

Plugging in! How can applied health research contribute to more effective health aid?

The case of short-term health work

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From September 2006 until February 2008 the short-term work of Dutch health workers in developing countries was subject to anthropological research for a Master's in Medical Anthropology and Sociology. The study provided an insight into the experiences of the professionals (both in the Netherlands and Ghana) involved in this sector. The aim of investigating experiences in this sector was to contribute to making Dutch health aid more effective. In order for that to occur, the insights provided by the study needed to reach the people that are able bring about change (i.e. policy officers, NGO's). This paper describes how this was done and what health researchers and professionals can learn and understand from this process in order to bring health research to practical use.

The first step for applied research is to identify a problem (such as a conflict or a lack of information) experienced by people within the target group(s), policy-makers, development practitioners, etc. It is also important to connect with and stay closely connected with the people involved throughout the whole research period and after its completion. Applied research does not stop when the report has been completed. Finally, one of the greatest challenges is to bridge the gap between theory and practice by reaching out to the target group(s). This means presenting the research results and providing a platform for discussion. The media can play a crucial role in this process.

[applied health research, short-term health work, anthropology, Ghana, developing countries]

Applied health research is carried out in order to contribute to the ongoing process of improving health conditions, including the provision of health care. However, in many cases the results and recommendations of health research have proved unable to be properly or adequately applied. There is a significant gap between the results of research and their application in real scenarios. This paper describes how health research could be applied – or ‘plugged in’ – by elaborating on four steps of major importance and improving the connection between research and its area of applica-

tion. This is carried out by carefully describing the process of an anthropological health research during the period September 2006 until February 2008 involving the short-term health work of Dutch professionals in developing countries.

Step 1: Identifying a problem and using it as the starting point for research

In the last few years an unknown but apparently growing number of Dutch health workers have visited developing countries for voluntary health work for a period of a few weeks or months, often during their holidays. Both older and younger people are involved in this short-term work, either as individuals or in teams. The volunteers provide basic health care or specialist care, either with an organisation or self-organised (e.g. Boissevain 2006, Leclercq 2006, Van de Kamp 2008a).

In the summer of 2006, a group of former tropical doctors expressed their concern and frustration about this new trend (e.g. Peerenboom 2006, Ravensbergen 2006). The debate interested me greatly after reading about it in one of the leading Dutch newspapers (De Visser 2006a, De Visser 2006b). One of the objections raised was that these short-term health workers underestimate cultural differences, which results in a negative impact on the quality of their work. Health consultant and former tropical doctor P.B. Peerenboom wrote quite cynically about it, stating that this short-term work had more to do with fulfilling a childhood's dream than with providing effective health care (Peerenboom 2006). In the same article Peerenboom recommended the Dutch Society for Tropical Medicine and International Health (NVTG) and the Royal Dutch Medical Association (KNMG) to write and implement a code of conduct for Dutch health professionals working in developing countries in order to prevent malpractice.

This critical discussion was the starting point for my research. I knew about this trend among Dutch health workers but I was unaware of the concern and frustration of their national colleagues. Regardless of this development being wrong or right, I considered this to be a significant problem, due to its (un)intentional influence on the attitude towards each other, and on the public's opinion on health aid. This led to the following questions: Why do these critics (seem to) oppose to this trend? Is short-term aid as bad as they say it is? Will a code of conduct improve the situation, and how? Who should be responsible for writing and implementing it? And perhaps most importantly, since this debate had so far mainly been focussed on what the Dutch opinions are: What do people in developing countries think of this situation?

Step 2: Connecting with people involved in the problem

Having formulated all the questions above, I decided to investigate the 'world' of Dutch health workers with an interest in working in developing countries. My objective was to explore the way in which anthropological research could contribute to

solving this problem. I carried out pre-research to enable me to develop the most appropriate research question.

In the first instance, I contacted the Dutch Society for Tropical Medicine and International Health (NVTG) and the Royal Dutch Medical Association (KNMG). I asked both organisations (a) whether they recognised the problem that these former tropical doctors expressed, and (b) whether they thought they should take action against malpractice in developing countries conducted by the Dutch health workers. Secondly, I started to contact other Dutch organisations that are active in this field to hear their opinion. In October 2006 I attended a conference organised by the NVTG, on 'Dutch Medical Doctors in Developing Countries: a debate on present and future'. At this conference I was introduced to several key figures, and was invited to join a committee which consisted mostly of member of the NVTG that worked on drafting the code of conduct for health professionals. In the following months I visited people that I had read about in the media in August¹. I also contacted people from the Dutch Ministry of Foreign Affairs and visited the policy maker involved in setting up retention schemes to reduce the medical brain drain in developing countries. Following the meeting I was invited to several conferences relating to the subject of Dutch health aid, where I was able to undertake further networking.

After this pre-research, I realised that the two groups of people (short-term and long-term health workers) were unlikely to listen to each other's arguments because both parties were openly critical of each other in the media. I also realised that the voice of a third group was missing; that of local health workers and policy makers in developing countries. To shed some light on which components were important in understanding the conflict I wanted to provide an insight into why people had such differing opinions on this subject. I formulated the following research question: *How do these three groups of people experience the work of Dutch short-term health workers?* The goal was not to criticise any individual or to 'judge' the Dutch short-term health work. I considered the insights (the direct goal) crucial in order to contribute to making Dutch health aid more effective (the indirect goal). I was inspired by what Ahmed and Shore wrote about the value of anthropology for improving aid:

In a very practical sense the findings of anthropology also link up with aid. What kinds of aid to send? How to send it? Who to send it to? Each of these questions requires an accurate understanding of leadership patterns, family structures, cultural values and political organisation. Without such knowledge the result is often disastrous (Ahmed & Shore 1995: 29).

By the time I had written my research proposal I had already made a significant number of visits to various people involved in both short-term and long-term medical aid in developing countries. Many of these people had contributed to the research by introducing me to other people, sending me articles or inviting me to relevant conferences. Some of them also helped me in formulating the research question. It gave them a feeling of involvement and it helped me focussing on the issue at stake. Occasionally I contacted people for two different (strategic) reasons, which I will clarify at Step 4.

Step 3: Staying closely connected with the people involved throughout the whole research period

Finding the right research area for my research outside the Netherlands was not an easy or straightforward task, since Dutch short-term health workers travel to many different countries and obviously I could not visit them all. I had to limit the research to one country. But which one? I decided to visit the country on which I could find the most relevant research information. I needed to know *where* Dutch short-term health workers were going to exactly and also *when*. In addition, I needed permission for the research project from the local health workers and authorities, as well as from the Dutch health workers, preferably before I travelled. I also wanted to visit *several* places within one country in order to observe various situations and scenarios. The task of finding the most appropriate country by a) identifying the right places within that country, b) finding people that would cooperate, and c) obtaining permission and consents was daunting. Ghana seemed to be the most prudent choice. However, by the time I flew to the Ghanaian capital Accra I did not have a definitive plan for the first period of research yet. I did arrange to meet my contact person at the Netherlands Embassy. He informed me about a Dutch team of orthopaedic surgeons that had just arrived at a hospital not far from Accra, and that they were planning to stay for two weeks. I immediately travelled to the same hospital and was fortunate to obtain permission from the general director, the medical director, the Ghanaian health workers and the Dutch team to conduct my research. After a further two months I had collected significant data (through interviews, observations, formal and informal conversations) from five different hospitals in Ghana. The direction of the research was greatly determined by the information I obtained from the people already involved.

After the collection of data, staying closely connected with the people involved proved crucial. Whenever I asked someone to give me some clarification or advice I would get an answer quickly. This was invaluable during the process of data analysis. A third advantage of staying closely connected was that some individuals contacted me after reading an article or book to highlight its relevance to my research.

Step 4: Reaching out to the people involved after the research report has been written

Applied research does not stop when the report has been written. The greatest challenge comes after the report: bridging the gap between theory and practice by reaching out to the people involved. Health researchers disagree on the question whether bridging this gap is the responsibility of the researcher (or e.g. health workers). Regardless of whether it is the responsibility of the researcher or not I chose to distribute the research results myself.

Before describing how I have used this fourth step in the process of my research, I will first describe the three main challenges and the findings of my research. Conse-

quently I will elaborate on how I connected to the people involved and what the results were of that process.

Challenges

The first challenge was: *Who are the 'people involved'?* Those who *participated in the research or those who can actually make a change?* Reaching out to the target group does not necessarily mean reaching out to the people who can make a change. At the start of the research, it was important to already identify and connect with people whom I expected to be able to bring about change. Furthermore, it was important to connect to parties that could put pressure on these people to change conditions. Connecting to both parties only after completion of the research would be too late; their involvement was necessary throughout the entire research process.

The second challenge or question has already been touched upon: *Who is responsible for bringing health research to practical use? Is it the researcher, or the people that can actually make the change?* I believe this is shared responsibility. The researcher is responsible as it is one of the objectives of applied research. The people that can bring about change have the responsibility to provide the best possible health care. In order to carry out this responsibility they also have to stay connected – to a certain extent – with the national and international field of health research.

After this shared responsibility is acknowledged by both parties the third question is: *What should be done to act according to this shared responsibility?* This highly depends on the research question and goal(s). In many cases as in this one it is unrealistic for the researcher to assume that the people who are able to bring about change will spontaneously ask for the research results. Therefore, the researcher should try to get them on his/her side by presenting his findings and recommendations in order to provide a platform for discussion.

Research results

The first group of people involved in my research were Dutch long-term health workers who had worked in a developing country for over a year. The opinion of Dutch long-term health workers on the work of short-term health workers varied greatly. Their greatest concerns were: inexperience with working in developing countries; lack of knowledge about the local situation, language and habits; inability to foresee possible risks; insufficient cooperation with local health workers and no guarantee for proper follow-up.

The second group consisted of Dutch short-term health workers who had worked in a developing country for a few weeks or sometimes a few months. Contrary to what many Dutch long-term health workers assumed, most Dutch short-term health workers had previously worked in a developing country. Some of them were well informed about the local situation, whilst others were not. They were all ill informed by the organisations that had sent them. Most of short-term workers considered the impact of their work as nothing more than 'a drop in the ocean', as many stated. The

most important motivation for working in short-term in health aid were 1) adventure, 2) curiosity, and 3) solidarity. The reason for their short-term stay instead of a longer period was solely practical: they could not or did not want to leave their work or family for a longer period of time.

The third and last group consisted of local health workers in Ghana working in hospitals visited by Dutch short-term health workers. The extent to which local health workers in Ghana appreciated the short-term work of their foreign colleagues was first of all determined by the extent to which they were informed about the date of their arrival, the size of the medical team, their qualifications and intentions. Sometimes they were not informed in advance on any of these questions. Secondly, their appreciation depended on whether the foreign health workers appropriately communicated with the local health workers during their stay. In some cases there was very little communication between the two groups. Not asking for or listening to the needs of the local hospitals lead to foreign health workers working in hospitals when in fact there was no real evidence they were required. As a consequence, local health workers were demotivated to work with their foreign colleagues and hospitals were forced to spend additional funding (on accommodation, transport and food for these foreign health workers). Funds they could not afford.

The data showed that the interpretations of the experiences of the three groups studied were highly influenced by their situation and culture. It has shown that Dutch short-term medical aid in developing countries needs major and significant improvement. The most appropriate way to achieve this objective would be to let local health workers in developing countries decide what kind of short-term aid – if any – they need most. Hence, the Dutch health workers would be more integrated within the framework of the local medical structure and local culture.

Applying the fourth step to the research

After the report had been compiled, I proceeded with contacting those who participated in the research and all others who were in one way or another involved. I identified the following stakeholders who could influence and improve this type of Dutch medical aid:

- Dutch Ministry of Foreign Affairs
- Dutch Society for Tropical Medicine and International Health (NVTG)
- Organisations that send Dutch health workers to developing countries for short-term medical work
- Dutch health workers that go to developing countries for short-term medical work, individually or in teams, through an organisation or self-organised
- Dutch health workers with an interest in going to developing countries in the (near) future for short-term medical work

Media proved an effective and powerful way to reach a considerable amount of stakeholders. From the start of the research I had already involved some key figures that could help me publish the results when the time was there.

The chief editor of the international bulletin of the NVTG had been kept informed throughout the whole process. It was not a coincidence that just after my thesis was written, I was asked to write an article on the research results for this bulletin (Van de Kamp 2008b), through which the results reached 900 Dutch health workers.

Articles about the results on the front pages of two Dutch newspapers *De Volkskrant* (Bruinsma 2008a) and *NRC Handelsblad* (NRC Handelsblad 2008) generated more media attention, contributing to the already existing public discussion on questions such as: 'Is there a problem?', 'Who is responsible?', 'What should be done?' and 'Should something be changed?'. The articles were published after I had been interviewed by a newspaper reporter (Bruinsma) on my research. She got my contact information from the reporter who wrote about Dutch health work in developing countries a year before, and whom I had connected with at the start of the research (De Visser 2008). Even the Dutch Minister for Development Cooperation was asked for his reaction (NRC Handelsblad 2008).

The media attention had a remarkable effect on the way of connecting with people, because people also started contacting me, instead of only the opposite way. I was asked twice to talk about the research on national radio (LLiNK 2008, VARA 2008). And up to today I am asked to give lectures on different events², mostly visited by students with an interest in travelling to developing countries for medical work. Participating in those events enables me to 'plug in' my research results and encourage people to discuss different aspects related to (the effectiveness of) short-term Dutch health aid.

Results of reaching out

The intention of plugging the research results into society (all relevant contact persons, media and relevant events) was to contribute to making Dutch health aid more effective and increasing its profile. But how can one measure improvements in the effectiveness of something as wide and complex as 'Dutch health aid'?

The media attention for the research results shows that the project contributed to the public discussion about the responsibility of Dutch health workers in developing countries³. One organisation that sends orthopaedic teams to Ghana made a list of 'do's and don'ts' based on the research results. This list, together with the thesis, is compulsory reading for every health worker going to a developing country through this organisation⁴. Did reaching out lead to an increase in the awareness of possible negative side effects of foreign health aid? It did for some people I received emails from, but on a large scale it is hard to tell since I did not follow up on this. The question how and when this awareness leads to more effective health aid is even harder to tell, because it is nearly impossible to be sure of a direct causal relation between research and changes in aid. The effects of research may take a very long time and follow unexpected routes. A researcher should always be aware of this and reflect on it while writing about the impact of (applied) research.

The most concrete and observable outcome of reaching out to the people involved was an invitation (which I accepted) to carry out further research into the subject for

an organisation that was yet to be founded and later became known as DuDoC (Dutch Doctors on Call). DuDoC was born out of the critical discussion on short-term medical work and the lack of cohesion between all those organisations that send out Dutch short-term and long-term health workers. In order to receive funding for coordinating Dutch medical aid by the Dutch Ministry of Development Cooperation, DuDoC needed to be able to provide the respective Minister with detailed information about the current situation⁵. Based on the data I collected, analysed and presented, in August 2009 the Minister decided to finance DuDoC for the first two years of coordination. I consider this to be a major step towards coordination of Dutch short-term medical work in developing countries.

Conclusion

As mentioned before, Ahmed and Shore stated in 1995 that questions related to sending aid require an understanding of certain patterns, structures and values. By investigating the experiences of different people involved in the short-term work of Dutch health workers I wanted to provide the missing insight, needed in order for people to understand the contradicting opinions about the new trend. As a researcher you never have full control over the impact of the research. However, researchers do have influence on the extent to which their results get plugged into daily routines and practices.

Having described the process of the research, it becomes evident that there are four important steps in implementing health research findings into daily routine and practices. The first step is to identify a problem in dialogue with people most directly involved in that problem. The second is to connect with these people, for three different reasons: 1) because they experience the problem (e.g. Dutch long-term health workers and health workers in developing countries), 2) because they can bring about changes towards solving the problem (e.g. Dutch short-term health workers), or 3) because they can apply pressure on the people that can authorise the changes (e.g. media and the NVTG). The third step is to stay closely connected with the people involved throughout the whole research period. The fourth step is to present the results to all people involved after the report has been written and to provide a platform for discussion.

It may not be the responsibility of the researcher to achieve the actual change but the researcher can initiate the change by strategically involving the right people in the process of the research from its commencement until after its completion. It all comes down to a strategy for involving those people, as the answer to the questions: 'What do I need in order to achieve the goal(s)?' and 'Who should I involve in order to get access to what results from the first question?'. After identifying and connecting with those people, it is a matter of staying connected.

The reason for this research to get plugged into society according to these four steps was to contribute to making Dutch health aid more effective (the indirect goal of the research). It contributed to the founding of Dutch Doctors on Call (DuDoC), an organisation focussing on coordinating Dutch medical aid. It also contributed to the public discussion about the possible negative side effects of Dutch health and the

responsibility of Dutch health workers in developing countries. Whether this research had more impact than that remains unknown since the correlation between the research and the current situation in Dutch health aid is hard to prove, as is the case for most research in various fields. However, this should not be a reason for researchers to refrain from narrowing the gap between applied science and social practice. Further research should be implemented in order to keep contributing to making necessary improvements to the efficiency and effectiveness of Dutch health aid, but getting the result plugged into society is a first and indispensable condition.

Notes

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This paper is based on a Master thesis on Medical Anthropology and Sociology at the University of Amsterdam. An earlier version of the paper was presented by the author at the CERES Summer School 2009 at the Radboud University Nijmegen. I would like to thank all people that participated in the research for their invaluable contributions. Special thanks go to Sjaak van der Geest and Aagje Papineau Salm for carefully and patiently reviewing the process of research and writing. I am also grateful for the comments of Ajay Bailey, Sara Blom and Hilde Anna de Vries. And last but not least: many thanks to Loes Koorenhof en Andrew Bourne for final editing of this text.

- 1 I visited P.B. Peerenboom, who wrote a very critical article on the Kenya Jeep Line Project of Rotary Doctors Netherlands (Peerenboom 2006). Then I visited J. Beltman, one of the general practitioners involved in this Rotary Doctors project, who strongly objected to Peerenboom's opinion (Beltman 2006). I also visited P. Rompa, an orthopaedic surgeon who I had read about in a newspaper 'De Volkskrant' (De Visser 2006b).
- 2 Events I participated in up to now: 1) Panel discussion: '*Aanpakken en wegwezen? Hoe nuttig is de uitzending van artsen en coassistenten naar Afrika?*' – Radboud University Nijmegen, Medical Faculty, 2) Lecture: 'Medische antropologie en de toepassing ervan in de wereld van Nederlandse medische tropengangers' – University of Groningen, Medical Faculty, 3) Workshop at 'Make my Day 2009': 'Een Afrikaanse kijk op de zaak: Kortstondige Nederlandse ontwikkelingshulp vanuit het perspectief van de Afrikaanse hulpontvangers' – University Leiden, Student Association for development co-operation.
- 3 More media articles are available on request (email the author).
- 4 I cannot refer to this list because this organisation does not want to be mentioned by its real name.
- 5 Among other things, I did research on the number and type of organisations sending out Dutch short-term and long-term health workers, the duration of their visits, the developing countries they go to and the average amount of money they spend on each mission.

References

- Ahmed, A.S. & C.N. Shore
1995 Introduction: Is anthropology relevant to the contemporary world? In: Ahmed & Shore (eds.), *The future of anthropology: Its relevance to the contemporary world*. London: Athlone Press, pp. 12-45.
- Beltman, J.
2006 Medisch toerisme. *De Volkskrant*, August 26: 7.
- Boissevain, M.
2006 In Vietnam zijn wonderen dagelijks werk. *De Volkskrant*, December 4: 4.
- Bruinsma, J.
2008a Onderzoek: Medische hulp Afrika chaotisch. *De Volkskrant*, November 10: 1.
2008b Medische hulp is niet altijd welkom. *De Volkskrant*, November 10: 2.
- De Visser, E.
2006a Arts-toerist biedt vaak matige hulp: Oud-tropenartsen pleiten voor gedragscode. *De Volkskrant* August 4: 1.
2006b Wonderdokters. *De Volkskrant* August 4: 22-23.
- LeClercq, R.
2006 Een wrange topvijftien: Nederlandse artsen registreren morbiditeit in de hooglanden van Kenia. *Medisch Contact* 61 (7): 275-277.
- LLiNK
2008 Hoe goedbedoeld is ontwikkelingshulp? *Atlas*, radio show, November 16 [<http://llink.nl/plugins/streamplayer.php?url=http://audio.omroep.nl/radio1/llink/atlas/20081116-18.mp3>].
- NRC Handelsblad
2008 Koenders: hulpindustrie moet open. *NRC Handelsblad*, November 10: 1.
- Peerenboom, P.B.
2006 Arts of toerist: Dokteren in Afrika is zeker niet vrijblijvend. *Medisch Contact* 61 (24): 1008-1009.
- Ravensbergen, S.
2006 Medisch toerisme aan banden. *IS, Internationale Samenwerking* Nr. 9, November, The Hague: Ministry of Foreign Affairs.
- Van de Kamp, J.
2008a *Aanpakken en wegwezen: een antropologisch onderzoek naar de korts tondige inzet van gezondheidswerkers in ontwikkelingslanden*. Master thesis, University of Amsterdam.
2008b Asking thém: Ghanaian health workers about Dutch short-term health workers in Ghanaian hospitals. *MT, Bulletin of the Netherlands Society of Tropical Medicine and International Health* 50-2: 6-7.
- VARA
2008 Komt onze hulp aan derdewereldlanden wel terecht op de juiste plek? *De Praktijk*, radio show, November 11 [http://www.avro.nl/player/radio/player.aspx?progId=podcast_watnu&iid=watnu_7209&stream=undefined].