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

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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

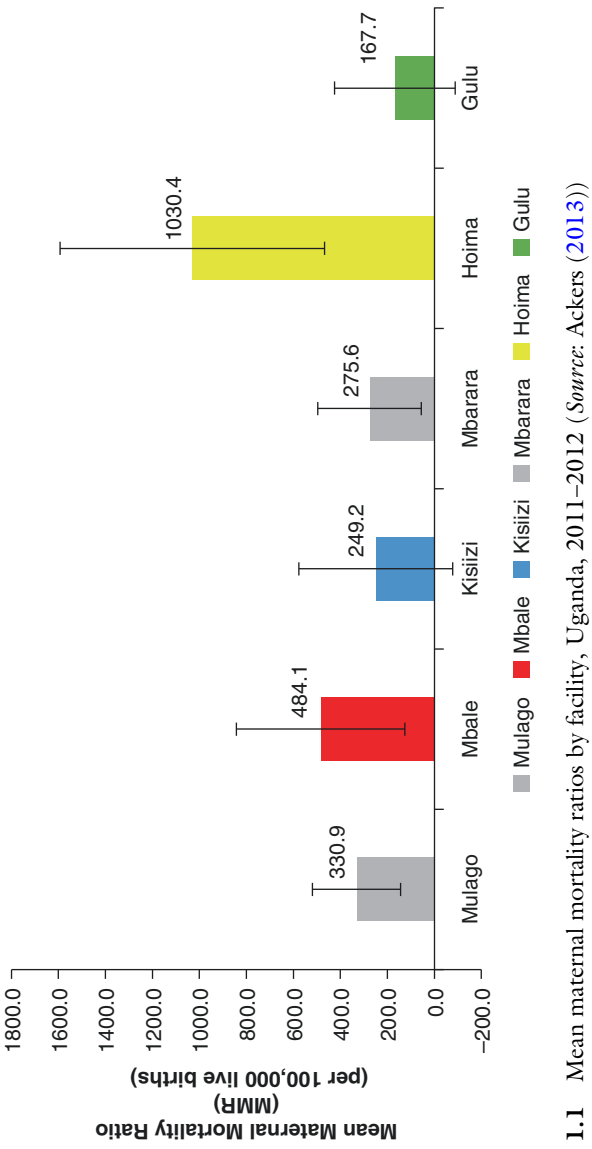

Fig. 1.1 Mean maternal mortality ratios by facility, Uganda, 2011–2012 (*Source*: Ackers (2013))

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).