

Contents

Forward

Bill Armstrong, CEO, Overseas Service Bureau

Introduction

Peter Hodge

All about volunteering

1. Why volunteer?
Peter Hodge
2. Development issues
Peter Hodge
3. Coping with culture shock
Peter Hodge
4. Papua New Guinea—a woman's perspective
Sue Harris
5. Security issues for volunteers
Peter Hodge
6. Falling in love overseas
Peter Hodge
7. Workplace issues: healthcare work
Sue Martyn
8. Workplace issues: teaching
Peter Hodge

Stories from volunteers

9. Standing out from the crowd
Sue Allan
10. Better than I thought
Louise Fraser
11. New ideas, new beginnings
Pauline Humphris

12. From Somalia with love
Terri Malone
13. Journalism behind the bamboo curtain
Steve Offner
14. Housing and community development go hand-in-hand
Bob Burgess
15. A years honeymoon in Sri Lanka
Mary and Peter Cameron
16. Another day in my life at St. James
Peter Hodge
17. Horses, via Earthwatch
Marguerite Bongiovanni

Organisations

18. Choosing an organisation
Peter Hodge
19. Longer-term placements
Peter Hodge
20. Shorter-term placements
Peter Hodge
21. Overseas Service Bureau
Peter Hodge
22. Volunteer Service Abroad
Peter Hodge

Appendixes

Index

Workplace issues: healthcare work

Sue Martyn

The healthcare system of a developing nation, along with its education system, is one of the most important infrastructures necessary for maintaining and improving the quality of life for that nation's people. The provision of healthcare, either free or at minimal cost to the consumer, goes a long way to ensuring that those who are economically disadvantaged do not necessarily have to suffer in health matters.

Most developing nations are characterised by a significant imbalance in wealth and economic influence among the population, with a minority of people owning or controlling a majority of the country's wealth. Subsistence living, whether as a small farmer growing crops for the family or an unskilled city worker on a minimum wage, provides little or no cushioning against the effects of illness. Government support in terms of pensions and allowances is generally very small.

When money is tight

It is unfortunate that when government funds become tight it is the health budget which is often slashed. Hospitals are told to make cuts and use resources more efficiently, staff are not replaced and morale falls.

Such was the mood during my time in Zimbabwe, and very often the end result was that patient care suffered. While people in high places preserved their 'good life', those in the public hospitals and clinics were less fortunate. Meat was removed from the patients' diet, pharmacies ran out of basic drugs, and supplies of clean linen dwindled. Companies who supplied milk and bread refused to do so

until the government paid their substantial bills. In such situations everyone becomes disgruntled, more obviously the staff than the patients.

What does a foreign healthcare worker, bursting with enthusiasm, do in such a situation? Get used to it, is probably the immediate answer! Things are highly unlikely to improve materially and a lack of resources is more likely the norm rather than the exception. Much can usually be learned from local colleagues in terms of initiative and the recycling and reuse of resources.

Secondly, maintain your own standards of care towards patients, despite time and money constraints, as providing attention is in itself a potent comforter. It is of course frustrating not being able to provide a particular drug to the sick or piece of equipment to the disabled. It was my experience, however, that people respond positively to a simple attitude of care, thus opening the way to a relationship between worker and patient. This relationship can provide rewards on both sides, despite difficulties with resources.

It may seem that this quality of care is in short supply as you observe colleagues in the workplace. It may be constantly frustrating that others do not work as you would wish them to, do not use techniques that you know are more effective, and do not appear to listen to the good advice that you are so keen to dispense. Considering a few points from the local worker's perspective may help this frustration.

Healthcare workers are civil servants in government employ, and generally are not well remunerated. Unemployment rates are often high (50% in Zimbabwe, for example), and once in a secure job workers are unlikely to resign despite deteriorating conditions and inadequate salaries. Fear of unemployment and lack of social welfare support present too great a risk. In addition, workers' unions are not well organised—a far cry from the powerful lobby groups that exist in developed nations. Once locked in to a position, many local healthcare workers spend year after year, decade after decade in the same job with few prospects of change or career advancement to stimulate them. Enthusiasm and initiative in such circumstances understandably dwindle.

Modern versus traditional medicine

As in many developing countries, Zimbabwean culture encompasses both the traditional and the modern. Conventional medicine has its place in the large hospitals and smaller rural clinics, in university degrees and mass immunisation programs, to name a few examples. Among the general and in particular the rural populations, great faith is also placed in the healing powers of traditional practitioners—the nyangas or witchdoctors. It is often to these healers that a person will first be taken for remedies which may include herbal potions, cleansings, flesh cutting and various other rituals, including exorcism.

Patients who later present at a health centre very often deny that they have first sought help from a traditional healer, and are unwilling to give details about the practices or medicines they have already tried. They may now be far more ill than previously. They may accept conventional drugs while in hospital but cease them as soon as they are discharged. Parents may disagree over their child's treatment, resulting in erratic doses being administered once the child returns home. In certain conditions, such as epilepsy, the lack of a positive outcome for the patient can be extremely frustrating and disheartening for the healthcare worker. In other situations, a mother-in-law, whose position within the family is very powerful, may refuse to allow her grandchild to attend a hospital because of mistrust of conventional medicine.

Bewitchings and curses are often blamed for conditions not well explained by doctors, and patients may be withdrawn from hospital by a suspicious family before tests or treatment are completed.

Striking an acceptable balance between conventional and traditional medicine is difficult enough for local colleagues, even with their intrinsic cultural understanding. For the foreign healthcare worker such situations may present additional confusion, conflict and frustration.

Discussing these issues with local colleagues is both fascinating and helpful, and will assist an 'outsider' in gaining valuable insight into the culture and beliefs of the people. At the same time, deferring

to the knowledge and judgment of your colleagues is likely to be the most appropriate way of dealing with any difficulties that arise.

The ‘Doctor is God’ syndrome

Consumer rights and empowerment are firmly established in Western cultures; informed choice, information hotlines and grievance mechanisms are now essential elements of modern service provision. No longer is the doctor considered to be god-like—infallible and unapproachable.

In a developing nation, however, you are likely to encounter a very different approach to the healthcare worker–patient relationship.

As a physiotherapist I often accompanied doctors on their ward rounds and was astounded at the passivity of patients and of mothers sitting at their sick child’s bedside. Few medical or nursing staff spent time explaining a diagnosis or a forthcoming test, let alone such things as possible risk factors, complications or treatment options. The staff commented among themselves while the patient was virtually ignored, and thus remained mostly silent. The patient seemed not to know what the problem was, how their condition was progressing, or what the treatment plan was to be. When questioned, a mother would inevitably tell me that the doctor hadn’t said anything to her.

Had the doctor or healthcare worker really said nothing, or had the mother not understood, or was she waiting for me to tell her something different, possibly better news? These things are very hard to gauge, particularly when language differences and cultural practices are also considered.

Maintaining continuity of treatment can also be difficult, dependent as it may be on such things as patient perceptions, ease and cost of transport to the health facility, and other family obligations. In Zimbabwe, for example, it is the mother’s duty to bring her child for appointments; yet she is also responsible for caring for her other children, for cooking, washing, gathering wood, carting water and cultivating the family fields!

In addition, use of public transport may entail a considerable walk, a long wait, a crowded bus, and possibly bad weather. Very few people enjoy the luxury of their own vehicle or a private phone from which they can easily cancel an appointment. With these things in mind, optimal treatment and treatment continuity can understandably be difficult to achieve. Much satisfaction, however, can be gained from those patients who value the care you provide to the extent that they attend regularly, despite the effort required.

When viewed as insightful and stimulating, such challenges can be full of learning opportunities for the foreign worker, rather than causing negativity and frustration.

The experience of HIV/AIDS

World statistics on the prevalence of human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS) are at their worst in sub-Saharan Africa and still rising in other developing nations around the globe.

Rather than being a disease of the gay community and of intravenous drug users, in Africa HIV overwhelmingly affects the heterosexual population—husbands and wives, newborn infants and teenagers, professionals, subsistence farmers, domestic workers and politicians—without distinction. Despite public education campaigns, the statistics seem ever-worsening. It would be difficult in Zimbabwe to find a single family that has not been affected in some way.

Cultural practices such as polygamy and ‘dry sex’ techniques, promiscuity and a certain kind of fatalism all contribute to difficulties in controlling the spread of the virus. Denial is very common, with the death of a family member often attributed to a ‘long illness’, ‘a short illness’, or to cancer or tuberculosis. Additionally, misinformation is rampant in the popular press. In Africa the stigma of AIDS is very strong despite its prevalence across all sections of society.

Every foreign healthcare worker must be prepared to come literally face-to-face with AIDS-affected patients. The reality of the pain and suffering of patients and their families may be accentuated, surrounded as it is by stigma and hopelessness.

In this situation healthcare workers are placed under much stress, treating AIDS-related illnesses with few resources and in the knowledge that treatment success will be rare. This point was brought home to me while working in the acute-care children's wards. Rotation to these wards was considered by the young resident doctors to be the worst in the hospital, so futile did their work seem to them. About 70 to 80% of the children admitted were HIV positive and would return time and time again as the disease progressed. I remember on one occasion a group of nursing sisters truly celebrating when a young boy fought his way back from a life-threatening renal disorder and was discharged as a lively toddler. It was rare, they said, to really feel able to cure their patients.

Every situation will have its differences of course, but the following are perhaps some ways of dealing with HIV/AIDS in a foreign work environment.

- Prepare and educate yourself.
- Adhere to all the prescribed health precautions in your work practices and, very importantly, in your personal life as well.
- Discuss cultural customs and sensitivities with local colleagues; ask for their advice and opinions.
- Unless very confident in your abilities, refer your patients to local colleagues for support and counselling. Trying to deal with such sensitive issues across both cultural and language barriers is probably unrealistic.
- Maintain an attitude of respect, care and compassion; these may be the only things you really are able to provide.
- Keep in mind that your work colleagues may have personal and family problems involving HIV/AIDS. Be aware, for example, of their possible need for time off work for family reasons.

The balancing act

When contemplating work in the healthcare sector of a developing nation, both positive and not-so-positive experiences are to be expected. There is joy and despair, satisfaction and frustration,

achievements and failures. The following describe some of my own experiences.

- The feeling of honour when a mother asked me to name her newborn baby. I chose ‘courage’, as the baby had struggled through and survived a serious respiratory illness; the mother then translated this into her native language.
- In the baby nursery I more than once flicked scuttling cockroaches out of cribs and picked up used, uncapped syringes from the floor.
- On a cold and windy day, when I thought no-one would turn up, a mother walked 5 km with her child on her back to keep our treatment appointment.
- Having spent weeks preparing for a particular training workshop, only a handful of people arrived out of 30 invitations —what a let down!
- The day finally arrived when I mastered a whole treatment session in the indigenous language, and there were smiles all round from staff and patients.
- So much time, often days, was spent trying to get a phone connection through the switchboard; and weeks and months were spent persuading the bureaucratic machinery into action!
- The joy and satisfaction of knowing that my work had made a difference to individual mothers and children, and receiving a home-crafted basket as a thank-you gift.
- Feeling tense and annoyed as my local colleagues lingered over a long tea break, while the patient queue grew ever-longer.

Much of what I have written in this chapter may seem obvious. Some of it I hope is insightful, despite the huge variety of conditions likely to be encountered in different work places. Enjoyment and success as a foreign healthcare worker in a developing nation is dependent on many factors, not least the personality of the worker. Keeping in mind the following may help to bring satisfaction to your work.

- Keep your humour, be affable and learn the ‘system’. Identify those people who are important to the achievement of your goals and get to know them. A friendly exchange of smiles with the accountant, the stores manager, the drivers and the paymaster can make a world of difference!
- Learn the local language—even your poor attempts will bring smiles, respect and help open doors.
- Follow up everything you initiate vigorously; never assume anyone will fully complete the task they are appointed to do.
- Be modest in your aims and goals—you can always raise them as you achieve success.
- Give yourself and your projects long time frames, as you are probably the only one in a hurry.
- Learn how and when to keep quiet, especially during staff meetings. First establish some credibility as a staff member before spilling out all those good suggestions.
- Respect and value your work colleagues, despite the differences in work ethics and practices you may find.

Finally, no two work places are the same and no two foreign workers alike. Fitting in, being accepted and being liked are all important to the success you will achieve in your new position. Remember that respect for your skills, however highly developed, is never automatic.