorting effects on local labour markets.

Notes

1. www.liverpoolmulagopartnership.org.
2. These include the national referral hospital, five regional referral hospitals, one mission hospital and a large number of feeder health centres. For details, see www.liverpoolmulagopartnership.org.
3. http://www.thet.org/wp-content/uploads/2011/09/HPS-Volunteering-Grant.
4. The SVP Annual Report 2013 provides full details of the project and its objectives. It can be found in the 'documents' section of the LMP website alongside a series of research and policy reports.
5. This concern forms the focus of a book based on the project (Ackers and Ackers-Johnson 2016).
6. Full details are reported in McKay and Ackers (2013).
7. The numbers cited here are constantly increasing as we continue to deploy volunteers and assess impacts.
8. We have used the prefix UHW to identify Ugandan Health Worker respondents; FG for focus groups and V for SVP volunteers.
9. The epistemological approach underpinning this research and the methodological implications of that are discussed in greater detail in Ackers and Ackers-Johnson (2016).
10. These figures only record deaths in the facility and thus miss cases where mothers die in the community.
11. Detailed data on causes of deaths can be found in McKay and Ackers (2013).
12. The health centres involved in the SVP benchmarking report reported no maternal deaths. Sadly this should not be seen as indicative of the quality of care in that facility but a practice of transferring mothers even when they are near to death. It

is not unusual for such mothers to die before or on arrival.

13. Placing volunteer doctors in midwifery lead Health Centre 3 facilities has proved unattractive to SVP volunteers although many have embraced these as an aspect of their systems-focused work. The authors are currently involved in a follow-up project evaluating the impact of professional volunteers on the volunteers themselves and the NHS (http://www.salford.ac.uk/nmsw/research/research-projects/move).
14. Absenteeism presents specific challenges for a programme such as the SVP committed to the principle of 'co-presence' and avoiding labour substitution wherever possible. Put simply, where Ugandan staff are regularly absent and the risk of lone working is high, we are unable to place professional volunteers (list of authors' references).
15. Doctors attached to HCIVs often bring their private patients into the facilities to operate on privately. The incidence of this is difficult to know as records are often (perhaps deliberately) imprecise.
16. In a pilot project, our charity has recently constructed purpose built accommodation for a Ugandan obstetrician in order to enable a regional referral hospital to attract a suitable candidate (they were faced with the prospect of having no obstetrician present at all which also meant we could not place long-term volunteers there). We have attempted to link conditionality principles to occupancy to ensure that the doctor works to his employment contract. We are currently monitoring the project. This work has been undertaken in conjunction with a sister charity 'One Brick at a Time' (OBAAT). For further details, see www.lmpcharity.org.
17. This may reflect wider issues associated with the relative autonomy and power of the medical profession (Sheikh and Porter 2011a,b).
18. Transport delays play a much larger role in other facilities (Aldrich 2014).
19. This region benefits from an unusually good ambulance service supported by Baylor (an American NGO).
20. There is insufficient scope in this article to go into detail on this but see Ackers and Ackers-Johnson (2016).
21. Co-presence is an operational concept central to the SVP model and requires that UK doctors are never involved in lone working (gap-filling). For further details, see Ackers and Ackers-Johnson (2016).

Acknowledgements

The Sustainable Volunteering Project (SVP) is funded by the Tropical Health Education Trust (THET) as part of the Health Partnership Scheme, which is supported by the UK Department for International Development (DFID). The Liverpool Mulago Partnership received a grant worth È492,620 from THET (grant reference 'VG8') over a three year period to administer the SVP.

Conflict of interest statement. None declared.

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Identifying and Mitigating Risks in Medical Voluntarism: Promoting Sustainable Volunteering to support Maternal & Infant Well-Being in Uganda

Journal of Medical Safety 2014 p.28-p.37 February, 2014

[NA015 Special Report]

IDENTIFYING AND MITIGATING RISKS IN MEDICAL VOLUNTARISM – PROMOTING SUSTAINABLE VOLUNTEERING TO SUPPORT MATERNAL AND INFANT WELL BEING IN UGANDA

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ABSTRACT

The concept of risk has begun to influence research on international migration/mobility and careers (Williams and Balatz, 2011; Ackers; 2013). At the same time, international experience in developing country locations has become an important dimension of clinical training and CV-building across an increasingly wide range of health professions. This has lead to burgeoning demand for placements in developing countries. Two of the authors (Ackers and Ackers-Johnson) coordinate the 'Sustainable Volunteering Project' which recruits and deploys 'volunteers' from a range of disciplines and cadres to promote the work of the Ugandan Maternal and Newborn Hub. The third, Dr Lewis spent a year working as an obstetrician in Uganda during 2012. Increasing interest in this type of professional placement coincides with a new risk environment. The paper will outline the risk assessment processes involved in the setting up and management of this project. It takes a holistic view identifying all forms of risk involved in these kinds of placement but focusing in particular on key human resource management issues around lone working and 'co-presence.' It presents important opportunities to share ideas and increase the efficacy and safety of international clinical placements in developing countries.

Key words: Clinical Placements, Developing Countries, Internationalisation, Career, Risk, Volunteering, Medical Electives, Maternal Health, Lone Working.

1. INTRODUCTION

The mobility of clinicians between developed and developing countries is by no means a new phenomenon. For many years medical students and clinical trainees (at various levels of seniority) have been encouraged to undertake elective placements abroad. Perhaps less visible but equally important, many very senior clinicians have established links perhaps through individual relationships or more organised 'Health Partnerships' which involve making regular visits to facilities in the developing world (Crisp, 2007 [7]; James et al, 2008 [9]). Such forms of what can be collectively known as 'professional voluntarism' derive from a complex range of motivations and goals (Ackers and Porter, 2011 [3]; Hudson and

Inkson, 2006 [8]; Thomas et al, 2011 [14]). The growth in 'internationalisation' in recent years has accelerated the pressure on especially early career professionals across all disciplines to spend time in a developing country almost as a rite of passage (Ackers, 2010 [1]; Lacey and Ilcan, 2006 ; Beaverstock et al, 2009 [4]; Cox, 2008 [6]; Coey, 2010 [5]; Smetherham et al, 2010 [13]). What these disparate mobilities have in common is exposure to risk and, unfortunately in many cases, a lack of understanding of risk amongst the organisations and clinicians responsible for encouraging these mobilities. This paper reports on risk management processes developed in the Sustainable Volunteering Project (SVP). As such it hopes to stimulate interest in risk and the development of more responsible and effective approaches to professional voluntarism.

The SVP is hosted by a UK Charity (the Liverpool-Mulago-Project or 'LMP' [a]). LMP has been involved in various forms of shorter and longer term clinical exchanges with Ugandan health care facilities for over 6 years. In 2011 it applied for funding from the UK Tropical Health Education Trust to up-scale this activity promoting professional voluntarism across a range of specialities and within the frame of a newly set up consortium known as the Ugandan Maternal and Newborn Hub (the 'HUB'). The objectives of the SVP are as follows:

- To support evidence-based, holistic and sustainable systems change through improved knowledge transfer, translation and impact.
- To promote a more effective, sustainable and mutually beneficial approach to international professional volunteering (as the key vector of change)

  As managers of the SVP we see these two goals as inextricably linked. This paper focuses on the measures we have taken to work towards the second goal (sustainable voluntarism) which forms the essential basis of the former (sustainable systems change and knowledge transfer).

2. RISK IDENTIFICATION

The first stage in operationalising the SVP was to commission a professional risk assessment. The authors had been aware for some time of the serious risks associated with international professional voluntarism. Furthermore, often inflated and misguided perceptions of risks amongst potential volunteers, their families and supervisors constituted a major obstacle to medical voluntarism. The SVP was fortunate to have the opportunity to commission a very experienced risk specialist to undertake the risk assessment. The risk analysis was undertaken on location in Uganda by Paul Moore, Chief Risk Officer at the University Hospital of South Manchester NHS Foundation Trust. Initial discussions with Paul Moore encouraged a broader understanding of risk in the specific context of medical voluntarism in Uganda. The Risk Assessment Report [b] defines risk very positively as follows:

The primary goal of risk management is to achieve objectives. Risk is the effect of uncertainty on the achievement of objectives. Effective risk management requires anticipation of opportunity, but also what could stop the achievement of the objectives, and through adaptation increase the level of resilience of the project maximising benefit for stakeholders and investors.

It distinguishes 'inherent' from 'residual' or mitigated risk:

Inherent risk represents the estimated level of risk exposure without taking any further steps to mitigate or neutralise the threat (i.e. what it would be if nothing was done); whereas residual risk represents the estimated level of risk exposure after taking additional steps to control the risk. Estimates of residual risk are therefore lower because they take into account the controls applied (Section 3 and 4). The completed risk assessment identifies the following key areas of risk associated with professional voluntarism in clinical settings in Uganda and ranks them on a scale from 'very low' to 'significant' risk:

[a] www.lmpcharity.org
[b] The full risk assessment is available on the LMP website: www.lmpcharity.org

Table 1: Risks Associated with Professional Voluntarism in Clinical Settings in Uganda.

Risk	Mean Score
Personal Accident or Injury including Road Traffic Accident	15.00
Terrorist Attack targeted at volunteers or project (suicide bomb, false imprisonment, kidnap or hostage)	15.00
Exposure to infection / tropical disease	12.00
Assault (verbal, physical, sexual)	10.00
Access to safe supply of food and drinking water at location	10.00
Lost (in unfamiliar and/or dark surroundings)	10.00
Needle Stick Injury (including provision of emergency HIV post-exposure prophylaxis)	10.00
Civil unrest / violent public disorder	10.00
Lone Working	6.25
Slips, Trips or Falls on uneven, wet and/or muddy ground	5.77
Unsafe or Unsupervised Clinical Activities	5.25
Sun Exposure	4.00

VERY LOW RISK			LOW RISK			MEDIUM RISK		HIGH RISK		SIGNIFICANT RISK			
1	2	3	4	5	6	8	9	10	12	15	16	20	25

Table 2: Residual Risk Exposure in 9 Hub Locations.

Table 2 then applies this risk assessment procedure to the 9 placement locations:

Hazard Profile	Overall Residual Risk Exposure (Taking Control Into Consideration)								
	Kabubbu	Kasangati	Mulago	Kawempe	Mbale	Hoima	Kisiizi	Mbarara	Gulu
Access to safe supply of food and drinking water at location	10	10	10	10	10	10	10	10	10
Assault (verbal, physical, sexual)	10	10	10	10	10	10	10	10	10
Unsafe or Unsupervised Clinical Activities	3	9	15	3	3	3	3	Unable to Evaluate	3
Civil unrest / violent public disorder	10	10	10	10	10	10	10	10	10
Exposure to infection / tropical disease	12	12	12	12	12	12	12	12	12
Lone Working	5	5	15	5	5	5	5	Unable to Evaluate	5
Lost (in unfamiliar and/or dark surroundings)	10	10	10	10	10	10	10	10	10
Needle Stick Injury (including provision of emergency HIV post-exposure prophylaxis)	10	10	10	10	10	10	10	Unable to Evaluate	10
Personal Accident or Injury including Road Traffic Accident	15	15	15	15	15	15	15	15	15
Slips, Trips or Falls on uneven, wet and/or muddy ground	6	6	6	6	6	6	6	6	4
Sun Exposure	4	4	4	4	4	4	4	4	4
Terrorist Attack targeted at volunteers or project (suicide bomb, false imprisonment, kidnap or hostage)	15	15	15	15	15	15	15	15	15
Are all risks acceptable (i.e. controlled as low as reasonably practicable (Y/N)?	Y	Y	N Co-presence & Lone working	Y	Y	Y	Y	N Incomplete assessment	Y

The results underline the priority attached by many organisations responsible for volunteer management to road traffic accidents. In Uganda the risks associated with routine travel on the roads are both the most prevalent and are often associated with very serious outcomes. Whilst terrorist attacks are less prevalent, the consequences are grave.

The SVP has invested considerable time in the production of a detailed Induction Pack and associated processes to reduce the risks

associated with all of the categories listed above.[b] The remainder of this paper focuses on an important but often neglected dimension of risk and one which is inherently linked to sustainability and development impact. Namely, lone working.

3. LONE WORKING AND RISK

The last row in Table 2 assesses the acceptability of 'controlled' risks (ie current risk identification and mitigation processes). In one location lack of information resulted in a negative return. Only in one location (Mulago) did the risks associated with lone working tip the balance resulting in unacceptable residual risk.

Lone working is rarely conceptualised in terms of risk. [c] However, lone working is a very common feature of international voluntarism and the risks associated with it are complex and multi-faceted. At one level it links to other more 'standard' concepts of risk. If a volunteer is working on their own they will face difficulties in complying with risk mitigation procedures following a needle stick injury, for example. Good practice in relation to HIV prophylaxis suggests that anyone suffering a needle stick injury should commence treatment within 2 hours. If an obstetrician is working on their own in theatre this may not be possible. Equally exposure to risks associated with the various forms of assault are much higher when a person is on their own. Lone working also presents serious challenges in terms of clinical competency. The SVP has developed a 'competency algorithm' to try to guide and empower volunteers pressurised into situations that test their competency often through a lack of access to supervision. Risks associated with potential litigation or more broadly 'blame' are also closely linked to lone working. Finally, and this is where risk is most closely associated with development impact, lone working fails entirely to deliver the objectives of projects like the SVP focused on knowledge transfer and capacity-building.

Table 3 shows the results of the risk assessment for one health facility in Uganda where the risks associated with lone working were particularly high (Mulago Hospital). The risk assessment report takes a strong stance on lone and 'unsupervised' working suggesting that volunteers with draw from such situations 'even if this leaves the patient at risk.' Such withdrawal may be called for both to prevent UK volunteers becoming substitutes for local staff or working beyond their competency. The report also links the risks associated with lone working to out-of-hours working (at night and during weekends).

Table 3: Lone Working, Co-Presence and Risk.

HAZARD	CURRENT CONTROLS	INHERENT RISK			RESIDUAL RISK			ADEQUATE	FURTHER ACTION FOR UMNH CO-ORDINATOR
		S	L	RR	S	L	RR	Y/N	
Unsafe or Unsupervised Clinical Activities	• Withdraw from undertaking clinical work in the absence of professional Ugandan Peers, or should you become a substitute for Ugandan staff • Never undertake clinical work beyond your competency • In an emergency it is accepted that a volunteer may be compelled to act or intervene clinically according to their level of competency. If compromised clinically or professionally you are required to withdraw from the clinical activity and report to your mentor, even if this leaves the patient at risk.	3	5	15	3	5	15	N We were informed by volunteers that they were exposed to working without supervision & access to a suitably qualified doctor. Also, volunteers working night / weekend shifts unsupervised.	Communicate controls and clarify understanding with volunteer(s) prior to departure. Establish and enforce the co-presence principle with officials at Mulago Hospital

[b] This is also available on the project website.

[c] The University of Liverpool policy on research integrity (ethics) has begun to recognise the risks associated with lone working in a research context and produces guidelines on the management of this aspect of risk http://www.liv.ac.uk/researchethics/

> '36. As a condition of ethical approval by the Hospital Ethics Committee, we were told that medical students were required to work during the weekends and at night. Both the volunteer and medical students spoke about difficulties accessing senior medical colleagues during the night. We were informed of a particular night shift wherein there were 2 still births, a death on the Maternity HDU and an obstructed labour – obstetric and midwifery staff apparently refused to attend and assist because they were sleeping (which we were told is normal practice and they are not to be disturbed whilst sleeping). We understand it was left to the volunteers to work through the problems as best they could. Medical students explained how they were often goaded into carrying out clinical examination or diagnostic procedures they did not feel competent to perform, and whilst they declined to carry out the procedures, they explained how this created some tension with Ugandan medical students also working at the Hospital. We were concerned here about the level of clinical supervision and support, but also the security implications of working at night.'
>
> (Source: Risk Assessment)

Paragraph 3 of the report describes the situation reported to them by volunteer medical students in Mulago.

The concerns expressed in the Risk Assessment are identified in other studies of professional voluntarism and reported by volunteers working in Uganda. Hudson and Inkson cite a respondent in their research on voluntarism who experienced this situation: 'A bad day is filled with frustrations and lack of understanding... all staff will have mysteriously disappeared' (2006:312). Similarly, respondents in an evaluation of the International Health Links Scheme (Ackers and Porter, 2011 [3]) expressed concerns about UK volunteers being left to work in the absence of supervision:

"We should say that we wouldn't send over junior British staff unless there's a senior [local clinician] on the wards and I wonder if that might set a bit of an example because I know some people have felt very exposed to situations they've never had to deal with before. There's a lot of gains to be had for the NHS (UK National Health Service), but I think we need to do that in a much more structured way"

In this case the respondent is not questioning the potential value to the UK health service of this exposure but is concerned about the risk to the individual and the contribution of this form of input. Evaluation of the experiences of volunteers working in the HUB echo these experiences. In one example, a very experienced professional volunteer described in his post return report how, as soon as he arrived on the ward, the local consultant made an excuse that his partner was not feeling well and left – and then failed to return. The Consultant in this case explained how, in the time frame of his short (10 day) stay, he managed to clear the backlog of untreated patients and relieve congestion. Clearly the patients were direct beneficiaries of this process but it would be impossible to justify this kind of voluntarism from the perspective of skills exchange or sustainability as no co-presence took place. And as soon as the volunteer returned to the UK, the wards would rapidly re-congest.

Another consultant clinician explained in her report how senior staff 'walked off the ward' the moment she arrived. These are common experiences in Uganda. The following excerpt from a blog written by a British obstetric volunteer illustrates the problem in more detail;

"The 2 weeks leading up to Christmas were perhaps the most intense two weeks that I've had at [the hospital]. Over these two weeks all of the SHOs [clinical trainees] were on exam leave and to make matters worse the interns [junior doctors] were on strike because they hadn't been paid. During this period I was the only junior doctor on the rota to cover labour ward, theatre and admissions (there would normally be 3-4 SHO's and 4 interns)! Two seniors were supposed to be covering labour ward during the exam period, however often only one would turn up and would go to theatre leaving me alone. On one day no specialists turned up at all, so I wasn't able to open theatre when there were 8 women waiting for caesareans. A woman presented with cord prolapse so I had to take her to theatre but she was the only caesarean that got done. To say I felt vulnerable would be an understatement, and in true [hospital] style everything you could imagine happened: eclampsia, twins, breech deliveries, abruptions, ruptured uteri. One particular incident happened when I was alone in admissions. A woman arrived in a semi-conscious state following an eclamptic seizure, and was now having an abruption (premature separation of the placenta leading to heavy vaginal bleeding). It

was very hard to auscultate a fetal heart beat and I feared the baby was dead. After delivering the baby with a vacuum it needed urgent resuscitation. I attempted to resuscitate the baby but it was futile, I didn't have a towel to dry the baby and the resuscitation equipment was broken. A very frustrating and upsetting day".

In another hospital, a HUB partner recounts the experience of a midwife they had placed in Uganda who,

"initially put herself on the staff rota. However, the local midwives stopped coming in because they thought, 'Oh she is there so that's OK'. So she took herself off the rota and started to come in at different times and did an assessment and made decisions about where her work was best needed. So she wasn't on the rota because, especially when it came to the evenings, she was invariably the only midwife there. I had a long chat with some other doctors and they said they'd seen the same thing. Two young [volunteer] doctors turned up and all the senior staff went on holiday the next day and that's unacceptable. It's very difficult to extract yourself from that situation".

The penultimate case illustrates the relationship between lone-working and competency with early career volunteers often under serious pressure to perform tasks that fall outside their experience and confidence.

4. RISK, LONE WORKING AND COMPETENCY

An important component of the risk dynamic concerns competency. Competency is both a matter of clinical skills/experience (objective) and one of confidence (subjective). For insurance purposes, and to safeguard the individual from trauma or stress, all volunteers must operate within a competency framework. They should never be put in a position of having to perform procedures that they are not, or do not feel, competent to perform in unsupervised environments. This presents serious challenges in the Ugandan healthcare system where the lack of senior staff or their failure to be present on the wards often leaves more junior staff in situations where they have to work out of the bounds of their competency. This is normalised for Ugandan healthcare staff and it is unsurprising within this culture that volunteers may be expected to do the same.

5. RISK LONE-WORKING AND BLAME

Another important dimension of risk concerns attribution of responsibility or 'blame'. In the UK risk is closely associated with litigation and defensive practice. Such concerns have, until recently, appeared to be less of a problem in developing countries where litigation remains unusual but by no means unknown. The kinds of risk associated with what Ugandan colleagues have described as the 'blame culture' present in Ugandan healthcare (linked closely to the risks associated with lone working) remained theoretical until recently. However, in recent months one of the SVP volunteers experienced a maternal and neo-natal death. The deaths occurred following a period in which the volunteer was left to work totally on her own in very challenging circumstances and with poor equipment (a typical scenario for a Ugandan doctor). The following day local staff attributed blame to the British volunteer suggesting that her negligence contributed to the deaths. This situation has caused serious concern to the volunteer and her mentors. Indeed the Ugandan mentor subsequently emphasised to the volunteer the importance of not engaging in lone working. In this case co-presence is as much about having a witness as it is about knowledge transfer.

Following the risk assessment process, the SVP developed a series of measures to mitigate the risks associated with lone working and promote the efficacy of knowledge transfer processes.

6. THE SUSTAINABLE VOLUNTEERING PROJECT AND THE 'CO-PRESENCE' PRINCIPLE

The principle of 'co-presence'[d] lies at the heart of operational practice. It embraces a number of key concerns shaping the management of the SVP:

1) Lone working represents a significant and uninsurable risk for UK Volunteers.
2) Working together with Ugandan mentors and peers is necessary for knowledge to be created and exchanged.
3) Reciprocal, bilateral contributions lie at the heart of genuine partnership.

7. WHAT IS CO-PRESENCE?

Co-presence simply means working together to share knowledge and ideas. In practical terms it means that UK professional volunteers should always be physically working alongside Ugandan peers in an environment that promotes skills transfer. Professional volunteers should not be seen as replacements for local staff, or fill-in for

[d] For more details see the SVP Annual Report 2013 http://www.lmpcharity.org/images/documents/SVP%20Annual%20Report%202013.pdf

them in their absence: they are not 'locums'. THE SVP takes the view that this style of 'locum-volunteering', in the Ugandan context, may further undermine health systems rather than supporting them.

The Ugandan health system faces serious human resource deficiencies. The Ministry of Health's, 'Health Sector Strategic Plan III 2010/11-2014/15' refers to a 'serious human resources crisis in the health sector' (2004: 20) caused by a 'lack of clear leadership, lines of responsibility and mandates' (2004: 20). It also identifies serious staff shortages and low productivity caused by, 'high rates of absenteeism and rampant dualism' (2004: 21). Further, a report by the World Bank (cited in the MOH plan) concludes that, 'Absenteeism is the single largest waste factor in the public health sector in the country' (2004: 21).[e] International professional voluntarism may exacerbate these processes actively facilitating both absenteeism and 'dualism' (private working). As Moyo (2009)[12] suggests, the role of international volunteers needs to change from when volunteers went to Africa to 'help' people and generated forms of dependency and passivity undermining systems change.

Having said that, co-presence does not imply that professional volunteers do not engage in clinical work. However, when they do so they must be appropriately mentored and engaged in active mentoring (according to their needs and the context).

Co-presence is a composite concept representing the quality of relationships. Effective relationships play a number of distinct but related functions in the context of professional voluntarism. These include:

- The promotion of volunteer **safety** and mitigation of **risk** (discouraging lone working and ensuring compliance with competency principles).
- The facilitation of effective **knowledge transfer** (through training, mentoring and co-working).
- The process of embedding **reciprocity**, accountability and conditionality.

8. IMPLEMENTING CO-PRESENCE

Implementing co-presence has been and continues to be a challenging process. It has met with resistance from UK supervisors and mentors, from individual volunteers and from local Ugandan staff. Professional voluntarism has a long history often linked to forms of colonial or missionary-style interventions or 'character-building' (in-at-the-deep-end) approaches to internationalisation. These attitudes persist among UK clinicians and donor organisations. One senior British clinician expressed the view that 'clinical' mentoring should and could be distinguished from risk assessment (or co-presence principles):

Risk assessment are really issues for [sending organisations] rather than clinical mentors and I would not like to [get involved] [Senior UK clinician]

In this case the clinician was unable to see the importance of linking clinical mentoring to notions of co-presence viewing his role more as one of clinical advice-giving (on a particular procedure or patient condition) and perhaps replacing the role of a local supervisor/mentor than on a more holistic development principle.

A small NGO expressed a similar response to the risk assessment process suggesting that risk assessment in itself was an expensive and unnecessary process:

The nature of difficulties facing health professionals in Africa is very different to anything that most trainees would experience in the UK. Problems present in their most extreme form and tragically can result in maternal death. If a doctor is unwilling or unable to operate in this environment [..] then he or she should not go to Uganda.

A more common concern expressed by potential volunteers prior to placements was that the implementation of the co-presence principle (and potentially withdrawing from a situation in which their competency is seriously challenged and no supervision/back-up is available) amounts to professional negligence. Indeed, for many clinicians the logic of 'co-presence' may lie in direct tension with the values enshrined in the Hippocratic Oath which UK General Medical Council guidelines explain as follows:

'Our first duty is to our patients, not to the Trust (employer), the NHS, or to Society … we must do what is in the best interest of our patients.'

Certainly the recommendations embodied in the risk assessment report requiring clinical volunteers to withdraw from clinical work at any time they are left to act as substitute labour and/or work beyond their competency raise clear tensions for clinicians trained in the culture of the Hippocratic Oath to prioritise patient needs above all else (including their own health and safety). Volunteers often express concern that complying with such risk mitigation procedures places them

[e] A summary of the Health Sector Strategic Plan III 2010/11-2014/15 can be found on the LMP website (www.lmpcharity.org/index.php/documents)

in a difficult relationship with local staff who are expected to work without supervision and outwith their competency on a daily basis.
The SVP has emphasised the importance of not becoming involved in these practices as volunteers are not the employees of Ugandan facilities and are in breach of their professional indemnity insurance if they do so. A team of volunteers spent some time developing a 'competency algorithm' to try to manage such situations [g]. This is very much a work in progress:

[g] This group was lead by Drs Helen Scholefield and Kim MacLeod of the Liverpool Mulago Partnership.

9. THE SVP COMPETENCY ALGORITHM

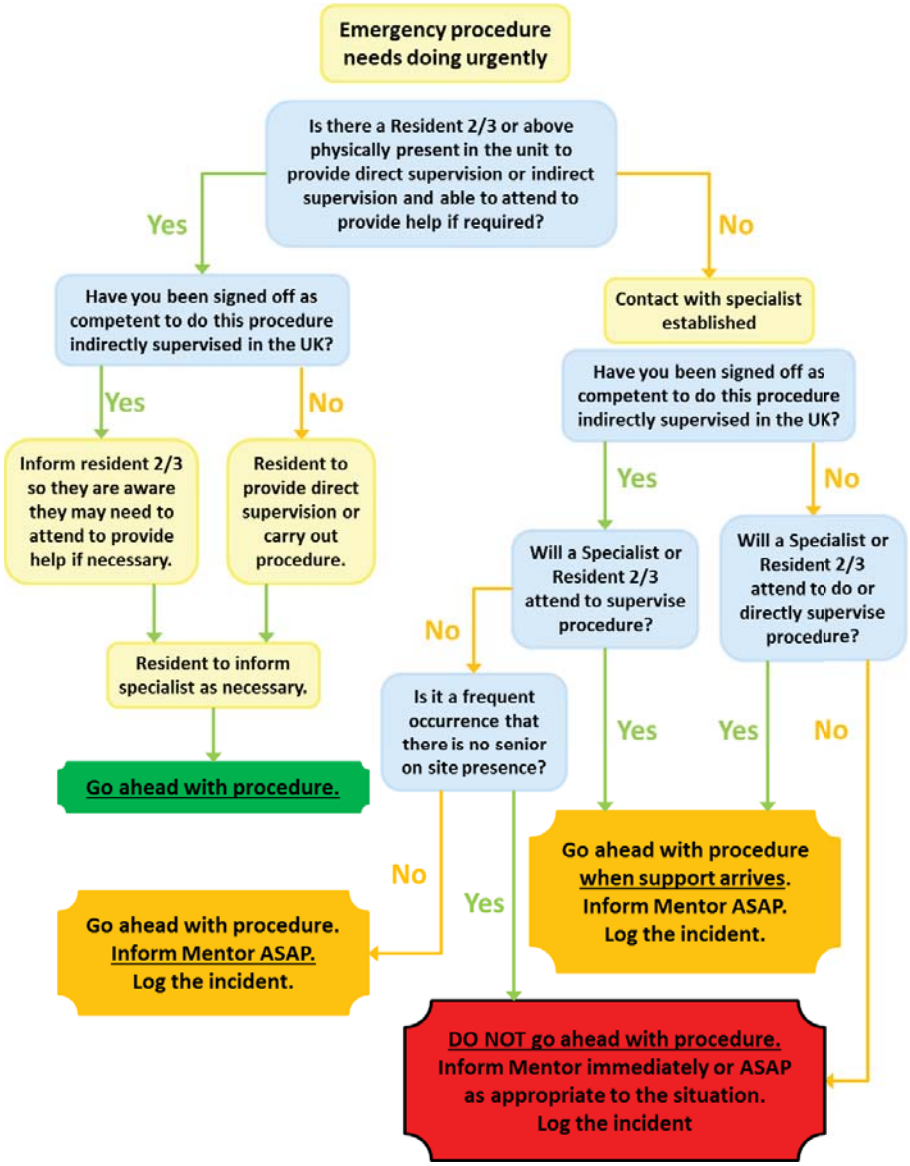

Figure 1

Risk forms a critical component of the volunteer Induction Process. The most important component is advocacy. Bi-annual volunteer/mentor workshops are held in Kampala involving all volunteers and their mentors complemented by workshops in the UK at regular intervals and frequent presentations at professional and academic events. This is augmented by regular site visits involving discussions with senior staff and mentors and revised negotiations during the placement of every volunteer.

Routine night working is prohibited for volunteers as working at night is associated with a high risk of lone working. Mentoring processes are also closely linked to co-presence. Each volunteer is allocated a mentor in the UK (someone in their broad area of specialism with experience of working in Uganda and often an ex-volunteer) and a Ugandan mentor. Mentoring is monitored and supported through monthly reporting mechanisms which require each volunteer to provide a detailed report of their activities that month. The report includes specific questions on volunteers' relationships with their mentors and both the Ugandan and the UK mentors are required to sign off the monthly report. The 'Monthly Reporting Template' also requires volunteers to record the following:

Co-Presence

- *Have you been working alongside Ugandan colleagues at all times?*
- *Can you describe who you have mainly been working with this month?*
- *Are there times when you have been left to work on your own? If so can you explain?*
- *Do you have any concerns about this?*

Figure 2

The reports are reviewed by the project manager and action taken where necessary to support co-presence and mentoring processes. The information is also collected for evaluation purposes. Evaluation of the SVP and specifically of co-presence is on-going. We plan to produce a detailed analysis of the data in a Final Report on the project in 2015. For the present time it remains a 'work in progress' and we continue to face challenges in implementation. The following quote from a volunteer is very typical and suggests that it may take some time to change traditional conceptions of the roles of professional volunteers:

'On my first day all the midwives left to have their lunch. I was the only midwife on the ward of 27 labouring or newly delivered women! I think there will always be difference in opinion as to whether we are replacement labour or not' (SVP Midwife Volunteer)

10. CONCLUSIONS

This paper has outlined the risks associated with the international placement of volunteers in healthcare settings in the developing world. Until very recently this area of risk has been neglected and volunteers (including medical elective students) left to 'fend for themselves'. This practice is both risky but also fails to comply with sustainability principles encouraging a 'gap-filling' approach to professional voluntarism. The risks associated with working in developing countries are real and risk assessment in itself cannot eradicate those risks. However, it enables us to move from 'inherent' to 'residual' risks and, most importantly to increase awareness and encourage a reflexive and attentive approach to risk. Enforcement, as Moyo (2009)[12] indicates, is critical to the embedding of the co-presence principle and to the preservation of relationships grounded in mutual respect and trust. Increasing awareness of risk and embedding the co-presence principle will, we hope, avoid the dangers identified by Moyo where the deployment of aid through volunteering perpetuates dependency and patronage. The onus is on all stakeholders to ensure that human resource management policies and practices ensure co-presence.

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Optimising Student Learning on International Placements in Low Income Settings; the Contribution of Cultural Brokerage

Scientific Research Publishing

Open Journal of Social Sciences, 2019, 7, *-*
http://www.scirp.org/journal/jss
ISSN Online: 2327-5960
ISSN Print: 2327-5952

Optimising Student Learning on International Placements in Low Income Settings: The Contribution of Cultural Brokerage

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How to cite this paper: Author 1, Author 2 and Author 3 (2019) Paper Title. *Open Journal of Social Sciences*, **7**, *-*.
https://doi.org/10.4236/***.2019.*****

Received: **** **, ***
Accepted: **** **, ***
Published: **** **, ***

Abstract

This paper challenges the assumption that student visits to low resource settings inevitably promote the acquisition of cultural competence. Much of the literature advocating the expansion of such "exposures" lists numerous positive outcomes with an emphasis on "cultural learning". With important exceptions, the concept of cultural learning remains uncontested, nestling in the fluffy haze of an inherently benevolent multi-culturalism. The emphasis in current research is on "learning" or "competency" at the expense of definitional clarity around the concept of culture itself. This results in a tendency to overemphasise (and essentialise) difference rather than commonality and conflates cultural learning with narrow (stereotypical) concepts of race, ethnicity and religion. The paper discusses the experiences of students undertaking placements in Uganda through Knowledge for Change, a UK charity hosting the Ethical Educational Placements project.

Keywords

Cultural Competence, Cultural Learning, International Student Placements, Global Health Education, Uganda

1. Introduction

There is a growing interest in the role that international placements, especially those in Low and Middle-Income Countries (LMIC's) can play in student and professional learning. Those studies that have addressed the outcomes of such placements typically identify "cultural" learning as a key component of this. In the Royal College of Midwives' Global Engagement Survey, for example, 81% of respondents reported gains in "cross cultural competence" [1]. In our own sur-

vey of students completing placements, 97% reported that the placement had a strong or very strong (79%) impact on their cultural awareness [2]. These findings are echoed in many other studies [3] [4] [5] [6]. Great attention is paid in this literature to the accompanying concept. Lough *et al.* [7] distinguish, "cross-cultural competence, intercultural effectiveness, intercultural competence, intercultural understanding and multicultural competence". Sargent *et al.* [8] with reference specifically to nursing, suggest that "cultural competence" (the most commonly used construct) is a composite outcome of cultural awareness, cultural knowledge, cultural skill, cultural encounter and cultural desire. Echoing the language of behaviour change theories, this approach suggests that when knowledge is combined with a willingness to learn, encounters (in the form of international placements) can play a critical role in building cultural competence. Rather than dwell on the distinctions between competence, knowledge and awareness, this paper focuses on the common denominator; the "elusive concept" of culture itself [9] in the context of our on-going action-research on placement learning.

The literature on cultural competence spans a continuum. At one end of this lies work that links cultural knowledge directly, if implicitly, with those aspects of diversity linked to race, ethnicity and religion. An example of this approach is cited in Cunningham *et al.*'s work on mental health amongst Afro-Caribbean children in the US. The authors explain that, "within the field of mental health services, the term 'cultural competence' generally refers to the ability to understand and function effectively in meeting the needs of minority populations" [9]. Leishman [10] argues that "immigrants" and refugees in Scotland have "substantially different health care needs" deriving not from their experiences of oppression or migration but from their "cultural backgrounds" [10] and nurses require cultural competence to manage these effectively. Another example can be seen in Elliot's paper on "cultural competent learning experiences for Aboriginal students" which makes a strong case for "increasing the numbers of Indigenous people working in healthcare" [11]. Whilst we would support measures to increase workforce diversity, we are not convinced that "ethnic matching" on the grounds that "Aboriginal health providers are more often acceptable to the community" [11] is either achievable or desirable. Nevertheless, this conflation of culture with ethnicity is echoed in the marketing of voluntourism by Gap Year Companies [12] [13] and in the motivations expressed by students applying for placements.

At the other end of the continuum, Garneau and Pepin propose a "constructivist definition" of cultural competence. Their paper opens with the statement that, "In nursing education most of the current teaching practices perpetuate an essentialist perspective of culture" [14]. Cultural competence in their view is about the development of critical, reflective practice to enable nurses to play a role in the reduction of health inequalities. As such, it "encompasses diversity that can assume many forms in society—such as age, gender, sexual orientation,

or socio-economic status—and is not limited to race and ethnicity" [14]. The authors argue that there are two opposing views of culture; the essentialist view and the constructivist view. The former has the tendency to equate culture narrowly with ethnicity with an emphasis on the differences between people. This approach also assumes that ethnicity is the most defining feature of relationships and difference and is homogenous and stable over time. Simpson uses the concept of "homogenised essentialism" to capture the risks associated with these over-simplified us—and—them; needy-helper dualisms [12]. The constructivist perspective understands culture as "the product of social constructions; a dynamic relational process of shared meanings" [14]. Attempts to understand how social positions overlap have previously been framed in terms of intersectionality [15] [16] [17] [18]. So, a health worker may be both Ugandan and female, for example, or a British student may have diasporic connections.[1] These complexities influence the way students on placement position themselves in relation to the people they encounter [19].

Crabtree *et al.* explore the processes of student learning in "unfamiliar cultural contexts" and argue, in a similar vein, that cultural competence is as much about recognition of power differentials and the "superior positioning" or "othering" of western paradigms as it is about the specifics of cultural difference [20]. In this frame, humility rather than the acquisition of substantive "cultural" knowledge is the goal. This conceptualisation of culture resonates far better with the 5 core "Global Health Competencies" outlined by Dias *et al.* [21]. In this schema, culture is integrated within Competency 1: "Diversity, Human rights and Ethics" locating culture firmly within an understanding of diversity in the widest possible sense linked to a human rights framework and principles of neutrality, impartiality and medical conscience [21]. The ultimate objective is to "respect the rights and equal value of all people without discrimination and provide compassionate and respectful care for all patients" [21].

Interestingly the interviews with professional volunteers in Uganda [3] suggested that the most valuable "cultural learning" was focused not so much on learning about exotic or different others but on learning what it felt like to be "other". One of the respondents described her experience as follows:

Certainly, in the UK you're kind of aware of all the cultural differences and you "do" equal opportunities but until you're actually in a place where you're the outsider, you don't realise how much it impacts [3].

We would argue that whilst exposure to "other cultures" will contribute to learning this will only lead to improved competence and practice if this learning supports a process of ever-emerging humility and awareness that, ultimately, we cannot achieve complete "cultural knowledge". Every person is an individual and has a right to be treated as such. In that respect, learning what it feels like to be an "outsider" or "other" is perhaps the most significant.

[1]For a more detailed discussion of intersectionality and the linked concept of translocational positionality see [17] [19].

2. Organisations and Culture

A search for the term "culture" in the context of the UK's National Health Service opens a Pandora's box of studies focused on organisational culture and its relationship to core values such as respect, compassion, care and patient safety. And yet, when we review papers on placement learning in LMICs the emphasis is immediately on the more familiar association between culture and ethnicity/religion. The reasons for this are unclear. Perhaps this reflects the association of such placement locations with exoticism and difference rather than the more mundane commonalities associated with organisational culture in public sector organisations across the world. Perhaps the emphasis on travel distracts us from these dimensions of culture to focus on the more exotic differences between "peoples"?

Although some of the more insightful studies make passing reference to health systems or the wider societal and political context within which placements and cultural learning takes place very few specifically refer to the role of organisations. This contributes to yet another stereotype; that health systems in LMICs are monolithic. Concepts of welfare pluralism or the "mixed economy" have been used for many years to characterise the complexities and inequalities associated with contemporary health systems [22] [23] [24]. Welfare diversity is the corollary of human diversity and inequality and, contrary to popular media portrayals, the concept applies just as much, if not more, to low and middle-income countries. Countries like Uganda have burgeoning private sectors in health both in the "for-profit" and "not-for-profit" sectors (heavily subsidised by international Aid). Many of the wealthiest people in Uganda also source their healthcare internationally. The so-called "universal" public health system in Uganda is best characterised as a residualised welfare system; at best an ineffective stigmatised "safety-net" for the countries' poor. In contrast with the UK's NHS, very few Ugandan health workers would consider using public health services themselves contributing to a culture of "othering" within the organisation as a whole. As an organisation focused on health systems change and improving access to quality healthcare for the poorest, Knowledge for Change is committed to working in the public health sector. This is where we place our students, and this is the organisational context within which they experience "culture" [25].

Hofstede defines organisational culture as "the collective programming of the mind which distinguishes members of the organisation from another" [26]. In keeping with the point about essentialism above, he reminds us that organisations are not homogenous and can be composed of various sub-cultures which may be mutually antagonistic. With specific reference to organisational culture in health care, Davies *et al.* point to the level of cultural diversity both between and within health providing organisations and the impact of counter-cultures that may impede change [27]. Carney refers to the lack of definitional clarity on the concept of culture in healthcare organisations suggesting its meaning varies from one situation to another [28]. Citing Deal and Kennedy, she describes cul-

ture as a driver of norms and the "way of doing things around here" [29]. Furthermore, "values are the explicit and implicit elements of the care culture that serve to determine the individual's action system" [30]. The influential Kings Fund report, "Caring to Change" immediately identifies "compassion as the core NHS cultural value" and the importance of organisational "socialisation" to the embedding of this value and to innovation in health care more generally [31]. This emphasis on organisational culture as a key target for change in the NHS is rarely echoed in the literature on global health. A recent paper by Mbau and Gilson is an important exception. The authors reflect on the failure to achieve health systems change in LMICs pointing to the "dearth of empirical literature around organisational culture" [32] as a potential barrier to reform. They note that organisations are themselves embedded within wider society and societal values and indicate the potential impact of hierarchy and power relations on those people employed within them.

3. Methods

The research presented in this paper builds on ten years' experience of ethnographic action research in Uganda. Specifically, the research is based on three linked studies. The first action-research study involved the design and evaluation of the ethical educational student placement scheme. The study funded over 80 students to conduct a four-week placement in Uganda and combined analysis of qualitative data including observational research, pre and post placement interviews and focus groups with the students as well as documents such as student applications, weekly and post-placement reports. This study also drew upon an online survey based on the student overall experience [2].[2]

The second study is Tate's doctoral research, which builds on this work and uses ethnographic and longitudinal methods to specifically capture the process of cultural learning amongst a cohort of midwifery students. The study utilises data taken from the student's initial application forms, pre-placement interviews, followed by two ethnographic field trips (one month each) to Uganda with 10 students, in July 2016 and March 2017 (5 students per trip). A further post placement interview with each student was conducted 12 months after the placement end date. The qualitative data from the two field trips included observational research, in-depth interviews and focus groups. The approach taken for this study allows the research to illuminate and track the student placement experience as well as explore any impact from initial application through to 12 months post-placement[3].

The third study focuses on respectful care in Ugandan public health settings. Using qualitative data analysis, the research explores mothers and midwives' understandings of the concept of respectful care and their experiences of the care they have received or delivered. The study involved 64 in depth qualitative inter-

[2]This study took place in 2016/17 and included pre-during and post placement interviews, observational research and an on-line survey. Full details of the methods are contained in [2].
[3]Tate's ethnographic doctoral study is due to finish in 2019.

views and three focus groups with health workers and mothers to assess their experiences of maternity care.[4] The findings have been analysed thematically using NVIVO10. Each study has received ethical approval from the University of Salford and Mountains of the Moon University, Uganda.

4. Results

Combining our data from the three studies has stimulated us to reflect on the relationship between culture and compassion in the placement locations and the influence this has on student learning. We would argue that much of the learning that students attribute to culture is as much about the organisational cultures associated with Ugandan public health facilities as it is about culture in general. One of the topics that emerge with some frequency in the interviews, perhaps reflecting K4C's focus on maternal and newborn health, is the perceived relationship between "culture" and bereavement care. The following case is quite typical. Lucy, a qualified nurse undertaking a post-registration midwifery program talks, in her pre-departure interview, so before visiting Uganda, about what she hopes to gain from the experience;

"*I want to learn about another culture*, *another health care system* […] *I am interested in new born bereavement care*, *I've dealt with it a few times here in the UK and the care given is to a really high standard*. *I would like to see how they do things over there*".

At this point Lucy presents herself as a learner keen to gain knowledge from Ugandan health workers about their approach to bereavement care. The interviewer follows up with:

"*What do you mean about bereavement care being different in Uganda*?"

"*I think they think over there that when a child has died at birth or shortly after that not seeing the child and not making memories with that child is better than seeing it*. *Because you can't process the bereavement*, *but we know in this country that that doesn't work*."

It is interesting to see how, in the last point Lucy shifts from a concept of herself as going to learn to one of imparting superior evidence-based practice and a shocking lack of humility.

She goes on to say,

"*I think they cope with* [*losing a baby*] *over there because it is a lot more common*, *culturally they've found a way to keep managing it*".

Interviewer: "*So when you talk about culture influencing this*, *what do you mean*?"

"*I think because they have a lot more children*, *and they don't have the same health care and they also have a lot more loss*. *So*, *they're taught to be quite strong as women*, *and I think in their culture they are strong as women and they birth on their own*".

It is difficult to tell from the narrative whether the respondent is referring to

[4]This study involved 64 interviews with mothers and health workers in 2017 and is reported in [33].

health workers or women in general here. The final comments would suggest she is talking about the experiences of (all) women in Ugandan society and that it is their culture, rather than the lack of respectful and effective services, that make women strong enough to birth without support. Lucy may be surprised to learn that the private ward at the National Referral Hospital in Uganda has a caesarean section rate of over 60% [34]. Jenny makes a similar observation, again before she goes on placement, and like Lucy, uses a form of words suggesting she is heading out to Uganda expecting to impart her superior knowledge rather than to learn as such:

"*I'd like to make sure the woman has the option to spend time with their baby if they don't make it. I've heard that they take the baby away straight away without giving mum a chance to see it. We know for long term coping and bereavement that it's best to spend time with the baby so I want to see how I can help there*."

It is interesting to reflect on the fact that both Jenny and Lucy had quite clear views about how bereavement is experienced and managed in Uganda even before they left the UK. But what are the sources of such views? Student applications often refer directly to the influence of media campaigns. Asked why she had expressed an interest in the placement Lucy replies:

"*I've just always wanted to do something like this, like since I was little. I always used to watch Comic Relief and all that and want to help*".

Research by Voluntary Service Overseas on the impacts of stereotypical portrayals of Africa found that "80% of the British public strongly associate the developing world with doom-laden images of famine, disaster and Western aid" [35]. The VSO report blames UK media for creating the widespread perception that people in the developing world (particularly African countries) "are victims, less than human and inferior" [35]. In a similar vein, [36] argues that Africa is often portrayed as an homogenous entity comprising uncivilized and heathen peoples who are culturally, intellectually, politically, and technically backward or inferior. Seay and Dionne [37] suggest that this leads to misinformation, stereotyping, validation of white privilege and excessive fear of foreigners. In theory, a placement presents a unique opportunity to challenge stereotypes and build more meaningful awareness of societies and health systems. On the other hand, there is a risk. Unless such processes are managed carefully and students are adequately prepared and supervised, rather than challenging such stereotypes, LMIC placements may simply reinforce them. As Crabtree *et al.* point out, immersion in another country (if it even is immersion) does not necessarily contribute to cultural competence [20]. Even in the context of hard-core poverty, "students can fail to pick up on the differing cultural context and social policy drivers in place" [20]. Of greater concern, the returning "pioneers" may exude a heightened sense of "cultural competence" authenticated and validated by their direct experience. This was almost certainly the case with Lucy and Jenny both of whom had met student nurses returning from placement who had experienced bereavement in Uganda. Another student makes a similar observation in a

post-placement interview illustrating the potential risks associated with this type of unmediated learning;

"*There is no compassion over there and so that was one of the hardest things coz when one of the babies died, and the doctors saw them dead, there was no grief, no compassion, no emotion, it was just really cold*".

This comment, made following her return to the UK, is an example of the dangerous and essentialising generalisations, attributed to "culture" that students may come home with and disseminate with the authority of "experience." In this context Crabtree *et al.* suggest that "peer support of other students … can generate unhelpful dynamics" [20]. Certainly, our ethnographic research with students on placements as a group would support this contention, that in the absence of a more experienced cultural broker/mentor, students, often distressed at their experience, use social time to discuss and often reinforce stereotypes. The influence of such discussions and the ability to challenge strongly held views depends very much on power dynamics within the student group and the presence of confident cultural brokers.

Another very common response from students concerns the relationship between time-keeping and culture and the impact on care. Pamela expressed an excitement in her pre-departure interview about the opportunity to learn about different cultures (presumably implying an interest in culture-as-ethnicity). The tone of an interview during her last week in Uganda indicates a growing frustration with this aspect of learning:

"*Grappling with the culture has been the hardest thing I had to deal with. I know so much more about it now than I thought I did three weeks ago*".

Pamela goes on to give an example of her "cultural" learning.

"*She* (*Ugandan midwife*) *basically just walked off because it was quiet, we reckon she went to the shops to be honest. I mean it was quiet, but you don't just leave do you? I know culturally it's different but that's just basic midwifery, you don't just leave. I think in their culture it's just about getting home, but I felt the patient should have stayed overnight—she wasn't well and they shouldn't have let her go.*"

Pamela is clearly concerned that a patient was discharged, in her view, prematurely and allowed to travel home on the back of a motorcycle. She attributes this behaviour, in terms of time-keeping and absenteeism, to culture but what does she mean by "their culture"—who are we actually talking about? Ugandan people as a whole, midwives as a sub-culture or the staff in that specific facility? In this case Pamela was witnessing a very common situation in the Ugandan public sector. Health worker absenteeism and poor attitudes to time-keeping and a desire to "clear the lines" and leave the facility are very typical behaviours. Our own research has evidenced these behaviours from the perspective of Ugandan health workers themselves as indications of a culture of disrespect [33]. On that basis we do not doubt that this situation took place, but it is important that students understand the factors influencing health worker behaviour and what culture means in this context. The association of a lack of compassion or

professional negligence with national as opposed to organisational culture is very common in student narratives:

"*I was smiling at her and telling her she was doing so so well but* (*Ugandan midwife*) *was just so stone faced like she had seen it a thousand times. I know she has but she should be encouraging her and telling her she's doing really really well, praising her and cheering her on. It's like there is no culture for praising women, they are just in and out, job done, see ya*."

In this example the student has "learnt" that the failure to praise and encourage women during labour is part of Ugandan culture with an inference that this behaviour is endemic. In another case, the student appears to suggest that this "normality" of disrespectful behaviour somehow signifies a lack of intentionality or responsibility – because it is "cultural". Put crudely, "they" don't know any better;

"*Sometimes it's different cultures you know the way they deal with things. Like sometimes people don't necessarily mean to be rude or awful, it's just how they've spoken most of their life you know or how they speak to people, and nobody's ever really turned around and said: 'Oh, well you shouldn't do that, you shouldn't say that to people*".

Does this imply that disrespect is a deep-seated aspect of national culture in Uganda? Certainly, this interpretation does not sit alongside students' cited experiences of the very welcoming Ugandan public during their stays [33]. It is very common for students to come away with the sense that Ugandan health workers "didn't really care". The following student links this apparent lack of compassion to culture;

"*Their culture tells them that they shouldn't really show that much emotion especially in public. Like when they're in labour, you shouldn't be making noises, how they are so silent is beyond me but, I think obviously if they've been brought up to be that way you know it's normal for them, but then outsiders coming in and seeing that you think, do the* [*health workers*] *not care at all*?"

In the first instance, the student suggests that it is culture that leads women to know not to make noise and that this cultural pressure leaves little room for individual choice or agency. Then, secondly, she infers that this same—or is it another form of culture—normalises a lack of care amongst health professionals. Without constant support, superficial impressions of Uganda/Ugandans and the Ugandan health care system, compounded by a lack of understanding of global and structural inequality and humility—encourages students to homogenise their hosts as foreign and "other". Others construct "Ugandan-ness" with what can be interpreted as a range of (contested) characteristics and emotions [38], or a homo nationalis [19] [38]. The student in the next example shows an awareness that culture is nuanced and not all health workers are equally disrespectful. Once again her language immediately suggests that she perceives her role as one of imparting superior knowledge rather than learning as such. The interesting thing about this example is that, not only is culture associated with poor attitudes towards patients, it is also associated with resistance to change:

"*The* [*Ugandan health workers*] *were really fascinating and so keen to learn. The main thing we noticed was the culture side of it—the attitude, so like a lot of the newer people coming through were brilliant and we couldn't fault them. One of the sisters we wanted to come and work over here, she was so good. However, there were others who just didn't want to change and their attitude towards patients was appalling. It was not the fact they didn't have resources, it was more that they didn't want to change what they were doing*."

Once again, the observations made by this student come as no surprise to us; disrespect and verbal abuse are commonplace in Ugandan public facilities and we have struggled over the past decade to understand the relationships between knowledge acquisition and behaviour change [25]. These issues are incredibly complex, and experts have failed to adequately theorise behaviour change in health care. It is interesting that this student realised that importing new knowledge in itself could not bring about change; the Ugandan public health system as a whole is not receptive to new knowledge and displays marked resistance to change. But it is all too easy to conclude that this is simply a question of culture. The student is doubtless aware of many examples of the gap between knowledge and behaviour change in the NHS but is not making this link. Perhaps the fact that she is in Uganda has distracted her from this more mundane association?

An interview with a local (male) health worker suggests that disrespect is not endemic in Ugandan health care and reflects in large part not Ugandan culture, as such, but specific organisational cultures[5]:

"*I think in the public sector, it may be a number of factors ranging from administration to attitudes of the health worker and maybe also the number of patients someone is seeing*".

Interviewer: "*Why would someone's attitude be different in a public facility?*"

"*Someone looks at people in a different way as if they cannot do anything* [*to challenge their care*] *and will not give enough care but when you are in a private facility then someone will know, 'Maybe I am going to be reported'? There is a lot of bureaucracy in a public facility so if you were to report someone it will take a lot of time. Because who do you report to? It is really hard and to chase that person if someone has done wrong, it is a very long system*".

Interviewer: "*So it's not just that the health workers in a public facility have less-resources, they also have less accountability in a sense that they can possibly get away with worse behaviour?*"

"*Yah* [*in private sector*] *they would be caught. Some people say it may be the salary—that public sector salaries are low—but when you look at mission hospitals—they pay less money. That's why I think it is more attitudes because the poor* [*patient*] *is not having power. If the person is some official in the Government, someone gives a lot of care and when you see such people coming, everyone is concerned. You make sure you give enough care. But there are also some good nurses maybe midwives too who feel everyone deserves and has a right to*

[5]This work is developed in [33].

get good service. Some people get money from patients in public settings like in busy hospitals, they say if you don't give us money we shall not work on you. Ask patients, they will tell you, that if you go here and you don't have money they will not work on you. It's not because of salaries. It's mainly because of the supervision, it's more administrative because they see their supervisors are not really taking action".

The respondent suggests that the behaviour of health workers is quite different in public facilities as compared to private, not-for-profit, facilities where accountability is much higher (and patients pay for their care). He also hints at the pervasive impact of corruption on care. The conversation then turns to consider whether the gender of the health worker, in the same public facility, influences respect. Supported by a female health worker present at the interview, he argues that men are more compassionate and goes on to link compassion with religion:

Female Health worker: "*Men* (*male health workers*) *show much respect than women*".

Interviewer: "*Why do you think that is*?"

Female Health worker: *I think men know women are passing through much pain, that's why they talk politely, show much respect. But a woman would be like*, "*Me too, I delivered - you have to pass through that pain*".

Male health worker: "*Culturally they know a woman is supposed to go into that pain of delivery, and also when you look at Ugandans, they have taken more of Christianity and I think in Christianity, they say a woman has to face this*".

We have cited this at some length to illustrate the resonance of this analysis of health worker behaviour with Garneau and Pepin's constructivist approach to culture and the complex web of power relations and inequalities that form the context within which our students learn [14]. Sargent [8] identifies the process of "cultural encounters" as one component of cultural competence – which on its own may lead to essentialism and stereotyping. Extensive research on theories of learning[6] has emphasised the importance of a "More Knowledgeable Other" [39] in a mentoring relationship to impart knowledge but also, critically, to mediate the learning process. It would be unthought of to expect a student to learn a clinical skill in the absence of such a presence and yet we expect cultural learning to take place through unmediated absorption. The Ethical Educational Placement scheme managed by K4C supports a much higher level of support for students which includes an induction process prior to departure and on arrival plus weekly de-briefing meetings and reporting. Perhaps most importantly all students are supported on the ground on a daily basis by an experienced Ugandan placement manager and a multi-disciplinary team comprising UK professional volunteers (including members of the Ugandan diaspora) and Ugandan faculty many of whom have spent time in the UK. These actors have an impor-

[6]Vygotsky (1978) argues that when a student is in the "zone of proximal development" (where the potential to learn is very high) the presence of a More Knowledge Other (or more capable peer) providing essential "scaffolding" will optimise learning outcomes [39]. For further discussion of these concepts and their application to student placements see [40].

tant role to play in mediating relationships with local health workers and encouraging students to reflect upon and make sense of what they are observing and experiencing and challenge assumptions. In particular, as a project we seek to import values of humility and reflexivity amongst our students. In recent months students on placement in Uganda have expressed concerns about a situation that they have both witnessed and that has compromised their relationships with local midwives. This involves the local midwives completing fake partograms[7] and, worse still, amending partograms completed by K4C volunteers and students to make processes look perfect. Lorna, a student on placement, speaks about this during a conversation in the evening:

"*They were trying to lie about partograms. I mean you can't just lie, that's awful*". *Her peer, Susan, replies*, "*I mean you can understand some of the things they do because that's all they know but false documentation is just really awkward …*"

Unfortunately, this process continues and a post-placement discussion between K4C staff and a group of returned midwifery students explored the same theme. One student opened the group discussion with the comment:

"*I expected mothers and babies to die but not from lack of care, I expected it to be a lack of resources.*"

At this point the K4C representative replies: "*What do you mean by lack of care*?" and the student replies: "*The way they talked to women; the way they treated them in labour. At Facility X the midwives were blatantly falsifying records and partograms so they followed the pattern perfectly. They don't care that the documentation is false or that women are in pain. They are like*, '*you just have to deal with it*'. *I realise it's a cultural difference, but they'd go into the ward and just slap or shout at the women*". The K4C representative replies: "*Do you think that the fact that they are not completing the partogram accurately is because, as individuals, they don't care*?" One student responds, "*I think the system has made them not care*" and another challenges this with, "*No, because the attendants* (*informal carers accompanying patients*) *with their sisters and daughters were different too; they would withdraw themselves emotionally from the patient as if they can't empathise*." A third (more reserved) respondent suggests "*is that a cultural way of expressing their care though*?"

This scenario illustrates the opportunity for cultural brokerage; the K4C representative explains in detail the background to the whole partogram issue. We won't cite the extensive discussion that took place at this point but give a flavour:

"*What you witnessed here was a health systems problem. We had discussions with* (*a senior health manager*) *recently—it is hard to get to the bottom of things in Uganda—but it seems a Belgian NGO has set up a project there based on Results-Based Finance. What you saw in* (*Facility x*) *was the consequence of Aid. After many years of poor outcomes, Aid agencies are now using results-based*

[7]A partogram or partograph is a composite graphical record of key data (maternal and foetal) during labour entered against time on a single sheet of paper. Relevant measurements might include statistics such as cervical dilation, foetal heart rate, duration of labour and vital signs.

systems to incentivise staff, in this case to take patient observations and record them. The idea that this can work without massive unintended consequences, is quite frankly absurd. Add to this the complication that Ugandan staff don't want to tell us (*K4C*) *what other NGOs are doing, and you end up in a mess. The partograms contribute directly and significantly to their income and this skews their behaviour*."

This discussion illustrates the importance of brokerage, before, during and post-placement in supporting genuine student learning. The point is not to excuse or gloss-over highly problematic behaviour; rather to understand it as a facet of organisational culture reflecting key systems dynamics (subsistence pay and lack of accountability).

The process of completing this review of cultural competence has lead us to propose further strengthening of processes to build in more dedicated time during the induction to cultural learning and, post-placement, to reflection on this. In the context of midwifery, Stanley suggests that cultural learning continues well beyond placement completion as a reflective process which, "can be better facilitated through the curriculum" [41]. Echoing the constructivist approach, Sargent argues that, "cultural concepts taught in isolation of concepts about healthcare systems, power, political policy and ethics might foster thinking that reinforce stereotypes" [8]. She is however less optimistic about the potential for effective cultural brokerage in the post-placement curriculum on the grounds that, "the assumption that faculty members are more culturally competent is not supported by evidence [8]. This is an important issue that immediately relates to our earlier point about the power of authenticated stereotyping in the post-placement classroom or health facility We cannot assume that Faculty at the students' home institutions have the experience or commitment to this process at the present time.

Our decision, as an organisation managing student placements, to explicitly recognise the importance of cultural brokerage has lead to proposals to add more structure to the process from pre-placement induction, through placement exposure and post-placement reflection. This echoes the guidelines proposed by the Working Group on Ethics Guidelines for Global Health Training (WEIGHT) and reported in Crump *et al.* [42]. Ahluwalia *et al.* [43] piloted the WEIGHT guidelines in a small study of Canadian rehabilitation students on placement in LMICs. They concluded that, "achieving optimal and effective cultural learning requires a more robust and coherent pre-departure training, on-site support and where possible, mandatory post-internship de-briefing" [43].

5. Conclusions

By utilising the data from the three studies, this research presents a unique insight into international exposures and uncovers the impact they have on health care students in terms of their cultural learning. We conclude that the process of leaving "home", as a normalised space where we typically take things for granted, and immersing oneself in contexts where we experience discomfort, as

"outsiders", presents critical opportunities for reflexive learning. Characterising these forms of learning narrowly as "cultural" has serious unintended consequences. In the first instance, it immediately indicates a narrow focus on ethnicity and religion; on learning about exotic "others" and not the mundane (ourselves). In the process, it essentialises difference legitimising rather than challenging stereotypes. The risk is that immersion, on its own, can validate such stereotypes. This interpretation of cultural learning emphasises difference at the expense of commonality. We have reviewed research which, rather than challenge the use of the term "culture", seeks to extend the concept to embrace all aspects of social differentiation and forms of inter-sectionality that describe an individual's relationship to community and welfare systems. Our findings emphasise the shared quality of (deeply contextualised) human experience whilst also reminding us of the importance of recognising and treating people as individuals. Individual experiences and needs are at once a product of their relationships with context (and the complex power dynamics defining that) and dimensions of personal agency (and individual choice). Subsuming all of this to a simplistic concept of "culture" is largely counter-productive.

Our analysis of professional and student mobilities suggests that, more often than not, when respondents talk of cultural learning, they are identifying what are, in the main, dimensions of occupational culture, rather than culture-as-ethnicity. Viewing them as such immediately draws attention to the commonality of experience across health systems and the consequences of poor accountability in public sector employment.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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Appendix 3: Statement of Candidate's Independent Work & Individual Contribution

The International Committee of Medical Journal Editors recommends that authorship of books and articles be based on the following 4 criteria. All those designated as authors should meet all four criteria for authorship, and all who meet the four criteria should be identified as authors:

1. Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work; AND
2. Drafting the work or revising it critically for important intellectual content; AND
3. Final approval of the version to be published; AND
4. Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

All co-authors of the publications included within this portfolio have been contacted via email and have agreed that the following table is an accurate representation of each author's individual contributions. Copies of all emails have been included as evidence.

Publication	**Co-authors & Contribution**	**ICJME Criteria for Authorship (noted above)**
1 - Mobile Professional Voluntarism and International Development: Killing Me Softly?	Ackers: 50% **Ackers-Johnson: 50%**	Ackers and Ackers-Johnson worked jointly on most aspects of the work including the literature review, data collection and analysis, interpretation of the dataset and writing of the publication. Both authors gave final approval for publication and are accountable for all aspects of the work.

		Ackers-Johnson was also responsible for the project design and management.
2 - The Ethics of Educational Healthcare Placements in Low & Middle Income Countries: First Do No Harm?	Ahmed: 34%	Ahmed, Ackers and Ackers-Johnson worked jointly on most aspects of the work including the literature review, interpretation of the dataset and writing of the publication. All three authors gave final approval for publication and are accountable for all aspects of the work. Ackers-Johnson was also responsible for the project design and management, data collection and analysis. He was also solely responsible for the design, implementation and analysis of the quantitative post-placement survey completed by students.
	Ackers: 33%	
	Ackers-Johnson: 33%	
3 - Healthcare, Frugal Innovation, and Professional Voluntarism: A Cost-Benefit Analysis	Ackers: 40%	Ackers, Ackers-Johnson, Chatwin and Tyler worked jointly on all aspects of the work including the literature review, interpretation of the dataset and writing of the publication. All four authors gave final approval for publication and are accountable
	Ackers-Johnson: 30%	
	Chatwin: 25%	

	Tyler: 5%	for all aspects of the work. The varying contribution percentages are based on the percentage of the final book written by each author.
4 - The Impact of Delays on Maternal and Neonatal Outcomes in Ugandan Public Health Facilities: the Role of Absenteeism	Ackers: 34%	Ackers, Ioannou and Ackers-Johnson worked jointly on all aspects of the work including the literature review, interpretation of the dataset and writing of the publication. All three authors gave final approval for publication and are accountable for all aspects of the work.
	Ioannou: 33%	
	Ackers-Johnson: 33%	
5 - Identifying and Mitigating Risks in Medical Voluntarism: Promoting Sustainable Volunteering to support Maternal & Infant Well-Being in Uganda	Ackers: 34%	Ackers, Lewis and Ackers-Johnson worked jointly on all aspects of the work including the literature review, interpretation of the dataset and writing of the publication. All three authors gave final approval for publication and are accountable for all aspects of the work. Ackers-Johnson and Lewis also presented the research at the IARMM conference in Heidlberg in Novmeber 2013.
	Lewis: 33%	
	Ackers-Johnson: 33%	
6 - Optimising Student Learning on International Placements in Low Income	Ackers: 35%	Ackers, Ackers-Johnson, Ahmed and Tate worked jointly on all aspects of the work including the

Settings; the Contribution of Cultural Brokerage	**Ackers-Johnson: 35%**	literature review, interpretation of the dataset and writing of the publication. All four authors gave final approval for publication and are accountable for all aspects of the work. The varying contribution percentages are based on the percentage of the final book written by each author.
	Ahmed: 15%	
	Tate: 15%	

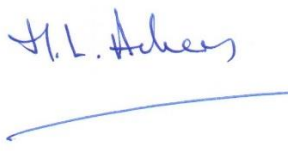
Date: 7th March 2019

Re. James Ackers-Johnson PhD by Published Works

I confirm that the table below is an accurate representation of James Ackers-Johnson's contribution to each of the publications.

Publication	**Co-authors and Contribution**
1 - Mobile Professional Voluntarism and International Development: Killing Me Softly?	Ackers: 50% **Ackers-Johnson: 50%**
2 - The Ethics of Educational Healthcare Placements in Low & Middle Income Countries: First Do No Harm?	Ahmed: 34% Ackers: 33% **Ackers-Johnson: 33%**
3 - Healthcare, Frugal Innovation, and Professional Voluntarism: A Cost-Benefit Analysis	Ackers: 40% **Ackers-Johnson: 30%** Chatwin: 25% Tyler: 5%
4 - The Impact of Delays on Maternal and Neonatal Outcomes in Ugandan Public Health Facilities: the Role of Absenteeism	Ackers: 34% Ioannou: 33% **Ackers-Johnson: 33%**
5 - Identifying and Mitigating Risks in Medical Voluntarism: Promoting Sustainable Volunteering to support Maternal & Infant Well-Being in Uganda	Ackers: 34% Lewis: 33% **Ackers-Johnson: 33%**
6 - Optimising Student Learning on International Placements in Low Income Settings; the Contribution of Cultural Brokerage	Ackers: 35% **Ackers-Johnson: 35%** Ahmed: 15% Tate: 15%

Sincerely,



Professor Louise Ackers
Chair in Global Social Justice
University of Salford

Re: PhD by Publication

Ahmed Anya

Mon 04/09/2017 16:42

To: Ackers-Johnson James <J.Ackers@salford.ac.uk>;

Cc: Ackers Helen Louise <H.L.Ackers@salford.ac.uk>;

Yes it's fine James, I'd hope that I could claim it for REF as only one of us can

Yes, still is n for tomorrow ☺

Sent from my iPad

On 4 Sep 2017, at 16:33, Ackers-Johnson James <J.Ackers@salford.ac.uk> wrote:

> Hi Anya,
>
> I hope you're well?! As you know, for the PhD by Publication I need to provide a qualitative or quantitative apportionment of my contribution to each of the books/articles submitted, and for this I need agreement from the other authors.
>
> For the student placements book I had included 33% as my personal input, splitting the remaining 67% between yourself and Louise (34%:33%). Are you happy with this? If so, please confirm via email for now then you may need to sign something further down the line too...
>
> P.s. are you still able to meet tomorrow? I have received Mark's email that he can no longer attend.
>
> Many thanks,
> James
>
> **James Ackers-Johnson**
> Project Manager | School of Nursing, Midwifery, Social Work & Social Sciences
> Project Manager | Knowledge for Change (Registered UK Charity No. 1146911)
> Room L530, Allerton Building, University of Salford, Salford, M6 6PU
> Phone: +44 (0) 161 295 2823
> Email: J.Ackers@Salford.ac.uk
>
> - Mobile Professional Voluntarism and International Development: Killing Me Softly? (2017 - Open Access)
> - The Ethics of Educational Healthcare Placements in Low and Middle Income Countries: First Do No Harm? (2017 - Open Access)
> - Healthcare, Frugal Innovation and Professional Voluntarism: A Cost-Benefit Analysis (2017 - Open Access)

Re: PhD by Publication

Chatwin John Roger

Mon 04/09/2017 16:34

To: Ackers-Johnson James <J.Ackers@salford.ac.uk>;

Hi Dr James
That's fine- how many papers do you need to do?
jc
Sent from my iPhone

> On 4 Sep 2017, at 16:28, Ackers-Johnson James <J.Ackers@salford.ac.uk> wrote:
>
> Hi John,
>
> Hope everything is going well in your new job? For my PhD by publication I need to provide a qualitative or quantitative apportionment of my contribution to the MOVE book and of course get your agreement as an author that you're ok with this.
>
> I've put down 30% as my personal contribution with the remaining 70% split between you and Louise (and Tasha 5%). Is that acceptable to you? If you could confirm via email for now that'd be great, then I may need to ask you to sign something further down the line...
>
> Many thanks!
> James
>
> James Ackers-Johnson
> Project Manager | School of Nursing, Midwifery, Social Work & Social Sciences
> Project Manager | Knowledge for Change (Registered UK Charity No. 1146911)
> Room L530, Allerton Building, University of Salford, Salford, M6 6PU
> Phone: +44 (0) 161 295 2823
> Email: J.Ackers@Salford.ac.uk
>
> - Mobile Professional Voluntarism and International Development: Killing Me Softly? (2017 - Open Access)
> - The Ethics of Educational Healthcare Placements in Low and Middle Income Countries: First Do No Harm? (2017 - Open Access)
> - Healthcare, Frugal Innovation and Professional Voluntarism: A Cost-Benefit Analysis (2017 - Open Access)
> <10.1007-978-3-319-48366-5.pdf>

RE: PhD by Publication

Tyler Natasha

Mon 04/09/2017 21:04

To: Ackers-Johnson James <J.Ackers@salford.ac.uk>; Tyler Natasha (N.Tyler) PGR <N.Tyler@edu.salford.ac.uk>;

Cc: Ackers Helen Louise <H.L.Ackers@salford.ac.uk>;

Hi James,

Congrats on PhD application. Hope you are well and maybe see you next week if you're in on the Tuesday.

If this is for anything other than your PhD examiner, I'd say 5% is a little disappointing, as I think there are only 5 chapters in the book and one of the chapters was Louise's edit of my work on learning (20%) and I'd say that I contributed 50% to that chapter and did all the background research, (the reference list is pretty much the extract same as my PhD chapter one), I found almost all the papers, NHS documents etc. and it was based on my thesis chapter and lots of it is pretty much my writing/ideas. But I understand that I didn't do any overall editing of/ or contribution to the other chapters at all. But if there's nothing official elsewhere and its only for the purpose your PhD, I would be happy to agree to 5% as I definitely didn't contribute any more than 10%, so it's not worth faffing over :)

Thanks,

Natasha Tyler

PhD Student, MOVE Project

School of Nursing, Midwifery, Social Work & Social Sciences
University of Salford

Room C530 Allerton Building, Salford M6 6PU

n.m.tyler@salford.ac.uk

07977446078

From: Ackers-Johnson James
Sent: 04 September 2017 16:27
To: Tyler Natasha; Tyler Natasha (N.Tyler) PGR
Cc: Ackers Helen Louise
Subject: PhD by Publication

Hi Tasha,

Long time no speak, how's everything going? I'm not sure if I told you but I'm applying to complete a PhD by Publication and for this I need to provide a qualitative or quantitative apportionment of my contribution to the MOVE book and of course get your agreement as an author that you're ok with this.

I've put down 30% as my personal contribution with the remaining 70% split between Louise, John and yourself as 40%, 25% and 5%. Is that acceptable to you? If you could confirm via email for now that'd be great, then I may need to ask you to sign something further down the line...

Many thanks!
James

James Ackers-Johnson
Project Manager | School of Nursing, Midwifery, Social Work & Social Sciences
Project Manager | Knowledge for Change (Registered UK Charity No. 1146911)
Room L530, Allerton Building, University of Salford, Salford, M6 6PU
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- Mobile Professional Voluntarism and International Development: Killing Me Softly? (2017 - Open Access)
- The Ethics of Educational Healthcare Placements in Low and Middle Income Countries: First Do No Harm? (2017 - Open Access)
- Healthcare, Frugal Innovation and Professional Voluntarism: A Cost-Benefit Analysis (2017 - Open Access)

RE: PhD by Publication

Ackers-Johnson James

Tue 05/09/2017 09:51

To: eioannou@doctors.org.uk <eioannou@doctors.org.uk>;

Hi Elly,

I'm good thanks still working away on the Uganda projects here in sunny Salford. Wow time really does fly by, sounds like you've been busy! Hope everything goes well with the upcoming baby popping! If it's a boy I fully expect you to name him after me :)

Best wishes,
James

From: eioannou@doctors.org.uk [eioannou@doctors.org.uk]
Sent: 05 September 2017 07:51
To: Ackers-Johnson James
Subject: Re: PhD by Publication

Hi James!

How are you? Yup got married and about to pop out a baby too so all a bit grown up!

I'm more than happy with that. Just let me know what I need to sign and when that's no problem.

Good luck with it!

Elly

On 2017-09-04 15:27, Ackers-Johnson James wrote:

> Hey Elena,
>
> Long time no speak, how's everything going? I saw on trusty Facebook you got married not so long ago, congratulations!
>
> The reason I'm emailing is that I'm in the process of applying to complete a PhD by publication here at Salford University and I want to use the OUP article: "The impact of delays on maternal and neonatal outcomes in Ugandan public health facilities: the role of absenteeism" as one of the submissions. In order to do so I need to provide a qualitative or quantitative apportioning of my contribution to the article and of course get your agreement as an author that you're ok with this.
>
> I've put down 30% as my personal contribution with the remaining 70% split between you and Louise. Are you ok with this? If you could confirm via email for now that'd be great, then I may need to ask you to sign something further down the line...
>
> Many thanks!
> James
>
> **James Ackers-Johnson**

Re: PhD by Publication

LEWIS, Emilie (CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST) <emilie.lewis@nhs.net>

Mon 04/09/2017 16:20

To: Ackers-Johnson James <J.Ackers@salford.ac.uk>;

Hi James,

First an MBA and now a PhD?! Very impressive! Yes of course I'm more than happy for you to use the paper. What's the topic of your PhD?

I'm good thanks, started my job as a Consultant at Salford last month. It's going well, it's such a contrast to being a registrar plus I have no obststrics in this job.

How's things with you? Are you still in Didsbury?

Em

From: Ackers-Johnson James <J.Ackers@salford.ac.uk>
Sent: 04 September 2017 15:32
To: LEWIS, Emilie (CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST); emilie_a_lewis@hotmail.com
Cc: Ackers Helen Louise
Subject: PhD by Publication

Hey Em,

Long time no speak, how's everything going? I saw on trusty Facebook you got engaged not so long ago, congratulations!!

The reason I'm emailing is that I'm in the process of applying to complete a PhD by publication here at Salford University and I want to use the IARMM article: "Identifying and Mitigating Risks in Medical Voluntarism: Promoting Sustainable Volunteering to support Maternal & Infant Well-Being in Uganda" as one of the submissions. In order to do so I need to provide a qualitative or quantitative apportionment of my contribution to the article and of course get your agreement as an author that you're ok with this.

I've put down 33% as my personal contribution with the remaining 67% split between you and Louise. Is that acceptable to you? If you could confirm via email for now that'd be great, then I may need to ask you to sign something further down the line...

Many thanks!
James

James Ackers-Johnson
Project Manager | School of Nursing, Midwifery, Social Work & Social Sciences
Project Manager | Knowledge for Change (Registered UK Charity No. 1146911)
Room L530, Allerton Building, University of Salford, Salford, M6 6PU
Phone: +44 (0) 161 295 2823
Email: J.Ackers@Salford.ac.uk

- Mobile Professional Voluntarism and International Development: Killing Me Softly? (2017 - Open Access)
- The Ethics of Educational Healthcare Placements in Low and Middle Income Countries: First Do No Harm? (2017 - Open Access)
- Healthcare, Frugal Innovation and Professional Voluntarism: A Cost-Benefit Analysis (2017 - Open Access)

Re: Cultural Brokerage Article

Ahmed Anya

Fri 08/03/2019 08:05

To: Tate, Natalie Jayne (PG) <N.J.Tate@edu.salford.ac.uk>; Ackers-Johnson James <J.Ackers@salford.ac.uk>; Ackers Helen Louise <H.L.Ackers@salford.ac.uk>;

I think you can say 35% and allocate me 15%

Get Outlook for iOS

From: Tate, Natalie Jayne (PG) <n.j.tate@edu.salford.ac.uk>
Sent: Thursday, March 7, 2019 10:36 pm
To: Ackers-Johnson James; Ackers Helen Louise; Ahmed Anya
Subject: Re: Cultural Brokerage Article

Hi James,

I'm happy to confirm that you contributed 25% to this article.

Best of luck with your PhD.

Thanks,
Natalie

Get Outlook for iOS

From: Ackers-Johnson James
Sent: Thursday, March 7, 2019 10:07:23 PM
To: Ackers Helen Louise; Ahmed Anya; Tate, Natalie Jayne (PG)
Subject: Cultural Brokerage Article

Dear Louise, Anya and Natalie,

I am preparing to submit my PhD by published works and I wish to use the JSS article: "Optimising Student Learning on International Placements in Low Income Settings: The Contribution of Cultural Brokerage" as one of the submissions. In order to do so I need to provide a qualitative or quantitative apportionment of my contribution to the article and of course get your agreement as co-authors that you're ok with this.

I've put down 25% as my personal contribution with the remaining 75% split evenly between the 3 of you. Please can you confirm by reply email that this is acceptable to you?

Many thanks,
James

Appendix 4: Copies of Ethical Approval Confirmations

Copies of all ethical approvals acquired for funded projects are included below. It should be noted that ethical approval has not generally been required for projects deemed to be classified as ‘Service Evaluation’.

MOUNTAINS OF THE MOON UNIVERSITY

DIRECTORATE OF POSTGRADUATE STUDIES AND RESEARCH

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL/NON-MEDICAL)
RE1/01 Ackers

CLEARANCE CERTIFICATE **PROTOCOL NUMBER: MMURECH003**

PROJECT: WE Care: Supporting Women's Empowerment and Respectful Maternity Care

INVESTIGATORS: **Prof. L. Ackers**

DEPARTMENT: **Social Science University of Salford Uk**

DATE CONSIDERED: **20th March 2017**

DECISION OF THE COMMITTEE: **Approved with minor revisions**

Use the space provided in the application to elaborate the procedures proposed for data collection.

NOTE:

Unless otherwise specified this ethical clearance is valid for 2 years and may be renewed upon application

MOUNTAINS OF THE MOON UNIVERSITY
23 MAR 2017
DIRECTORATE OF POST GRADUATE STUDIES AND RESEARCH
P. O. BOX 837, FORT PORTAL

DATE:23rdMarch2017 **CHAIRPERSON**:.....
(Assoc. Prof. M. Muhumuza)

cc:

.....
.....

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the administrator Directorate of Postgraduate Studies and Research.

I/We fully understand the conditions under which I am/we authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved, I/we undertake to resubmit the protocol to the committee. **I agree to a completion of a yearly progress report**

Signature

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL INQUIRIES

Research, Innovation and Academic Engagement Ethical Approval Panel

College of Health & Social Care
AD 101 Allerton Building
University of Salford
M6 6PU

T +44(0)161 295 7016
r.shuttleworth@salford.ac.uk

www.salford.ac.uk/

30 July 2014

Dear Louise,

RE: ETHICS APPLICATION HSCR14/58 – Measuring the Outcomes of Volunteering for Education (MOVE)

Based on the information you provided, I am pleased to inform you that application HSCR14/58 has been approved.

If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible.

Yours sincerely,

Rachel Shuttleworth

Rachel Shuttleworth
College Support Officer (R&I)

Research, Innovation and Academic Engagement Ethical Approval Panel

Research Centres Support Team
G0.3 Joule House
University of Salford
M5 4WT

T +44(0)161 295 2280

www.salford.ac.uk/

26 November 2015

Dear Louise,

RE: ETHICS APPLICATION HSCR 15-125 – Reducing Infection through holistic and sustainable Improvements in Hand Hygiene (Uganda)

Based on the information you provided, I am pleased to inform you that application HSCR15-125 has been approved.

If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible by contacting Health-ResearchEthics@salford.ac.uk

Yours sincerely,

Sue McAndrew
Chair of the Research Ethics Panel

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL/NON-MEDICAL)
RE1/01 Howell

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: MMURECH002**
PROJECT:	Blood Donor/non-Donor Behaviour: Motivations and Barriers in Uganda
INVESTIGATORS:	**Ms. J. Howell**
DEPARTMENT:	**Social Science Knowledge 4 Change**
DATE CONSIDERED:	**20th March 2017**
DECISION OF THE COMMITTEE:	**Approved with moderate revisions**

Please clarify the ethics procedures used to obtain the blood samples that are basis for your research. Use the space provided in the application to elaborate the procedures marked.

Also provide separate informed consent form for the participants.
NOTE:

Unless otherwise specified this ethical clearance is valid for 2 years and may be renewed upon application

MOUNTAINS OF THE MOON UNIVERSITY
23 MAR 2017
DIRECTORATE OF POST GRADUATE STUDIES AND RESEARCH
P. O. BOX 837, FORT PORTAL

DATE:23rd March2017

CHAIRPERSON:.....
(Assoc. Prof. M. Muhumuza)

cc: Prof. Louise Ackers

.....

.....

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the administrator Directorate of Postgraduate Studies and Research.

I/We fully understand the conditions under which I am/we authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved, I/we undertake to resubmit the protocol to the committee. **I agree to a completion of a yearly progress report**

Signature

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL INQUIRIES

MOUNTAINS OF THE MOON UNIVERSITY

DIRECTORATE OF POSTGRADUATE STUDIES AND RESEARCH

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL/NON-MEDICAL)
RE1/01 Welsh

CLEARANCE CERTIFICATE **PROTOCOL NUMBER: MMURECH001**

PROJECT: Introducing antibiotic stewardship guidelines for midwives in the Kabarole District of Uganda: an action research study.

INVESTIGATORS: **Ms. J. Welsh**

DEPARTMENT: **Social Science University of Salford UK**

DATE CONSIDERED: **20th March 2017**

DECISION OF THE COMMITTEE: **Approved unconditionally**

NOTE:

Unless otherwise specified this ethical clearance is valid for 2 years and may be renewed upon application

MOUNTAINS OF THE MOON UNIVERSITY
23 MAR 2017
DIRECTORATE OF POST GRADUATE STUDIES AND RESEARCH
P. O. BOX 837, FORT PORTAL

DATE:23rdMarch2017 **CHAIRPERSON**:.....
(Assoc. Prof. M. Muhumuza)

cc: Prof. Louise Ackers

.....

.....

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the administrator Directorate of Postgraduate Studies and Research.

I/We fully understand the conditions under which I am/we authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved, I/we undertake to resubmit the protocol to the committee. **I agree to a completion of a yearly progress report**

Signature

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL INQUIRIES

MOUNTAINS OF THE MOON UNIVERSITY

DIRECTORATE OF POSTGRADUATE STUDIES AND RESEARCH

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL/NON-MEDICAL)
RE1/01 Gavin

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: MMURECH004**
PROJECT:	Assessing the antibiotic resistance profile of bacteria isolated from cases of maternal sepsis in Fort Portal, Uganda
INVESTIGATORS:	**Mr. A.J. Gavin**
DEPARTMENT:	**Environment and Life Sciences, University of Salford UK**
DATE CONSIDERED:	**20th March 2017**
DECISION OF THE COMMITTEE:	**Approved with minor revisions**

Elaborate convincingly why the proposed study is considered to be NO risk and yet it is dealing with patients or their relatives with possible physical discomfort or Psychological stress. Also explain what ethical procedures were followed to obtain the blood that you will working with taken on a clinical basis as part of the programme to reduce maternal sepsis.

NOTE:

Unless otherwise specified this ethical clearance is valid for 2 years and may be renewed upon application

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