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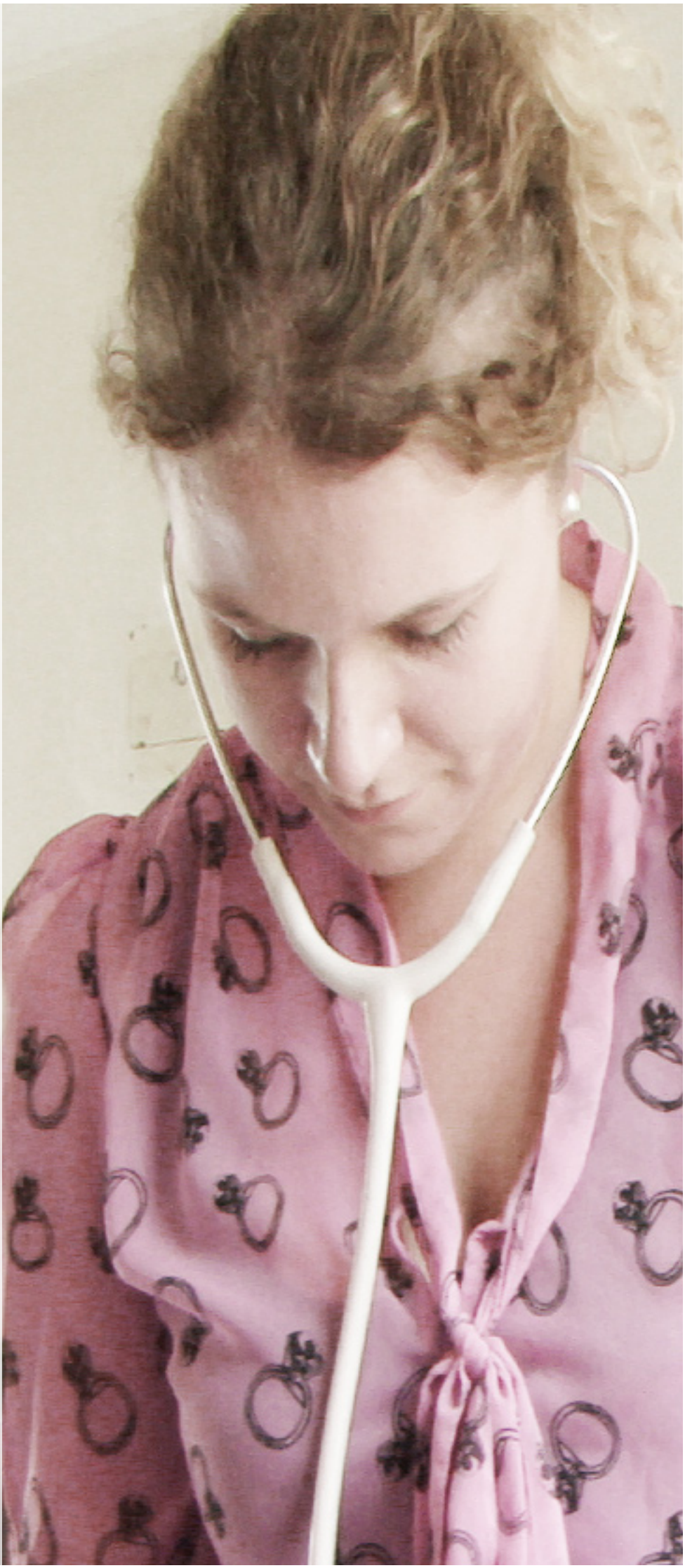
Policy Report



Understanding ‘Co-Presence’

University of Salford MANCHESTER

The Sustainable Volunteering Project

Policy Report 2014

Understanding ‘Co-Presence’ in the Sustainable Volunteering Project

Prepared by:
Professor Louise Ackers
Mr James Ackers-Johnson

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Any enquiries regarding this publication should be sent to:
h.l.ackers@salford.ac.uk

Executive summary

The principle of 'co-presence' lies at the heart of the Sustainable Volunteering Project (SVP), and is an indicator of the quality of relationships established between professional volunteers and their Ugandan mentors and peers.

Why Co-Presence?

Co-presence 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.

What is Co-Presence?

Co-presence simply means working together to share knowledge and ideas. It acknowledges that different types of knowledge and skills can move between different health workers in multiple directions (skills transfer is not a one-way process).

In practical terms it means that UK professional volunteers should always be working alongside Ugandan health workers in an environment that promotes skills transfer. 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, when they do so they will be appropriately mentored and mentoring (according to their needs).

Monitoring Co-Presence

Co-presence in the SVP is monitored on an on-going basis through a complex evaluation process.

Enforcement

Where clear breaches of the Volunteer Agreement are evident and indicate a failure of either party to respect the co-presence principle, appropriate enforcement action will take place.

Introduction

The principle of 'co-presence' operationalises the objectives of the Sustainable Volunteering Project. The objectives 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)

Professional Volunteering in the SVP is focused on these objectives and not on service delivery / workforce substitution.

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.

Co-presence from a risk perspective

In July 2012 the SVP commissioned a comprehensive independent risk assessment of HUB facilities (www.lmpcharity.org/index.php/documents). An important component of risk as identified by the Chief Risk Advisor concerned lone working. In some locations, notably Mulago Hospital, lone working was identified as a 'very serious risk' to volunteers.

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. This presents serious problems related to risk and also undermines the building of relationships conducive to knowledge transfer (effectively reducing the opportunity for shared learning). In this context, professional volunteers may take on the role of substitute labour or 'service providers.' This will undoubtedly bring benefits to the patients they 'serve' but contributes little to sustainable systems change and may, indeed, reduce the impetus for change (propping up broken systems).

Hudson and Inkson 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' (2006:312).

Respondents in an evaluation of the International Health Links Scheme (Ackers and Porter, 2011) expressed similar 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.

In another 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 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:

> "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 were on exam leave and to make matters worse the interns 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. We had 2 days with no IV fluids in the whole department, this meant no caesareans, and keeping fingers crossed that no women had a PPH. 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 and it's very difficult to extract yourself from that situation".

These are a few examples of an endemic problem. [1]

Risk and blame

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 poor equipment (a typical scenario for a Ugandan doctor). The following day local staff attributed blame to the British volunteer. This situation has caused serious concern to the volunteer and her mentor. Indeed the mentor has 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.

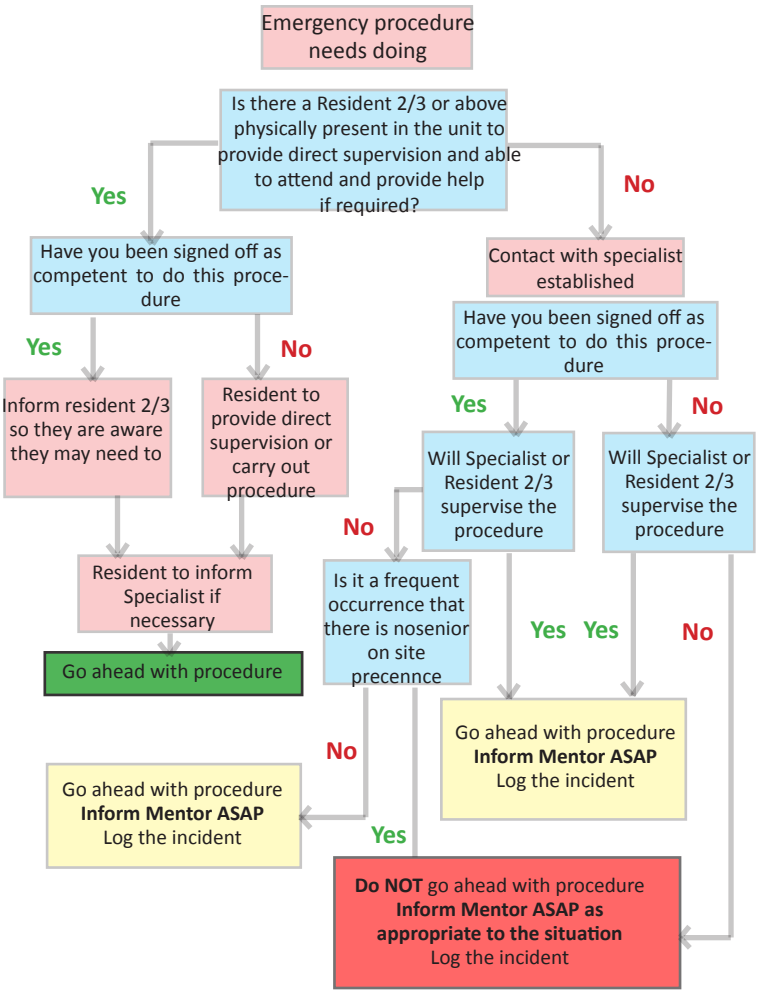
[1]These cases are reported on in more detail in Ackers, 2013 (forthcoming).

The competency algorithm

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.

The SVP has emphasised the importance of not becoming involved in these practices as they are not the employees of Ugandan facilities and are in breach of their professional indemnity insurance if they do so.

With this in mind, the following 'algorithm' was developed following discussions at the Induction Meeting (June 2012). The first draft (for consultation) has been compiled by Dr Kim Macleod and Dr Helen Schofield. The SVP community continues to discuss this algorithm and we plan to refine it in the light of volunteer experiences and project evaluation:

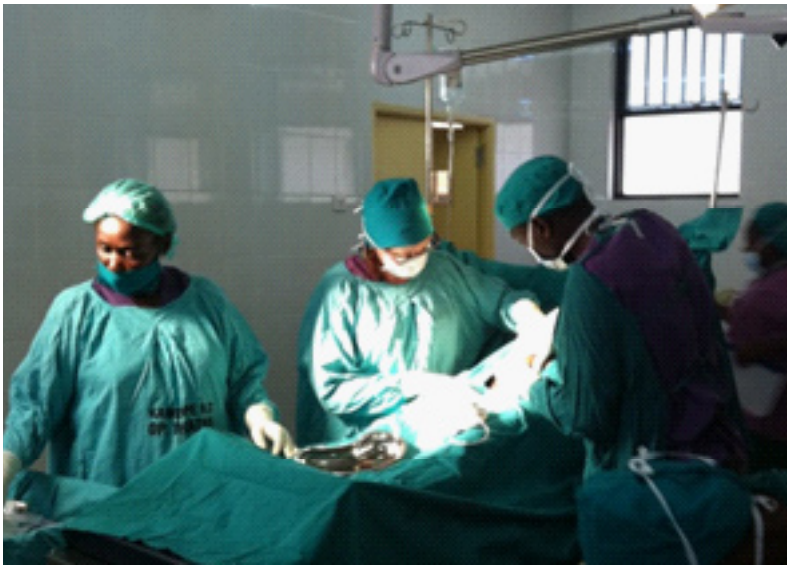


Relationships and conditionality:
The 'professional volunteer agreement'

Moyo (2009) describes the growth in conditionalities attached to aid, giving 'donors' the right to apply conditions to aid flows. These are typically concerned with aspects of governance, accountability and, more explicitly, corruption. Moyo argues that, 'whilst the approach makes sense', it has 'failed miserably' (p.39). Not so much because the approach was wrong but because there was no enforcement and aid continued to flow even when conditions were 'openly violated'.

Reciprocity is perhaps a more 'gentle' concept than conditionality but evokes the same notion of an 'agreement' between consenting partners where neither is simply a 'donor' or a 'recipient'. Negotiating co-presence requires stable and trusting partnerships based on reciprocity and bilateral exchange rather than unilateral 'donations'.

In this case the professional volunteer is making a contribution, of their time and skills, to the human resource environment in Uganda. Professional volunteers do not receive a salary during their stays, however, at an individual level they do gain important skills and experience whilst on placement in Uganda. In addition to these very individual experiential gains, the SVP takes the view that the returns on this human resource investment (on the part of the individual, the organisation and the funding body (the Tropical Health Education Trust) and ultimately the British tax payer) are maximised when the hosting organisation makes a reciprocal investment. This may be an indirect 'investment' on the part of the Ugandan institutions in the form of ensuring that health workers, especially mentors, are actively engaged in co-working with the volunteer. That implies, and can be monitored through, the principle of co-presence. If the Ugandan mentor or peers exploit the 'opportunity' of having a 'spare pair of hands' to take time off their work in the public sector then this contravenes the conditionality principle.



Operationalising co-presence

The co-presence principle in SVP is operationalised first and foremost through the 'Volunteer Agreement', Mentoring arrangements and Monthly Reporting. Every volunteer commences their placement with a Volunteer Agreement which includes the names and contact details of a UK and Ugandan mentor and a negotiated role description. The concept of co-presence and its relationship with mentoring and their role in Uganda is spelt out in the communication materials and discussed with applicants wherever possible face-to-face. Key actors in the constituent Health Partnerships play an important role in preparing Ugandan partners for what is often viewed as a rather different and, in many cases, challenging approach to their responsibilities.

The Ugandan health system faces serious human resource deficiencies. The Ministry of Heath's, 'Health Sector Strategic Plan III 2010/11-2014/15' refers to a 'serious human resources crisis in the health sector' (p.20) caused by a 'lack of clear leadership, lines of responsibility and mandates' (p.20). It also identifies serious staff shortages and low productivity caused by, 'high rates of absenteeism and rampant dualism' (p.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' (p.21). [2]

The culture of absenteeism is further reinforced by many years of 'locum-style' voluntarism compounding an expectation that volunteers will play the role of 'gap-fillers' or substitute labour.

The principle of co-presence presents a challenge for SVP volunteers. Many suggest that it may be 'easier' to simply be put on staff rotas and comply with cultural expectations. However, the experiences of the first tranche of volunteers indicate powerful support for the concept as a mechanism to optimise effective co-working and knowledge transfer. The existence of the principle and its embodiment in the volunteer agreement empowers volunteers to adhere to working practices that they firmly believe in. None of the volunteers placed in Uganda to date have questioned the validity of the concept although many have found it difficult to adhere to at all times.

[2]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)

Attitudes of Local Healthcare Staff

Attitudes of Ugandan mentors and peers have varied widely. At one end of the spectrum Ugandan mentors were already working within this frame and needed no persuasion of its value. In one case a Mentor instructed all the local interns and residents to ensure they remained at work for as long as the volunteer was present always working alongside her.

At the other end of the continuum, Ugandan mentors who appeared to understand and respect the principle failed to comply with the spirit of co-presence as soon as their mentees arrived. In one case the mentor even failed to maintain telephone communication, made no effective contribution to the volunteer intervention and effectively stole a large amount of funding raised to support that intervention. The SVP will not use this mentor again.

Between these two poles we can observe the effective implementation and embedding of the principle with volunteers and their Ugandan mentors working hard to adhere to it. This does not imply that the wider community of health worker peers either understand or have sympathy with the concept. Volunteers are regularly/usually challenged by the expectations of local staff that they should be gap filling or 'mucking in' rather than focusing on capacity-building and training. In some instances volunteers have suggested that they are viewed as 'cash cows' rather than co-workers. Interviews with volunteers (in this case medical elective students prior to the SVP) as part of the risk assessment found similar

> *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 (cited from risk assessment 2012)*

In the Canadian conference (Workshop on Maternal Health) Ugandan colleagues expressed the view that volunteers needed to show concern for the well-being of the local staff to challenge very low levels of motivation through improvements in the working environment. The Workshop made the following recommendation:

'Volunteers and collaborators should consider how to organise their work to improve the working environment for Ugandan health staff'. (www.lmpcharity.org/index.php/documents)

One way of doing this (apart from engaging in career enhancing training) is to relieve some of the daily workload. One Ugandan mentor spoke to the coordinator about co-presence enquiring whether this meant that he had at all times to accompany the professional volunteer during clinical work. He said that if this was the case it would add to his already very demanding workload. The coordinator explained that the principle did not require this. Co-presence could be satisfied by the volunteer working alongside more junior employees in the same discipline or indeed amongst other cadres of staff with the critical proviso that such work did not contravene the competency principle. In this respect co-presence does not imply a lack of clinical input.

Indeed the co-presence principle was also put in place to reduce the practice of taking staff off the wards into hotels and such like for more formalised and didactic training sessions. Colleagues within the Ugandan Maternal & Newborn Hub had expressed concerns that this practice had not been as successful from the point of learning. It also has the unintended consequence of reducing staff presence on the wards and putting pressure on an already depleted resource. Formal training continues to happen within the SVP but, wherever possible, implementation is supported through mentoring and co-presence on the wards.

Monitoring Co-presence

Co-presence is a complex concept and presents real challenges in terms of evaluation. The SVP evaluation is capturing the processes of human resource engagement from a qualitative perspective on an on-going basis. As the project evolves and more volunteers are recruited we will begin to code and analyse the qualitative data more comprehensively. The examples cited above are presented here as illustrations. In addition, the Monthly Reporting Template asks 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?

Mentoring

- Can you confirm that you have met your Mentor in Uganda at l east once (in person) and discussed this report with them? Yes [ ] No [ ]
- If not can you explain why?
- Can you confirm that you have emailed your Mentor in the UK at least once and discussed this report with them? Yes [ ] No [ ]
- If not can you explain why?

Responses to the questions on co-presence were compiled and scored out of 5, 5 being the ideal outcome where the co-presence principle was always being adhered to, and 1 being the worst outcome of the co-presence principle never being adhered to.

Initial results show that, on average, volunteers have 'mostly' been working alongside Ugandan colleagues (mean = 4.4). Volunteers have very rarely been left completely on their own (mean = 4.8). 66% of monthly reports have been discussed with Ugandan mentors and 73% have been discussed with UK mentors.

Enforcement

The SVP monitors co-presence for evaluation purposes and also to guide the recruitment and management of volunteers. Volunteer recruitment includes a formal HR process, including application forms, interviews and references. They are also required to sign a tailored 'Volunteer Agreement' outlining their role, responsibilities and potential disciplinary procedures.

Monthly reporting and interviewing during placements enables us to monitor progress and the quality of relationships.

Where evidence indicates that the Volunteer is failing to respect the Volunteer Agreement appropriate disciplinary action will be taken and they may, in serious cases, be required to return to the UK.

Similarly, the SVP monitors the engagement of Ugandan mentors and peers. Where we become aware of a persistent lack of engagement and failure to respect the co-presence principle the SVP will remove the volunteer from that institution and place them in an environment, within the HUB, where their contribution is recognised and valued. Enforcement, as Mayo indicates, is critical to the embedding of the co-presence principle and to the preservation of relationships grounded in mutual respect and trust.

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