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Policy Report

Volunteer and Health
Worker Relationships

University of
Salford
MANCHESTER



The Sustainable Volunteering Project

SVP Policy Report

The Importance of Volunteer/Health Worker Relationships to Project Outcomes

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Introduction

Policy Report 2014:1 summarises the findings of the project evaluation on a key aspect of Human Resource Management; namely the quality and dynamics of relationships between Volunteers and their Ugandan peers.

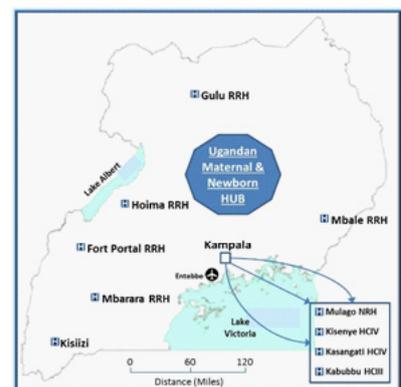
Existing research examining the relationship between the mobilities of the highly skilled and the transfer of knowledge emphasises the critical importance of effective relationships. Relationships form essential conduits for co-learning and the exchange and implementation of knowledge and skills.

The SVP evaluation indicates considerable investment and success in the transmission and sharing of knowledge through a combination of formal training and on-the-job mentoring/co-working largely in response to locally articulated needs. This contributes directly to capacity-building potential.

However, there is little evidence to demonstrate that this learning translates into effective and sustainable systems change. Put another way, that the knowledge gained from SVP interventions informs behavioural change at the individual level and in organisational culture and practices to improve maternal and new-born outcomes.

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.¹ 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’.

The Policy Report tries to develop our understanding of the factors shaping these ‘implementation’ and ‘sustainability’ gaps.² The Final Section presents policy questions for discussion.



¹Concrete examples of this will be presented in future Reports.

²The Policy Report summarises the findings presented in a research paper (Ackers and Ackers-Johnson, 2014).

1. The Co-Presence Principle³

The Co-Presence Principle drawn from research on knowledge transfer processes informed the design of the SVP. Specifically the concept implements Project Objectives on knowledge transfer, sustainability and systems change. It is also a direct response to the Risk Assessment (and concerns about lone working)⁴.

Co-presence is based on the notion that effective knowledge exchange requires co-working. Lone working is neither safe nor constitutes an effective mechanism for knowledge exchange. The SVP Volunteer Agreement requires that volunteers comply with the co-presence principle at all times. Monthly Reporting tools monitor co-presence. Co-presence forms part of the Induction Process, project review/evaluation and is regularly discussed in project workshops and with Ugandan mentors.

SVP volunteers have made significant and valiant efforts in challenging and often hostile circumstances to work within the spirit of the principle. However local organisations including some health partnerships and staff continue to resist and misunderstand the principle and the need for it.

³ For further discussion see Policy Report 2013:1.

⁴ See Risk Assessment on the project website: www.Impcharity.org

2. Co-Presence: Necessary but Insufficient?

The failure of effective knowledge transmission to bring about individual and organisational change demands further investigation. Co-presence, on its own, may not be sufficient to support the emergence and sustainability of effective trust relationships. Research suggests that the personal characteristics or attributes of individuals influences the quality and effectiveness of relationships. The impact of this varies according to circumstances and context.

The dynamics of individual status and the persistence of caricatures or stereotypes form elements of what social scientists refer to as 'positionality' with important implications for the role that mobile professional voluntarism can play in supporting effective and sustainable systems change. Key dimensions of 'position' or volunteer characteristics include (amongst others):

Gender
Age
Professional Affiliation (cadre)
Migrant Status (ethnicity, skin colour etc.)
Seniority
Culture (broadly including cultures of corruption)

The evaluation suggests that the persistence of caricatures of the 'Volunteer' are having a serious and detrimental impact on relationship-building and trust. Professional volunteers in Uganda are typically referred to collectively as 'muzungus'. This label is used generically to refer to 'white' people. Strictly translated as 'aimless wanderers', in practice the label incorporates a complex range of assumptions about the status (resources), motivations and roles of volunteers.

The problem, in terms of encouraging professional volunteers to work in more sustainable ways (and within the spirit of co-presence), is how these caricatures impact working relationships. To provide a simple but important illustration, one of the SVP obstetric volunteers was referred to by colleagues in Uganda as 'Dr Donor'. This immediately signals powerful misconceptions about the role of volunteers and the health partnerships (and NGOs) they are engaged with.

'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'⁵

⁵Williams, A. and Balatz, V. (2008) International Return Mobility, learning and knowledge transfer: A case study of Slovak doctors', *Social Science and Medicine* 67 1924-1933

The 'muzungu' caricature masks significant heterogeneity within the population of volunteers. The SVP has deployed UK volunteers with a Ugandan background sometimes referred to generically as the 'diaspora'. Equally some volunteers have previously spent considerable time in Uganda or other developing countries. Other volunteers may be black/mixed race British nationals. These experiences contribute to the composite, multi-faceted, qualities of individual volunteers which when added to gender, life-course and many other characteristics shape relationships with Ugandan professionals.

Gender	Female (24): Male (5)
Age	Under 30 years (3): 30-39 (20) 40-49 (2) over 50 (4)
Career Stage ⁶	Early career (8) Mid-career (15) Experienced (6)
Discipline	Social Science (2) Obstetrician (7) Nurse (6) Midwife (8) Anaesthetist (5) Bio-medical Engineer (1)
Migration Status:	All volunteers hold UK citizenship 5 from non-white ethnic groups and could be classified as 'migrants.' 2 were working outside of the UK immediately prior to placement. 2 were born in Uganda. 2 have previously volunteered in Uganda, one for over 2 years.

Figure 1. Volunteer Characteristics (SVP, March 2014)

The only common denominator is that all SVP volunteers were working in the UK at some point before taking up their placement. Whilst the funding body require volunteers to have a legal right to work in the UK, many have dual nationality with countries including Tanzania, Uganda, South Africa and Germany. From a religious perspective the volunteer population is characterised by diversity representing agnostics, various Christian affiliations, Muslim and Jewish faiths.

⁶This is a proxy measure. For clinicians we have counted anyone with less than 3 years specialist training as early career; those with more than 4 years but not at consultant level, mid-career and Consultants as 'experienced'.

⁷See note 2.

The 'muzungu' caricature translates more concretely into working practices that undermine co-working, to generate resistance and hostility and expose volunteers to high levels of risk. In the overwhelming majority of cases muzungu volunteers are viewed as gap fillers by local staff.⁷ The following Ugandan clinician 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."

The more serious consequences of these assumptions can be seen in the following (illustrative) narrative. In this case the obstetrician volunteer had undertaken to work a night shift (which the SVP now actively discourages following the Risk Assessment):

"We arrived at 8pm. 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. [The 2 medical student volunteers] didn't know what to do. They couldn't do the triage audit [their assigned task] because there were no staff on triage. There was an off duty security guard taking bribes off patients and moving them to the labour ward. Then I had the doctors 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 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 muzungu in these working environments can be hard as no one really wants to help you if it interferes with their routine."

The experience of lone working described here is something that the SVP tries to prevent. But this is difficult when staff are present but asleep (which is by no means unusual). What is clear here is that no knowledge transfer was taking place and that presumptions about the relationships between local staff and 'muzungu' volunteers undermined any effective co-working.

3. Gender and Relationships

The concept of muzungu is gendered. As noted above, the overwhelming majority of SVP volunteers are female. Female volunteers suffer pervasive and endemic discrimination as individuals as do their female counterparts in Uganda. This discrimination has an important impact on relationships and, as a consequence, on knowledge transfer and impact.

The Department of Health's 'Framework for voluntary engagement in global health by the UK health sector' (2014) makes a clear statement on respect for 'culture':

'Health workers must practice within the cultural context of the host environment and recognise the importance of respect for cultural sensitivities.'

However, *'volunteers should adhere to and display the values set out in the NHS Constitution and observe codes of practice set out by regulators in the UK and in host countries so that people can trust them.'*

Considerable tensions exist in these two statements particularly when faced with the daily reality of gender inequality. The following examples (from mid career volunteers) illustrate typical experiences of female volunteers:

'I think you've got to understand the society you work in. I would say being female is a disadvantage. Traditionally their culture, when 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], literally, physically did this [shows how she was pushed] and pushed me out of his way. Not in any forceful way, but it was definite.

I have come up against fairly misogynistic attitudes and misunderstandings about whether or not I am actually a doctor. On one occasion my ability or qualifications for teaching on the neo natal resuscitation course were questioned.'

It is difficult to justify this situation in terms of cultural differences per se. The first volunteer stresses the importance of understanding – but this is not the same as acceptance or capitulation. And it is important not to simply tolerate these forms of prejudice that are damaging both to the individuals concerned and to the Ugandan healthcare system (through talent wastage of Ugandan disempowered female healthworkers).

4. Gender, Religion and Development Actors

Generally speaking Uganda is a tolerant multi-faith and multi-cultural environment and volunteers do not have to respect rigid dress codes or religious practices in the workplace.⁸

Having said that, the health system in Uganda embraces a range of providers within the frame of 'public-private-partnerships.' And some of these are themselves development NGOs managed by foreign volunteers which bring with them very powerful local religious cultures affecting relationship-building.

These 'cultures' are almost always gendered. In some cases these may involve the rejection of or hostility towards volunteers (and Ugandan employees) on grounds of personal status or behaviour. This includes discriminatory behaviour towards non-married (heterosexual and homosexual) couples especially if children are involved and enforcement of out-dated (and often professionally inappropriate) dress codes (particularly for women). They may also include a requirement to engage in religious worship in the workplace. In some cases they also imply constraints on clinical decision-making and practice particularly in areas such as family planning, sexual health and abortion.

These 'conditions' do not represent a unitary 'Ugandan' culture but are the manifestation of quite specific and often imported religious values. And 'Culture' is being used here quite often as a smokescreen to conceal unethical and often illegal practices.

5. Seniority

The experiences of female volunteers also raise the importance of 'seniority' as another critical component of 'position'. The Ugandan Healthcare system is very hierarchical. In that context seniority (real and perceived), together with professional status (particularly given the low levels of nurse and midwife empowerment) combine to shape effective relationships.

This manifests itself in a number of ways. As noted above, it often means that even very experienced female doctors are treated with suspicion or derision. The following senior female obstetrician illustrates a common experience: *'People here think that I am younger than I am definitely, but my personal perception of the relationship that I have with [my line manager] is that he does not take me particularly seriously.'*

⁸The imposition of harsh policies with regard to homosexuality and the 'mini-skirt' have not, as yet, had an immediate impact on volunteers although volunteers are very aware of these and it may indeed discourage application to the SVP.

In other situations, the combination of gender (as a form of inferiority) with professional status (such as nursing for example which is highly feminised) seriously undermines the ability of female midwifery or nurse volunteers to engage in effective team-working. An experienced volunteer midwife on her second placement in Uganda explained how she was treated in the context of a multi-disciplinary 'Well Woman' intervention: We had a Ugandan Doctor that spoke to me absolutely appallingly like, 'get this', 'do this', 'do the other'.

These dimensions of culture and their implications on women as a whole and on nurses and midwives (as professional groups) damage relationships and effective team working that is so necessary in the Ugandan system.

6. Diaspora Volunteers

There is a received wisdom (common sense notion) that volunteers from 'the' diaspora possess additional resources which increase their ability to form effective relationships and generate sustainable impact.

In very simple terms diaspora volunteers, particularly if they are black and speak local languages, may be distinguished, in some contexts, by local health workers from the caricatured 'muzungu.'

This raises the question of what it means to be a member of 'the' diaspora. Does the concept embrace volunteers with any form of African descent or is it restricted to Ugandan links? Does it apply equally to volunteers who were born in the UK (2nd or 3rd generation) or require that they are born and educated in Uganda? Or should they have some prior experience of working in the Ugandan healthcare system? Do volunteers with an East African Asian descent represent the same collective diaspora?

Research suggests that membership of 'the diaspora' is not an attribute but a process and cross-cultural contact is an essential element of resource here.

Anthias suggests that the attention to diaspora can produce further stereotypes and may be 'over-celebratory;'

'It is equally important to attend to differentiations within 'diaspora' groups, such as those of gender and class, as well as differences between different diasporas, thereby treating them situationally and contextually. Whilst diasporic groups have been thought of as particularly adaptable to a globalised economic system (Cohen 1997) it is important not to think that they are essentially constituted in this way' (2008:11).

The SVP has recruited a number of volunteers who could be described as coming from the Ugandan or African 'diaspora'. One of these was asked; 'Besides being a very nice person, do you feel that your position as a Ugandan brought up in the UK has influenced your relationships?' He replies:

'Because I am nice, because I am a Ugandan and because I am British; being British gets me access a lot of the time and when I talk to people they realize how nice I am before I even start explaining [my background]. I have really got on with people that others found very difficult to get along with which I think is kind of true with the kind of personality I have, the way I approach people. And being Ugandan where I need to speak Lugandan, I will. The combination has worked in my favour.

The point about 'being nice' here is significant as it raises the relationship between positionality as 'status' and individual agency (or power to act). This volunteer has formed particularly strong relationships. It is relatively easy to attribute this to his status as a member of the 'diaspora' when it may in fact reflect a combination of his expertise and professionalism, discipline, gender and personality. Most importantly it may reflect his own, quite individual, decision-making processes and personal agency.

The point here is not to suggest that volunteer members of the diaspora do not bring something distinctive to interventions but rather to avoid the creation of further stereotypes that conceal the complexity of relationships.

7. Culture, Corruption and Relationships

The impact of corruption on development interventions is widely rehearsed. Indeed evidence of endemic corruption in the use of Development Aid lead to the withdrawal of direct state aid to Uganda by the UK and many other European Countries.

It is interesting that there is no mention of corruption and its impact on Health Partnership and Volunteer interventions in the Department of Health Paper (2014). And corruption is rarely if ever discussed openly in the context of volunteer engagement, inter-personal relationships and impact.

Moyo's influential book 'Dead Aid' (2009) presents a forceful argument that Development Aid may be both ineffectual and damaging: *'The consequences of the Aid model have been ruinous, reinforcing client regimes, instilling a culture of dependency and failing to deal with corruption.'*

On the other hand, research suggests a potential for Volunteers (as highly skilled migrants or outsiders) to act as *'boundary spanners'* to *'challenge the legitimacy of practices within organisations'* (Williams, 2006)

Echoing the concerns about seniority and status raised above, the SVP evaluation underlines the difficulties that even quite senior clinical volunteers experience in terms of engaging with systems and policy:

'I don't even know how [a volunteer] would go about [engaging with policy]. 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.'

Her concerns about the ability of volunteers to engage with policy (and systems change) lead her to focus instead on the individual – and hope that they will become effective custodians of knowledge.

Corruption and its impact on the work environment and health practices coupled with the, often unspoken but essential, requirement that volunteers do not engage with corrupt practices generates serious challenges. Health Partnerships should adopt a 'zero tolerance' approach to corruption whilst safeguarding their volunteers.

Moreover, in a systems change model there is an implicit commitment to actively challenging corruption particularly where it affects clinical practice. This forms an (implicit) element of the NHS statement (above) that, 'volunteers should adhere to and display the values set out in the NHS Constitution and observe codes of practice set out by regulators in the UK and in host countries so that people can trust them.'

This value position is a fundamental and core element of the Volunteer role and 'position'. And this stands in direct tension with working environments and individual behaviour in Ugandan health facilities. Fundamentally, corruption has a determining influence on relationships and knowledge transfer processes and presents significant challenges to Health Partnerships and Volunteers. Our concern with corruption here includes the imposition of small, informal 'service' fees and charging for publicly provided medicines and consumables, misuse of public resources (such as ambulances for example) to endemic bribery undermining all principles of clinical need and triage. Corruption also encompasses the normalised processes of 'moonlighting' and absenteeism which leave many facilities understaffed.

The evaluation has underlined the importance that strong relationships play in enabling the translation of knowledge into action. Trust lies at the heart of relationships. It is impossible to begin to discuss knowledge application and behavioural change in the Ugandan health system without talking about corruption.

The following excerpts illustrate the impact that corruption has on relationships between Ugandan health workers and professional volunteers. The first quote comes from a Ugandan mentor (midwife) and the second, from a volunteer midwife. It is very important to emphasise that both volunteers and their Ugandan colleagues are aware of this dynamic and the need for change:

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 bed-sheets' so she won't want the volunteer there.

In the second example, the volunteer midwife describes a situation all too familiar to volunteers as patients are charged for every consumable and medication (often already provided by the State):

The [consumables] are on site but the [local staff] charge. There's rackets going on for every single thing a woman needs. [The patients] have to buy everything. If they haven't got the money then you know. I threw my toys out of the pram by saying 'how on earth do you expect me to work in a labour ward without a pair of gloves'. The [midwife] said, 'if you need a pair of gloves, get the mother to buy a pair for you'. I said 'no'.

The consequences of this type of situation are complex. On the one hand, they expose volunteers to serious risk when they are not permitted to use available provisions such as gloves. More broadly, they act as a specific barrier to co-presence. Local staff do not want volunteers present to interfere with these processes resulting in pressure to engage in lone working.

There are serious reasons why such situations arise ranging from high level decisions about pay in the healthcare sector (resulting in subsistence remuneration); administrative and managerial inefficiencies leaving workers unpaid for months at a time and the presence of staff in facilities, ostensibly working as 'volunteers' on an unpaid basis who then utilise their position to raise income from bribery and sales.

The Ministry of Health Uganda Health Sector Strategic Plan III 2010/11-2014/15 identifies a human resource 'crisis' in Uganda resulting in very poor productivity. According to the report, low productivity is caused by, 'high rates of absenteeism and rampant dualism' (p.21). Further, a report by the World Bank,⁹ concludes that, 'Absenteeism is the single largest waste factor in the public health sector in the country' (p.21).

These system failures are not fundamentally about a lack of resources but about prioritisation and management. They necessarily fall outwith the responsibility of UK Development bodies and individual Health Partnerships. But arguably they could come to form key elements of much needed conditionality.

⁹ World Bank (2009) Fiscal Space for Health in Uganda.

It is important that Health Partnerships and volunteers resist attempts to provide funds for commodities – either in the form of consumables, equipment or salary augmentation - as this reduces the pressure for systems change and actively encourages corruption.

A further and very distressing outcome of these processes is the damage they cause to existing trust relationships built up over many years between Ugandan and British colleagues. Observance of relationships existing between muzungus (especially more senior actors) and local staff has led in a number of cases to threats to Ugandans either on the presumption that they are receiving financial incentives (back-handers) or that they are acting as informers. In many respects the presence of foreign NGOs has exacerbated this situation as the 'custom' of paying top-up salaries and encouraging moonlighting reinforces expectations.

In response to a discussion about the placement of volunteers (and following the placement of quite a few volunteers without mentor remuneration) a senior Ugandan clinician suddenly requested a stipend for Ugandan staff to mentor SVP volunteers. This was precipitated by the practices of a US organisation which paid generous 'top-up' salaries and illustrates the divisive effects that NGO policy can have on the ground and the tendency of this to inflate and distort expectations.

'The [Ugandan] mentor must be given a stipend or some allowance to do this like the other institutions are doing. Remember these are volunteers but they are learning a lot more! PLEASE DO NOT SEND MORE VOLUNTEERS HERE UNLESS THESE CONDITIONS ARE FILLED (email request in capitals).'

Whilst the inference here, that the UK is sending volunteers over to be trained for free, is important and needs to be discussed in the context of the seniority and experience of volunteers, this approach reinforces the caricature of volunteers as 'cash cows' and distorts volunteer-health worker relationships.

It also fails to recognise Health Partnerships as communities based on reciprocity and co-learning. Certainly, UK healthworkers and volunteers that devote time to training and mentoring their Ugandan colleagues both in Uganda and the UK do not expect remuneration.

Reducing these relationships to some form of one-sided cash nexus debases the ethos of health partnership and professional voluntarism.

This is not to infer that financial dynamics are unimportant in this voluntaristic endeavour. Indeed we would argue that Health Partnerships should be grounded in sound and reciprocal business plans with firm conditionality criteria attached to both parties. This is an approach we are currently piloting in the setting up of a new Health Partnership in Fort Portal. It was also the basis on which plans for the Uganda-UK Health Alliance were formulated to include reciprocal contribution (including in-kind forms). In practice this immediately failed to happen in practice. And many of the administrative 'costs' associated with volunteering (clinical registration and visas to name two) have increased substantially as income streams for Ugandan bodies. We would argue that these should be both facilitated and paid for by Ugandan partners.

The following comments made by a very senior hospital manager and 2 Ugandan doctors indicate the effects of this problem on volunteer relationships:

'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'.

'I also had to do a lot of explanation to the midwives. I told them there is no money. This is about sharing knowledge/experience. But of course others say, 'hey you are associating with the white people, give us some of the money that you have got'.

These presumptions that relationships with 'muzungus' involve back-hander payments to the Ugandans involved has a very direct and immediate impact on knowledge transfer. Strong relationships are viewed with suspicion and create jealousies. One of the most damaging outcomes of this is the practice of moving Ugandan staff who have established strong working relationships with UK volunteers. In almost every case involving a Ugandan employee spending time in the UK with colleagues from the Liverpool Mulago Project (LMP) the Ugandan has been moved either on return or even before they return to another ward or facility.

In effect, the Ugandan staff are being punished and a deliberate attempt made to weaken relationships. Establishing strong and effective relationships is achieved at a high personal risk to some of the Ugandan health workers and they may pay a heavy price (including disciplinary action) on return. In some instances we have only been able to maintain relationships through private meetings outside of the workplace to ensure that we are not seen together in public. Co-presence then becomes high risk and impossible to achieve on the wards.

Corruption also raises questions around disclosure on the part of volunteers. Asked for advice on how volunteers should handle experiences of corruption and whether they should report it to seniors, a Ugandan doctor suggests that this may pose a high risk to relationships:

‘There are so many reasons they should not report them to the senior – I used to talk about these things with (SVP volunteer). The thing is if they report it to a senior that person will then scold them then the message will go out that [the volunteers] are here to spy.’

8. Volountourism

Ugandan healthworkers raised another dimension of volunteer ‘characteristics’ related to perceived motivations for voluntary work. One doctor describes his previous experiences of working with volunteers:

‘where I used to work we called them volunteer tourists. They turn up about 10 and go at 11. Then after 3 days go on safari. They are more or less like a tourist – just around’.

These experiences of working with volunteers (in this case not SVP volunteers) serves to reinforce the ‘Muzungu’ stereotype and, in many ways, the literal interpretation of a muzungu as an ‘aimless wanderer’.

A Ugandan midwife echoed these concerns referring to a surgical camp she organised for volunteers:

‘These are real tourists. The patients are there from 8am and the volunteers come at 2pm or 3pm. Then they say. ‘Now we want to go to Queen Elizabeth National Park (lots of laughs). We were ashamed and disappointed as we had mobilised everyone. We said if you come here we want to know the conditions. Are you going to be here Monday to Friday – what times will you be here – we need to know that so and so will be on duty. We can’t schedule for you running up and down the hills.’

It is impossible to know the basis on which the volunteers referred to here were deployed. They may well be volunteers who have elected to go to Uganda on an individual basis (as 'free movers') outwith the frame of any organised program and at their own personal cost. And they may well be using their annual leave or taking unpaid leave to combine touristic objectives with 'altruistic' support. Or they may be engaged in gap-year style activities.

Within organised volunteering projects, such as the SVP, such perceptions may mask the reality of volunteer roles and the lack of clarity and communication about roles particularly when volunteers are working in different locations. Put simple when they are absent from a facility they may be working elsewhere.

This has been the case in Kampala, for example, where attention to referral pathways involves volunteers working in different locations.¹⁰ This may be interpreted by staff based in the facilities as reflecting a lack of commitment. Transparency and communication is the key in these situations. The volunteer is not the property of a facility and, critically they are not Ugandan employees. This will necessarily lead to diverse working patterns within the frame of agreed working hours.

At the other end of the spectrum some facility managers have placed considerable pressure on volunteers to work very long hours including nights and weekends and take very little time off. Many Ugandan healthworkers are forced into working excessive hours. The SVP Volunteer Agreement specifies working hours and leave entitlement broadly in line with NHS guidelines and the Risk Assessment. We expect facility managers to respect this. Indeed we believe that this is an important component of standard setting within health systems (namely that health workers turn up to work on time and remain at work for prescribed hours).

One of the key features of the Ugandan health system is the almost total lack of effective human resource management with many staff failing to 'report' for work at all (without sanction) and openly engaging in private work whilst others commit to punishing schedules (without reward).

¹⁰Policy Report 2014:2 focuses on the work in Health Centres in Kampala.

9. Summary

This Policy Report has summarised some of the issues identified in the course of the SVP evaluation that undermine relationship-building to the detriment of knowledge exchange and fundamentally limit the effectiveness of Health Partnerships working in the Ugandan context.¹¹

These are very complex, sensitive and difficult problems. As researchers we firmly believe they extend beyond the bounds of the Sustainable Volunteering Project to taint all interventions involving volunteers and health partnerships. Furthermore, we would argue that the SVP has gone much further than most initiatives to identify and challenge and build core elements of conditionality into the volunteering program.

As one, relatively small, player in a very large playing field populated by many other development actors, we believe that our own endeavours to identify, employ and evaluate approaches to sustainable professional voluntarism and challenge the 'muzungu' stereotype are undermined by the behaviour of other organisations.

In many cases this involves the temptation to 'turn a blind eye' or apply a 'sticking plaster' (through donations of consumables or incentives payments) or, in many cases, an outright rejection of the principles of co-working and partnership to engage in forms of direct service provision effectively replacing local health workers and undermining the Ugandan Health System.

¹¹The findings of the SVP evaluation apply to the Ugandan context. Whilst many of the issues raised may arise in other national situations as researchers we have a firm belief in contextualisation and the specificity of local economic, political and social environments.

10. Key Issues and Policy Implications

This section attempts to identify some ideas to enable the Health Partnership community and Funding / Regulatory Bodies to respond to the research evidence and trial new approaches to increase the efficacy of interventions, reduce the unintended consequences of well-intentioned practices and improve maternal and new-born health.

11. Volunteer Roles and Structured Placements

Initial operationalisation of the SVP recognised the importance of structure to volunteer placements both to support volunteers and to focus activity. The motivations shaping volunteering behaviour are diverse and some volunteers are more tolerant of structure than others.

The SVP 'Volunteer Agreement' is an important tool to support the process of volunteer management and role delineation.

The results of the evaluation suggest that the process of defining volunteer roles could be firmed up still further to increase the clarity of roles and require volunteers to work to those roles and specifically request changes.

Clarity of role facilitates improved co-working and makes it easier to engage with local mentors and health workers.

12. 'Contracts' with Human Resource Managers

The emphasis to date, in terms of human resource management, has been on the responsibilities of the volunteers and the UK partners with an emphasis on volunteer preparation and especially pre-departure training/induction.

One way of improving relationships would be to demand a higher level of reciprocity from the Ugandan counterparts.

This is of particular importance in terms of achieving effective co-presence. Ugandan managers should allocate co-workers to work alongside UK volunteers at all times and be aware that the absence of such workers will result in withdrawal of UK volunteers. Co-presence requires physical presence and cannot be satisfied by mobile phone communication.

Co-presence requires the setting and enforcement of working hours and responsibilities.

The reality of pay in Uganda at the present time at least means that health workers cannot survive on public sector remuneration. This needs addressing. In reality about half of the health workforce are paid low salaries and fail to perform any effective work through absenteeism or idleness (demotivation) whilst the other remainder endeavour to supplement meagre public wages by out of hours working resulting in exhaustion. This makes it very difficult to achieve a level of co-presence and co-working necessary for effective capacity-building and systems change. Drawing up contracts that permit private work within a wider frame of public engagement – subject to audit and sanction - would be one way of utilising staff more effectively until pay levels are increased. This would support more effective engagement with volunteers.

13. Rotation of Ugandan Health Workers

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 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.

Consideration should be given to the idea of developing firm contracts with managers perhaps through MOUs or local 'Human Resource Compacts' agreeing to 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 Alliance) and withdrawal of Health Partnership support.

14. Remuneration and Salary Augmentation

Encouraging coordination in policy between Health Partnerships and organisations deploying volunteers (nationally and internationally) would greatly improve clarity and progressively erode misconceptions about the role of Health Partnerships and volunteers.

UK Health Partnerships should avoid in all circumstances paying top-up salaries and per diem payments to Ugandan health workers as enticements to undertake training. Individual volunteers should be encouraged to donate¹² any funds / equipment through their Health Partnership and not directly to local health staff or facilities. This will help to reduce the expectation that volunteers will behave as 'Dr Donors' or 'Father Christmas' and increase an understanding of the focus on capacity-building. Health Partnerships should develop and adhere to clear policies on the donation of equipment, consumables etc.

15. Recognising and Responding to Corruption

The issue of corruption and its impact on volunteer engagement and well-being should be discussed openly and frankly with representatives of the Uganda-UK Health Alliance as a matter of urgency and suggestions put forward to enable Health Partnerships and volunteers to respond to and report corruption without fear of reprisal. For the time being volunteers should be encouraged to report all of their experiences to the sending organisation/ Health Partnership. A separate mechanism may be required as the SVP Volunteer Agreement is designed to be seen and signed off by both the UK and Ugandan mentors. Volunteers are reluctant to use this reporting tool for very sensitive issues.

¹² The SVP has a donations policy advocating this approach following cases of theft of volunteer donations. We are also developing an equipment donation policy as part of the sister project on biomedical engineering. Both of these issues will form the basis of subsequent Policy Reports.

16. Equality, Culture and Religion

The concept of cultural pluralism encourages respect for other cultures and cultural practices. The 'celebratory' aura of this concept stands in stark tension with core international human rights. Understanding a culture or practice is one thing – condoning or failing to challenge breaches of basic human rights is quite different.

Health Partnerships as agents of change should distinguish these elements of culture and actively support international standards of human rights many of which are at least formally shared by Ugandan protocols.

Gender discrimination, homophobia and racism are unacceptable in any context and should be challenged. Volunteers (and local health workers) should be able to practice their own religions or to withdraw from religious worship.

Organisations sponsoring health partnerships and volunteering programs in Uganda should take steps to ensure that the UK partners comply with the letter and spirit of UK equality and human rights law and do not abuse the opportunity of working in Uganda to promulgate outdated and discriminatory practices that would fall foul of NHS codes of practice.

More specifically Health Partnerships should be prevented from discriminating against volunteers on the grounds of race, religion, gender, sexual orientation and marital status. Where such practices are uncovered funding should be immediately withdrawn.

UK public money (including charitable tax relief) should not be used to support UK-registered organisations whose practices would breach codes of ethical conduct in the UK. ¹³

This not only distorts the truth; more importantly it encourages the continuation of interventions which may in reality be achieving very little and, of greater concern, exacerbating systems damage.

17. Evaluation and Monitoring ¹³

The importance of evaluation and monitoring goes without saying. Indeed it is a fundamental requirement of the project funders.

Capturing the complexity and nuance of inter-personal relationships that lie at the very heart of the knowledge transfer objectives of health partnerships demands sophisticated approaches grounded in research experience.

More specifically it requires the design and operationalization of multi-method approaches including a component of in-depth more anthropological and qualitative research.

Furthermore it requires that the researchers themselves are thoroughly embedded in the project at all levels and throughout the project life course.

Fundamentally the emphasis placed on relationships and relationships based on equality and trust are a pre-condition not only of the transfer of more substantive (including clinical) knowledge. They underpin researcher relationships. Indeed the very concept of 'positionality' stemmed from work on feminist research methods that centre-staged power relationships between the researched and researchers.

More formulaic approaches to evaluation derived from variants of the 'log frame' approaches in international development work will ultimately fail to capture the level of understanding required and may, in that process, err in favour of giving an illusion of more positive outcomes.

¹³Evaluation methods and approaches will be discussed in greater detail in Policy Report x (forthcoming).

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¹³This would require liaison with the Charities Commission.