CHAPTER 5

Conclusions: Towards a Model for Sustainable Professional Volunteering

Abstract Chapter 5 presents a brief summary of key issues. Returning to the conceptualisation of professional volunteers as knowledge intermediaries, it emphasises the critical learning opportunities associated with placements in low-resource settings. It then cautions against equating mobility metrics with notions of excellence per se, arguing that any experience must be judged on its outcomes if we are to preserve principles of equality of opportunity in National Health Service (NHS) careers. It then presents the Sustainable Volunteering Model as the basis for future evidence-based up-scaling that complies with highest ethical principles whilst respecting the duty of care to professional volunteers.

Keywords Sustainability · Ethical deployment · Volunteer placements model

Introduction: Professional Volunteers as Knowledge Brokers

Our previous work has characterised professional volunteers on international placements as 'knowledge brokers' engaged in forms of collaborative knowledge generation and mobilisation (Ackers 2015). Ongoing evaluation substantiated through the MOVE project has underlined the resonance of this conceptualisation. Extracting individuals from this process and attempting to distinguish volunteer learning and the returns to sending organisations such

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as the NHS, whilst necessary, is also highly problematic both from a 'measurement' and an ethical perspective. The introduction to this book made a somewhat arbitrary distinction between explicit clinical skills and tacit knowledge. We identified the growing emphasis attached to tacit knowledge and 'transferable' or soft skills in NHS staff development priorities and, in Chapter 3, evidenced the impact that international placements have on these areas of learning. In reality, hard and fast distinctions between explicit and tacit knowledge break down as tacit knowledge is increasingly associated with all skills implementation. Williams and Baláž contend that these diverse forms of learning operate in combinations to bring about innovative thinking and behaviour change criticising the tendency to view skills in isolation as technical competences or, 'something that can be taught and assessed'. Meusberger (2009) makes a similar point, distinguishing knowledge from 'information'. The work of these authors recognises the importance of more socially situated and socially constructed forms of tacit knowledge to knowledge translation process. When it comes to understanding not simply whether new knowledge or skills are generated but more importantly whether these can be utilised in either the low-resource setting or the NHS on return, the distinction between forms of explicit and tacit knowledge loses significance; they are 'essentially complementary . . . because all forms of codified knowledge require tacit knowledge in order to be useful' (Meusberger 2009: 31).

We have seen how repetition of clinical skills on international placements not only hones skills but also builds the confidence required for skills utilisation. Similarly, whilst triage, audit or management skills can be taught, in theory, it is the experience of actioning these skills in dynamic cultural and political contexts that generates higher-level experiential learning and opportunities for knowledge translation and implementation in future environments. The UKs Medical Research Council highlights the increasing importance of 'complex interventions' to the contemporary NHS (MRC 2008; Richards et al. 2015). The multi-professional experiential learning that takes place on international placements provides opportunities for the kind of systems thinking so important to complex interventions. It enables individuals to step outside of their immediate position and view organisations more holistically from the outside.

Chapter 1 discussed the use of the word 'volunteer' in global health research and policy arguing that although the term captures a factual legal situation (that they are not employees in the host locations), it fails to convey the reality of individual motivations and learning. The

prefix 'professional' was added to emphasise the essentially professional quality of these forms of highly skilled mobility as 'embodied knowledge' (Williams and Baláž 2008). We used the language of lifelong learning to break away from conventional stereotypes tying knowledge transfer processes to career stages; learning and teaching occur simultaneously across all stages of a professional career and life-course. This approach enables us to understand the contribution of even very early career health workers (or students) to low-resource settings and the learning opportunities for even the most senior of cadres. The concept of knowledge brokerage captures these processes perfectly by placing health workers as critical knowledge intermediaries both during their placements and on their return to the NHS. Exposure to new learning combined with existing knowledge creates significant innovation potential. Sadly, host organisations and systems in low resource settings often fail to create environments receptive to this new knowledge. We have discussed these processes and the unintended consequences of professional voluntarism elsewhere (Ackers and Ackers-Johnson 2016). The MOVE project was tasked to capture the volunteer learning associated with international placements and the conditions for its optimisation. As a project, we were not instructed to assess the impact of that knowledge premium or the potential for knowledge translation and behaviour change within the NHS. Our interviews with returned volunteers would suggest that further work needs to be done to ensure that the NHS is more receptive to this knowledge if we are to realise the potential benefits associated with frugal innovation.

The knowledge, networking and mobility capital that professional volunteers gain as a result of their sojourns represents huge potential for the NHS. It also augments individuals' CVs in a way that adds to their 'employability security' (Opengart 2002) insuring them against the risk of dependency on any one employer and opening up opportunities across diverse sectors and countries. The growth of 'portfolio careers' increases opportunities for creativity and agency. The interviews have identified a number of cases where individuals have used their placements to re-imagine their careers and perhaps move out of the NHS into other health systems or other forms of work. Some actively chose professions such as medicine and nursing to pursue careers in global health; others became interested in global health or development work as a direct result of their exposure. The majority renewed their motivation to return to the NHS and use their new skills

and confidence to stimulate innovation. Ultimately it is for the NHS to find ways of harnessing these qualities and energies to enhance the UKs National Health Service.

The remaining section of this chapter addresses some of the more operational aspects that need to be addressed if international placements are to be developed as a wider lifelong learning 'offer' accessible to all NHS employees rather than simply providing enhancements to the CVs of more privileged doctors.

Mobility 'Metrics' and Equality Issues

In Chapter 1 we referred to the notion that professional mobility is a selective process and that mobile professionals are often identified as sitting amongst the 'brightest and the best'. Ferro (2006) suggests that mobility can take on a symbolic quality (or rite of passage) reflecting social norms as much as genuine ability or potential. Mobility, she argues, contributes to a 'self-actualisation process' that could be achieved through other mechanisms including forms of virtual connectedness. This work is of importance to the MOVE objectives (of presenting an evidence-based model for professional voluntarism) for two reasons. First, whilst mobility is clearly one means of achieving accelerated and enhanced learning, it is not the only way and it is critically important that health workers who have experienced international placements are evaluated according to the experiences and learning they have gained and not from the 'fact' of their involvement alone. International placements in low-resource settings are unlikely to generate consistent and comprehensive skills sets as such as every context and deployment is quite distinct. A study of doctoral mobility in the social sciences warned of the consequences of treating mobility as an indicator (or metric) of 'excellence' and concluded that 'mobility is not an outcome in its own right and must not be treated as such (as an implicit indicator of internationalisation). To do so contributes to differential opportunity in scientific labour markets reducing both efficiency and equality. Mobility is one means of achieving international research collaboration and knowledge transfer. It is not an end in itself' (Ackers 2008).[1] We would argue that the same applies to international placements and their role in the development of health professionals. Any automatic association (or presumed correlation) between placement mobility and notions of excellence could generate forms of discrimination privileging those in a position to access opportunities. Secondly, and linked to this, it is of utmost importance that we acknowledge

the fact that health workers are not equally footloose and able to respond to mobility opportunities. Family and caring responsibilities and financial status as well as the attitudes of employers and line managers will have a significant effect on their ability to action any aspirations they have towards mobility (Ackers 2008, 2010; Boyd 1989). These processes are gendered and impact differently across the life course. Lifelong learning and its counterpart, the 'boundaryless career', will shape in important ways individuals' abilities to engage in international placements. Whilst finance alone will rarely be the only factor impeding mobility, the Sustainable Volunteering Project (SVP) certainly found that less well-remunerated cadres of staff such as nurses and midwives were more reliant upon compensatory payments to facilitate their engagement in international placements in comparison to doctors most of whom either have access to immediate resource or the ability to forgo income in the expectation of deferred gratification.

This issue of equality of opportunity will grow in significance if international placements become more of an expectation across all cadres of staff. At the present time it is primarily evident in relation to medical trainees where the expectation of mobility has existed for some time. Widening participation programmes will increase the potential for inequity in medicine as will the introduction of tuition fees for nursing, midwifery and allied health professions.[2] The survey results presented in Chapter 2 suggest that women are less likely to exercise these forms of mobility during the years associated with child bearing and rearing. These will often coincide with periods of accelerated career progression for their male counterparts. Consideration needs to be given to the barriers to engagement in international placements and the implications of these in terms of equality of opportunity. Promoting the view that international placements provide unique and career-enhancing opportunities will necessarily increase the demand for such placements and the kudos attached to this experience. The potential for opportunities to generate inequalities will be linked to, amongst other factors, length of stay and the perceptions of learning outcomes associated with this variable.

Length of Stay on International Placements

The general consensus, at least among theorists of highly skilled migration, would seem to be that the distinction between short- and long-term stays holds little validity and may indeed constrain our understanding of learning (Ackers and Gill 2008; Iredale 2001). When discussing potential

stays with professional volunteers, the issue of length of stay usually forms the basis of the first enquiry; 'How long do I have to stay for?' Length of stay is also identified as a key issue for the host setting where conventional wisdom and the practices of dominant deploying organisations (such as VSO) have favoured extended stays (of over two years).[3] Our own evaluation of the relationship between length of stay and host impact informed by contemporary research on highly skilled mobilities and business travel provides a powerful critique of this perspective arguing that length of stay is only one of a number of key variables impacting knowledge mobilisation processes (Ackers 2015). Length of stay in isolation tells us nothing about learning or impact.

In considering optimal models, we start from the premise that some element of co-presence (physical meeting) is critical to relationship-building and the formation of effective inter-organisational interventions (Williams and Baláž 2008; Meusberger 2009). The Tropical Health and Education Trust (THET) recognise this in their scoping visit funding stream enabling interested parties to meet and develop plans. The formation of strong relationships is critical not only to host impact but also to all forms of bi-lateral learning, including volunteer placements. Stays for the purpose of project initiation and development can be quite short and intense and need to involve those individuals central to programme organisation.[4] The continued development of inter-institutional links can be maintained through regular short stays; indeed, repeated (return) or cyclical stays have a powerful symbolic and practical impact in maintaining relationships and an up-to-date understanding of contextual dynamics. Shrum et al. made a similar point in the context of understanding project failure and corruption in Ghana arguing that strong and effective relationships are 'built through repeated visits over time' (2010: 161). Our paper describes another type of stay focused specifically on knowledge mobilisation objectives at organisational as well as individual level. 'Long-term volunteers' (defined by THET as stays involving a minimum of six months) play a critical 'anchoring' function (Ackers 2015: 140) providing continuity and communication in environments where virtual methods (email etc.) are rarely optimal. These long-term volunteers play a key role in maintaining organisational relationships and communication channels; they also support those volunteers who are unable to stay for longer periods to engage effectively in knowledge mobilisation roles and bi-lateral learning. In the context of established and active health partnerships stimulated and reinvigorated through repeat short stays and underpinned

by long-term anchoring volunteers, short stays focused on targeted interventions can prove to be highly effective. Although our own survey did not identify a high incidence of repeat stays, our experience of working within the frame of the Ugandan Maternal and Newborn Hub provides numerous examples of repeat short stay visits especially amongst more senior clinicians. This is borne out by Smith et al.'s study (2012) which found that 33% of doctors on international placements of less than a month had returned on at least five occasions. Other literature supports the contention that short stays are conducive to volunteer learning (Dean 2013; Dowell et al. 2014; Dowell and Merrylees 2009; Smith 2012).

Long stays in the absence of active health partnerships run the risk of lapsing into service delivery often involving lone working and 'fly-in-fly-out' random short stays deliver little for host settings or volunteers. The exception to this may be emergency relief work, although even in these circumstances this must take place within the frame of credible and effective organisational relationships. Organisations like the 'Mercy Ships'[5], for example, may provide effective opportunities for intense clinical learning on the part of short term and relatively junior health workers.

From the perspective of volunteer learning, length of stay is fundamentally about personal objectives and tailored volunteer deployment. Ackers (2015) argues that there is no ideal length of stay:

> The experience of short-term clinical exchanges in Health Partnerships suggests that where the visits are well organised, prepared for in advance and form an integrated component of a mutually planned and coordinated project, they can play a very important role in promoting knowledge transfer. The existence of clear (negotiated) project objectives (and annual priorities) tightens the focus, promoting continuity of the knowledge transfer activity. (Ackers 2015: 143)

On the basis of our contextualised experience we would disagree with Williams and Baláž's assertion that three-month stays represent a 'minimum for significant and effective learning' (2008: 1927). However, short stays have cost and management implications. A consultant anaesthetist volunteer describes the importance of having effective management systems in place particularly for short-term volunteers:

> They've got to be managed very well. Any placement has got to be managed well but I think it's more important with a short-term placement. You need to make sure that you don't force in someone who's used to having a lot of

> support. Here in the UK we have a very hierarchical structure – even a consultant can always get a second opinion on something. Even if people [criticise] the NHS, you'll never be on your own, even as a consultant. You can always ring up your director and say 'I'm really in [trouble] here, what would you do?' But then you've got to make sure that if you're a relatively junior person and you're going into an environment where you're not supported, then you've got to make sure that it's not going to be catastrophic. I mean, you get disasters [overseas] that you don't see in the UK, so you've got to make sure that there's some kind of network, some kind of infrastructure in place that's able to rescue them, protect them, whatever you want to call it. Which is going to be difficult. It'd be dreadful if a young doctor went out there who was really eager, really keen, and they end up in a situation where they want to go for help, but no help arrives cos there is no help there.

We have presented this quote in some detail as it leads naturally into the final section of the book which sets out the Sustainable Volunteering Model. We present this model here not as an example of 'best practice' but rather as guidance to aid potential policy transfer. Policy transfer is a complex process and it is never possible to pluck one model out of its context and attempt to transpose it into another quite different environment (Park et al. 2014, 2016). To echo the language of learning theories, the translation and operationalisation of this 'model' to another setting requires a further layer of knowledge brokerage by a 'knowledgeable other' (individuals or organisations with deeply contextualised knowledge of the local hosting environment). Strachan et al. make a similar point:

> Placement structures may not transfer appropriately, and there will certainly be new patterns of negotiation, organisation, strategy and management to learn, as well as new relationships to build and new needs to engage with. (2009: 12)

Towards a Model for Sustainable Professional Volunteering

Sustainable and Ethical Deployment

First and foremost, professional volunteering needs to comply with ethical standards; the primary concern here is commitment to reciprocity and mutual benefit. This balance can be illustrated by reference to the original

SVP objectives which themselves echo the objectives of our funding body the Tropical Health and Education Trust and its funding, body, UK Aid:

1. To support evidence-based, holistic and sustainable systems change through improved knowledge transfer, translation and impact.
2. To promote a more effective, *sustainable and mutually beneficial* approach to international professional volunteering (as the key vector of change).

Arguably, we could have added a new dimension to capture more fully the bi-lateral learning processes and expanded the expectation of system change to cover not only the Ugandan health system but also the NHS.[6] However, at this stage our concern with health systems was primarily with the low-resource setting (Objective 1), the reciprocal component emerging only in individual-level analysis (Objective 2). With these thoughts in mind, the SVP intervention and its evaluation was framed 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 (Ugandan 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.

In this framework, volunteer deployment can be justified provided it meets either Scenario 1 or 2. In Scenario 3 volunteer learning as a goal in its own right cannot be justified and it would be unethical to deploy NHS volunteers to low resource settings in that kind of environment.[7]

This generates important challenges for international placements in the NHS and these have cost implications. First and foremost, to even begin to achieve the outcomes above, volunteer deployment must take place in organisational settings grounded in strong and meaningful relationships and a deep understanding of and commitment to local context. This implies some form of intervention focused on the needs of the host setting. It is not ethical or effective to randomly deploy UK health workers to facilities in low-resource settings as has been the case in the past with medical electives and many missionary style outfits. Investment in the host setting need not and arguably should not imply major financial donations; indeed, we have argued in our sister volume that these are in most cases damaging and counter-productive (Ackers et al. 2016). The major contribution the UK is providing is skilled and willing personnel although carefully planned 'in-kind' contributions may optimise volunteer safety, volunteer learning and host benefits.[8] But it does imply investment in a global health infrastructure and intelligence.

A serious consideration for the NHS and deployment agencies are the operational costs associated with effective volunteer management. These will include a lean but efficient organisational set up in the UK working in close relationship with a lean and efficient receiving organisational team in the host location. In addition to building and investing in relationships with key stakeholder communities in both locations, the team will have an active presence and understand the ever-changing dynamics of context. At present organisations such as THET have relied heavily upon a volunteering ethic to support this

infrastructure and many, if not most, health partnerships are managed on a pro bono basis. Unfortunately, this cannot ensure that the most effective and sustained skill base is in place to manage potentially growing volumes of quality-assured international placements.

Volunteer Management[9]

Once this environment and the relationships that connect it are developed to an adequate level, perhaps through short stay exchanges, volunteer selection processes can be developed in compliance with best practice in UK employment policy. 'Volunteers' by definition are not employees but this should not be seen as a rationale for avoiding or evading sound employment principles. The SVP Model invested considerable effort in advertising/dissemination to raise awareness of opportunities throughout the target community paying particular attention to non-medical cadres who are often neglected in these processes. We then generated a comprehensive recruitment system.

Transparent and Equitable Recruitment Process

At present, the supply of placements is managed by a disparate range of largely unregulated providers motivated by quite diverse goals. Some of the larger organisations, such as VSO, may be committed to providing equality of opportunity to prospective volunteers. Others may have no interest or experience in this aspect of their work or may utilise quite discriminatory selection criteria. At present, providers operate their own selection systems. A number of SVP volunteers spoke of being rejected by VSO, for example, on the grounds that they were not legally married or, in one case, was a single parent. In another situation, a hosting organisation explicitly discriminated against any volunteers who were not practicing Christians (and requested the insertion of a question in the SVP application form asking for details of the church they currently worshipped at). They also refused to accept volunteers who were not legally married in a heterosexual relationship and made it clear that volunteers were required to attend chapel daily during their placement. These organisations filtering applicants with overt religious 'rules' that fail to comply with UK equality law and policy should not be allowed to provide placements that are affiliated to UK public or charitable organisations.

Age and Seniority

Another area of potential tension between the needs of individual volunteers, employing organisations such as the NHS and deploying/hosting organisations concerns age and seniority. Whilst the latter may explicitly prefer more senior or experienced individuals (as noted above) or more mature people perhaps around retirement age who can stay much longer and have fewer pressing family or financial commitments, there is relatively little 'knowledge premium' for the NHS to be made from sending very senior (and expensive) staff towards the end of their career. Interviews with the Army Reservists who play an important, if specific, role in volunteer deployment indicated a strong preference for mid-career individuals who are already highly skilled in their chosen field; primarily clinicians in the 40–45 age group. The interviews suggest that this strategy may prove quite fruitful in identifying and investing in future leaders.

Overall our research would suggest that international exposure at early career level has the sharpest impact on learning; also that early career exposures tend to stimulate ongoing engagement in global health. From an equality perspective sending organisations should see this in the round, balancing the net gains from facilitating early career mobility with the motivational and project-related benefits of mid- and later career engagement. Experienced volunteers with extensive clinical and life experience, particularly if they have worked in low-resource settings offer considerable stability and resilience to composite international teams.

Volunteer 'Matching'

Once a candidate satisfies the deployment criteria, a 'volunteer matching process' ensues in full consultation and with deference to the Health Partnerships engaged on the ground. Unlike organisations such as VSO, the SVP does not advertise detailed positions/roles. Once potential volunteers come forward, it seeks to identify where and how they could contribute to project objectives (including their own learning objectives). Whilst the placement of professional volunteers cannot be supply lead (and focused solely on the needs of prospective volunteers), neither should it be solely demand lead. The articulation of demands from low-resource settings typically places an emphasis on long stays of the most highly qualified staff often with the intention of substituting for local staff. Our research would suggest that this is rarely the most effective form of

deployment in capacity-building projects such as the SVP,[10] in terms of the needs of either their volunteers or their employers (the NHS); it does not deliver optimal benefit to the low-resource setting and can be positively detrimental. This is a negotiation process that demands a high level of contextual knowledge of volunteer supply, intervention dynamics and resilient trust relationships. Strachan points to the critical role of relationship building and trust to effective volunteer deployment (2009: 3).

Having identified a potential 'match' the SVP then provides details of the volunteer to the hosting organisation/s. In the SVP case, these organisations are individual health partnerships linking hospitals/universities in the UK with hospitals/universities in Uganda. Wherever possible we link only with public health facilities and strongly advocate that approach in order to support system strengthening rather than the development of parallel systems. One of the unique qualities of the SVP was its basis in a consortium of Health Partnerships known as the Ugandan Maternal and Newborn Hub (the HUB). The HUB was a response to the perceived need for very grounded cooperation and mutual support within the Ugandan HP community; working together in this way enabled us to develop an efficient secretariat that assumed many of the core roles of volunteer management in a democratic environment and wherever possible and appropriate respecting the subsidiarity principle (that individual HPs were primarily responsible for managing their own interventions on the ground).[11] Having this infrastructure and bi-annual volunteer workshops aimed at building relationships and supporting team working gave us the opportunity to support short and longer stay volunteer mobility within Uganda (volunteers could be based across two sites, for example, or teams could get together at certain times for multi-professional interventions).

In theory, other organisations could become involved in this process without undermining the emphasis on deeply contextualised relationships. Health partnerships could act as effective intermediaries linked to commissioning organisations, for example, which is in effect how THET have managed their 'long-term volunteering programme.'[12] Strachan et al. point to the fact that most placements are organised in response to a demand from a deploying or host organisation and most 'sending' organisations do not run placements themselves but use intermediaries for this process (2009: 6/9). However, the more intermediaries become involved the more complex the relationships will be and the greater the potential for poor-quality communication.

The next stage in the SVP process is to set out an initial volunteer role description which then forms the basis of a signed volunteer agreement. The volunteer role description involves direct negotiation between the SVP management team, HP leads and the volunteer in question and seeks to balance the needs of the intervention/s they were contributing to; their own defined learning/career/personal needs, the overall objectives of the SVP and any concerns about risk. The volunteer agreement is in all cases an iterative document[13], and we explain to volunteers that this will go through a process of constant evolution in response to the changing environment and project objectives as well as their own learning and ambitions. In addition to regular email and face-to-face and telephone communication, a monthly reporting mechanism is used to assess progress and identify any concerns/opportunities.

Supervision, Risk and the Co-Presence Principle

The principle of 'co-presence' lies at the heart of the SVP volunteer agreement setting out the expectation that every professional volunteer will be working alongside a Ugandan counterpart.[14] As noted in Chapter 4, co-presence is the single most important principle underpinning a risk mitigated and ethical placement. Mechanisms must be in place to enforce and monitor adherence to co-presence and respond accordingly to breaches of this principle. Individual volunteers and host locations are required to sign up to this commitment. In practice, the long history of breach of conditionality principles in Aid (Moyo 2009) has encouraged a tendency to ignore such principles without reprisal. As such, co-presence takes a long time to embed within a programme and every new volunteer will be faced with the expectation that they will go on rotas and engage directly in service delivery. As noted above many professional volunteers, especially doctors, will be tempted to ignore the commitment to co-presence, especially if they interpret this as a challenge to their primary commitment to individual patient care (for a discussion see Ackers et al. 2016). This underlines the need to impress on every volunteer that they are one member of a complex intervention and must comply with project objectives and principles; managing volunteers in this way demands an investment in infrastructure both in the UK and on the ground. Volunteer induction is a critical component of the 'volunteer journey'.

Building Relationships with Professional Volunteers: Induction through to Debriefing

Much of the international placement literature argues that adequate support before, during and after international placements optimises learning and impact. Certainly volunteer induction is critical to effective deployment (Gedde et al. 2011). Induction is commonly associated with a physical 'induction pack'. In the SVP we assessed existing products and on the basis of our risk assessment developed a 'pack' tailored to the local context. In practice this is a living document continually adapted over time as new challenges or opportunities/resources emerge. Some discussion has taken place over the relative merits of formal induction meetings either in the UK or in the host setting. However, the original plan of holding group meetings either in-country or in the UK has been amended to provide more individual-based approaches largely not only because volunteers are coming and going at all times of year (and not in blocks as originally anticipated) but also because many were unable to commit to week long programmes prior to departure. In practice, the SVP has combined interviews and face-to-face meetings with measures to connect new volunteers to the wider volunteer and project community.

As important as preparation, the literature on placement learning not only emphasises the importance of reflection both in terms of translating and applying knowledge but also mitigating trauma or culture shock on return (Briscoe 2013; Clampin 2008). According to Kolb (1983), reflection is a key component of experiential learning and much of this reflection continues to happen post return (Murdoch-Eaton 2014). Protagonists of 'transformational learning theory' emphasise the longitudinal quality of volunteer learning as individuals consolidate their new knowledge into existing schemas (Fee and Gray 2013). In the SVP model, we have tended not to view this as before-and-after events but rather as a continuous relationship-building process linking volunteers not only into project management teams but also and perhaps most importantly with previous, existing and future volunteers to build volunteer communities. From a volunteer deployment perspective, our strong preference now is to locate volunteers in clusters encouraging cross-professional and inter-generational mentoring and support. We have found that both optimise impacts in host settings and opportunities for volunteer learning, creating active co-supervision and co-learning contexts. Importantly this is also a cornerstone of risk mitigation.

These processes are labour intensive and rest on the quality of personal relationships and active knowledge of project interventions on the ground. Whilst larger organisations may have the volume of volunteers to support and require intense pre-placement induction and de-briefing, we would argue that it is detailed knowledge of activity on the ground that is most important in supporting volunteer deployment.

Responsibility for volunteer induction in the SVP context was shared throughout the management team with HP leads contributing to the induction pack and playing a critical role in in-country volunteer induction. Wherever possible new volunteers accompany or join one of the HP leads. We also encourage volunteers to 'overlap' so that they can support each other and encourage continuity in project interventions (whilst being cautious about labour substitution[15]).

Risk Mitigation and Administrative Issues

Once a volunteer placement has been planned and the volunteer agreement set out our in-country support manager sets processes in motion to ensure that every volunteer has the necessary clinical registration and visa/work permits. We have referred (above) to the importance of conditionality and reciprocity. In practice, receiving countries are accustomed to behave as the passive 'recipients' of Aid with little interest in or attention to the risks involved. The Ugandan Maternal and New-born HUB with the assistance of the UK-Uganda Health Workforce Alliance[16] has established a smoother system so that volunteers now obtain their clinical registration prior to arrival and work permits within the first three months of their stay (when entry visas expire). Following ongoing lobbying by the SVP we have managed to secure work permits at no cost; we are currently pushing to reduce the costs associated with clinical registration.

The SVP purchased a bespoke health insurance plan suitable for volunteers engaged in hands-on clinical work; most existing off the peg insurance policies are not suitable for professional volunteers. As managers we felt it was important to have all the volunteers covered by one policy so that all volunteers are aware of procedures and emergency contact details (included in the induction pack). This process is relatively expensive.

Despite considerable effort and lobbying over the last five years, it has become even more difficult to provide professional indemnity insurance cover for professional volunteers. For the first three years of the SVP, doctors could receive cover from the Medical Protection Society (MPS)

or the Medical Defence Union (MDU). Since then, both organisations have tightened up and are giving it only on a case-by-case basis. In the case of the MDU they require details that adequate supervision is in place. The Royal College of Nursing (RCN) covers all its members including students and this extends to midwives registered with the RCN. However, the Royal College of Midwives refuses to extend professional indemnity cover to any of its members leaving a significant loophole in cover. More detail on risk management including protocols on HIV prophylaxis and Ebola are contained in the SVP Volunteer induction pack on the Knowledge for Change Charity website (www.knowledgeforchange.org.uk/).

Notes

1. This has been explicitly recognised in the MOVE project through the assessment of the potential for a psychometric tool to assess the learning outcomes deriving from international placements.
2. From 2017/18, new students on nursing, midwifery and allied health professional pre-registration courses (which lead on to qualification with one of the health professional regulators) in England will take out maintenance and tuition loans like other students rather than getting an NHS grant (Council of Deans of Health 2016)
3. VSO are currently reviewing this policy and encouraging shorter stays.
4. Valuable learning also takes place at this level and many of the actors will be senior UK clinicians (and evaluators) but the primary objective of these visits will be to enable the learning of others.
5. www.mercyships.org.uk/
6. We paid some lip service to the NHS as a system in the scenarios but this was not a focus of our intervention at that point in time. Our current work involving undergraduates is more explicitly holistic.
7. We assume that similar assumptions will be made by NHS facilities hosting undergraduate students.
8. A simple example here would be the work SVP volunteers undertook in a multidisciplinary team to effect the opening of a large facility which then became a valuable placement site (Ackers 2014).
9. Strachan (2009) and Comhlamh (2016) provide excellent guidelines on ethical volunteering.
10. We would expect this to be different in emergency relief organisations.
11. An area of considerable tension concerned delegation of principles of equality and fair deployment which were challenged repeatedly by the UK lead of a mission hospital.
12. http://www.thet.org/our-work/what-we-do

13. Strachan et al. emphasise the importance of volunteer 'flexibility' ad a willingness to respond to changing demands and circumstances (2009: 10).
14. This is discussed in Chapter 4 and in footnote 6.
15. In some cases we deliberately planned gaps in volunteer deployment to assess where interventions had led to behaviour change on the ground and reduce the risks associated with dependency. Continuity of project does not necessarily imply continuous presence in a particular health facility.
16. The 'Alliance' was established in 2013 By Lord Crisps following a high-level meeting with the Ugandan Ministry of health. In practice its activity has been quite minimal until it was recently received support from THET and the Global Health Exchange (GHE): http://www.globalhealthexchange.co.uk/projects/uukha/