commentary

Global Health Psychology: Research, Volunteering & Consultancy

Lucie Byrne-Davis
University of Manchester
Eleanor Bull
University of Manchester
Amy Burton
Staffordshire University
Nimarta Dharni
Bradford Institute for Health Research
Fiona Gillison
University of Bath
Wendy Maltinsky
University of Stirling
Corina Mason
NHS Grampian
Nisha Sharma
Solent NHS Trust
Jo Hart
University of Manchester

Since we started working in global health, we have lost count of the number of Health Psychologists who have told us of their attempts to volunteer internationally and the difficulties in finding a project in which they can use their specific skills and knowledge. Imagine then, our surprise, when we read the editorial in the launch of the journal 'Global Health Science and Practice' in 2013 entitled 'The 6 domains of behavior change: the missing health system building block'. This editorial described the global health priorities that would be addressed by an application of knowledge and skills in behaviour change. Not written by a psychologist, but by a public health specialist from the United States Agency for International Development, the editorial sets out a broad range of possible contributions that psychologists, with expertise in behaviour change, could make to improving and understanding health and healthcare (Shelton, 2013)[1].

Our own involvement began with a chance conversation with a colleague who worked in a 'health partnership'. These are collaborative partnerships between UK organisations and organisations in low and middle income countries (LMIC) with an aim of strengthening health systems mainly through supporting education and training of healthcare professionals. Typically, UK healthcare professionals will engage in education, training or mentoring of their counterparts in the LMIC, whilst learning skills themselves about teaching, tropical disease management, and managing with low resources to name but a few. The partnership in this case was between Gulu Regional Referral Hospital, a large government funded hospital in the north of Uganda, and University Hospital of South Manchester (UHSM). The partnership had been active for about 7 years at the time and there was good evidence that education was being conducted and was having an impact on the knowledge and skills of the workforce. With the partnership team, we reviewed their assessments of knowledge gain in two courses, maternal and adult acute illness management, which were 25 item multiple choice questions before and after training, based on the knowledge taught in the training and we found that learners were improving in their knowledge from pre to post course (Byrne-Davis et al, 2014; McCarthy et al, 2015). It was not clear, however, what impact the knowledge gain or the gain in skills, which was not robustly assessed, was having in practice. Nor was it clear what the UK workforce were learning. With grants from UHSM and the Global Health Exchange (the international arm of Health Education England: http://www.globalhealthexchange.co.uk), we began to explore ways of understanding the impact of learning on healthcare professional behaviour in Uganda (Byrne-Davis et al, 2016) and, with colleagues at the University of Salford, ways of

measuring the impact of volunteering on the UK workforce.[1] We created a collaboration of experts in behaviour change, Professors Marie Johnston and Chris Armitage and an expert in workforce and health professional education, Professor Ged Byrne. Working together, we found the health partnerships and volunteers to be willing and able collaborators and we learnt a great deal about working across countries and with a large multidisciplinary team.

Thinking about the personal growth this opportunity had afforded us, alongside the benefits to the health partnership and the contribution to the psychological literature, we decided to investigate possibilities to scale up our work. Our key priorities were to increase capacity for global health work for psychologists, make a difference to the health partnership projects and contribute to the science. Byrne-Davis and Hart, with co-applicants Johnston and Armitage, approached an organisation that, with funding from the Department for International Development, offered grants to health partnerships: The Tropical Health and Education Trust (THET: www.thet.org). After we had shared our vision and a proposed project plan, they offered to fund a pilot project for 12 months, beginning in January 2016. Our plan was simple (and complicated!): to recruit volunteers with expertise in behaviour change and to place them in existing health partnerships with a remit to: 1) support the partnership in reaching its aims and 2) conduct small scale action research based on certain basic frameworks, that could be pooled across the projects to ask and potentially answer crucial questions about the science of behaviour change in these applied settings. We had over 40 applicants and placed 11 psychologists in 5 partnerships. We worked on projects including:

1) Emergency obstetric training in Uganda with the UK Royal College of Obstetrics and Gynaecology to investigate practice change following training. We coded the training for behaviour change techniques (BCTs) (Michie et al, 2013), recommended enhancements to the course and trained Ugandan and UK Health professionals in behaviour change.

2) Twinning midwives in Uganda with the UK Royal College of Midwives; We interviewed midwives about barriers and enablers to mentoring and we trained UK and Ugandan colleagues in behaviour and research methods.

3) Medication safety in Beira, Mozambique with Ipswich Hospital, UK. We coded training for BCTs, audited a cardex system and multidisciplinary team working and we trained UK and Beira staff in behavioural theories and approaches.

Challenges and the future

Working as volunteers in projects geographically dispersed across continents is undoubtedly challenging. We found that some of the methods used in health psychology might not be possible to use with healthcare professionals in these countries. For example, there is no tradition of using Likert scales and we have multiple anecdotes that these did not make sense to our healthcare professional colleagues. So far, we have either reverted to qualitative methods to explore psychological determinants of practice or we have reduced the Likert responses to simple agree / disagree / don't know, with the resulting reduction in richness of information. The difficulty in using Likert scales is an issue that we are exploring in an ongoing study in the UK, Rwanda and Malawi. The balance between consultancy and research is a

[1]The MOVE project is a University of Salford and University of Manchester project to explore and assess the personal and professional development benefits of international placements for the UK NHS workforce.

difficult one. We are creating evidence quickly so that it can be used to improve each project and ultimately make crucial changes to help patients and the public. These data are necessarily, therefore, less robust than data collected for research purposes only: there are more compromises and there is less time to pilot and refine questions and methods. We are beginning to have ideas about methods that might be more appropriate and are investigating these. There are always ethical questions about researching and learning in low-resource settings: are we doing more harm than good? Are we prioritising our own development over the development of researchers from those countries? There is a lot of interest now in the mutual benefits of health partnerships (see THET, In Our Mutual Interest: http://www.thet.org/resource-library/in-our-mutual-interest). Volunteers gain personally and professionally from volunteering and it is crucial to set out the mutual benefits and costs in any memorandum of understanding between partners. The use of LMIC settings as a resource for research data is also a concern. We made a commitment to try to create a community of people working in LMIC in health and social care workforce research. We recently applied for funding and held a meeting in Rwanda of around 40 colleagues working in this field from nine countries and are hoping that this will be a start to the sharing of resource and expertise amongst HIC and LMIC researchers for our mutual benefit. We continue to apply our ethical standards, to adhere to principals of sustainable development and to work in partnership, ensuring that the relationship between ourselves and the health partnership is one of mutual benefit and ultimately benefitting our current and future clients, patients and the public.

As for the health partnerships, they were unanimously, enormously enthusiastic about the contribution of the psychologists to their projects. Their feedback (http://www.mcrimpsci.org/case-studies/emergency-obstetric-training-in-uganda/) to us included:

"I think from our perspective it was like a piece of the puzzle that had been missing that we hadn't realised and…I think every project is trying to make changes to behaviour and without understanding what that is and what that looks like then they are not really going to get anywhere so I think it is a really fundamental part to the work that we are trying to do."

"Without you we wouldn't have thought as much about importance of the barriers, behaviours and cultures, and how people behave in their clinical practice. People seemed to get the importance of this when we went on the wards because you communicated this in your presentations and activities. With you we were able to hear about 'the unspoken things' in the partnership, as you are neutral and don't mind asking about difficulties and why things don't happen. With you guys we were able to focus more on the key areas we wanted to change… Really, you guys made us see things that are right in front of us but we didn't see them until you were here."

It is clear from the comments that, as Shelton says in his editorial, that having expertise in behaviour change is a game changer when it comes to addressing issues in global health.

The future is, as always, uncertain. The experiences have given us all a clearer vision about the impact of our research, a greater desire to engage in activities in which we can advise as well as study and access to a global health movement that we did not know existed. In terms of research, there are grants to apply for, studies to conduct, students to supervise and collaborations to be developed across international borders. In terms of advice and consultancy, we remain at the disposal of the global health community and have been developing open access e-learning on behaviour change (see www.mcrimpsci.org), writing open access publications about our work and leaving an

open door for educators and health system managers who wish to discuss the psychological determinants of healthcare professional practice.

Final Reflections

Reflecting on the potential impact of our collaboration, we had the following thoughts. In our work we are trying to help educators to move from knowledge to practice change rather than ourselves change anyone's practice. The way the projects were set up (without us – they were already established when we started working with them) meant that the data on practice change were not being collected before we started work with them, so we can't tell if our working with them did help them achieve increased practice change. What we have given partners is a) the desire to 'think behaviourally' about education and training b) a framework to think about what their interventions are trying to change – C, O, M (Michie et al, 2011)– and a theory-based way of thinking about how change might happen. For some of them, we helped them tweak their education and training (e.g., adding implementation intentions), which previous evidence would suggest would make practice change more likely but we don't have those data – that would require further research.

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Lucie Byrne-Davis
HCPC Registered Health Psychologist and Senior Lecturer in Assessment and Psychometrics in the Division of Medical Education at the University of Manchester, UK
lucie.byrne-davis@manchester.ac.uk

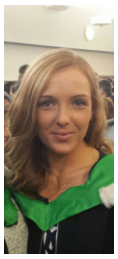
Eleanor Bull
HCPC Registered Health Psychologist and Research Associate at the University of Manchester, UK
eleanor.bull@manchester.ac.uk

Amy Burton
HCPC Registered Health Psychologist and a Senior Lecturer in Health Psychology at Staffordshire University, UK
amy.burton@staffs.ac.uk

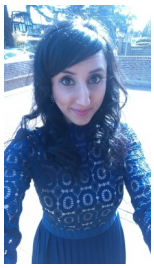
Nimarta Dharni
Chartered Psychologist & Research Fellow at Bradford Institute for Health Research
nimarta.dharni@bthft.nhs.uk

Fiona Gillison
HCPC Registered Health Psychologist and Senior Lecturer in Health and Exercise Psychology in the Department for Health, University of Bath, UK
f.b.gillison@bath.ac.uk

Wendy Maltinsky
HCPC Registered Health Psychologist and Research Fellow, University of Stirling and Psychology Programme Leader University of the Highlands and Islands, Scotland
wendy.maltinsky.ic@uhi.ac.uk



Corina Mason
Health Psychologist in Training at NHS Grampian
corina.mason@nhs.net



Nisha Sharma
Health Psychologist in Training at the University of the West of England and Behaviour Change Practitioner at Solent NHS Trust, UK
nisha.sharma@nhs.net

Jo Hart
HCPC Registered Health Psychologist and Reader in Health Professional Education in the Division of Medical Education at the University of Manchester, UK. Chair Elect of the UK Division of Health Psychology
jo.hart@manchester.ac.uk