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Co-Development and Innovation in Global Health: A Case Study of Educational Change

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Abstract

Aim: Ten years ago, Ghana's mental health services were severely lacking, accelerated through 'brain drain' as trained psychiatrists and mental health nurses left the country to work overseas. A group of UK global health workers was closely involved in a ten-year large-scale innovation aimed at helping to improve mental health services in Ghana at community level. A new generation of mental health workers in Ghana was created adding hundreds of practitioners to the workforce, meaning that thousands of Ghanaians would potentially receive support. The research reported here explored the UK group's involvement to identify significant lessons learnt.
Method: An 'ideological narrative' was obtained through engaging the research participants in insider practitioner research. They were supported in this process by a university-based researcher, who offered an 'outsider' perspective. This novel type of narrative meant participants could not only give account of their own practice and an awareness of their own learning, but also become more aware of the significance of the often unstated, and possibly unconscious, values informing their stories.
Results: The lessons learnt by the UK global health workers from involvement in this innovation are explored within five themes: Curriculum development as an ongoing process; 'we are all learning' and the notion of 'co-development'; timescales and the importance of culture; the interconnected nature of practice; and education as development.
Conclusion: This research is intended to help shape individual and group efforts that are involved in global health projects generally through project participants articulating the significant lessons learnt about educational change and the nature of development associated with such projects as ongoing 'co-development'. It also has the potential to contribute to a wider dialogue with curriculum developers, educators, and others involved in practice innovation, all of which inevitably involve others and are never ended.

Keywords: Mental health; Curriculum development; Global health; Ideological narrative; Insider practitioner research

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1. Introduction

This article offers an 'ideological narrative' constructed by a group of UK global health workers about a ten-year project aimed at helping to improve mental health services in Ghana. This novel type of narrative, which is values-based, was obtained through engaging the research participants in insider practitioner research,[1] which helped them not only give account of their own practice and an awareness of their own learning, but also become more aware of the significance of the often unstated, and possibly unconscious, values informing their stories.

As such, this approach can help shape individual and group efforts that are involved in global health projects generally through project participants articulating the significant lessons learnt about educational change and the nature of development associated with such projects. It also has the potential to contribute to a wider dialogue with curriculum developers, educators, and others involved in practice innovation.

This paper starts with an outline of the 'innovation' – the Kintampo Project – which established educational programmes to prepare two new kinds of mental health workers for clinical practice in Ghana. It describes how and why, project participants, supported by an experienced university researcher, gave their accounts of working on the project. The resulting ideological narrative comprises the following five main themes: educational issues; 'we are all learning'; timescales; the interconnected nature of practice; and education as development. The lessons learnt from involvement in this global health work are then explored within these themes. Finally, the next steps are outlined in terms of imperatives regarding onward empirical research and conceptual development and practice.

1.1. The Kintampo Project – the context of the research

Ten years ago, Ghana's mental health services were severely lacking, and the situation was confounded through 'brain drain' as trained psychiatrists and mental health nurses left the country to work overseas.[2,3] By 2008 Ghana had around 10 psychiatrists for a population of c. 24 million. Most were hospital based at 3 large coastal institutions, with very little service across the country despite its (albeit limited) public transport infrastructure.

The Kintampo Project (as the work was coined, being based in a large town of that name in the middle of Ghana) was a large-scale innovation designed specifically to help develop a new generation of mental health workers in Ghana, unique to the country, who would work mainly in the community. Adding hundreds of mental health workers to the workforce meant that thousands of Ghanaians with mental health disorders and their families would potentially receive support, often for the first time. As the practice of these mental health workers was new, there was no experience of their likely clinical role; nobody had prepared them before for this; and there were no identified educators or supervisors to support them, so at the start of the project there were no initial or in-service opportunities for them as professionals. All of that had to be devised and introduced.

A Ghanaian college that specialised in educational programmes for community-based health workers (based in Kintampo) contacted the UK's Tropical Health Education Trust (THET). A Link (the technical term used by THET for joint projects) was formed with a UK team centred on a mental health NHS Trust in the South of England, with an agreement made to work together to prepare relevant educational programmes.

From the start it was always intended that the project would last 10 years as this was thought to be sufficient time to establish a new and sustainable additional mental health workforce in Ghana, and long enough for the college to have built up its educational capacity and capability for these students. The UK input to the Kintampo Project ended by mutual consent in 2016.

1.2. The UK team

The UK team members who participated in the Kintampo Project comprised a self-selected group of volunteers, led by a British consultant psychiatrist with experience of working clinically, and living as a family, in Ghana. The team included psychiatrists and mental health nurses together with an educationist from a UK university with experience in curriculum development in higher education.

Following closure of the project, five members of the UK team formed a research group to explore further their working practices for the project and, more specifically, the thinking behind them. They were supported in this process by a university-based researcher, who had not been part of the Kintampo Project and could offer an alternative 'outsider' perspective.

2. Methodology

The approach chosen was insider practitioner research,[1,4] where practitioners, alone or with others, carry out a critical enquiry into their own practice.

This form of enquiry has its origins and methodological basis in educational research and teacher development.[5,6] In Tripp's (1993) work in schools, a teacher is seen as a 'practitioner-researcher', who would work in collaboration with an 'outsider researcher', usually with an academic research background. Together, both would have equal control over the research process, often achieving outcomes that were equally valuable professionally.[7]

For the current research the 'outsider researcher' supported the research group by enabling them to construct an 'ideological narrative' of their practice, one that unearths and articulates the philosophical and values-base of their practice whilst engaged in the Kintampo Project. This type of narrative was a characterisation the research group developed to capture the importance of values in framing their account of the Kintampo Project, and became known to the group as 'ideological narrative', because it focused on the beliefs and values underpinning the group's account of their experiences. This is distinct from the way in which learning from other global health partnerships is arrived at and shared.[8,9]

One strength of insider practitioner research is its ability to support the creation of such narratives. Another is that it helps maintain an important characteristic in practitioner research, a critical perspective where practitioners together can 'challenge the taken for granted' in their practice[8] and often otherwise 'hidden'[1] aspects of their practice.

Practitioner research, by its very nature, is a form of case study,[10] which highlights the importance of rich in-depth knowledge of 'a bounded unit'. The case study in this research is one of educational change.

2.1. Data collection

Reports that had been produced following the Kintampo Project UK team's visits to Ghana over the project's ten-year life-span provided extensive data on the kinds of work undertaken, and offered valuable records of the practice situation and a source of knowledge about events and processes.[4]

The 46 reports provided background information for the 'outside researcher'. Via semi structured interviews the researcher held discussions with members of the research group, partly to allow each of them to explore more fully their practice and also for the 'outside researcher' to gain insights into and accounts of their practice.

Data collection continued through group meetings between the research group and the 'outside researcher' between July 2018 and November 2019 to explore further in a shared manner the assumptions, beliefs and values underpinning their practice and experiences. As well as exploring some of the tacit assumptions of the research group members, the interpretations made by the 'outside researcher' (who of course also had 'underpinning values and assumptions') could be checked. It was through this part of the process that the research group members enhanced their collective understanding of the Kintampo Project. A collaborative dialogue about the learning they wanted to share continued with the writing of this article with drafts being reviewed and serving to further explore their practice during the project and the principles, values and assumptions that underpinned the research group's involvement in the Kintampo Project.

2.2. Ethical considerations

In carrying out the research, the British Education Research Association's (BERA) Ethical Guidelines for Educational Research[11] were adhered to. Informed consent was gained from the research group, including the right to withdraw at any stage without explanation and withdraw any data until publication. The interviews were digitally recorded and once transcribed the recordings were deleted. Typically, the data were anonymised and research participants' confidentially guaranteed as far as possible. However, in this project with the participants as the named authors of the paper, this was neither achievable nor appropriate. Ethical approval was granted from the University of Winchester, the 'outside researcher's' employer.

2.3. Data analysis

Taken together, the data comprised transcripts from five research group member interviews (approximately 240 min) and the researcher's notes from four group meetings (approximately 350 min). An analysis was performed using the process of induction to derive codes from the data. The researcher carried out an initial survey of all the data and iteratively developed codes following Wellington's strategy of 'continuous refinement'.[12] The preliminary results of the coding were shared and reviewed at the meetings with the

research group members as they were supported by the researcher in their work researching their own professional practice. They decided whether these codes fitted with their experiences, and there were revisions to some codes to ensure convergence.[13] The main themes developed to represent the data after coding and categorisation (i.e., grouping of codes) emerged from collaboration with the UK researchers and are presented in a 'lessons learnt' section as sub-headings with exploration of each key lesson following on. To reflect that it is the UK research group's narrative, 'we' and 'us' are employed in the discussion.

3. Results

The ideological narrative comprises the following five main themes: educational issues; 'we are all learning'/co-development; timescales: interconnected nature of practice; and education as development. The substantive lessons learnt are now discussed in this integrated findings and discussion section.

3.1. Educational issues: curriculum development as an ongoing process

The Kintampo Project was, for us from the start, educational change work. During the project it became much clearer to us that it was fundamentally 'curriculum development', and that this takes time, perhaps being conceived of as timeless: It's not something you do once, let alone only at the start of an educational project. It was also clear to us that it was not our curriculum to develop: As the UK project team, we held back from our Ghanaian educational colleagues from 'making recommendations'. Our belief was that assisting them to do it themselves with our support would lead to a more sustainable, long term solution. However, the Kintampo College staff had a strong focus on 'producing a syllabus' and on 'content' as well as 'outcome'. Therefore, they had much less focus than we had on 'process' and on the educational underpinnings of the intended programmes, the nature of knowledge and the principles behind teaching and learning. We have experienced this in the UK when working with UK colleagues on similar matters.

We felt there was a need to develop an agreed appreciation of the underlying educational issues, initially amongst some of the UK team too, which required sharing and discussing; not just principles but assumptions, beliefs and values. At times we felt progress was slow, and that we achieved very little convergence. Very significantly, however, only a couple of years after the teaching programmes began, the College held a 'curriculum review', and the outcome was the inclusion at that point of many of the ideas posited but not pursued by the UK team from the start. Curriculum is as much about process as product. We were reminded through this that any curriculum proposal can never be more than a proposition – a hypothesis to be tested in action.[5]

3.2. We are all learning: 'co development'

Working with our Ghanaian colleagues was particularly revealing. We came to appreciate that whilst working particularly in Ghana, the Kintampo Project was 'their show', not ours. Despite an early underlying philosophy that the Kintampo Project should be Ghanaian led, we still had to learn what this meant in reality. We found we had to think very carefully what part we should play, and were playing, in it, and then we had carefully to execute those roles to the best of our ability, whilst at the same time recognising – accepting even – not only that 'we couldn't do it for them' but that we ought not.

We came to understand more clearly that our approach reflected Crisp's definition of the term 'co-development', an approach that recognises we are working together on the same issues and that in order to do so we as colleagues (not as 'the developers' and 'the developed'!) must show mutual respect and understanding.[14]

In our discussions for this research we discussed at length the concept of 'the White Saviour' whereby some people from the West (and in this case more specifically the UK) see themselves as 'saving' Africa, and international development projects serve as a place for 'white heroism', satisfying the needs of participants by thinking that they will make a difference.[15] Working on the Kintampo Project we believe that we minimised this risk through co-development and through being focused on the project despite the temptation to try to do other (what was perceived as) 'good work' along the way. As a research group we recognised the dangers as potentially ever present unless challenged.

Seen in this way, the entire Kintampo Project has, from the start, been 'co-development', between two groups from different countries working together to achieve something important that otherwise might not have happened. Through the process all parties achieved personal learning and development. Perhaps we shouldn't be surprised that practitioners in the caring professions unquestionably engage in co-development. In their everyday clinical work, our mental health

colleagues adopt co-development with their patients, 'working with' people rather than 'trying to change them'. This is also true of our educational colleagues when they see teaching and learning generally – and curriculum development particularly – as a partnership of equals.

Co-development in both the clinical and educational professions is a 'belief system', though perhaps is not always well articulated by practitioners, and often assumed or taken for granted. Nevertheless, it can, as we've shown in this research, be 'put into words' if supported in the process of its articulation.

3.3. Timescales: the importance of 'culture'

Global health projects, particularly when they involve educational innovation and development, require time. From the start we felt that ten years might be needed, for sustainability. We had concerns that similar overseas projects that lasted only a year or two often appeared to achieve little during that time, and any gains might regress rather quickly. Partly, these short-term projects reflect the limited availability of funding, linked to the requirements and expectations of funding bodies for projects to demonstrate significant output and outcomes within a short timescale. Sustainable educational innovation, especially with related changes to clinical practice, takes longer than that. We need to be thinking about curricular timescales in terms of decades and even generations, not years.

Another aspect about time was that our view on this differed from theirs: We'd tried always to be prompt; our western propensity to feel time pressured meant we'd be anxious, concerned and sometimes even irritated if kept waiting! This revealed how crucial it is to understand 'culture'. We had to remind ourselves that our culture was different from that in Ghana. From the outset we worked hard to understand theirs. However, what we came to appreciate gradually but crucially was just how important it was for us to understand our own culture, and more particularly how difficult it is to do that. This came about because we were open to questioning what we thought we knew about and make what was familiar, strange. This reflexivity in the research process brought about disruption in our thinking so that we came to understood things anew.

3.4. Interconnected nature of practice: interdependence

Regarding the development we were engaged in – preparations for novel clinical practice - there was consideration needed in terms of the interconnectedness (even interdependence) of education, workforce, and clinical service. Changing one of these components, such as the introduction of the new workforce that we were engaged in, would inevitably have an impact on other workers, affect clinical practice, and require particular forms of education. All three – education, service and workforce – need to be and were considered at the same time, and in that sense are inseparable. We had taken this principle with us to Ghana at the start of our work there as it had underpinned new recommendations in the UK made by Professor Sir John Tooke regarding developments in medical education.[16] This thinking significantly influenced our early dialogue with the Ghana Health Service and the Ministry of Health as well as in the subsequent discussions at the Kintampo college with educators and clinicians. It was new thinking for them, and remains so elsewhere, not only in low- and middle-income countries. We continue to use it to inform our understanding of and practice in the UK.

3.5. Education as development: development as education

Quite fundamentally, education and development are intrinsically and inextricably linked.[17] We learnt through working on this project and engaging in this research that any education inevitably leads to development, and any development has educational consequences – or at least ought to: we realised this only happens if both the education and the development are underpinned by the same assumptions, principles and values.

For education and development to be linked, engaging in one of these or both require a shared mindset. We went to Ghana believing that education ought only ever be participatory and emancipatory,[18] that teachers and learners are active participants in the construction of knowledge. Indeed, we saw knowledge not as something fixed and external to us (and potentially taught) but something that is in us all, awaiting for us to become aware of and articulated by us (in other words, the role of 'education' was to make that possible).

We felt this way of seeing education was particularly necessary for the Kintampo Project since the proposed new mental health practitioners did not yet exist, so nobody knew at the outset what their practice would entail. It couldn't be taught, only learnt. Our suggestion was for the curriculum planners to allocate 70% of curricular time to practice-based learning, and

only 30% to college-based work. To achieve this, we felt, it was important to promote an understanding of curriculum as 'praxis' (though we didn't use that term) whereby learners and teachers, working together, would be active participants in the construction of the required practice of these new health workers.

As such, it would contrast with the more conventional (and widely held) view of curriculum as a 'product to be delivered', where learners are 'pots to be filled' as passive recipients.[18] Rather, we believed, the knowledge the students would require for their practice, would be situated in that practice, and needed to be 'found' by them there. This had enormous implications both for the educational work conducted at the college as well as during the proposed practice placements, and for the development of educators. This became not just a crucial element of the curriculum discussions but an ongoing feature of the programme, culminating in the eventual graduates from the programme becoming the clinical teachers of the subsequent generations of students, and them devising and running their own 'continuing professional development'. We now see these as perhaps the most encouraging signs indicating potential 'sustainability' as they – the new practitioners – have become independent, 'doing it themselves'.

The links between education and development are clearer through the lens of 'co-development', through the 'co-ness' of education and development – that is, seeing them as needing to be interrelated. Adopting the term co-development, we believe, helps make the point about education and development being interchangeable terms but only by going about both in a particular way. Education can be effective and sustainable, if the teacher and the learner are interchangeable and work together to construct an understanding of what is to be 'known', and development will only be effective through collaboration and compromise.

4. Conclusion

This research is thought to have the potential to help shape individual and group efforts that are involved in global health projects more generally because it encourages in-depth understanding of educational issues, concerns about development and the nature of practice and educational change, and the values and assumptions underpinning those matters. In addition, through reporting this work, there is the potential to engage in a wider dialogue with curriculum developers, educators, and others involved in practice innovation.

In this paper an ideological narrative has been offered by a group of UK global health workers, revealed to them through their involvement in practitioner research. The research group understands theirs is not the only narrative that could be constructed even by the same group, let alone by another group either in the UK or in Ghana. Nor did the UK research group sense they possessed a narrative until they embarked on discussions that formed the basis for this research; indeed they had some concerns that there is a risk their thinking will have elements of the 'white saviour' concept. There is, therefore, an indisputable case for the Ghanaians involved in the project constructing their own narrative. Work is now being planned by the wider group, and the intention is closely to involve the Ghanaian team, perhaps working with them to engage in the same process of practitioner research.

The way in which the UK team was involved and participated in the project adopted what they hoped would be a sustainable approach to improvements in mental health in Ghana through supporting and enabling development by the people there. In the short term, the influence the UK research team's thinking had on the wider project can be seen, at a simplistic level, as the Kintampo Project has led to hundreds of practitioners graduating from the College and entering the country's mental health work force.

Arguably the more important question relates to the Kintampo Project's long-term effects, and on future educational development at the College there. Sustainability is the current concern of much development work but the concept has many interpretations and requires further critical consideration than we can give it here. At another simple level the Kintampo Project's effects are (currently) still happening with capacity continuing to grow – programmes are running, students are studying, graduates are graduating but is this sustainability?

In our title of this paper we called the work reported here a 'case study'. Case studies invariably and inevitably are cases of something, and sometimes of many things.[19] In this research, the 'case study' concerned a piece of educational development. The data collection became a case of 'ideological narration'.

Perhaps our main conclusion is to urge others to view the notion of sustainability through the lens of co-development – the working together of people to achieve something important that might not otherwise have happened. In this light sustainability becomes more of a process than an outcome – a journey not a destination – never achieved but constantly evolving, always 'work in progress'. Then, the more important

question concerns the ideological narrative that underpins it, and it is that which needs to be determined and sustained.

Ethical approval

Ethical approval was granted from the University of Winchester for this research.

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Declaration of competing interest

None.

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References

1. Fish D, Coles C. Professionalism eroded: professionals under siege. In: Fish D, Coles C, eds. *Developing Professional Judgement in Health Care: Learning Through the Critical Appreciation of Practice*. Oxford, UK: Butterworth-Heinemann; 1998:3–14.
2. Crisp N. *Turning the World Upside Down: The Search for Global Health in the 21st Century*. Boca Raton: CRC Press; 2010.
3. Amuakwa-Mensah F, Nelson A. Retention of medical doctors in Ghana through local postgraduate training. *J Educ Pract*. 2014;5(5):120–133.
4. Jarvis P. *The Practitioner-Researcher: Developing Theory from Practice*. San Francisco, CA: Jossey-Bass; 1999.
5. Stenhouse L. *An Introduction to Curriculum Research and Development*. Oxford: UK: Heinemann; 1975.
6. Schön DA. *The Reflective Practitioner: How Professionals Think in Action*. New York, NY: Basic Books, Inc; 1983.
7. Tripp D. *Critical Incidents in Teaching: Developing Professional Judgement*. Abingdon, Oxfordshire: Routledge; 1993.
8. Lasater K, Upvall M, Nielsen A, Prak M, Ptachcinski R. Global partnerships for professional development: a Cambodian exemplar. *J Prof Nurs*. 2012;28(1):62–68.
9. Doherty J, Conco D, Couper I, Fonn S. Experience with clinical associates. *Glob Health Action*. 2013;6:147–156.
10. Pollard cited in Hamilton L, Corbett-Whittier C. *Using Case Study in Education Research*. London: Sage; 2013.
11. British Educational Research Association (BERA). *Ethical Guidelines for Educational Research*; 2018. https://www.bera.ac.uk/publication/ethical-guidelines-for-educational-research-2018. Accessed February 5, 2020.
12. Wellington J. *Educational Research*. London: Bloomsbury Publishing; 2015.
13. Saldana J. *The Coding Manual for Qualitative Researchers*. Sage Publishing; 2016.
14. Crisp N. *One World Health: An Overview of Global Health*. Boca Raton: CRC Press; 2016.
15. Straubhaar R. The stark reality of the 'White Saviour' complex and the need for critical consciousness: a document analysis of the early journals of a Freirean educator. *Compare*. 2015;45(3):381–400.
16. Inquiry MMC. *Aspiring to Excellence: Final Report of the Independent Inquiry into Modernising Medical Careers*. London: Aldridge Press; 2008.
17. Kingsbury D, McKay J, Hunt J, McGillivray M, Clarke M, eds. *International Development: Issues and Challenges*. London: Palgrave; 2016.
18. Freire P. *Pedagogy of the Oppressed*. Harmondsworth: Penguin; 1972.
19. Golby M, Parrot A. *Educational Research and Educational Practice*. Exeter: Fairway Publications; 1999.

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