Appendix 1

Data Collection and Methods

This was a qualitative, interview-based study which broadly utilised the principles of grounded theory (Glaser and Strauss 1967). Therefore, rather than basing out explorations on a firm hypothesis, we attempted to develop a plausible representation of the worldview in which our participants were embedded and engaged in a research strategy which incorporated the ongoing analysis, comparison and theorising. The purpose of utilising semi-structured interviews was to achieve an understanding of varying conceptualisations of professional volunteering, the different meanings it had for people and its place in their lives and career planning. We also wanted to explore more mundane issues such as how professional placements worked for people on a practical level; how and why they undertook them; what people thought they got out of them; and how these experiences impacted their work and career once they returned to the NHS.

Interviews

Our primary corpus of in-depth semi-structured interviews comprised a wide range of returned volunteers and other stakeholders ($n = 51$). These data were collected during 2014 and 2015 and included a representative sample of NHS employees which was designed to broadly reflect the current spread of staff across all grades.[1] The sample comprised 11 qualified or trainee doctors 16 nurses and midwives; 6 clinical support staff; 10

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managerial and administrative staff; and 8 'others', which included ambulance and maintenance staff, cleaners and caterers etc. Of the entire sample, 8 respondents (15%) had not been on a placement or had no overseas experience. We initially recruited participants via our existing NHS contacts based at the University of Salford, and the University of Manchester Medical School. A significant proportion of volunteer or ex-volunteer respondents were contacted via established links with organisations that provided overseas placements.

We were fortunate in that half of the research team had extensive experience working in the field of overseas development and professional placement provision, and the other half in NHS training evaluation and healthcare research. This gave us a broad base of primary contacts connected and whom we were able to access. We placed only broad restrictions on which individuals we approached, and recruitment of participants was routinely snowballed from an initial contact with a key player, for example, a returned professional volunteer or a charity administrator volunteer. This person provided an all-important level of legitimisation to other potential interviewees. Connections and subsequent interview opportunities tended to develop organically from here. This approach was informed by an understanding of professional volunteering charities and how they are embedded in a web of other groups and networks that intersect with the NHS. Interview recruitment was continued until saturation was achieved. That is, until the process was adding nothing new to our understanding of a given theme.

We used qualitative and semi-structured interviews, and these were always conducted informally. This enabled us to adapt to the variety of positions and perspectives that were in evidence. Our interview schedules (i.e. the questions we asked and the themes we chose to explore) were continually reviewed and revised as necessary on the basis of emerging evidence, and we individually tailored the interviews of each interviewee. We explicitly pursued negative cases as a means of enhancing the validity of our propositions as they developed. In the context of this study, this particularly meant talking to staff and stakeholders who were not actively engaged in professional volunteering, as well as those who were, to those who had experienced barriers to involvement and so forth. There were, however, a number of thematic elements which were addressed in every case. These were as follows: (1) their basic demographic information; (2) their relationship to, or role within the NHS (doctor, nurse, placement provider etc.); (3) their experiences of being on a professional placement

abroad; (4) the way these experiences had affected or changed them; (5) the processes they had gone through to get a placement; (6) barriers or enabling influences they had encountered and barriers they could see being an issue for other people; (7) finally – particularly in the case of returned volunteers who were back in their NHS roles – we wanted to explore the impact of their experience on their everyday work, and on their relationships with the colleagues and patients, now that they were back in the UK.

These themes formed the basis for the majority of interviews, although again the specifics of individual cases and their particular relation to a given group often meant that the interview format we actually used differed quite widely between participants. Interviews were audio-recorded where possible and transcribed verbatim. Analysis of transcription data was conducted alongside ongoing analysis of data from our other main sources.

Documentary Analysis

During the course of the MOVE project, we collected a very wide range of documents and other media. This material helped us contextualise the findings that we generated from our other sources, but also often provided useful tangential trigger points for our analysis. We looked at publicity material and formal documentation from a range of relevant organisation; official and unofficial policy documentation; information and marketing material from placement providers; internal auditing and evaluation material (SVP project); NHS and DOH statistical data; personal diaries and blogs written by participants; and photo, video and audio material. Our selection of material was informed both by our initial research questions and by themes that were emerging during the course of the study. The importance of documents and media varied. However, we were deliberately eclectic in our definition of what we considered to be relevant, and as a result, only a proportion of the large corpus we amassed were actually incorporated into our analysis.

Ethnographic and Observational Work

Ethnography was not initially intended to be one of our primary methods. However, in the course of the study, the research team, many of whom had other roles organising volunteer work (see Ackers and Johnson 2016) had the opportunity to undertake several field trips to sub-Saharan Africa.

There, they were able to conduct participant and non-participant observation with long-term professional volunteers in the field. We were also able to undertake background ethnographic observation while accompanying groups of student doctors and nurses on shorter-term elective placement trips to Uganda and Central Southern India during 2015–2016. Subsequently, this observational material made a very useful addition to our primary corpus and our appreciation of the context in which professional volunteers – in a developing country at least – are required to work.

The actual observational work carried out was therefore quite varied and opportunistic. It ranged from spending time with professional volunteers in the field, primarily doctors, anaesthetists, nurses and midwives, but also biomedical engineers and administrators. We were able to observe them as they worked and saw how the environments they engaged with influenced what they did. We were also able to obtain data from 'around' these environments to enable everyday detail of the setting to emerge. These included 'satellite' encounters, such as those which might occur between UK volunteers and local staff or between local staff and patients when UK staff were not present. Observations like this helped clarify and flesh out some of the more subtle cultural interrelations that were reported and allowed us to compare the reported perspectives of volunteers (as relayed in interviews etc.), with direct observations of ongoing behavioural dynamics.

Data from the Sustainable Volunteering Project (SVP)

We were fortunate to have full access to a large corpus of the interview and ethnographic data collected as part of the *Sustainable Volunteering Project*. This was a separate action-based researchstudy that pre-dated MOVE, and which provided us with some significant data – particularly relating to narrative accounts and interviews with current and returning (NHS) professional volunteers engaged in work in sub-Saharan Africa. A full outline of the *Sustainable Volunteering Project* (SVP) is given in Appendix 2, but broadly, the data we were able to access were originally collected as part of an extensive internal evaluation programme which was carried out for the duration of the project. These data included the following:

1. Pre-, mid-, and post-placement interviews with long-term volunteers
2. Monthly reports (containing qualitative and quantitative data)

3. Interviews with the Ugandan Health Facility management and staff
4. Interviews with UMNH partnership coordinators
5. Interviews with mentors
6. Recorded workshops and focus groups
7. Site visits and observations made by the LMP evaluation team

We were also able to gain access to a large collection of email correspondence between volunteers in the field and SVP staff. This corpus is particularly interesting, as it is composed mainly of material relating to long-term volunteers. Most of the SVP volunteers, for example, were in a country for at least three months, and personnel frequently stay for over a year. This length of stay is relatively uncommon for NHS-based professional volunteers taking time out for work-related or ongoing training placements (the average stay being around a month), but could be argued to be most impactful – in the context of both the volunteers themselves and the country they are working in. In the context of this book, we are not specifically concerned with arguments over the benefits or otherwise that professional volunteering has on local populations, but with these types of extended stay, a whole raft of subtle, in-depth, contextual knowledge becomes available to an in-country person who would not necessarily be apparent to those engaged for shorter periods.

Ethical Approval

Ethical approval for the MOVE study was obtained from the University of Manchester Research Ethics Committee and the University of Salford Research Ethics Committee in 2014. As an independent evaluation-based enterprise, the SVP project was not subject to formal academic or NHS ethical approval. Permission to use these data on a case-by-case basis was obtained from the Tropical Health Education Trust (which funded the SVP) and the appropriate project steering groups.

Note

1. In recruiting to the study, we aimed to broadly match the proportions of respondents from each staff cadre with current actual staffing levels within the NHS.

Appendix 2

The Sustainable Volunteering Project

Background and Objectives

The Sustainable Volunteering Project (SVP) is managed by the Liverpool-Mulago Partnership (LMP) and was initially funded by the UK Department for International Development via the Tropical Health Education Trust's Health Partnership Scheme. Financial support has also been received from the Royal College of Obstetricians and Gynaecologists (RCOG) and the Association of Anaesthetists of Great Britain and Ireland (AAGBI). The THET-funded project began in April 2012 and ran for a three-year period, ending March 2015. The SVP continues and is now funded in association with our partner charity Knowledge for Change (www.knowlege4change.org.uk/)

The LMP had been placing professional volunteers in Kampala for over four years before applying for funding for the SVP. The SVP, however, marked a substantial increase in the scale and scope of this activity, widening the LMP's focus outside of Kampala to support other Health Partnerships involved within the Ugandan Maternal & Newborn Hub (UMNH) and also broadening the cadres of Health Professionals supported to include not only obstetricians but also paediatricians, anaesthetists, midwives, nurses and biomedical engineers.

UMNH is a consortium of UK-Uganda Health Partnerships established by the LMP in 2011 and encompassing the LMP, the Basingstoke-Hoima Partnership for Health, the Gulu-Manchester Health Partnership, the PONT-Mbale Partnership, the Bristol-Mbarara

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Link, the Kisiizi-Chester Partnership, the Kisiizi-Reading Partnership and a partnership between Salford University, Mountains of the Moon University and the Kabarole Health District.

The professional volunteers complete placements of varying lengths (between 6 and 24 months) and engage in a variety of initiatives, training programmes and on-the-job mentoring schemes which aim to increase capacity and improve the skills of the health workers, both in Uganda and in the UK. The SVP's focus is on capacity building, and systems change and its objectives are twofold:

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)

The SVP does not have a focus on service delivery or workforce substitution as this activity is not judged to be sustainable.

Volunteer Management and Support

All SVP volunteers are recruited, selected and managed by the LMP (and more recently also K4C). The main organisations targeted during the initial LTV recruitment were the Royal Colleges of Obstetrics and Gynaecology, Anaesthetists, Nursing and Midwives. The Royal Colleges either circulated an advertisement by email or posted it on their websites. The advertisements were also circulated by UMNH members to their local deaneries and hospitals. This initial advertisement process was successful in raising sufficient interest from prospective LTVs, the key to the success being the LMP's ability to utilise the existing links and networks established over previous years. As the project matured, an increasing number of LTVs were recruited through word-of-mouth advertisement by previous SVP LTV's and during project dissemination events, national and international conferences and workshops. Examples of such events include the British Maternal and Foetal Medicine Society's 'Annual Conference' (2013), the AAGBI's 'World Anaesthesia Society Conference' (2013), the Global Women's Research Society Conference (2012) and the Development Studies Association's 'Annual Conference' (2013).

Selection

Following an initial expression of interest, two processes are run simultaneously before a candidate can be recruited to the SVP. The first process involves prospective LTVs completing an application form and attending an interview (usually face-to-face) in order to ascertain, for example, whether a candidate would be suitable, when and why they wish to undertake a placement, what support they might require, what they hope to achieve and what skills they possess which would be of benefit to the health system in Uganda. Two references are required to objectively verify a candidate's suitability and identify any additional support they may require.

The second process involves circulating the candidates' details to UMNH partnerships to assess which of them would be interested in hosting the candidate should they be recruited to the SVP. This process was designed to align the supply of LTVs with demand on the ground in Uganda and the ability of the local UMNH partnerships to host them. An LTV is only recruited if both of the selection processes yielded positive results.

Placement Logistics

The subsequent stage following an LTV's recruitment is their pre-placement induction. Each LTV is provided with a comprehensive induction pack containing useful information on UMNH placement locations, what to expect in Uganda, placement logistics and travel, insurance and emergency contact details, health and safety and advice on pensions and other personal finances. LTVs receive a 'volunteer agreement' to sign and return to LMP management which outlines the LMP's organisational expectations, a code of conduct, a statement on co-presence, potential disciplinary procedures and a personalised role description. Volunteer agreements are drawn up in conjunction with the LTV, the relevant UMNH partner organisation and the in-country counterparts to maximise stakeholder involvement and ensure all parties remain informed and satisfied.

Each placement location/facility and all LTV accommodation were professionally risk assessed at the beginning of the SVP. This risk assessment is shared with LTVs in advance of their placement, advising them of the potential risks of placements in Uganda, how the risks can be mitigated and what to do in the case that the risk materialises. The LMP also purchased a bespoke and comprehensive travel and medical insurance policy at the beginning of the SVP to cover all LTVs, ensuring each of

them had adequate and sufficient cover throughout their placements. Having one familiar and reliable insurance policy and emergency contact number for all LTVs is beneficial in terms of project management and reduces individual LTVs and organisational risk.

In addition to insurance, the LMP also arranges LTV flights, clinical registration, visa/work permit, accommodation, airport transfers and the majority of placement related travel in line with the recommendations of the risk assessment. The risk and logistical burden put on LTVs is reduced by, for example, using safe and reliable drivers for travel, only selecting flights that arrive at suitable times and only using safe and risk assessed accommodation. Controlling these processes centrally allows for better coordination and achieves some economies of scale in terms of the procurement.

Placement Support

LTVs have access to a wide range of support during their placements. In terms of financial support, LTVs receive a monthly stipend to assist them in covering their costs at home and in Uganda. The stipend is paid directly into their bank account, with the initial payment being made on the date of their outbound flight and consecutive recurrent payments made at monthly intervals. The Tropical Health Education Trust's Health Partnership Scheme is able to fund the employer and employee pension contributions of those LTVs previously employed by the UK NHS for the duration of their placements, marking a less direct yet potentially hugely beneficial provision of financial support for LTVs.

Each LTV is assigned a UK and a Ugandan mentor to provide clinical, mental and pastoral support and advice during their placement. Suitable mentors are selected by the LMP in collaboration with UMNH partners and in-country stakeholders, and usually come from the same disciplinary background as the LTV, as well as having previous experience of working/volunteering in Uganda. Many of the UK mentors selected are themselves former SVP LTVs that have returned to the UK but are keen to retain links with the project. The mentors serve as the first point of contact for LTVs; however, frequent communication with LMP management is also encouraged in case any problems arise that the mentors cannot deal with. LTVs provide written reports to LMP management on a monthly basis so their health and well-being can be monitored.

SVP workshops are held every six months. All SVP LTVs and stakeholders are invited to attend along with other LTVs working on similar projects, for example, the 'Global Links' project run by the Royal College

of Paediatrics and Children's Health. Each LTV conducts a short presentation detailing their placement activity, successes and any challenges faced. The events stimulate useful discussion and learning and enable the LTVs to build networks which provide platforms for effective peer-to-peer support, partnership and co-working.

Project Evaluation

An extensive and comprehensive evaluation programme has been carried out for the duration of the SVP. Data is collected by LMP management and evaluation teams, PhD students and the LTVs themselves for evaluation purposes and includes the following:

1. Pre-, mid- and post-placement interviews with LTVs
2. LTV written monthly reports (containing qualitative and quantitative data)
3. Interviews with Ugandan Health Facility management and staff
4. Interviews with UMNH partnership coordinators
5. Interviews with LTV mentors
6. Recorded workshops and focus groups
7. Site visits and observations made by the LMP evaluation team
8. Logging of stakeholder email communication
9. Reviews of new and existing literature relating to professional volunteering
10. Publications and presentations conducted by the LTVs at conferences and other dissemination events

All data is collected, anonymised, coded and analysed using Nvivo software. The SVP has evolved and strengthened on an iterative basis since its beginning in April 2012, based on the outcomes of the project evaluation and the growing experience of the project managers.

Volunteer Deployment in the SVP

The SVP placed 44 professional volunteers across the UMNH partnership locations over the course of the initial three-year period between April 2012 and March 2015, achieving a combined total of 358 'volunteer months'. The total number of volunteer months spent at each UMNH location is illustrated below in Fig. A.1. The average (mean) placement

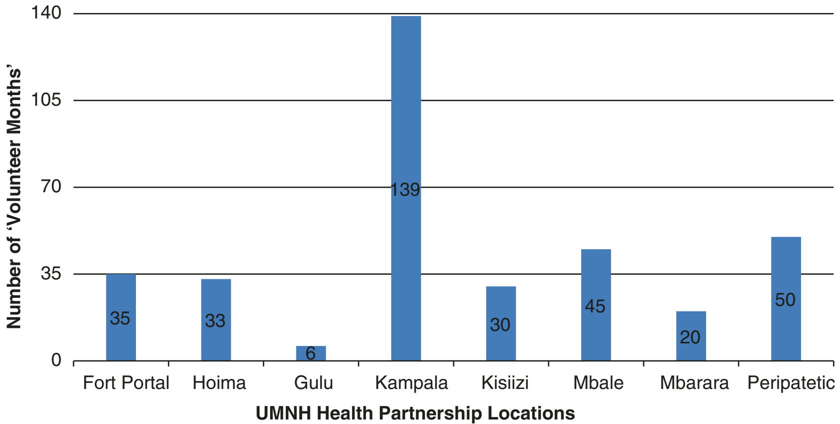

Fig. A.1 Number of 'volunteer months' spent at each UMNH health partnership location

duration across all disciplines was 8.1 months; however, the most common placement duration (modal average) was six months. The shortest placement duration was one month (the volunteer ended their six months placement early) and the longest placement was 26 months.

The professional volunteers came from nine broad professional backgrounds; the highest number coming from Anaesthesiology (10) and

Table A.1 SVP volunteers by professional background

Health professional disciplinary background	*Number deployed during the SVP*	*Total combined number of volunteer months*
Anaesthetists	10	71
Obstetricians	9	60
Midwives	8	60
Nurses	6	48
Foundation year 2 doctors	4	30
Paediatricians	3	33
Social scientists	2	24
Biomedical engineers	1	26
General practitioners	1	6
Total:	**44**	**358**

Source: Created by the authors.

the lowest number coming from General Practice (1) and Biomedical Engineering (1). Table A.1 details the number of volunteers deployed from each of the disciplinary backgrounds and the total number of volunteer placement months completed. Multidisciplinary team working was a key feature within the SVP and was believed to be the most effective way of achieving the desired outcomes of the project.

Appendix 3

The Move Survey

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Measuring the Outcomes of Volunteering for Education

1) Staff Group

- Allied health professionals
- Healthcare scientists
- Medical and dental
- NHS Infrastructure
- Scientific and technical
- Qualified Ambulance staff
- Nursing, midwifery and health vis
- Support to clinical staff

2) Career stage

Pre-University
Student
Early career
Mid career
Experienced
Post retirement

3) Age

- Below 25
- 26-30
- 31-40
- 42-50
- 51-60
- 61-70
- 71 or over

4) Gender

- Male
- Female
- Other

5) Nationality

- British
- European
- Non-EU National – High income Country
- Non-EU National – Low income Country
- Other

6) Have you had **any periods in another country, either as an employee or volunteer**?

- Yes
- No

Placement 1 (form included space for multiple placements)

What kind of placement was it?

- Healthcare
- Other

Economic status of country:

- High income
- Mid income
- Low income

What stage of your career were you at?

- Pre-degree
- Degree / training
- Early career
- Mid career
- Senior
- Retirement

7) Would you be happy to be interviewed about your experience as a volunteer abroad?

Name

Email / phone number

Fig. A.2 Measuring the outcomes of volunteering for education

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