

**Examining the experiences of doctors as volunteers in Uganda and  
the potential tensions that arise when  
attempting to create 'sustainable' change through voluntary  
placements**

Natalie Tate

Masters in Social Policy Research

University of Salford

School of Nursing, Midwifery, Social Work and Social Sciences

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## Abbreviations

<b>BMA</b>	British Medical Association
<b>CEHURD</b>	Centre for Health, Human Rights and Development
<b>DFID</b>	Department for International Development
<b>FSD</b>	Foundation for Sustainable Development
<b>GHEC</b>	Global Health Education Consortium
<b>HC</b>	Health Centre
<b>HEE</b>	Health Education England
<b>HENW</b>	Health Education North West
<b>HPS</b>	Health Partnership Scheme
<b>HM</b>	Her Majesty's Government
<b>LMIC</b>	Low to Middle Income Country or Countries
<b>LMP</b>	Liverpool Mulago Partnership
<b>MDG</b>	Millennium Development Goals
<b>NGO</b>	Non-Governmental Organisation
<b>ODI</b>	Overseas Development Institute
<b>SVP</b>	Sustainable Volunteering Project
<b>THET</b>	Tropical Health Education Trust
<b>UN</b>	United Nations
<b>UMNH</b>	Ugandan Maternal New Born Hub
<b>VSO</b>	Voluntary Services Overseas
<b>WCED</b>	World Commission for Environment and Development
<b>WHO</b>	World Health Organisation

## Abstract

International professional medical volunteering of qualified doctors has grown in recent decades. It is claimed that this activity has the potential to both benefit and harm volunteers as well as the countries which host them. This research focuses on the subjective experiences of British medical volunteers in Uganda, and aims to investigate the relationship between the career goals and objectives of volunteer doctors as well as their sending organisations. Potential tensions which arise between fulfilling these objectives and the interests of the host country - in this case Uganda – are also explored.

The study was conducted using qualitative approaches to gather data and a thematic analysis was used to draw out the themes identified within the data. The author's position provided a unique approach to the methodological approach which was influenced by ethnography.

The results of the study provide a more in depth understanding of volunteer experiences and illuminate professional and personal skills gains, as well as five key themes relating to tensions and ethical issues encountered during a voluntary experience in Uganda.

# 1. Introduction

## 1.1 UK involvement in global health and the growth of health care volunteering

In recent years, the value of international global health has been recognised by the UK Government, host nations in low to middle income countries (LMIC), individual volunteers and UK health organisations. This is shown in the rise of global health activity recently undertaken by the UK Government.

In 2008, the UK government produced the first ever cross- government strategy (HM Government, 2008) to highlight the challenges that the UK faces in global health:

*‘Our responsibility is to harness the opportunities of globalisation to improve the health of people across the world and in particular people in the UK’ HM Government (2008)*

The publication outlined a set of ten principles and five actions that the UK Government would focus on over the next five years to improve health for people all over the world, including the UK. The principles included:

*‘Promoting outcomes which support the achievement of the MDGs and the MDG Call for Action; learn from other countries’ policies and experience in order to improve the health and well-being of the UK population and the way we deliver healthcare and work in partnership with other governments, multilateral agencies, civil society and business in pursuit of our objectives’ HM Government (2008)*

The principles focus on building relationships and working in partnerships with other governments (in LMIC’s) around the world to ensure the responsibilities of global health issues are responded to. The ‘actions’ also promote a strong focus on ‘working with others’,

*‘We will: work effectively with non-governmental partners, especially when developing and implementing government policy; foster greater coherence and consistency of policy and action with non-governmental partners; and work more transparently’ HM Government (2008)*

Since this first government publication on global health strategies, the UK has continued to increase global health efforts and has since published several policy papers on this matter, including; 'An outcomes framework for Global Health 2011-2015' which outlined the UK agenda for global health over four years. As well as another 'Global Health Strategy Plan for 2014-2019', which again detailed a strategic plan of objectives surrounding the UK efforts towards global health.

## 1.2 What is global health?

With such increase in government activity and the era of rapid globalisation, it is important to understand what global health actually is. However, the definition of 'global health' is still relatively uncertain. This was noted by Koplan et al (2009), who point out that without a common definition, it will be difficult for all involved in global health issues to agree on what is it they are trying to achieve collectively, Koplan et al, (2009).

Currently, there are several definitions of global health available. Marušić (2013) discusses how this concept in medicine has rapidly increased in recent years, like Koplan et al (2009) Marušić argues that it is important to find a common definition of what global health actually means. In the article 'global health – multiple definitions- single goal' (2013), Marušić begins by stating that the concept of global health is relatively new in the world of medicine but has increased steadily in recent years:

*'The explosion of global health research starts in the 21st Century, with an increase from 110 published articles in 2000 to 1250 articles in 2010. This increase continues at even steeper rate, with 1714 publications in 2011 and 2268 in 2012' Marusic, (2013).*

In the UK, the government policy document Health is Global (HM Government, 2008) defines global health as:

*'Health issues where the determinants circumvent, undermine or are oblivious to the territorial boundaries of states, and are thus beyond the capacity of individual countries to address through domestic institutions. Global health is focussed on people across the whole planet rather than the concerns of particular nations. Global health recognises that health is determined by problems, issues and concerns that transcend national boundaries (HM Government, 2008).*



This definition highlights important ideas around the general aim of improving health worldwide but does not give any ideas of how this might be achieved and what the outcomes might be.

Another definition from the 'Global Health Education Consortium' (2015) defines global health as a subspecialty:

*'It relates more to health practices, policies and systems...and stresses more the differences between countries than their commonalities' GHEC, (2015).*

This definition acknowledges the broader aspects of global health and touches on an interdisciplinary approach (this is an important factor in the developing concept of global health action and an emerging theme this thesis focuses on). The broader aspects outside of health and specific clinical input approaches looks at government policies and practice and how integrated input from various disciplines can potentially create better and more sustainable outcomes.

In Canada, a special panel is used to choose the most appropriate definition of global health to reflect the countries current strategies. In 2009, Canada's panel chose Koplan et al's (2009) definition of global health;

*'Global health is an area of study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide. Global health emphasizes transnational health issues, determinants, and solutions; involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration; and is a synthesis of population-based prevention with individual-level clinical care' Koplan et al, (2009).*

After reviewing the current definitions of global health, Koplan et al's (2009) definition proved to be the most relevant in terms of what this thesis is focusing on and agrees with. Koplan et al address the general idea of improving health for all worldwide, but most importantly, emphasises multidisciplinary work and collaboration which relates to partnership and mutual benefit. This has become an increasingly emerging theme in global health literature and in particular a successful approach within health projects, including the project used in the sample for this study (The Sustainable Volunteering Project).

Koplan et al (2009) raise this issue of a need for a common definition of Global health and point out that without this it will be difficult to agree on how progress will be made and monitored. Communication and understanding is therefore key to a global effort towards a shared single goal; without a common definition of all aims and objectives, those involved in all aspects of global health cannot work towards a shared goal.

## 1.2 Approaches to global health

Approaches to action on global health issues are currently conducted in various forms through various government and non-government organisations around the world. Such efforts range from humanitarian efforts in crisis situations (e.g. disaster relief), scientific research (e.g. HIV drug trials and data collection) or long term volunteers training and working with local staff.

Examples of organisations tackling global health issues include the 'World Health Organization (WHO)'. 'WHO' direct and coordinate authority for health within the United Nations system, they are responsible for providing leadership on global health matters, including shaping the health research agenda. WHO priorities and areas of work include, working towards the completion of the Millennium Development Goals, interventions during disease outbreaks as well as promoting health and developing/ strengthening health systems through collaborations with policy-makers, global health partners, civil society, academia and the private sector to support LMIC's to develop (WHO, 2015).

Examples of other organisations focused on global health matters include Oxfam, the renowned aid and development charity with 70 years of experience, working and campaigning with partners in 98 countries worldwide, Oxfam (2009).

The Overseas Development Institute (ODI), is another long standing organisation which focuses on research within LMIC's, they aim to 'inspire and inform policy and practice which lead to the reduction of poverty, the alleviation of suffering and the achievement of sustainable livelihoods in developing countries. Through partners in public and private sectors, in both developing and developed countries', ODI (2015).

One of the most common approaches is aid work through service delivery, which typically sees an organisation deploy highly skilled health professionals from a high income country

to a partnered low to middle income country e.g. UK and Uganda. Oxfam and ODI have adapted and developed their approaches through such partnerships. This thesis focuses on this approach as applied specifically to *volunteering*.

### 1.2.1 What is volunteering?

Conventional definitions of 'volunteering' or what it means to be a 'volunteer' often evoke altruism, and a sense of selflessness, a drive to help others without (individual) benefit. It appears that most definitions of volunteering conceptualise it as;

*'Activity or service carried out without pay, to benefit the environment, the community, and persons other than those living within the household or close relatives', Atlas, (2008).*

Fundamentally, volunteering can take numerous forms, with volunteers not forming a standardised group, Bussell & Forbes, (2002) and little consensus over the features of a typical volunteer or volunteer placement. Within the field however, international volunteering (which routinely implies a flow of volunteers from high income to low income countries) is a rapidly growing phenomena, Bussell & Forbes (2002).

Large organisations such as Voluntary Services Overseas (VSO) utilise this model (volunteering) to provide their efforts on global health action. They deploy highly skilled volunteers to work on health related projects around the world. VSO work in 22 LMIC'S around the world and currently has 662 partnerships within the countries they work. The VSO website gives an overview of the organisations vision and approach;

*'Our vision is simple: A world without poverty. Our approach is unique; sending skilled volunteers from sectors such as health, education and business to work with partners who have requested our help. VSO enables a two way exchange that benefits the volunteer and the community they serve far beyond the life of the placement', VSO (2013)*

The overview touches on the theme of partnerships and the 'two way exchange' which sees the volunteer benefitting from giving their time and knowledge to the LMIC in which they conduct the placement. Identifying such benefits is an emerging theme in the rise of global health activity, this is discussed in the following sections of this thesis.

Another example of this is the American organisation the 'Peace Corps'. They also deploy volunteers to LMIC's around the world, their aim is to *'tackle the most pressing needs of people around the world and work towards sustainable change'* Peace Corps, (2015).

Like VSO, the Peace Corps also acknowledge the benefits to the volunteer in their mission statement;

*'When they return home, volunteers bring their knowledge and experiences and global outlook- that enriches the lives of those around them'* Peace Corps, (2015).

Both organisations have a strong focus on a 'two way exchange' between the volunteer and the host nation (LMIC). The theme of mutual benefit is of great importance to both organisational aims and objectives. This is a reflection of the rise of global health activity as well as the growing understanding and utilisation of the benefits to which volunteering and partnerships provide, mutually.

### 1.3 Rise of global health volunteering and partnerships

In an era of rapid globalization, individuals frequently travel overseas to volunteer.

According to 'Tourism Research and Marketing', Bussell & Forbes (2002) the rapidly growing phenomena of 'international volunteering' attracts over 1.6 million volunteer tourists each year through at least 300 organisations worldwide. These organisations working on global health (both government and non-government organisations) are mainly based in high income countries, they have established links with low to middle incomes countries (LMIC'S) and deploy their volunteers to work in the LMIC's to work on specific projects which aim to fulfil the aims and objectives of the organisation, Bussell & Forbes (2002).

These established links have now become an important component of a successful global health project and the benefits of such strong links and 'partnerships' are now becoming increasingly common in global health strategies and policies. (This is how the Sustainable Volunteering Project was developed; the project was formed through a consortium of existing health care partnerships between UK and Ugandan hospitals – The Ugandan Maternal and New Born Hub).

'Global Health Partnerships, The UK contribution to health in developing countries' (Crisp, 2007) highlighted the growth and importance of global health partnerships. The report details the steady increase of such links between the UK and LMIC'S for health related projects and sought to look at how the UK could use the experience and expertise in health to best effect to help improve health in developing countries. (Crisp, 2007).

The report highlighted and recommended what the UK can do to help achieve the Millennium Development Goals (MDG's)<sup>1</sup>. In doing so, it concluded that these goals can only be met if developing countries are able to take the lead and own the solutions and are supported by international, national and local partnerships based on mutual respect (Crisp, 2007).

This conclusion recommends that the LMIC must take the lead in fulfilling development objectives and only be supported by high income countries. Thus, making the partnership equal and not heavily reliant on the high income country to take the lead in creating change and improvement in the LMIC.

Crisp (2007) goes on to discuss reasons why high income countries should engage in global health partnerships for development:

*'The UK and other developed countries should grasp the opportunity – and see themselves as having a responsibility as global employers – to support a massive scaling-up of training, education and employment of health workers in developing countries. There is much more rigorous research and evaluation of what works, systematic spreading of good practice, greater use of new information, communication and biomedical technologies, closer links with economic development and an accompanying reduction in wasted effort', Crisp (2007).*

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<sup>1</sup> Millennium Development Goals – The Millennium Development Goals (MDGs) are eight international development goals that were established following the Millennium Summit of the United Nations in 2000, following the adoption of the United Nations Millennium Declaration.

Effectively, the idea of partnership, mutual learning and benefit will help to create a more 'Sustainable' change. Which is an essential value for global health issues and is at the centre of the global health project used as the same for this study, (The Sustainable Volunteering Project). Sustainable change in the context of global health development was defined in 1992 as;

*'Development that meets the needs of the present without compromising the ability of future generations to meet their own needs' Bruntland Report for the World Commission on Environment And Development, (1992).*

The UK's current engagement with global health projects aiming to achieve sustainable change include partnerships which range from the large well-known non-governmental organisations (NGOs) to many other smaller organisations that provide education and support, advocacy for particular conditions and direct service, including the SVP.

With the UK's recent expansion of global health activity and the growth of volunteering within this field, this thesis intends to focus on the volunteer experience within the field of international global health.

In order to understand the context of an international voluntary experience further, the researcher identified the intended outcomes/ individual goals of the volunteers and the objectives of the sending organisations as well as considering the needs of the receiving health care system in Uganda.

## 1.4 Thesis Structure

This thesis has so far introduced the context of the current UK involvement in global health volunteering.

The following chapters begin with a literature review which explores the current research surrounding three key areas of volunteering which will help to further understanding the subjective experiences of volunteers working in LMIC's, focusing specifically on any tensions or ethical issues felt by volunteers which has been identified already.

Chapter four provides a detailed policy analysis of current UK volunteering organisations and their activity, funding, aims and objectives. Chapter four also introduces the objectives and principles of the Sustainable Volunteering Project, which is the organisation used as part of the sample.

Chapter five gives an overview of literature which discussing what Uganda wants and needs from global health volunteers, giving detailed accounts from Ugandan health care workers perspectives.

In Chapter six the methods used for data collection and reasons for are given as well as discussing in depth the author's unique position as a volunteer with the SVP. This chapter also discusses the methodological approach for data analysis as well as limitations and ethical issues to the study.

Following this, Chapter seven is the first data analysis chapter which evaluates the data collected in relation to the motivations of volunteers within the SVP.

Chapter eight looks at the skills gained in practice by SVP volunteers in Uganda and chapter nine is the final analysis chapter which investigates the tension and ethical issues encountered by SVP volunteers during their placements in Uganda. All of the analysis chapters (7, 8 and 9) use a thematic approach which helped to answer the research question in detail.

The concluding chapter (ten) gives a summary of the main findings as well as discussing the considerations and recommendations for future research.

### 3. Literature review

This thesis will investigate the subjective experiences of medical professionals who conducted a voluntary placement in Uganda through the Sustainable Volunteering Project (SVP). It also aims to investigate how they achieved their objectives and illuminate any ethical issues or tensions that arose between fulfilling these objectives and the sustainable interests of the host country, Uganda.

In order to understand the context of the voluntary experience, as well discover potential tensions or ethical issues which may relate to the experiences of the SVP volunteers; the literature review was constructed around some key papers addressing three significant ideas/ questions within global health volunteering:

- How motivation is currently measured and what motivates people to want to help and/ or volunteer?
- What are the benefits for medical volunteers as individuals?
- What are the current ethical implications or tensions of such voluntary placements attempting to create 'sustainable development' in LMIC's?

The aim of this review is to bring these themes together to understand the factors which may lead to or create tensions to rise during a voluntary placement, particularly those trying to create sustainable change whilst adhering to methods or principals which challenge a more traditional approach such as service delivery.

#### 3.1 Motivations

Every year, people from around the world engage in international volunteerism, whether it is providing health care in an LMIC, language teaching in schools, or humanitarian efforts in disaster relief. Numerous international organizations such as Voluntary Services Overseas (VSO), the British Red Cross, or Marie Stopes rely heavily on volunteers to develop and sustain their programmes and carry out their aims and objectives.

VSO have 592 established partnership schemes between the UK and LMIC's, they currently have 927 international volunteers, 130 youth volunteers and 294 working in 31 LMIC's around the world who sustain the efforts of the organisation, VSO (2015).



Despite this rapid growth in both economic and social terms, the motivation of unpaid volunteers is still relatively understudied. According to Johnson (2010), most research on motivation has focused on 'work-related' motivation, which would apply to careers and paid work thus not directly relating to 'volunteerism'. It is argued that work related motivation is deemed to have a greater impact on the economy. It's regarded as more important and therefore more researched, Johnson (2010).

Some research on 'work-related motivation' is definitely applicable to volunteers as they are often looking for professional development or more specifically, on a 'CV building mission', Johnson (2010) and fulfilling objectives in line with their current training to use in their portfolios.

However, there is a profound difference - volunteers are not paid (although in some instances volunteers are given a stipend for living costs). Therefore should we assume unpaid volunteers are always motivated by other altruistic aspects? And if so, what are they? Johnson (2010).

Volunteer motivation is a relatively under-researched. It can be associated with both *economic* and *social factors*:

The '*economic*' factors may not necessarily be financial, but usually relate to the benefits for the organisation or for the individual. Within the context of this research and the volunteers used in the sample, the economic benefit might be the gains to the NHS and the doctor as an individual for their professional career development and returns to the NHS.

For example; a British doctor volunteering in Uganda for six months, dealing with difficult medical situations with limited staff and resources. Their skills and knowledge are expanded and strengthened during the placement, they then return to the NHS with increased clinical skills as well as better management and communications skills, creating benefit for the NHS and the volunteer's future career as a doctor. The economic factor of 'career development' is a common theme within volunteer motivation research and is also a theme explored in this thesis.

The '*social*' factors relate more to altruism and selflessness, and the practice or principle of concern for 'others', Hudson and Inkson (2006). For example; a volunteer considering the sustainability element of their work to the local environment in which they have conducted their placement. This might be the local community surrounding a hospital or health centre

in Uganda. Altruism is also a theme explored in current research, as well as an interesting area of discussion which emerged from the interviews conducted for this thesis.

An important development within motivation research was the creation of the 'Voluntary Functions Inventory' (VFI). This is one of the only measuring method used in qualitative research to illuminate the motivations of volunteers.

In order to develop the VFI and understand the factors and functions influencing people who choose to give their time, skills and resources to volunteer further, Clary and Snyder (1998) conducted a study which aimed to find out the reasons behind current volunteers decisions to devote their time to a role, without pay.

The study analysed empirical research on volunteering conducted through various groups of volunteers in America. The authors applied the functionalist theory, also known as 'functionalism' which is a perspective developed by Emile Durkheim. 'Functionalism', interprets elements or 'functions' of society to show how they contribute to the stability of society as a whole, with each 'part' organised to fill and depend on other to form and shape society, Crossman, (2013).

Clary and Snyder (1998) adopted this theoretical perspective to hypothesise six 'functions' or 'parts' which they believed were contributions served through the motivation to volunteer.

The functions hypothesised were, '*Values, Understanding, Social, Career, Protective and Enhancement*'. Clary and Snyder (1998).

To develop this further, Clary and Snyder (1998) conducted six studies with American volunteers. The method included a 7 point 'strong agree – strongly disagree' Likert scale which contextually defined each of the hypothesised functions. Each function was then attached to five samples and the participants identified the level of importance/ relevance of each function.

For example, the function of '*values*' was attached to the statement: '*I am concerned about those less fortunate than me*' to which the volunteer would then rate the statement on the 7 point Likert in order of importance to their motives to volunteer).

The outcome of the study resulted in the development of the Volunteer Functions Inventory (VFI). This is one of the only tools developed to measure the motivations of volunteers

which has now been adapted in other studies aiming to understanding motivation since its inception. The introduction of the VFI provided a platform for further research as well as providing a profound way to determine volunteer motivations.

Bruyere and Rappe (2007) used the VFI, to identify the motivations of volunteers working within the environmental and conservation field. The results of this study suggested that most volunteers had an altruistic response to their values, *'helping the environment'* emerged as most important on the VFI, a purely altruistic motivation. Other responses included *'improving areas that volunteers use for their own recreation'*, *'learning about the natural environment'* and *'socializing with people with similar interests'*, Bruyere and Rappe, (2007). The VFI usage in this particular study drew out a fairly even outcome of individual benefit vs. the environment in which the volunteer conducts their work. Which the author's state *'potentially makes up the perfect volunteer'*. It was hope by the authors that this study would develop volunteer organisations to provide volunteers with an experience that meets their motivations. *'By developing programs with volunteer motivations in mind, managers will better be able to recruit and retain volunteers within their organizations'* Bruyere and Rappe (2007). The authors aim would help to create volunteers who hold a good balance between helping themselves in various forms, as well as helping the objective of the organisation they are attached to.

Other research studies which has used the VFI in various forms include; Switzer, Switzer, Stukas and Baker (1999), who studied the motivations of medical students to volunteer, they focused on gender and used comparison to other volunteers also utilised the VFI, they found high reliability and validity in the VFI.

While the VFI represents an exceedingly useful tool, Shye (2010) argues that the use of the VFI it is not without its flaws and potential limitations. Its use of a Likert-rating scale limits volunteer responses. An alternative to this might be the use of an open-ended probe, which might allow the researcher to identify functional motives among potential volunteers that are not included in the VFI, Shye (2010).

For example; *'You identified your main values on the VFI, can you explain why you chose these?'*

Considering the use of open ended probes was important when planning and conducting interviews and other research for this thesis; such as observational work and discussions with the SVP volunteers.

It was important to note the six functions hypothesised by Clary and Snyder (1998) when investigating the motivations of the SVP volunteers. The values on the VFI provide the only recognised list of outcomes in volunteer motivation and consider all aspects to what people discuss as attributions to their decision to volunteer. This was an important finding of the literature review and enabled the research into SVP volunteers to have a base line in terms of themes, which encouraged the interview to follow 'Masons' thematic approach .

### 3.2 Benefits to individual volunteers

The direct and indirect benefits to individual British volunteers who choose to embark on an international medical voluntary placement are complex and sometimes contentious.

Currently, UK doctors at both pre and post training are under increasing pressure to gain further clinical and non-clinical international experience, this is shown in the British Medical Association statement from 2014, which highlights the reasons and growing importance of international placements for UK doctors in training:

*'With an increasingly diverse patient population in the UK, an ever more integrated global healthcare system, and unprecedented access to people and places around the world, it is more important than ever before that UK doctors are able to access opportunities to gain international experiences'. British Medical Association, (2014).*

The benefits of volunteering in an LMIC is emerging as a popular research topic, as the field continues to grow. Jones et al (2013) conducted the first systematic review of the current research concerning international volunteering and its benefits to individuals. The review consisted of both published and grey literature relating to the cost or benefit to the UK at an individual (the volunteer), institutional and system level. *'The benefits volunteers described were then mapped out to provide a framework indicating key outcomes of the volunteer experience within partnerships' Jones et al (2013).*

Initially, the review found 40 individual benefits to volunteers from the data collected, they were then grouped into 7; *clinical skills, management skills, communication and team work, patient experience, dignity, policy, academic skills and personal satisfaction and interest*, Jones et al (2013). From the limited literature this review provided an important framework for future research and development into this area.

The benefits identified relate strongly to the emerging themes in the SVP evaluation and helped to develop the interview schedule for this research. Each of the seven benefits were mentioned in various forms from SVP volunteers themselves, as well as some being identified by myself as a fellow volunteer with the SVP.

Jones et al (2013) conclude that the existing evidence of benefits is descriptive and that more work is required to quantify the costs and benefits within such health partnerships. Interestingly, Jones also concludes that the review provides a strong argument that the benefits gained are transferrable back to the NHS; *'benefits to individuals and institutions could be maximised when volunteering is formally embedded within continuing professional development processes'*, Jones et al (2013). This conclusion supports the BMA's statement that it is increasingly important for medical students and trainees to consider international placements to gain wider experience to bring back to an increasingly diverse patient population in the NHS. *'It is more important than ever before that UK doctors are able to access opportunities to gain international experiences'*. British Medical Association, (2014).

In contrast to the professional development impact, Hudson and Inkson (2006) conducted a qualitative study on the 'personal impacts' of voluntary development workers. The study focused on the aid organisation Voluntary Service Abroad (VSA) (a similar organisation to VSO), based in New Zealand. The longitudinal study drew out the experiences of the volunteers and focused on the idea of a 'transformation' through their learning, as well as the possible impact on their future career.

The study strongly follows a framework developed by anthropologist 'Campbell', (1968, 1988) called *'The hero's Journey'*. This framework is based on the themes of heroism and the motif of *'a going and a returning'*, *'an adventurous excursion providing an expansion of human potential within a life journey'*. The participants of Hudson and Inkson's (2006) study found commonalities with themes from 'The Hero's Journey' framework, such as a change

in values, beliefs and understanding in terms of cultural differences, opinion on aid work and also their own personal life and choices they had made.

Most of the current literature suggests that the experience of a voluntary placement has a positive effect on an individual, both personally and professionally. However, some research has concluded that the experience was disruptive for the volunteer and in fact caused them to use the experience for major change in their lives. Starr (1994) conducted a longitudinal study on the experience of long term Peace Corp volunteers 20 years after their assignment and concluded that the experience typically *'was viewed as a turning point in their life course'*. He went on to suggest that the volunteers had *'used this time as a sanctioned withdrawal from conventional society in order to discover their true self'* Starr (1994).

Further to this, one study conducted by Reark Research (1998) found that most of the volunteers stated their experience was positive but 10 per cent felt it had *'hindered them'*, as well as suggesting that the experience caused short term disruption, Reark Research (1998).

Jones et al (2013), acknowledges the limited literature and argues for further research into understanding the benefits and the impact of health partnerships and voluntary experiences. *'Effective evaluation would allow individual links to monitor progress, and enable comparison between links, allowing examples of best practice to be gathered and shared. Valid data in this area would allow enhancement of benefits and minimisation of costs, and this has the potential to hugely improve health partnerships and to upscale involvement across the UK, and indeed internationally'*, Jones et al (2013).

The general consensus of volunteer motivation literature is that the experience mostly proves positive for individuals, yet there is a theme running through most conclusions that there is a need for further research into the benefits and what they bring back to the UK.

### 3.3 Current tensions and ethical considerations within international volunteering

As discussed in the introduction, international volunteering is a rapidly growing phenomena and in recent years has seen more and more students and trainees conducting placements

through global health organisations such as the SVP, for both educational (skills gain, CV building) and personal (genuine desire to serve in a LMIC).

However, the growing popularity may have seen a rise in voluntary organisations as well as medical schools and deaneries respond by releasing the students and trainees, but the ethical considerations of the activity undertaken throughout the placement has not kept up the pace. In fact, there is little research into what effect these placements have on the LMIC (in this instance, Uganda) at all. In the following section, VSO reports (2014) are discussed, which detail some of the concerns from Uganda's health care system in terms of needs and challenges, however they do not go into detail about the current effect voluntary services directly have in terms of tensions or ethical issues. Most of the published material into 'the effects of voluntary placements in LMIC's' often evokes positive messages and figures which detail how many people have been trained or how many lives have been saved.

However, the focus of this research was to investigate the finer details of such activity and uncover the subjective experiences of tensions and ethical issues which are currently not widely discussed in global health.

In light of this concern, this literature review aimed to focus on what individual volunteers currently aim to achieve during their placements and identify whether volunteers objectives have brought up any tensions and/ or ethical considerations.

Ethical issues within international volunteering is a relatively new concept and the literature available is limited. However, the literature does confirm that some research has been conducted within this area and it is becoming increasingly prevalent within global health as the field of international volunteering grows.

Fee and Gray (2007) introduce this suggested tension in their study which examined the learning experiences of expatriate volunteer workers deployed by the Asia Pacific largest international volunteer agency as well as the relationship and impact on the host societies, they describe this relationship between the partnerships from the beginning as '*contentious*', as well as '*being 'helped or harmed by their presence*'. The authors side with '*Dependency Theorists*' who argue that '*rather than helping poorer nations, the main legacy of most international development activity is the exploitation of local resources and labor*', Fee and Gray (2007). Although the authors suggest the study is based on '*the negative side*

*of globalisation'*, the authors do state the positives of such partnerships and global volunteering, they state that this activity does provide *'a critical and increasingly influential link between the economically and culturally diverse nations in Asia and the Pacific and are central to the circulation of knowledge and cross cultural understanding'*, Fee and Gray (2007).

Elit et al (2011) also conducted research on the ethical issues encountered by medical students from Canada whilst conducting their medical elective placements or as they call them 'international health electives (IHE's)'.

The study involved 12 semi structured interviews with students who had recently returned from their IHE in a developing country, the results generated five themes relating to ethical issues encountered; *(1) uncertainty about how to help, (2) perceptions of Western medical students as different (3) moving beyond ones scope of practice (4) navigating different cultures of medicine (5) unilateral capacity building, Elit et al (2011)*

This appears to be the most concrete study in terms of specific themes identified and was a useful list of themes to work with in the research for this study. There appears to be no other published works which detail the tensions or ethical implications felt or realised in the volunteer studies. Therefore, Elit et al's findings were the most appropriate themes to follow during the research conducted for this thesis. Somewhat unsurprisingly, the themes identified in the SVP are similar to Elit et al's findings, this is discussed in the following chapters.

#### 4. UK Volunteering organisations - policy analysis

In order to understand the volunteer perspective and experience further the author identified the aims and objectives of the UK-based organisations who fund, deploy and organise voluntary placements used for the sample of this thesis. This provides an understanding of how organisational responsibilities match up with the aims and objectives of other key stakeholders: the funding bodies, the individual volunteers, and the host country's health system.

The organisations looked at were the deploying organisation for the sample used. The Ugandan Maternal and New-born Hub and the Sustainable Volunteering Project (SVP). As



well as the government funding bodies The Department for International Development (DFID) and the Tropical Health Education Trust (THET).

#### 4.1 Ugandan Maternal and Newborn Hub (UMNH) and The Sustainable Volunteer Project (SVP) overview

The volunteers who took part in the research for this report were deployed through the Sustainable Volunteering Project. The SVP is a UK based organisation set up in 2011 to deploy highly skilled professional (British) volunteers to Uganda to promote sustainable and professional volunteerism within the remit of improving maternal and new born health. Details of the SVP aims and objectives are given later in this chapter.

The SVP forms part of the wider consortium of health care partnerships in Uganda: – The Ugandan Maternal and New-born Hub (UMNH). The UMNH was created to support the coordination and consolidation of 8 existing UK – Uganda obstetric health care partnerships based in the UK. It was hoped that the ‘hub’ would lead to and create opportunities for collaboration as well as develop a wider platform for audit and evaluation in for Ugandan obstetric health care. The UMNH website confirms the mission statement;

*‘To reduce maternal and infant mortality and improve the standard of maternal and newborn healthcare across Uganda through the placement of volunteers; and improve communication and knowledge exchange between various similar healthcare partnerships’ Ugandan Maternal and New Born Hub, 2013.*

The hope of the UMNH creating opportunity for further development projects was proven successful in March 2011 when the SVP was established after all partners in the UMNH agreed to support the new project.

The SVP funding comes from the UK Department for International Development (DFID) and is managed by the non-governmental organisation (NGO) the Tropical Health Education Trust (THET).



**Tropical Health Education Trust (THET)**



**Sustainable Volunteer Project (SVP)**

## 4.2 Department for International Development

The Department for International Development (DFID) is the UK government department responsible for administering overseas aid. According to a recent business plan,<sup>9</sup> the overall aim and vision of the government department is as follows:

*'We will concentrate our efforts on supporting achievement of the Millennium Development Goals, creating wealth in poor countries, strengthening their governance and security and tackling climate change. The prize, in doing so, is huge: a better life for millions of people, and a safer, more prosperous world for Britain' DFID, (2015)*

It is interesting to note here that DFID acknowledge their aim is to benefit 'Britain' as well as the LMIC's. The theme of mutual benefit, partnership and shared learning filters through to sending organisations and is emerging as a common approach to development within organisations, moving away from the more traditional and altruistic approach to development work and aid.

More traditional approaches to aid include donations or sending volunteers to provide service delivery etc. This is especially common in the Ugandan context. There are numerous organisations in country that provide donated equipment and voluntary health care Service provision. However, in recent years development work has steadily moved away from this approach and the idea of 'sustainability' is rapidly becoming higher in terms of development organisations agendas. This movement is reflected in DFID's overall aims and objectives, they hope to achieve long term and sustainable goals, which in turn will also benefit the UK.

Focusing specifically on the subject of health, DFID's responsibilities and priorities include the following:

**Responsibilities:**

- Honouring the UK's international commitments and taking action to achieve the Millennium Development Goals
- Making British aid more effective by improving transparency, openness and value for money
- Improving the lives of girls and women through better education and a greater choice on family planning

**Priorities:**

- Help immunise more than 55 million children against preventable diseases
- Save the lives of at least 50,000 women in pregnancy and childbirth and 250,000 newborn babies
- Help at least 10 million more women to use modern methods of family planning by 2015
- Help halve malaria deaths in 10 of the worst affected countries (DFID,2015)

#### 4.3 The Health Partnership Scheme (HPS)

In order to help achieve these objectives, DFID funded the Health Partnership Scheme (HPS). This scheme was introduced to support the development of health services in some of the world's poorest countries, including Uganda. The programme aims to partner UK health institutions and professionals with LMIC counterparts, to strengthen health systems through health service skills transfer and capacity development. The Scheme pays for a broad range of partnerships; including paired institutional partnering which twins a single UK health institution with a single LMIC health institution. They also provide start up grants which help to facilitate new partnerships.

The SVP was funded through the Long Term Volunteering Partnership Scheme; which is:

*'For the placement of UK volunteers who will support the delivery of projects. These placements are for a minimum of six months and the focus is on health system strengthening through teaching and training in the classroom or on the job', DFID, 2013.*

DFID introduced the scheme to work towards the Millennium Development Goals (MDGs) in Uganda. These are a set of eight international development goals that were established in 2000 following the Millennium Summit at the United Nations.

The eight goals are:

1. Eradicate extreme hunger and poverty
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development, United Nations (2015)

The HPS focuses on goals 4, 5 and 6 to reduce child mortality, improve maternal health and combat HIV and AIDS, malaria and other diseases.

In terms of Uganda, DFID created an 'operational plan' in 2014 which detailed the top priorities and spending on development Uganda. One of the top priorities is 'improving maternal health and government accountability', which is the SVP's overall aim. To put this into practice, DFID created the HPS and it is managed by Tropical Health Education Trust (THET).

#### 4.4. Tropical Health Education Trust (THET)

THET was founded twenty five years ago. Its aim is to focus on health and education development through training and capacity building in LMIC's around the world. THET's founder, Professor Sir Eldryd Parry stated the following with regards to THET's organisational aims:

*'If there's mutual trust and a willingness on both sides to learn more from each other, a readiness to adapt and a readiness to try new things then good work will happen', THET (2015).*

Like DFID, THET's founder acknowledged that 'good work' will develop through mutual learning. The quote below explains how THET approach their objectives:

'We achieve our goals by working through collaborative partnerships with individuals and institutions and provide a flexible framework for people to work together effectively and responsively for the longer term.

*'While the primary focus of our work is to bring lasting improvements to healthcare in developing countries, our approach results in mutual benefits for both partners. We believe that international volunteering is a valuable asset to the UK health service and continually work to ensure volunteering achieves recognition of the contribution it is making to the quality of health services overseas and in the UK' THET, (2015).*

THET's approach has a very strong focus on partnerships and mutual benefit, which is why the HPS is ideally managed by THET, it encompasses DFID's vision of shared learning, strengthening partnerships for development which will help to achieve MDG 8 – Developing a global partnership for development.

The THET website indicates the priority of working with LMIC's for equal mutual benefit, and emphasises the value to the UK and NHS as well as the lasting impact on the LMIC. This will be of particular interest to a prospective volunteer considering taking on a placement to gain experience which is relevant back in the UK.

As well as this shared learning management style, THET also discuss their set of eight core 'values and principals' in their organisational overview:

- 1. Strategic and Effective Health partnerships have long-term aims, measurable plans for achieving them and work within a jointly-agreed framework of priorities and direction.*
- 2. Harmonised and Aligned Health partnerships' work is consistent with country health plans and complements the activities of other development partners.*
- 3. Sustainable Health partnerships operate in a way that delivers high-quality, measurable projects which meet targets and achieve long-term results.*
- 4. Respectful and Reciprocal Health partnerships plan, implement and learn together, listening to one another with respect and dignity.*
- 5. Organised, Accountable and Transparent Health partnerships are well-structured, efficient and can justify the decisions they make to stakeholders'*
- 6. Responsible and Trustworthy Health partnerships conduct their activities in a reliable way and cultivate trust in their interactions with stakeholders.*
- 7. Flexible, Resourceful and Innovative Health partnerships are able to adapt and respond to altered circumstances and embrace change, and are able to find ways to overcome challenges, introduce new ideas, think creatively and implement new methods.*
- 8. Committed to Joint Learning Health partnerships regularly reflect on their activities and results, articulate lessons learned and share knowledge with others. THET, (2015).*

These values are intended to create an understanding of the working style, approaches and methods taken by THET in country and give an understanding of their management style. This is useful for prospective volunteers as it allows them to gain an understanding of how their placements will be managed, and what flexibility they may have within the organisational structure.

The SVP, adheres to both DFID and THET's aims and objectives, as well as having its own vision and set of goals. The SVP deploys volunteers to carry out the work DFID and THET hope to achieve in LMIC's, although the SVP is conducted in Uganda only. The SVP was chosen as one of THETs HPS programmes to work in.

#### 4.5 SVP objectives

The SVP project has six specific aims and objectives:

SVP Aims and objectives:

1. *To improve Maternal and Infant well-being through the provision of Sustainable Professional Volunteers within partnerships*
2. *To take the UMNH consortium forward in an evidence-based environment*
3. *To develop, evaluate and promote a model for future sustainable and effective professional voluntarism*
4. *To take the UMNH consortium forward in an evidence-based environment*
5. *To encourage north-south (international) and south-south (national) knowledge transfer.*
6. *To promote integration and engagement with health systems.*
7. *To improve evaluation and audit.*
8. *To consolidate and mobilise additional resources, SVP, 2013.*

The SVP seeks to help achieve MDG 4 and 5 and overall has a strong focus on the volunteer activity and all work conducted through the project to have a sustainable impact.

*'The project will recruit and deploy professional volunteers from a range of disciplinary backgrounds in response to clearly identified and shared needs within the UMNH. The focus is on effective knowledge exchange and implementation, not simply service delivery, which places an emphasis on multi-disciplinary and multi-national team-working. The community of volunteers and their colleagues in the UK and Ugandan Partnerships will work together to promote the knowledge exchange process. The volunteers will join an active community within a learning and training environment' SVP (2013).*

#### 4.6 SVP Values and Principles

It is clear from the project aims and objectives that the SVP has a strong focus on sustainability and hopes to create a platform for professional voluntarism in Uganda. In order to achieve the objectives set, the SVP have developed some interesting ideas to ensure the core values and principals are adhered to during the voluntary placements. This

include the concept of 'co presence', which is an integral part of the voluntary placements which helps to achieve the projects objectives.

#### 4.6.1 Co presence

In order to conduct the project work using the values of sustainability and sustainable change, the SVP introduced the concept of 'Co-Presence' as a core element of each voluntary placement. In simple terms, this means that a volunteer should never work alone, i.e. the volunteer doctor must conduct clinical practice alongside a Ugandan counterpart at all times. This is a value the volunteer must consider and comply with throughout their placement.

The concept of co presence is drawn from migration research, in particular from Williams (2006). Williams attempts to explore the role of skilled migrants within concepts of knowledge transfer. Further to this, Ackers (2014) (Coordinator of the SVP) adapted this concept in the context of international volunteering:

*'Co-presence simply means working together to share knowledge and ideas. It acknowledges that different types of knowledge and skills can move between different health workers in multiple directions (skills transfer is not a one-way process). In practical terms it means that UK professional volunteers should always be working alongside Ugandan health workers in an environment that promotes skills transfer. Professional volunteers should not be seen as replacements for local staff, or fill-in for them in their absence: they are not 'locums'. Copresence does not imply that professional volunteers do not engage in clinical work, however, when they do so they will be appropriately mentored and mentoring (according to their needs).'* Ackers, (2013).

This approach allows the SVP volunteer to view their placement beyond its purely clinical aspect, and to consider the broader concepts of development and knowledge exchange. It further gives the volunteer an opportunity to engage in non-clinical skills such as teaching and communication.



The DFID requirement in this project to make the placements long term (6 months +) not only encourages sustainable change but also ensures there is enough time to really engage with the environment, people and culture using the co presence principal. Therefore, enabling the project aims and objectives to be fulfilled.

#### 4.6.2 Risk, competency and blame culture

The concept of 'risk' for an individual within the context of international volunteering is typically associated with considering what you are insured for as a volunteer; such as accidents, clinical accountability, illness etc.

In relation to the SVP, principles were drawn from a paper by Williams and Balaz (2012). The paper discusses the concept of risk within the context of highly skilled migration and contrasts the different approaches of knowledge transfer to theorising risk, in terms of scale, social constructionism, and being informed by risk as opposed to being at risk.

Further to this, the co-presence principal also relates to the idea of risk and competency. If the volunteer adheres to the principal of co presence during their placements, they are protecting themselves from lone working, especially if the work is outside of their competency without supervision.

It is common for an international volunteer conducting a placement in Uganda to be viewed as an '*extra pair of hands*' especially if there is a shortage of staff, too many patients, or an emergency Ackers, (2014). Although the volunteer is there to support and help, being viewed as an extra pair of hands and the role of service delivery is a view the SVP hope volunteers can avoid. The implications of this have a negative impact in terms of sustainability and also because of risk.

Various forms of risk are associated with these kinds of placements. Policy Report 'Identifying and Mitigating Risks in Professional Voluntarism: Lone Working, Competency and Risk', considers these to include, road traffic accidents, terrorist attacks and needle stick injuries, Ackers, (2014)

Lone working is not in itself associated with high levels of risk. It is common for a healthcare worker to conduct clinical and non-clinical activity alone in both the UK and Uganda, as well as all over the world:

*'Lone working is rarely conceptualised in terms of risk. However, lone working is a very common feature of international voluntarism and the risks associated with it are complex and multi-faceted. At one level it links to other more 'standard' concepts of risk. If a volunteer is working on their own they will face difficulties in complying with risk mitigation procedures following a needle stick injury, E.g. Good practice in relation to HIV prophylaxis suggests that anyone suffering a needle stick injury should commence treatment within 2 hours. If an obstetrician is working on their own in theatre this may not be possible. Equally, exposure to risks associated with the various forms of assault are much higher when a person is on their own' Ackers, (2014)*

It is hoped that the use of co presence would protect the volunteer from such risk and also create an environment in which effective knowledge transfer and on the job training can take place. Which would fulfil the core SVP objective of creating sustainable change SVP, (2013).

#### 4.6.3 Competency

Lone working presents serious challenges and risk in terms of clinical competency. The risks associated with competency to volunteers within the SVP would mainly relate to clinical practice within the volunteers current stage of training. For example, junior doctors may be presented with clinical scenarios that they would not be in the UK at their current stage of training i.e. delivering a baby with unexpected complications, with limited staff and resources and having to lead the situation. In the Ugandan health system, they may have to deal with such situations, (potentially alone) or at least act as the most senior member of staff on site. The co presence principal is also designed to protect them from such situations as well as lone working. If they are working alongside a member of staff who is not a doctor i.e. a midwife, they may be the most senior and experienced person there. It is the volunteers' decision whether to deal with the situation or not, if they do, they would be

effectively be practicing outside of their competency, and what they are allowed to do in the UK. Therefore, putting themselves and even the patient at risk. This is discussed in the following SVP report:

*'An important component of the risk dynamic concerns competency. Competency is both a matter of clinical skills/experience (objective) and one of confidence (subjective). For insurance purposes, and to safeguard the individual from trauma or stress, all volunteers must operate within a competency framework. They should never be put in a position of having to perform procedures that they are not, or do not feel, competent to perform in unsupervised environments. This presents serious challenges in the Ugandan healthcare system where the lack of senior staff or their failure to be present on the wards often leaves more junior staff in situations where they have to work out of the bounds of their competency. This is normalised for Ugandan healthcare staff and it is unsurprising within this culture that volunteers may be expected to do the same', Ackers, (2014)*

Working beyond competency is also subjective to the individual. Within the SVP for example, it was noted during the research that some volunteers have felt comfortable taking on clinical scenarios that are above their level or competency. An example of this emerged during a discussion between the researcher and a volunteer (a post F2 doctor), who had spent the day in theatre with the assistance of a Ugandan doctor.

*'I have done a few c sections today, it was amazing. The babies have been fine. I am doing the incisions on my own now'*

The volunteer was confident to conduct the surgery after only assisting for a day with a Ugandan doctor. Although the volunteer was complimented by their Ugandan counterparts on their surgical skills, it was understood that this would not be possible in the UK. In fact, the post F2 doctor would not be able to lead a surgical procedure such as this until much later on in their training. Effectively, they were working outside of their competency. Other SVP volunteer were not so keen to lead procedures or take on any clinical activity that was outside of their current training level in the UK. Others felt they could contribute

according to their current skills and knowledge, which would purposely minimise them from risk.

This approach to purposely avoiding risk was noted with another post F2 doctor. During the time of this interview, the volunteer doctor was working in a smaller HCIV. He was actually the only doctor at the centre, which was a busy facility delivering babies as well as having an antenatal and post natal clinic. The potential for clinical activity at this facility was vast for this volunteer, they had access to a range of patients and technically had the most authority, knowledge and qualification as the only doctor on site. However, interestingly, he chose not to take the lead in theatre or prescribe any drugs he wasn't comfortable with, he would refer them onto the National Referral Hospital instead.

During the interview, the researcher asked why he preferred not to take the lead in certain situations. He responded with reasons involving risk but also about sustainability.

*'It has taken some time for the midwives to get used to me as the doctor on the ward who sometimes doesn't act as a doctor. I've used this time to develop relationships and create*

*an*

*understanding of what I am here to do and not do. Sometimes it has been challenged if I have chosen to refer and not deal with a patient on site, which is difficult but the risk implications were to high not just for the patient but for me and the other staff as well.*

*When I do deal with patients I always include the other staff, otherwise there is no point me being here. I'm still learning loads of new stuff, even when I'm not doing 'doctory' type stuff,*

*it's all interesting and relative to me and my learning'.*

The desire to gain experience beyond individual competency depends on the volunteer's objectives and how they go about achieving them. The above quote demonstrates how the volunteer was able to control and limit their risk implications by using co presence but also ensuring they did not work outside of their clinical competency. The volunteer was able to manage his own learning and development whilst maintaining a positive and sustainable change with the local staff.

Co presence is designed to protect the volunteer from the risks of working outside of clinical competencies. However, if a volunteer desires this experience, they potentially have an environment where it would be possible to work above their level on several occasions (such as the above quote). This leaves the volunteer and the patient open to risk as well as causing tensions between the volunteer's and local staff as well as their sending organisations, if they choose not to adhere to the risk prevention concept of co presence. Tensions of working outside of clinical competency is discussed in more detail later on in this thesis.

#### 4.6.4 Blame culture

Another important dimension of risk concerns responsibility or 'blame'. In the UK health system, risk is closely associated with litigation and defensive practice and staff are continuously aware of their responsibilities and potential accountability if anything goes wrong. Such concerns have, until recently, appeared to be less of a problem in developing countries where litigation remains unusual but by no means unknown, Ackers, (2009)

In the maternal health care system in Uganda, there have recently been examples of litigation and legal action. These have been seen as opportunities to gain awareness of human rights, and access to safe maternal health care, or simply to raise awareness of negligence, Centre for Health, Human Rights and Development (2013). Currently, Uganda accounts for 2% of annual maternal deaths globally. This translates into 492 maternal death per month and 16 deaths per day, WHO, (2014). This is a very high figure and yet we also know that there are potentially more deaths unaccounted for i.e. mothers that died at home or on the way or never made it to a health facility are counted or estimated. These deaths are up to three times higher than the target of 131 deaths per 100,000 live births set to be achieved by 2015 under the UN Millennium Development Goals 4, WHO (2014).

In an attempt to help achieve MDG 4, as well as improving maternal health services for mothers in general throughout Uganda; the maternal health campaign of Centre for Health, Human Rights and Development (CEHURD) aims to improve the current situation by mobilising and working with civil society partners and communities to claim the right to

health of women through court action, engaging state actors, and promoting dialogue on women's health.

The establishment of this organisation has also helped to raise the level of successful legal cases for women in Uganda, CEHURD, 2014). An example of a recent case involved a mother of three who bled to death in a maternity ward at one of Uganda's public hospitals, she was not seen a doctor for over 12 hours despite her families pleas for help to the nursing staff. By the time the obstetrician arrived, she had died. CEHURD became involved with this case and filed for a Constitutional Petition (Constitutional Petition No. 16 of 2011) that sought to investigate and prove how the lack of essential maternal health care provided had led to the death of this mother as well as other as well as highlighting that this infringed their fundamental rights to health and life. The case is currently with Uganda's Supreme Court awaiting decision on whether litigation should proceed. This is an important step for Ugandans maternal health system and a reflection of how legal action and rights for women to receive adequate maternal health care is becoming more prevalent within public agenda, CEHURD, 2013.

Although an important step forward, this movement and awareness of litigation may also increase health care staff to feel threatened or concerned about accountability and blame, they may point fingers at other staff, or even a volunteer.

An SVP volunteer did have an experience which involved her being in a situation involving blame. The situation is explained in one of the policy reports:

*'In recent months one of the SVP volunteers experienced a maternal and neo-natal death. The deaths occurred following a period in which the volunteer was left to work totally on her own in very challenging circumstances and with poor equipment (a typical scenario for*

*a*

*Ugandan doctor). The following day local staff attributed blame to the British volunteer suggesting that her negligence contributed to the deaths. This situation has caused serious concern to the volunteer and her mentors. Indeed the Ugandan mentor subsequently emphasised to the volunteer the importance of not engaging in lone working. In this case co-*

*presence is as much about having a witness as it is about knowledge transfer.’ Ackers, (2013)*

After this unfortunate event involving an SVP volunteer, the volunteers arriving after the incident were made aware of the previous volunteers experience and the importance of risk was reiterated. It was noted that volunteers varied in terms of how much they chose to ‘protect’ themselves from risk. During an observational visit, the researcher noted that an SVP volunteer (a very experienced Midwife) was left alone to deliver a baby, which she will have done at home on many occasions throughout her career. However, the labouring woman was moments away from delivery but the SVP volunteer refused to be alone in the room without a local staff member to assist. Despite being well within her competency, the SVP volunteer was considering the risks to herself as well as the patient. On this occasion, the delivery went smoothly and a healthy baby was born with two midwives present, the SVP volunteer and after a few tense moments, a local midwife working at the centre.

The core values of the SVP are therefore influenced by DFID and THET’s aims and objectives, and the way in which voluntary placements are conducted are aligned with achieving the objectives already outlined. Volunteers must consider the broader objectives set by their funding body and deploying organisation, and have an understanding of how their placement will help to fulfil the overall aims and objectives, as well as considering their own objectives. How the volunteer combines these shared interests and goals and how this influences their overall experience is discussed in the following sections.

## 5. Identifying Uganda's needs through policy analysis

DFID and THET have created policy reports, operational plans, aims and objectives for the work they have identified as being required in Uganda. However, in order for the voluntary placements to work alongside local Ugandan staff within the health care system on the ground, what the country itself wants in relation to health care development must be understood.

In 2015, VSO published three policy documents, all of which had the main title - 'Our side of the story', VSO (2015). The documents all aimed to explore the lived experiences and opinions of Ugandan health professionals, as well as focussing on the role of volunteering within sustainable development.

In the first policy report entitled 'The lived experience and opinions of Ugandan health workers', research was presented on the lives of Ugandan health professionals and their experiences of working within the current health system. Their experiences with foreign aid and foreign volunteers were also discussed. The report highlighted several challenges, viewpoints and common experiences of 122 Ugandan health workers from all regions of Uganda, covering government, non for profit and private ownership health facilities (the issues raised are discussed in the next section). The health workers documented included doctors, clinical officers, midwives and nurses. The report aimed to gather evidence of what the Ugandan health workforce feel they need in order to facilitate and advocate change on a global level.

This report is extremely insightful and would provide invaluable information on the Ugandan perspective for a volunteer considering or beginning a placement.

The author of this thesis spent over 12 months living and working in Uganda and became aware of the negative image of local (Ugandan) health care workers presented in the media, political speeches and general public opinion. The negative image of health care workers includes absenteeism, lack of care and sympathy towards patients and corruption. The VSO policy report aimed to illuminate the challenges health care workers face in practice which may give reason to these perceived opinions.



## 5.1 Overview of Ugandan health care worker challenges

VSO's detailed report highlights the main challenges Ugandan health care workers face, these challenges within the working conditions were categorised into five themes: 'workload, infrastructure, equipment and medical supplies, availability of essential medicines and pay' VSO, (2014).

The report investigates each challenge in detail. The themes which emerged within these categories present conditions which would also effect voluntary placements. The conditions identified are to and would affect a voluntary placement include:

- Unmanageable workloads
- Most health care facilities in a state of disrepair with non-functional operating theatres
- Shortage of basic medical equipment, with only 40% in good condition
- 60% of health care facilities have registered 'stock outs' in essential medicines for the past ten years
- Ugandan doctors and nurses salaries are the lowest in East Africa

All of the above will have direct influence on the volunteer's ability to fulfil the various objectives, including their own and their sending organisations.

Focusing specifically on the first challenge 'unmanageable workload'; according to the Ugandan Ministry of Health, almost half of the health worker positions in health centres and hospitals are vacant – a shortfall of 25,506 staff, VSO (2013). This creates huge challenges in terms of workload for the present staff which can cause them to feel overwhelmed both physically and mentally. Therefore, it is easy to understand why the Ugandan health workers may appreciate or prefer the volunteer to provide some service delivery or be 'an extra pair of hands', Ackers (2013), to take the pressure off the current local staff, give them a break and ease the overwhelming workload by sharing it. This creates challenges for the volunteers who want to achieve sustainable change and not just provide service delivery and be 'an extra pair of hands'. This has emerged as an experience felt by some SVP volunteers, which is discussed in the analysis chapters.

As a volunteer, it is important to understand the context and challenges the Ugandan staff face with workload prior to the placement to ensure they can provide what is needed but also ensure their own objectives, values and principles can be adapted to the Ugandan setting to provide an optimum outcome for all involved.

The issue of having such contextual understanding of the host country is a theme which has been raised in current international volunteer placement literature. In 2011, Elit et al conducted a study on the ethical issues encountered by medical students during their elective placements in an LMIC. The study illuminates the challenges the volunteers faced (similar issues to the SVP volunteers were drawn out, see analysis chapters). Elit et al (2011) concluded that one of the main concerns illuminated from the results was the importance of pre departure country context training; *'preparation will be further enhanced if pre departure training is accompanied by efforts on the part of the students to learn about the social, political and cultural contexts of the locales in which they will conduct their placements'*, Elit et al, (2011).

This theme was also raised with some of the SVP volunteers, prior to arriving in Uganda some had good knowledge of the country context and challenges within the health system they would be working, whilst others became aware of these issues during their placements.

Reflecting on some of the concerns raised in the VSO report, some interesting points relating to the needs of the Ugandan health care staff were also raised in the SVP evaluation research which was conducted by the author in 2013. During a discussion with a Ugandan midwife in the focus group; whom had worked alongside SVP volunteers as well as many other international volunteers from various organisations around the world, the midwife was asked what she believes volunteers bring to Uganda, her reply suggested that she felt the volunteers had a motive that was not necessarily in line with what is best for Uganda; *'All you want to do is come here and train, train, train!'*

The point she was making is that training the local Ugandan health workers is not the answer. Although a lot voluntary organisations, including the SVP have focussed efforts on

training local staff, the midwife was expressing her view that this is not the only way to make sustainable change.

After spending over a year in Uganda, I can understand what she means. There are many organisations pumping money into training staff, but it is often not considered what happens to those staff trained after the training has been completed and the volunteers conducting the training leave. The Ugandan health care system is more unpredictable than the UK's NHS in terms of staff movement. For example, a Ugandan midwife can be moved to another area miles away from their home very abruptly, medical staff are constantly changing in health facilities. So if training is conducted at a health centre, six months later there is a good chance those staff trained might be elsewhere in the country. Those skills are still hopefully utilised elsewhere, but in terms of evaluation and continuity, the movement of staff create limitations to sustainability.

Reflecting on how this might affect the volunteer placement, the volunteer and their sending organisation might consider alternative ways of promoting sustainable change which does not involve too much training. Perhaps, a more interactive/on the job knowledge transfer approach could be considered rather than formal training sessions.

It has been noted within the SVP that whilst formal training sessions have proven successful on the day the training was commenced, follow up evaluation of the sessions have often proven that the training was not successfully implemented. For example, neo natal resuscitation<sup>2</sup> is a clinical scenario which has had a lot of input in terms of formal training from the SVP as well as many other voluntary services in Uganda. It is one of the largest areas in which Ugandan health care workers are not performing well within the Ugandan health care system. Despite multiple efforts not only from the SVP, the success rates with neo natal resuscitation are still very poor.

The VSO report provided a recent overview of what it is Ugandan health care workers want from voluntary placements. It is an important area to be considered in detail for organisations as well as volunteers as individuals to apply and develop their objectives to

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<sup>2</sup> Neonatal Resuscitation is intervention after a baby is born to help it breathe and to help its heart beat. Before a baby is born, the placenta provides oxygen and nutrition to the blood and removes carbon dioxide. After a baby is born, the lungs provide oxygen to the blood and remove carbon dioxide.

work in line and alongside Ugandan health care workers, thus, creating an effective partnership and a more sustainable impact.

## 6. Research Design and Methodology

### 6.1 Introduction and Research Aims

This research aims to build on from the idea of mutual benefit through ‘volunteering’ and investigate further what the UK, and more specifically UK doctors hope to achieve and learn from LMIC’s. Also, try to encapsulate how the volunteers balance their own learning objectives with the development objectives of the (UK based) organisation they are attached to, as well as considering the sustainable impact on the Ugandan health system.

This thesis will focus on ‘medical volunteering’, in particular UK doctors as volunteers. Healthcare volunteers make up a significant proportion of the total number of international volunteers, Bussell & Forbes (2002). Despite unprecedented growth in this area, there is still little known about the impacts of international medical volunteering.

This lack of knowledge is amplified by the expansion of diverse types of programs and organizations sending volunteers overseas. As the field continues to grow, it is important to learn the most effective ways for producing the intended outcomes. This knowledge can contribute to the enhancement of program and policy effectiveness as well as efficiency.

It is anticipated that there will be differences in an individual volunteer’s and a sending organisation’s objectives, which contribute to both the volunteer experience for the individual and the host country they are deployed too. This research aims to investigate how these objectives are fulfilled and draw out any tensions or ethical issues which arise within that process during the placements, which aim to promote sustainable change and development.

## 6.2 My Position

### 6.2.1 The sustainable volunteering project (SVP)

The study utilises qualitative research conducted as part of the ‘Sustainable Volunteering Project’ (SVP), a UK based project set up in 2011 to deploy highly skilled professional (British) volunteers to Uganda to promote sustainable and professional volunteerism within the remit of improving maternal and new-born health. The ‘SVP’ forms part of a wider consortium of health care partnerships in Uganda – The Ugandan Maternal and New-born Hub (UNMH).

The Sustainable Volunteering Project offers an opportunity for doctors to volunteer in Uganda and engage in assisting existing clinical infrastructure in an environment they would not experience otherwise. The SVP offers volunteering placements to postgraduate doctors from F1 level right up until consultant level<sup>3</sup>. The project has completed placements with doctors from various specialities and backgrounds, as well as different interests, experience and levels of training.

The data used for this study was drawn from previous research conducted by the author (myself) as part of an in-house evaluation<sup>4</sup> for the SVP. As well as 13 in-depth interviews that were also conducted with SVP volunteers and a focus group with other SVP volunteers and clinical leads from each UMNH site, (see appendix for sample demographic table).

The author (myself) was recruited as a volunteer researcher (Social Science) through the SVP from June 2013 until March 2014. In this role I was involved in extensive project data collection and evaluation. This primarily included participant observation and qualitative interviews with volunteers at various stages of their placements. Subsidiary data that was available to the author included volunteer application forms, interviews with Ugandan health care workers, as well as volunteer reports blogs and emails written during placements.

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<sup>3</sup> (F1 & F2 level are the first two years post-graduation, after this a Doctor chooses their ‘speciality’ training which could be Obstetrics or Paediatrics etc. Speciality training starts at ST1 and continues up until ST6/7 before the Doctor becomes a Consultant).

<sup>4</sup> In house evaluation for the SVP included information collected from the volunteers such as CV’s, application forms, interviews, emails etc. This was stored in a password protected file with only SVP staff having access to. The data was inputted into Nvivo 10 for analysis.

### 6.2.2 Role and responsibilities as 'Social Science Researcher' with SVP

Prior to and during the beginning stages of this Masters by research, I lived and worked in Uganda for over 12 months (July 2013 - September 2014). During this time I was deployed by the Ugandan Maternal and New-born Hub (UMNH), as the Social Science volunteer. The position was funded for the first 12 months by the Sustainable Volunteering Project (SVP) and based in Kampala with regular travel/ visits to the other various sites in Uganda where the UMNH were operating. The role involved all aspects of project research and evaluation, including conducting interviews with the volunteers (both individual and group) throughout their placements, observing their activity, and providing support and feeding back to the coordinator and funding body in the UK.

### 6.2.3 Engagement opportunity with SVP volunteers

Whilst carrying out the role, I lived in a shared house with other SVP volunteers in Kampala. This position gave me a unique opportunity to gain insight into the voluntary experience in Uganda.

As a volunteer myself, I spent time in various settings with the volunteers as well as their Ugandan counterparts, including health professionals and other local staff. I was able to observe how volunteers engaged in their placements, how they adapted to a new environment, how they developed relationships, and most importantly for this study, how they attempted to carry out their objectives and balance these with the sustainable values of the SVP as well as the consideration of their Ugandan counterparts.

The observational focus of the research included; looking at clinical practice, knowledge transfer and relationships in a health care environment. As well observing professional practice, I was able to observe scenarios outside of work - informal meetings between volunteers and Ugandan staff, conversations over dinner at the volunteer house I lived in etc.

## 6.2 Methodological approaches

This study was conducted using qualitative approaches which was influenced by ethnography. Due to my unique position as researcher in the field (as the SVP social science

research volunteer in Uganda) for a prolonged period of time (over 12 months), I felt a qualitative approach was most appropriate to yield to most relevant data.

I believe qualitative methods allowed me to explore the research question and enabled me to develop the themes identified as the research project itself developed and I became further contextually aware.

Qualitative research is characteristically exploratory, fluid and flexible as well as context sensitive, Mason (2002). There is no set way to design a qualitative strategy or method, and the design itself is ongoing and fluid within the context it is being conducted. This approach was most appropriate for me to conduct observational work and semi structured interviews as well as constantly being aware of the context of being in Uganda as a volunteer, taking stock and being reflexive.

I had to ensure that my position as a fellow volunteer within the project enabled an appropriate amount of interpretation whilst being equally engaged with the social world I found myself in alongside the volunteers.

In relation to my position in Uganda and my relationship with the volunteers, as well as my own knowledge and background, being aware of this position was important throughout the research process. I had to ensure my bias and assumptions (which had formed over time in Uganda and being immersed within the project) were not heavily influential in the interviews, thus considering how questions were phrased, i.e. ensuring the volunteer spoke from their point of view only. Further to this, whilst conducting the interviews it was important for me to make the interviewee feel at ease when discussing any difficult or sensitive issues, as well as issues with the management of the SVP.

As a fellow volunteer, I was able to understand the volunteer placements on the ground in Uganda, which was a definite benefit and enabled me to be a source of support. However, this also (potentially) put me in a position in which the volunteers may not have wanted to discuss any negative comments regarding the placements and/ or the management of the SVP. Therefore, it was essential for me to be 'reflexive' and ensure my position was not influential to the interviewee.

## 6.5 Sample

The target population for this study were British doctors who are considering or currently volunteering in a LMIC, as well as the organisations and other stakeholders who would arrange such placements. Doctors were specifically chosen as a sub sample because I hypothesised that it was doctors who had the most specific objectives, and who therefore experienced the biggest tensions whilst completing health care placements. Choosing to focus on doctors promised to illuminate the tensions specific to this type of volunteer working within the Ugandan health care system.

My position as the researcher was invaluable when identifying appropriate participants. As a fellow volunteer, living and working in such close proximity both personally and professionally to some of the SVP volunteers, I had access to a target sample.

Therefore, my sampling method was purposive and opportunistic. 'Opportunity sampling', which is sampling tool that uses the knowledge and attributes of the researcher to identify a sample, Brady (2006). For example, using a researcher's local knowledge of an area on which to base a study or using a researcher's past experiences to contact participants or gatekeepers.

Opportunity sampling is often grouped together with incidental types of sampling such as convenience sampling, volunteer sampling and purposeful sampling, Brady (2006).

This approach was taken as my position and 'local knowledge' (i.e. living and working with the SVP volunteers) enabled me to draw upon SVP volunteers as the basis of my sample.

The sampling frame and process of selecting participants (sampling) was relatively straightforward, as the volunteers were working within the same project as me in Uganda. Therefore, relationships and understanding of my role and my research had already been established before the sampling took place. Further to this, my access to the SVP in house database allowed me to orient myself to the project and the volunteers prior to arriving in Uganda. The SVP data gave me a good working knowledge of the project and access to data on each individual volunteers/interviewee's background and current placement activity etc.

The selected sample of volunteers from the SVP were either current or post placement in Uganda, from various medical specialities as well as training levels. A total of 13 participants



were selected from the Sustainable Volunteering Project, 10 of which were doctors. The doctors interviewed consisted of four post F2 doctors (no chosen speciality yet), two ST5 Obstetricians, one ST3 Obstetrician, one ST5 Paediatrician, a Consultant Obstetrician and a nearing Consultant Anaesthetist.

Three other interviews were conducted with other SVP (non- doctor) volunteers, which consisted of two Midwives and a Neo Natal Nurse, making the total sample 13<sup>5</sup>.

The reason the additional interviews were used in the sample was to gain a perspective from other (non -doctor) volunteers which included midwives and nurses. During the interviews these volunteers gave their opinion on the role of doctors within the SVP. The author found relevant and useful data with these interviewees despite the interviewees not being doctors, and therefore decided to include these in the sample.

The sample of 13 (10 Doctors, 3 other health care professionals) was chosen to enable the researcher's preference to conduct 'in depth interviews' within the time frame and availability of the participants.

#### 6.6 In - depth semi - structured interviews

All 13 participants were interviewed during or post SVP voluntary placement in Uganda. The interviews took place in both the UK (if the volunteer had returned from their placement) and in Uganda (if the volunteer was currently carrying out their placement). The researcher was working as an SVP volunteer (social science) throughout the data collection process.

Because the aim of the study was to yield detailed qualitative data from such a unique and different experience for the health professionals, it was decided that in- depth, semi-structured interviews would be most appropriate.

The interview schedule was constructed around the analytical framework I had developed for the in- house SVP evaluation file, using Nvivo software during my role as the social science volunteer alongside my SVP colleague. I used the Nvivo framework to develop my own interview schedule for this research. The themes already identified through the in-

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<sup>5</sup> See appendix for demographic table

house SVP evaluation guided my schedule and allowed me to cover areas already emerging via the SVP in house evaluation as well as my own interests and the themes identified in the literature. Keeping the areas broad and fluid yet allowing the discussion to flow by presenting topics, themes and issues relating to the research question, as well as using probes and prompts to delve further into the area.

## 6.7 Data analysis

The semi structured interview approach was used to help illuminate ‘themes’ from the volunteer feedback and discussion. The thematic approach taken, relates to Mason’s thematic method (1996); ‘thematic, topic centred, biological or narrative approach’.

An example of the interview schedule below shows how Mason’s thematic method was used to guide the interviewee through the questions via relevant themes and topics identified in the literature:

### *1. Theme identified – Tensions or ethical issues*

*Question - There has been suggestion on a ‘tension’ between what Ugandans want from volunteers and what the volunteers want... have you come across this at all?*

The themes identified are discussed in further detail in chapters 7,8 and 9. The thematic method was used to illuminate several areas of

The interviews were conducted in private and each interview lasted between 40 minutes -1 hour. The interviews were recorded and stored in a password protected file. Once I had transcribed them, the interviews were coded and analysed with the aid of Nvivo software.

## 6.7 Limitations to the study

- 1) Time – Although the researcher’s position allowed a prolonged period of time to be spent in Uganda, the volunteer’s time is often maximised. Therefore time was a potential limitation to some of the interviews. Each interview lasted at least 45 minutes, combined with the researcher’s understanding of the context through secondary research previously collected through the SVP role, this was an adequate amount of time to conduct a thorough interview yielding detailed and appropriate data.

2) Interviewer effect – The researcher’s unique position was an integral part of the study and influenced how the research was conducted. However, the effect of this position had both pros and cons. In terms of relating to the sample, I had built up a lot of prior knowledge of the volunteers and their experiences, themes were beginning to appear (within the data collection for the SVP in-house evaluation) and relationships were developing, which were all influential factors when conducting research. I was personally and professionally immersed within the data (through living and working with the volunteers) which was effectively ‘insider research’, Brannick, T., & Coghlan, D. (2007).

3) This prior knowledge enabled me to conduct the interviews from a unique perspective. The positives of this, included, the ability to prompt during interviews and fill in gaps with the knowledge gained through the experience of living with the volunteers and being so close to the sample.

A potential disadvantage of the researcher’s position and the effect on the interviews may have been that they were in fact too immersed within the data, struggle to ‘step outside’. This again relates to Mason, (2002) of being ‘reflective’.

4) Generalizability Due to the study being qualitative and relatively small in terms of sample, it is assumed that the findings will not be possible to generalise and as usual in qualitative research, generalising is not a priority as the data collected is very context specific. Although in evaluation research it can be a priority, this limitation has been considered and whilst there have been previous studies undertaken in Uganda which are focusing on similar ideas; few have studies have utilised in depth qualitative data to describe in detail and further explore these tensions. Therefore compared to other research within this field, this study aimed to build on any current context to generate questions and fill this research gap by explaining experiences and outcomes through explanation and interpretation. For this reason, the researcher favoured depth over breadth.

## 6.8 Ethical issues

1) Confidentiality, Anonymity and Informed consent When this research was conducted

I was both the author and a fellow volunteer on the SVP programme. As the Social Science volunteer, all of the SVP volunteers understood from the beginning that any interviews, discussions or observations made by myself may be used within this thesis as well as in the SVP evaluation. It was always made clear that the data collected would be confidential and stored in a password protected location with any names or other obvious details anonymised using pseudonyms. Any data published would be protected and also anonymised.

However, as the sample is small and specific, the characteristics of each volunteer are potentially identifiable, it is impossible to state that the data can be 100% anonymised to all. Therefore, the author can only state that they will do their best to keep the volunteer's identity anonymous. The author will also check with any respondents before any data is published by sending them a draft of the thesis which includes any of their responses.

2) Psychological damage/ harm to the volunteers Some of the experiences in a Ugandan health care setting can be difficult. Although all of the sample are health care professionals in the UK, who deal with illness, upsetting situations and difficult decision-making already, the Ugandan health care system and the medical cases/situations the volunteers will come across are incredibly different and far from what they are used to at home. The 'recalling' of their experiences can be upsetting and difficult to discuss. This is something the researcher had to consider and deal with appropriately and sympathetically. However, such conversations can also be 'cathartic' for the volunteers and present opportunities for valuable debriefing.

## 7. Volunteer motivations in the SVP

In order to understand the motivations of volunteers from the SVP, the author conducted qualitative research with the SVP volunteers which consisted of data collected prior to the placements and interviews both pre, during and post placement. The analysis of the SVP data began with examining the initial applications, and also the pre placement interviews with volunteers who went on to complete a placement in Uganda.

The application form asks three specific questions, which aim to give the applicant a chance to explain their reasons for applying, discuss their motivations and objectives for the placement as well as their future career plans. The questions are as follows:

*SVP Application form questions*

- 1. Please explain in no more than 250 words your reasons for applying for this position.  
What interests you in the position?*
- 2. Please describe briefly how you believe this position will contribute to your own training and experience?*
- 3. What do you plan to do (from a career/employment perspective) on your return?  
SVP (2013)*

The applications formed a key part of the data collection and analysis. The answers give clear statements, directly from the volunteer detailing what motivates them to conduct the placement.

Aiming to discover the reasons behind the decision to embark on a voluntary placement in Uganda. The following discussion is based on the examination of SVP volunteer applications as well as initial interviews from volunteer doctors beginning their placement in Uganda.

The analysis of the application forms illuminated four key themes concerning their 'motivation' to volunteer with the SVP:

1. Previous voluntary experience within a 'development setting' (LMIC) and a desire to return with more experience/ seniority
2. Length of stay – A desire to stay for longer period of time (6 months +)
3. Specific interest in the organisation's (Sustainable Volunteering Project) values and principles (In particular the commitment to sustainability and the 'co presence' method)
4. Anticipated skills gains (personal and professional)

### 7.1 Previous voluntary experience within a development setting (LMIC)

Most of the volunteer applications examined mention 'previous voluntary experience within a 'development setting' (within a LMIC) and a desire to return with more experience/ seniority'. According to the total received applications, most of the doctors confirmed that they had previous short term voluntary experiences in a LMIC, either as part of their medical elective or a voluntary placement outside of their training which was pre graduation or very early on in their training. The experience had influenced their decision to return later on in their career to conduct another voluntary placement.

The following case is typical of the applicants with previous experience of a voluntary placement:

*'Three friends and I spent four weeks working in a state hospital (in a low income setting). We went with high hopes of 'making a difference' but it quickly became apparent that the most useful service we could provide was the donation of the money which we had fundraised. Our medical knowledge at that stage was inadequate to help them in any meaningful way. At that time, I made a conscious decision that I would volunteer again for a longer period when I had gained more knowledge and skills' SVP volunteer application, (2013).*

The above quote touches on some of the social factors underpinning volunteer motivation. The volunteer strongly suggests that they 'hoped' to be able to 'make a difference' to the host nation, they envisioned creating a strong impact on the local environment but felt they could not make that impact during their first experience, either as a student on an elective or at a very early stage of their career. This is seemingly due to the fact that they were 'juniors' and didn't have what they believed was adequate knowledge to provide the impact they hoped to at that time.

Another SVP volunteer raises similar issues relating to their reasons for applying for the placement in Uganda:

*'Since my medical elective, I have wanted to take part in a developing world project as a Doctor. I have resisted the temptation to go earlier in my career but now, as a senior Anaesthetic Registrar, I feel that I would be both useful to a project and comfortable taking on this role. I have enquired into a number of different African anaesthetic projects but feel that the SVP will provide an ideal combination of education, training and clinical work' SVP volunteer application, (2013)*

Again, the issue of medical knowledge and seniority is raised by this volunteer. It seems that the volunteer believes being a senior registrar will enable them to make a more useful contribution throughout the placement. However, having 'senior' medical knowledge is not considered a crucial attribute in relation to the SVP objectives, this raises interesting question about why volunteers feel they need so much knowledge in order to 'help'.

Another volunteer reiterates the theme of 'previous experience' influencing their decision to return with more knowledge, which they believe will enable them to feel they can 'help' more effectively:

*'As a medical student I felt pretty helpless. Sometimes I might still feel pretty helpless at this level (ST5) but I have a lot more skills and knowledge now to help'*

*'I don't like being in a situation where I'm not the best person to deal with it, I wanted to know I had a lot of experience under my belt before I went out' (SVP volunteer interview, 2013)*

In terms of previous experiences with global health placements, each volunteer suggests that they felt their medical knowledge at that stage was insufficient to make a difference. There is a dismissive and negative tone towards the initial experiences because of their current level of knowledge at that time.

The theme of feeling that they simply could not help to make a difference at that time underpins each of the quotes. This could be strongly argued as untrue. Even without medical knowledge, the volunteers could have engaged in other activity outside of clinical

practice to support the LMIC in which they were conducting their placement. This could have been through audit, data collection, manual work etc. Within the SVP, it was not always the clinical knowledge that produced the most successful placements or indeed the most impact to Uganda.

An example of this was when the first social science volunteer (non-medical) of the SVP (predecessor to the author of this thesis) produced the Benchmarking Report, SVP (2014). The volunteer spent 6 months collecting data from each location and health facility that the SVP served and deployed volunteers to work in alongside Ugandan counterparts. The data collected, included the total maternal deaths, neo natal deaths, HIV rates, ruptured uterus etc. from each site.

The report provided a benchmark for each site in terms of their data. Data collection is often not completed regularly in Ugandan health facilities, and even if it is, it is renowned for being skewed or inaccurate. This is noted in a report by the Foundation for Sustainable Development (FSD);

*'The scope of Uganda's success, however, has come under increased scrutiny. The government repeatedly misused international funds directed toward AIDS relief efforts, and in 2002, a medical journal 'The Lancet' published research that questioned the accuracy of previous reports in Uganda that indicated a dramatic decline in HIV infections. It is claimed that statistics have been distorted through the inaccurate extrapolation of data from small urban clinics to the entire population—90 percent of whom live in rural areas'. FSD, (2013).*

Considering this information, the SVP report was the first of its kind for some facilities within the UMNH in Uganda. It provided a clear view of what was happening in each in site in terms of department and patient trends, areas for concern etc. Allowing each facility to work towards change, acknowledge areas that required attention as well as and being able to compare and refer back to the benchmarking report to capture future development, which in turn may increase staff motivation; if staff can see where improvement need to be made and understand what needs to be done to achieve this, they will also be able to see how things have changed with accurate data collection and see how their hard work is paying off and creating a better working environment as well as patient care, thus creating a



clear understanding, motivated work force. The report was essentially one of the biggest achievements for the SVP and created a valuable and sustainable impact.

This suggests that not all impact has to come from medical knowledge and challenges the volunteers understanding of her role only being successful if she had more knowledge of medicine.

It is interesting to note for future volunteers, particularly early career or even medical students that they should be aware it is not only medical knowledge that will enable them to have a successful placement which will benefit themselves as well as the LMIC. Further to this, the volunteers also articulates that 'time' is a factor with volunteering, 'length of stay' is discussed as another emerging theme in the next section.

The SVP objectives do not state explicitly that the volunteer needs to have any specific senior medical knowledge to contribute to a successful placement, nor does the SVP identify specific criteria for volunteers to apply, in terms of level of experience. Therefore, the idea of needing senior medical knowledge has developed through the volunteer's previous experiences, not through a requirement of the SVP.

The volunteers suggest that they were 'inexperienced' at the point of the initial placement or that their contribution may not be maximised at that level. Therefore, they recognised the needs of the host country upon arrival and identified the fact that their role might be more beneficial in the future with more knowledge and skills. This does highlight that the volunteers have taken the host country into account when evaluating what they can do to help, but in terms of the SVP objectives, senior medical experience and knowledge is not seen as a necessity to carry out a successful placement.

This raises interesting questions, as the majority of volunteer's state they are conducting the placement to learn and develop their own professional skills and knowledge, yet the point raised here was that they felt being more senior and having further experience, skills and knowledge would enable them to conduct a more worthwhile placement, this seems contradictory as if the skills and knowledge are already in place to a 'high' level, the development of those would arguably not be on their agenda.

As the researcher spent more time with the volunteers, it became apparent just what type of skills the volunteer did learn through the placement, some of which were unexpected as

well as those they stated they wanted to achieve via their applications. What was actually achieved is discussed in the following chapter.

## 7.2 Length of stay

Length of stay was the next theme to be drawn out of the motivating factors in the SVP applications. Some of the applicants with previous experiences of volunteering explain that their voluntary activity was undertaken on a 'short term' basis. A volunteer discusses their previous experience and how they were influenced by the SVP's focus on the 'long term' placement:

*'A huge motivation was actually time, I really want to know what it's all about but also I wanted the time to do that and a lot of other placements out there are short. Development is something that I'd quite like to do long term and it seemed like a good project to start. And I didn't really know an awful lot about aid beforehand so it was quite a good six-month period for me to come and do it and to really spend time to learn' SVP volunteer initial interview, 2013.*

The minimum length of stay for an SVP placement is six months, this was a DFID/ THET requirement when the project first began (See DFID/ THET objectives in policy analysis chapter). The volunteer above articulates that they felt this would be enough time to engage, learn and understand the project. The SVP approach to placements typically begin with observation only for the first few weeks, giving volunteers a chance to adapt to the new environment, the culture, the local area as well as the work place and the staff they will be working with. The volunteer below discusses the first month of her placement:

*'I have spent the first month working in the different locations with other volunteers in various clinical areas. I have spoken to other volunteers and local staff about possible projects and am developing some ideas. I feel that I have made good progress in developing project ideas and beginning the work, I am yet to decide what I want to focus on for my placement' SVP volunteer mid placement interview, 2013*

This volunteer spent ten months in Uganda, they wanted to find a specific project to focus on and spent the first month trying to figure out what that could be. After nearly three months of mainly observational work alongside Uganda colleagues in various UMNH locations, the volunteer developed a successful project which screened new born babies for hearing.

The project saw the volunteer team up with Ugandan colleagues from the health centre they worked in to develop a process of hearing testing for new born babies. In the UK new born screening for hearing is done with highly technical equipment which is not available at this centre in Uganda. Therefore, the volunteer improvised by building a sound proof box, with a small incision made at the top to allow sound through. The babies were placed in the box and their hearing was tested by releasing a variety of sounds. The project proved to be a success and was taken on by the Ugandan colleagues after the volunteer left. However, the project did only last without the volunteer for a short while, as cost of keeping up the box as well as staff time was not provided once the volunteer had left. Unfortunately, this is somewhat typical of a volunteer project within a placement environment, which relates more to the sustainability elements which must be considered by a volunteer when deciding what they want to do. However, this project did prove successful for a short time and provided benefit for the babies tested and the volunteer.

Focusing on a specific project is likely to be more beneficial to the volunteer in terms of their objectives relating to professional development, especially when explaining their experiences in their portfolio or CV. In this instance, the volunteer will be able to show initiative by choosing an appropriate and worthwhile project, management skills by organising the project by herself as well as audit and clinical skills.

This placement and project in particular was a good example of how the longer term placement can be beneficial for both volunteers and the host country. The volunteer took some time to get used to the environment, build relationships and gain an understanding of what they could bring to the local setting within the time frame they had. A shorter term placement may not have allowed scope for such engagement and understanding.

Some of the volunteers who had previous 'short term' experience of working in a low resource setting confirmed that their initial experience influenced their decision to return and take on a long term placement:

*'At that time, I made a conscious decision that I would volunteer again for a longer period when I had gained more knowledge and skills'*

The volunteer confirms they would want to return for a 'longer period', suggesting that shorter stay placements are not as effective or play a different role. The issue of longer term vs. shorter term placements is a clear theme in the SVP data and an area that has been discussed in previous volunteer motivation research.

The importance of the long term placement is summed up below by a returning volunteer doctor. After spending their elective placement in another part of Africa, this volunteer returned to complete a long term placement:

*'The SVP emphasis on the 'longer term placement' and the importance of knowledge transfer and networking; I believe will help to improve and standardize the healthcare system in Uganda. I fully support the concept of the long-term volunteer to enable such sustainable change and achieve the project aims and reduce vulnerability of the local personnel' SVP volunteer application, 2013.*

This section has identified a number of issues related to volunteer motivation. Firstly, that previous experience of a voluntary placement and wanting to return with further knowledge and experience. Secondly, that the length of the placements influenced the volunteer's decision to apply for a placement in Uganda with the SVP.

These two influential factors raise some interesting questions; the perception of the volunteers seems to be that being early into their career and having only 'some' knowledge, minimal experience and skills and shortness of time can be issues which may negatively affect or limit what they (as volunteers) can bring to Uganda in terms of helping. However,

the question of what they (volunteers) want to gain from the experience does not directly correlate with the two issues raised. If the volunteers want to return after a previous experience with more knowledge and skills in order to conduct what they believe will be a more worthy placement to the local environment and project they are attached to, then it could be argued that there will be no benefit in terms of their own knowledge and skills development. Having more skills and knowledge will benefit Uganda (positively) but may not have any benefit to the volunteer's skills and knowledge development.

The issue of time (longer term placements) appears to be a positive factor in terms of motivation, but again this does benefit Uganda mainly. By having longer terms placements this will help create continuity and sustainable change for Uganda, but for the volunteer why would being in country longer be a benefit, this point is not raised. It is interesting that the first two points raised about motivation relate directly and only to what benefits Uganda. The next two themes relate more to what benefits the volunteer. This relationship between who benefits

### 7.3 SVP commitment to sustainability and the value of co presence

The next theme drawn out from the analysis of volunteer motivations in the SVP evaluation, was the specific interest in the SVP focus and commitment to the value of 'sustainability' and the value of 'co presence'.

One of the SVP's core values is its focus on 'sustainability', which is defined by the 'World Commission on Environment and Development, WCED, (2015) as:

*'Sustainable development is development that meets the needs of the present without compromising the ability of future generations to meet their own needs. It contains within it two key concepts:*

- *The concept of **needs**, in particular the essential needs of the world's poor, to which overriding priority should be given; and*
- *The idea of **limitations** imposed by the state of technology and social organization on the environment's ability to meet present and future needs' WCED, (2015)*

In the context of the SVP, the commitment to sustainability relates to the above definition as it aims to meet the needs of the Ugandan health care system by placing UK health professionals to work alongside Ugandan health care professionals and create improved care for maternal and new born patients which can be sustained after the SVP volunteers placements have finished. The change and improvement will come from Ugandans and only be supported by the SVP, which will ensure future generations are not reliant on outsiders such as SVP volunteers to enable change, but for the Ugandan health professionals to take the lead.

As part of DFID's requirements for the project was also to ensure the placements are 'long term' (6 months minimum). The project holds a strong view on ensuring the placements are not simply 'service delivery'. This means the volunteer cannot carry out services and just be 'an extra pair of hands'. They must ensure they work alongside their Ugandan peers to enable effective knowledge transfer and on the job training, which ultimately helps to achieve the overall aims and objectives of the SVP.

These two attributes of the SVP were a positive and motivating influence for some of the SVP volunteers, and are specifically mentioned within applications. One volunteer discusses the reasons why these values attracted them to the project:

*'I like the sustainability element to this project, it is not just about service delivery and I like that there is no danger of just being an 'extra pair of hands'. I like the idea of being able to suggest projects and audits to promote sustainability as well as mucking in and being part of the team'.*

The volunteer explains how they understand why the project has such a strong focus on sustainability and can envisage how 'co presence' will influence their placement in a positive way.

They use the word 'danger', in terms of being an extra pair of hands, this relates to the idea of risk which is discussed in the following section.

As a principal value of the SVP, it is also important that volunteers understand the reasons behind co presence. This was noted in some of the applications:

*'I am very interested in this position because of the concept of sustainability, and I wholeheartedly agree that teaching a man to fish is far better than giving a man a fish'*

*'Obviously it's great to come and train, which is what so many projects do in Uganda, but my personal goals relate to sustainable change, that is very important and that's why this project seemed different to me'*

The quotes from volunteer applications above show that the volunteers understand the benefits of the concept of co-presence and the commitment to sustainable change. As mentioned in the above quote, volunteering is often just about training and service delivery. Although the SVP encourages training and accepts there will always be an element of service delivery as the placements are designed to help, support, train and allow knowledge transfer to take place (as long as conducted in line with co presence) the project is different to many others because of the commitment to sustainability and its approaches through use of co presence.

So far, the volunteer motivations within the SVP relate to the more altruistic elements of motivation. Each volunteer showed an interest in the sustainability of their placements and hoped to achieve long lasting impact to the Ugandan health care system. Most were motivated by a previous experience which developed an interest in the core values of the SVP.

#### 7.4 Anticipated personal and professional skills gain

The final theme emerging from the evaluation of the applications was the anticipation of personal skills gain, which is not as 'selfless' or 'altruistic' as the previous motivations discussed in this chapter. Skills gain has proven to be the biggest theme in volunteer

motivations with the SVP, it is a gain all volunteers hoped to achieve in some way during their placements in Uganda.

As identified by Jones et al (2013), personal and professional (including clinical skills gain) was one of the benefits identified in the systematic review, and is a growing area in terms of motivation for volunteers. A development of this theme is the potentially controversial side to this idea of individual gain, as recognised by Fee and Gray (2007) as the ‘the negative side of globalisation’. If volunteers are hosted in a LMIC and develop their skills and their knowledge before returning to the UK, it must be considered what the host country gains from such volunteer activity.

The literature review acknowledged the growing pressure on doctors to gain as much clinical experience as possible during their training, to enhance their CV’s and portfolios. Voluntary placements with projects such as the SVP provide scope for skills gain that would not normally be possible in the UK. Therefore, the potential for ‘skills gain’ forms a large proportion of the motivation to volunteer.

The volunteers discussed the skills they ‘hoped’ to gain during their placement. These skills can be identified into seven categories as shown in figure 1.

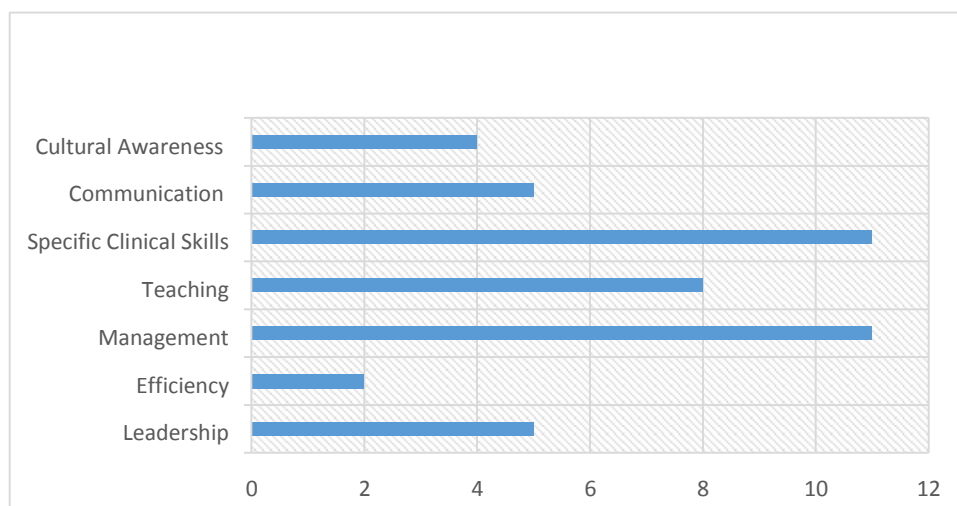


Figure 1<sup>6</sup>

<sup>6</sup> Figure 1 - The clinical and non-clinical skills volunteers hoped to achieve during their placement , SVP data (2014)

Figure 1 shows the various motivating factors in terms of gains. ‘Specific clinical skills’ and ‘management’ form the highest score in terms of anticipated gains. Both skills are more accessible in terms of experience in Uganda than they would be for a volunteer in the UK.



This is due to the nature of the setting, the access to clinical scenarios that would not be accessible in the UK as well as the need to use managerial skills, this could be due to the lack of staff and resources. The volunteer might be the most senior member of staff on site and have to use managerial skills that would not use or develop in at their level in the UK.

Medical voluntary placements are often associated with 'clinical practice', assisting with clinical situations and different diseases that would otherwise not be experienced until later on in training in the UK or perhaps never experienced at all. The SVP placements for doctors do involve clinical practice which will enable clinical experience and gain. However, in the SVP focus on sustainability, (which promotes placements not to only carry out service delivery and focus more on knowledge transfer through co presence) the project emphasises the non-clinical impact of the placements. The data shows that the non-clinical gains are just as relevant for a volunteer's motivation as the more clinical skills gain.

The SVP offers the volunteers experiences they would not encounter in the UK. They will find themselves in clinical situations which challenge their competency and level of practice in the UK, this not only develops clinical awareness and knowledge but also enables the volunteer to use and develop non-clinical skills such as communication and management. The volunteers are likely to find themselves working with a scarce amount of physical resources as well as short staff numbers. These two factors alone require many different non-clinical skills such as, management and leadership. The volunteer must be adaptable and figure out how to work effectively with scarce resources, how to lead a team with minimal staff etc.

A volunteer about to start at consultant level identified three important skills she hoped to gain during her placement: Leadership, Management and Efficiency, all of which are nonclinical skills:

*'Professionally this placement holds the potential to develop my non-clinical skills.'*

*Leadership: my training makes me a recipient of an advantage many of the local practitioners never had and the operating principles that the SVP embodies, that of staff development, education, and progression in skill would multiply the benefits of my training.*

*Management: the limited resources –staff, skills and equipment are a challenge given that the aims of patient safety, excellent care and delivering good patient experience are similar to what is aimed for in the UK.*

*Efficiency: trying to deliver quality in a resource limited setting, learning from local practices and different equipment etc. unique to the setting- being resourceful and finding solutions  
and helping make the best of what is there'*

It is interesting to note that this volunteer was a nearing consultant level, therefore coming to the end of their training. Perhaps clinical skills gain was not as high on the agenda for this volunteer as it might be for a more junior doctor. As a consultant doctor, management and leadership are skills more relevant and necessary than they might be for an early career doctor in terms of career development.

Comparing these anticipated skills gains to a junior doctor's anticipated skills gain, it is apparent that the non-clinical experiences are not as important to the junior doctor volunteer in terms of what they hope to gain from the placement. An ST3 doctor discusses their reasons for applying:

*'I understand the importance of leaving a sustainable change will involve less clinical work and more management and knowledge transfer etc. But if this placement had no clinical work at all I would have said no. Some doctors might not mind that but where I am and my interests, I want to do clinical work'*

This is typical of a junior doctor's application, the objective of gaining clinical skills is high on a junior doctor's agenda, more so than a more senior doctor. As shown in figure 1, clinical

skills gain form the largest of the motivating factors from the applications. The clinical skills gained in practice during the placements are discussed further in the next chapter.

This chapter has identified the reasons (themes) behind the SVP volunteer's decision to conduct a placement in Uganda through analysis of the volunteer applications and initial interviews during the recruitment process. Themes 1 and 2 (discussed on page 28-29), were focussed on the benefits to Uganda. However, the other two themes (3 and 4) were geared more towards what benefitted the volunteer. This raises an interesting dynamic as to what these placements achieve and what volunteers believe they will achieve for themselves and the host country. Point 4 (anticipated skills gain) was an issue all volunteer raised in their pre departure applications and discussions. It is the biggest motivating factor within the context of the SVP volunteers and is solely focussed on them (volunteers) as individuals, with Ugandan benefit not being part of this theme. The anticipated gains vs. what was gained in practice turned out to be different, this is discussed in the next chapter.

### 7.5 Volunteer training programme formalities

A key point relating to the diversity of contexts and experiences of the volunteer placements can be influenced by the institutions that are attached to, i.e. their deanery or college. Prior to applying for a placement with the SVP or any other international placement organisation, a trainee doctor must apply to their employer, deanery or college for time out of work and their training. This can be a difficult process depending on how supportive, or able the employer is to release the trainee doctor. Further to this, some colleges and deanery's allow the experience to count as part of the training, meaning the experience will be accounted for and used as part of the trainees learning outcomes. There are some colleges and deaneries that do not allow such experiences to officially count towards the training programme.

In the cases of the SVP doctors, each volunteer had a different experience. Some were able count the experience as part of their continued training programme and others had to take a career break out of training. One volunteer was actually forced to resign in order to complete the placement as their deanery was not supportive of their decision to take the role with the SVP.

During a discussion in Kampala at a UMNH workshop involving the SVP volunteers (including non-doctor volunteers) and Professor James Walker from the Royal College of Gynaecology; there was a discussion surrounding the issue of career development and training programme expectation. The suggestion was made that the expectations and formalities of undertaking a placement during a training programme are different for each individual volunteer depending on their discipline as well as their college or deanery. Participants confirmed that some colleges and deanery's are more supportive than others when releasing a trainee to undertake a placement outside of their training programme. Some encourage and allow the experience to 'count towards training' and others support it as an out of training experience. The quote below from an SVP Paediatric volunteer illustrates this point;

*'The first thing from the doctors perspective; we can gain so much from working overseas but we cannot get our log book signed off and we cannot get procedures signed off. We have online e portfolio which thankfully the Royal college has kept activating for us so we can use for personal reflection and audit but in terms of getting procedures and clinical work experience signed off... as I quote someone very correctly said if you have not written it down you have not really done it. Flipping it the other way round the benefits that certainly I have gained I would not have at my current level in the UK. And I think that is something that our placements have really helped us with and what I would strongly encourage from the Royal College perspective is to allow us to keep our e portfolios open so that hopefully one day will count' Focus group, (2013).*

The volunteer confirms how beneficial the placement has been in terms of career development and understandably feels frustrated that this experience is not officially counting towards her training, despite the volume of invaluable experience she has gained from the placement which economically will benefit the NHS upon her return.

Although this research focuses on doctors only, an interesting point was made by a midwife during the same group conversation;

*'Can I just say that not all of us here are doctors- I know you know that but also it does not mean that what we have to produce while we are here is different, our expectations of the people that have let us go are really quite different with the majority in the room. I've just been sent off on a career break whereas some of you have to follow a programme. You're all talking about your training programmes and the boxes that you have to tick but actually it's not quite as strict for other people' Focus group, (2013).*

The midwife raises the issues surrounding the formalities of career breaks and release from training programmes and suggests that this is different for every discipline and deanery or college. Some deaneries might be more able to release than others due to over staffing, whereas others might be less able to if there is a shortage of staff etc. This can effect and limit a volunteer's opportunity to conduct an international placement as well as effecting what they actually do on placement.

Initially, the SVP planned to send volunteers out in groups three times per year, all at the same time. The initial plan was to give the volunteers a structured group induction upon arrival, with the placements lasting 6 months and the start – end date all being the same per group. However, because of the formalities relating to the release of trainees varying from each volunteer's deanery or employer, this was not possible. As mentioned in the above quote, some of the SVP volunteers had no problems when applying for a career break or time out of their training, however others went through different and difficult processes in order to get time out of their training to conduct the placement. An example of this was with a volunteer doctor nearing consultant level in the SVP, who was forced to resign from their position in order to take on a six month placement in Uganda. In a follow up discussion post placement, this volunteer had returned to the UK and a position within the same deanery on a locum basis (hourly paid work) and was still seeking a full time position. During the post placement interview, the volunteer did express concern that the decision to resign may have affected their employability level post placement, although they were committed to their decision to take on the placement and do not regret resigning.

The formalities surrounding the 'release' of a trainee from their employers is a consideration the volunteer must take into account prior to applying for an international placement. The

difficulty of the process affect their motivation to apply. If the deaneries and colleges came to a consensus surrounding the release of staff to conduct such placements, this may create a more structured method of deploying volunteers.

## 8. Skills gained in practice (SVP volunteers)

The analysis of the applications in the previous chapter gave a clear idea of what volunteers hoped to gain during their placements in Uganda. The following section details the subjective experiences of the volunteers during their placements, specifically focusing on what they feel they actually gained in practice. The section begins with what the SVP volunteers gained in Uganda (clinical and non-clinical) as well as other gains the volunteers feel they have made during the placements, some of which were not anticipated.

The following data was captured from interviews with the SVP volunteers both during and post placement in Uganda. These interviews were conducted with a semi-structured approach, following Masons (1996) method of a 'thematic approach', designed to understand the key themes relating to the research question; motivations, aims and objectives and actual experiences.

The first section focuses on clinical skills gain. Figure 1 shows clinical skills formed the largest anticipated gain and set objective from the applications and interviews. Therefore the author sought to focus on this during the empirical work and investigate how the anticipated skills compared to the actual skills gained in practice, as well as looking later on at how this objective caused some tensions for the volunteers.

### 8.1 Clinical skills gains

There are huge opportunities for volunteers to gain clinical experience in a LMIC such as Uganda. During a volunteering placement in Uganda, volunteers would expect to experience clinical activity that would otherwise not be encountered until a later stage in training or even never encountered within the UK at all, SVP, (2013). This might be from dealing with a disease which is common in African countries but not in the UK, such as malaria. Or more specifically to the SVP's remit of maternal health; late stage child birth complications which may have been spotted earlier in the UK because of advanced technology.

Jones et al (2013) state that the systematic review of individual gains strongly argues that such experiences do provide skills and knowledge which is transferable back the UK and the NHS. However, after conducting the research for this thesis, I believe there are some skills and knowledge areas gained (such as specific clinical conditions only common in African countries) which may not necessarily be transferrable or as useful back in the UK, but they are considered 'extra' skills and professional development which as stated by the BMA is becoming 'more and more important for a doctors career in the UK'. This explains why clinical skills gain is so high on volunteer agendas and one of the main objectives of their placements.

Although this exposure to clinical situations and the overall experience is an obvious benefit for a volunteer doctor, this is also a growing concern and a potentially controversial side to these types of placements, which was described by Fee and Gray (2013) as '*the darker side to globalisation*'. The suggestion for concern is that the benefit is actually not mutual between the volunteer and the LMIC (in this instance the Ugandan health care system) they carry out their placement. This area of concern may create tensions between the volunteer and their Ugandan counterparts (hosts) as well as the volunteer deploying agencies.

The suggested 'tension' was apparent to the author of this thesis during their time in Uganda as the social science volunteer working and living with some of the SVP volunteers during their placements in Uganda. After spending time living and working with medical professionals as SVP volunteers, I became aware of the contributing factors which created this tension.

The tension stems from being unable to please all during the placements, and whether it is possible to have an ethical placement which does please all. In the context of the SVP, a volunteer would have typically set out personal objectives prior to arrival in Uganda, as well as considering the objectives of their sending organisation (THET, SVP etc), on top of that they should consider what the host nation (in this case –Uganda) wants from their placement as well. With so many objectives and interests to consider, it is difficult for the volunteer to 'please all'.

In the case of the SVP, it became apparent that the interests of the volunteer sometimes counteracted what might be best for the Ugandan health system. This was most apparent when volunteers sought to gain clinical skills, which as the results show, was the most motivating factor for an SVP volunteer.

To illustrate the desire to gain specific clinical skills, the following case study details one specific clinical scenario which was high on several volunteers' agendas.

## 8.2 Case study - 'The Ruptured Uterus'

The case study uses the example of a popular clinical scenario that many of the volunteers sought to experience in Uganda and listed as an objective. This particular case study illustrates how some of the suggested tensions came about from wanting to experience this specific clinical scenario.

Uterine rupture is an obstetric emergency that further complicates obstructed labor or previous scars on the uterus due to caesarian section. It is a common contributor to high maternal and perinatal mortality and disproportionately affects mothers in LMIC's.

In the SVP benchmarking report, the cases of maternal mortality caused by uterine rupture at Mulago National Referral Hospital made up 7% of total maternal deaths in 2012, SVP, Benchmarking Report (2013).

One ST3 Obstetrician volunteer doctor articulated in a pre-placement interview that she has a specific interest in the clinical case of uterine rupture and hoped to experience the case in practice whilst in Uganda. It seems the anticipation of gaining experience with this type of case specifically was a prompt for her application.

*'I want to gain some experience which I could not have gained in the UK to make me a better Obstetrician, Uterine Rupture specifically that was the big part of what prompted me I think'*

In the interview the volunteer explains how the specific case of 'uterine rupture' was a medical condition they wanted to experience whilst in Uganda. The volunteer reported that this clinical scenario is not as common in the UK and other developed countries such as the US and Australia. For that reason, it is not a clinical case volunteer doctors will come across



often to improve or gain skills in within their own country during their career. By coming to Uganda, where the case of uterine rupture is common, the volunteer has a higher chance of gaining experience and improving their clinical skills to deal with such cases.

It is interesting to note that the volunteer in the above case states that experience with uterine rupture specifically, will make them a 'better obstetrician'.

*'I want to go home having done breech deliveries and I've done a lot of uterine rupture repairs which I am focusing on now, that will be two things on my CV that I won't have had unless I'd done something like this'*

The above quote from a post F2 doctor volunteer shows how they had purposely set out with the objective of 'doing a lot of uterine rupture repairs', which they appear to have successfully achieved and can now return to the UK having fulfilled this objective. The volunteer suggests that this is a skill they have developed from being in Uganda, and that they would not have been able to do if they had not taken on this placement (due to the case being more common in Uganda). Therefore they were able to fulfil their objective, benefit from the experience and return to the UK as a 'better doctor'.

The case of the ruptured uterus is a clinical scenario that a several SVP volunteers sought to gain experience with during their time in Uganda. Another post F2 Doctor had just arrived in Uganda to begin their placement, during an interview they also articulated that the case of the ruptured uterus was high on their agenda for their placement objectives:

*'What do you expect to gain from working here?'*

*'Loads of experience you know, conditions that we read about but don't see in the UK. Obstructed labour is a really obvious example to me, because nobody ever gets to the point where they're going to rupture their uterus because we intervene so much earlier. So yes, I hope to be allowed to get a bit more hands on with that than I would at home'*

As the volunteer suggests, a post F2 Doctor in the UK would probably not come across this case. If they did, they would not be hands on with it until much further in to their training. If the volunteer is able to be hands on with a ruptured uterus case in Uganda, but not able to in the UK, this may bring up some ethical issues. The question of whether volunteers should engage with clinical activity which is beyond their training or experience is considered here.

The specific case of ruptured uterus became a focus of some of the volunteer's placements in terms of their individual projects. One volunteer arrived in Uganda and after a couple of weeks decided to focus her efforts into an audit, looking at the socio-economic factors which affected cases of ruptured uterus:

*'I noticed how high the incidences of ruptured uterus is here. It averages at about 10 per month. So mid Feb I started looking at the cases prospectively, trying to capture what the delays are in these women getting obstetric care'.*

The volunteer aimed to quantify the incidence and assess demographics, risk factors, surgical management and outcomes for patients presenting with a ruptured uterus. This was a three month, prospective observational study, conducted between February–May 2013 at a Regional Referral Hospital in Uganda (one of the UMNH sites). All women presenting with a ruptured uterus, partial or complete, were included. SVP, (2013).

It has also been noted that the particular case of the ruptured uterus also raises questions of skills transfer back to the UK. As previously discussed, ruptured uterus is a clinical scenario that is not common in the UK, therefore is this a clinical skill that is transferrable back to the UK? One volunteer articulated this point during an interview;

*'Definitely for my level I have been a doctor and I have gained skills in practice, but I am not sure how these new skills are transferable back to the UK practice because I have been dealing with uterus rupture and some more obscure things happened and not likely to see them for a long time in my practice, or maybe I never will at all'.*

However, the obstetrician interviewed did go on to state that the skills gained for dealing with a ruptured uterus can also be used for more common clinical scenarios in the UK, in particular female hysterectomy's. The volunteer confirmed that she had not realised the use of the skills gained from dealing with so many ruptured uterus in Uganda until she was back on her training programme in the UK and dealing with other complex cases requiring the skills and knowledge gained from the specific case of ruptured uterus.

Travelling to Uganda to complete a placement with such specific objectives proved to be common within the SVP volunteer's agendas. Which raises questions as to whether the skills gained are important to the NHS. Jones et al (2013) argue that the benefits of these placements need to be further researched in order to encourage more international placements and investigate further what the benefits of these placements are in terms of returns to the UK and the NHS.

The case of the ruptured uterus is a good example of why further research is required. As the case is not actually common in the UK, yet volunteers are keen to engage in more experience with it. The benefits back to the NHS were discussed by one volunteer who stated the skills gained were useful for other clinical scenarios (hysterectomy) but this was not the initial aim for her. This raises interesting questions about what clinical skills are beneficial and where they fit into the returns to the UK and the NHS.

### 8.3 Drug usage

Analysis of the data suggests that most of the clinical skills gains have come from volunteer working in environments which are challenging and sometimes lead to working outside of the volunteer's competency, the following quote is typical of a volunteer articulating how they achieved clinical skills gain.

*'I have done a lot more paediatric anaesthesia than I've ever done here without supervision, so that is a clinical skill I've gained. I was anesthetizing neo natal's which I don't do at home, and definitely not unsupervised.'*

The consultant anaesthetist interviewed commented on the use of different drugs as a skill they feel they have gained; they explain how their experience has led to skills in different drug administration:

*'Skills in using drugs that I've never used before or I didn't commonly use, such as Halothane, invariably you become more skilled in using them, because you're pushed out of your comfort zone, sure you should always work within your competence but you invariably end up just by doing more cases and less resources, you become more confident with your abilities'*

Although a skill gained, this does present some risks to the volunteer. As discussed in relation to Ackers (2014) paper of 'Risk' which raises the issue of working outside competency. However, if this is the most effective way volunteers feel they gain clinical skills this may be a difficult issue to overcome and for the sending organisation to monitor.

#### 8.4 Holistic clinical skills

In reverse of this, volunteers have also confirmed that they have gained a wider range of holistic medical skills, which they may not have achieved by working with equivalent doctors only. A post F2 doctor working in a HC began his placement by working alongside midwives on labour ward, he was the only doctor on site (there is supposed to be a doctor there full time, however it is common in Uganda for this to not be the case). He discusses his experiences in an interview;

*'I've come here as a relatively junior doctor and there is no one in my position at the hospital (no other Ugandan doctor), the doctors at the health centre are basically not really there, at all. So there is no co presence for me in terms of doctoring so I guess how I managed that is by making myself a midwife. I think its good experience for me, practically it's a lot of hands on stuff, I'm doing a lot of midwifery work, which, if I go into obstetrics is good, it's useful to have that basic background isn't it. When I say basic that's a bit rude really, I just mean it will be useful to know how things should work normally, compared to when things go wrong, so that's really useful. With co presence I think I've got it because I'm working as a midwife and then I think I will work on the more complex cases when/ if I feel I have the capacity to do so but the problem is the lack of doctors on site so it's the only safe thing to do at the moment, working as a midwife. I'm much better at delivering babies than I was two months so that's brilliant, that's really fun and satisfying'*

The volunteer explains how working with midwives has provided him with valuable birthing skills, which he may not have gained if he worked with doctors alone. Back in the UK, he would not have gained such specific birthing skills either, as this is more a midwifery role in the UK and he would not be working alongside midwives at home. He positively illustrates how working within this role (working with midwives) can be a valid learning experience for a volunteer doctor, he suggests that his understanding of 'basic' knowledge has increased which will enable him to understand and manage more complex cases later on when he feels more comfortable after gaining more experience. This is potentially an invaluable skill for this doctor; in the UK there are often tensions between cadres of staff i.e. midwives and doctors, often due to a lack of understanding of each other's roles or competency. This post F2 has had a real insight into the daily workings and skills of a midwife, which could potentially make future relationships between himself and midwives back in the UK more cohesive and proactive.

However, this interview was conducted early on in his placement; other volunteers have suggested that working on basic skills and knowledge can become mundane for a volunteer and they might lose interest in the work. This issue was highlighted with another junior doctor who had come to the end of their placement at a health centre. The health centre delivers an average of 5- 7 babies per day, the centre has a doctor present on occasions but not regularly or reliably. This meant that the SVP junior doctor was often the only doctor present on site.

*'I enjoyed my time here (at the health centre mentioned above) but there wasn't enough experience for an early career doctor – there was no doctor for me to work with most of the time, I worked with midwives. I don't think a registrar should be there. I think a registrar might be frustrated and possibly a little bit bored working here but they would have the bonus of knowing more and be able to be a more general doctor type. 'For me, I expected to do more practical stuff like sutures but because of the set-up of it, there was a lot of suturing with any anaesthetic , quite high risk so I avoided it'*

Initially the volunteer doctor (above), like the other post F2 volunteer working with midwives, was also happy to work with midwives and use their existing skills as well as develop more holistic medical skills associated with midwifery care. Whilst doing so, they did feel some essential clinical skills were gained;

*'I feel confident now going into a labour wards and doing examinations and if there was an emergency with PPH or something like that I will be more confident and in general I feel more equipped to deal with emergencies with the skills I gained at the health centre'*

However, as the project researcher and evaluator, I observed the volunteer this post F2 doctor develop a desire for more complex clinical experiences, in some instances this involved working beyond their experience or competency level as a junior doctor in order to experience such clinical scenarios and gain the desired skills. For example, the SVP's value of 'co presence' means the volunteers must not work alone, this would mean should not deliver babies alone. However, observational work showed that the volunteer was sometimes delivering or at least managing births alone, sometimes with complications such as pre eclampsia. In such cases the volunteer would have to manage the patient and the baby with intense monitoring and use of drugs and, due to scarce resources, this would often be done without the use of any equipment. In the UK, this would be done with up to date monitoring equipment.

The volunteer's confidence did increase and they began working as a doctor at the health centre, sometimes acting as the only doctor on site. Which is positive in many ways for their development but this did raise some challenges in terms of risk and competency, as discussed in Ackers (2014) policy report.

### 8.5 Non clinical skills gains

Although clinical skills make up the majority of the anticipated skills gains (Figure 1), the non-clinical skills have proven to make a large proportion of what volunteers claim to have gained from the placements. In post placement interviews, volunteers articulated how the non-clinical aspects of their experiences have impacted them professionally.

Similarly to the clinical skills gains, the volunteers gained the non-clinical skills by working within environments that they would not be exposed to in the UK, at least at this stage of their training. An ST3 Anaesthetist explains how her experience in Uganda has developed her professional non-clinical or 'soft' skills;

*'I think I've learned a lot from leadership, service development and communication. I think my people handling skills - I've got an intern who is particularly difficult to manage, I'm trying to get the best out of him, those kind of skills have come on a lot'*

Leadership and communication are typical non clinical skills the SVP volunteer feel they gained during their placements. The volunteer below explains what non clinical she developed and during her placement, and also how her current skills developed and adapted within the Ugandan context and vast differences in the working and learning environments;

*'I've used some of my teaching skills, but I've realized teaching out here is so different to the UK and a lot of the skills I have for teaching in the UK aren't applicable here and its quite hard to engage student out here in that way because they are not used to being taught in the way I do in the UK, so I've had to adapt a lot of my teaching skills. Practically, I've done quite a lot of operating, mostly with the interns and its really helped me with my practical tutoring, most of the time in the UK I've been teaching relatively simple operations whereas here none of the operations are simple so I've been letting them do it and that means that when they get stuck they might have made a difficult situation very difficult so then its stretched my skills to get them out of that situation i.e. creating big tears during birth. It's helped me to let go a little bit, I think before I came I was quite quick to jump in whereas now I'm happier to let them make the mistake and then show them how to fix it, only small mistakes. I think it works better that way, it's easier to learn from a mistake. I'm allowing them to make mistakes where I probably wasn't previously'*

In this instance the volunteer explains how the environment enabled her to develop communication and management skills. She explains that at ST3 level in the UK there are

some teaching and management elements to her role, but the experience in Uganda allowed her to develop those these skills further.

These non-clinical skills in practice were only able to be developed because of the different working environment and regulations Uganda has. In the UK, the volunteer would probably not be managing an intern by herself, it also may not be possible for the volunteer to *'let them make the mistake and show them how to fix it'*. Both these examples bring up the issue of risk for the volunteer as well.

Management and communication are typical skills that volunteers feel to have gained in practice from their experience with the SVP. The following quote comes from another SVP volunteer, and illustrates how his experience has helped to develop his communication skills.

*'I feel like I am actually benefitting a great deal from communicating with different people, you are meeting these guys and we are meeting people even up to directorship level who are inputting lots of quite useful ideas into me and I'm meeting guys who are meeting at a technical level within a low-resource setting which is something that I was never used to, so this is also quite beneficial to me professionally. I think I'll be stronger from here, professionally'*

This is another example of the Ugandan health setting providing opportunities for volunteers to work in an environment and have opportunities that would not be available to them in the UK at this stage in their careers. This does not only relate to clinical scenarios, this volunteer is a bio medical engineer and therefore gained in many non-clinical skills:

*'I've become more resourceful because of the lack of resources and equipment that works. I've learned to anticipate what's ahead and what might go wrong and get myself ready for it, whereas back home I have an assistant so I don't have to worry. So it makes me prepare, work as a solo anaesthetists and not rely on anyone else to help. I've also done a few quality improvement projects which has been a really obstacle and I've come to learn how*



*you have to strategize, deal with different personality, when to move forward, when to stop  
and  
observe so a lot of inter personal and inter cultural skills that I've had to learn. I've also  
learned about myself, to understand myself more, ask myself why I am frustrated'*

The following post F2 Doctor explains how their experience in Uganda has influenced their practice since returning to the NHS. During the interview, the volunteer explained that they returned to the UK on an 'old age psychiatry' rotation and didn't feel the skills gained has been transferrable just yet. However, they did explain that they were about to begin a palliative care rotation and anticipated the skills and experience gained in Uganda would be useful for this particular rotation.

This particular volunteer was involved in setting up a new neo natal unit in a health centre during their placement in Uganda. During the interview they explained how they were looking at job descriptions, discussing with staff what roles and responsibilities people had, and planning the overall day to day management of the new unit in the HC. This experience led to a feeling of better understanding in terms of service development and other outer workings of a clinical settings.

*'I am going into palliative care, I'm more savvy with looking at service development now and actually looking at services. So at the moment in the memory clinic I'm about to start in, they are currently reassessing how its run and discussing potential changes. And I think I'm aware of management now and making sure if we're going to change the service have we thought of everything and considering all the pit falls and ultimately is it sustainable. I'm  
considering  
every detail now because I had to in Uganda'*

She also explained how the difficult conversations with families has helped to develop her communication skills which will be transferrable for the palliative care role she was about to start.

*'And personal, how to deal with the frustration and then in the end it made me understand the other person more, why are they behaving like this, putting it in perspective and taking it in a pace that is more realistic and not in a 'muzungo'<sup>6</sup>*

*time frame instead of being upset'*

Much of the non-clinical skills mentioned correlate with Jones et al's (2013) findings which were mapped into a framework. From the non-clinical gains identified within the SVP volunteers experiences discussed in this section, the results fit into three of Jones et al's 'domain's' which make up the framework. Those domains are *'management skills, communication and teamwork, patient experience and dignity and service/ policy development implementation'*. All of which are useful and important skills for any medical professionals career.

## 8.6 Unexpected gains

Whilst conducting and analysing the research for this chapter, it was noted that much of the discussion during the interviews as well as conversations with the volunteers (outside of interviews) whilst living in the shared house, related to another theme in terms of gains in which the volunteers feel they had achieved or realised during their time in Uganda. The issues raised surrounded the theme of what impact these placements make in Uganda and a greater understanding of this type of action (professional voluntarism) on global health. It appeared this knowledge and 'deeper understanding' was not expected from the volunteers but one that they have found very eye opening and influential, which is commonality with Hudson and Inksons (2006) findings of *'openness, realisation and knowledge expansion through the 'hero's journey'*. This issue raised some interesting questions about the volunteer experience.

### 8.6.1 More in depth understanding of development

Most volunteers (not only the SVP volunteers) will have an underlying and stereotypical 'altruistic' vision of what their voluntary placement will achieve in terms of outcome. Feelings of wanting to help, achieving help and overall seeing volunteering as an all-round

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<sup>6</sup> 'Muzungo' is a commonly used expression in Uganda which describes a person from 'European descent'.

positive for all involved. However, as a fellow volunteer the author experienced an ‘eye opening’ realisation that actually; not all voluntary impact is good. This realisation or change in views was also acknowledged in Hudson and Inkson’s (2006) research, when some of the volunteers had a strong realisation during or after their experiences that ‘*Aid is business*’, and the somewhat stereotypical notion of all aid being good aid as well as the complications and complexities of development work were realised during the placements. This was a topic of discussion with the SVP volunteers whilst in Uganda, and a very interesting and unexpected theme to come out of the research conducted for this thesis. In the mid placement and post placement interviews, most of the SVP volunteers confirm that they are pleased with their experience overall and that it has been an overall benefit to them. However, some acknowledge that they have realised that their placements may not have been as beneficial to Uganda as they initially assumed.

The following quote from an ST3 doctor illustrates this point;

*‘I think I was a bit foolish to think that you can do ground breaking work in six months. There is a definite benefit to the individual, you learn something about yourself, your profession, your capabilities and I think you can only better yourself but whether it benefits Uganda I’m still unsure’*

Here, the volunteer acknowledges the benefit for her as an individual but also iterates that her initial understanding of what the placement will achieve was somewhat unrealistic or as she explains ‘foolish’. This conclusion was based on what the placement would do for Uganda, suggesting that considering Uganda’s needs over the six month period may have been underestimated or misunderstood prior to her arrival. Another volunteer discusses this theme in a post placement interview after a six month placement in Uganda;

*‘I’m really glad I’ve done it, I can’t believe it’s over. It’s something I always really wanted to do from when I started my training and I would like to do something like this again.... it’s definitely given me a greater understanding of international work and I am not sure I would*

*do this again. I would probably come as an independent, not part of an organisation and come for a really really long time'*

This volunteer explains how the experience has not only altered her opinion of volunteering in Uganda but also made her change her mind over coming with an organisation. This volunteer in particular worked in the national referral hospital and was surprised by how many other international organisations were present in the hospital. With so many different agendas working towards a general shared goal, it was the overwhelming numbers and confusion of who was doing what within the hospital wards that led to this volunteer coming to her conclusion. As her interest other international organisations working at the hospital grew, she decided to place a white board in the maternity unit at the hospital and asked each international volunteer (from any organisation) to put their details on the board to create better communication between the unit's guests. She discusses her experience and her conclusions in more detail;

*'I think I'm going home with a much greater idea of actually what it means, it's difficult, everyone (volunteers) has their own agenda of what they want to do and what they want to achieve and what they want to provide or produce or work on. Like I'd be very wary and say, if you're coming for a month? Well, it's not not worth it but you're only going to take. You won't be able to give that much in the space of a month, I kind of personally feel. You can't just barge in and go, 'I want to do is this, this, this and this'. It just doesn't work like that. Even like getting the international board up, seems like a very simple task – it's taken over a month for that to happen!'*

The volunteer has reached these conclusions after spending six months at the hospital in Uganda. Her experiences have not only led her to gain clinical skills, new culture etc. but also helped her gain a greater understanding of 'global health development' in general. She mentions how volunteers arrive with their own set agenda and objectives and 'barge in', as the ST3 volunteer explains this is foolish and it doesn't work. In her attempts to create better communication of who is doing what by putting the board up in the hospital. She was surprised at how long such a 'simple task' took to be implemented. Unfortunately, after her departure the international board was not sustained and it is no longer in use. Although a

frustrating experience, it is one that has led the volunteer to gain a true insight into the world of global health and its difficulties, it has actually influenced her enough to suggest she would do it again, but differently.

*'I would highly recommend it – I've learnt and got so much out of it and really enjoyed it and just thought...the time has flown and that's the sign of a really positive experience. If people wanted to really come and really do a lot of work and stuff, I would struggle not to say – go for six months minimum...'*

Again, the issue of time is mentioned again, six months seems to be the minimum time volunteers suggest going for after their experience which is also the DFID requirement for the SVP placements.

Overall, the chapter has shown that the volunteers did gain most of the anticipated skills identified earlier. However, they were also faced with challenges and new experiences which enabled them to gain skills and knowledge that was unexpected. On the whole, the experience was positive for all of the SVP volunteers. How they managed to achieve such objectives was not without its challenges, which is discussed in the following section.

## 9. Tensions and ethical issues encountered by the SVP volunteers

The previous analysis chapters have exposed an insight into the subjective experiences of volunteers within the context of the SVP in Uganda. So far, the research has illuminated what motivated them to volunteer, what they hoped and expected to achieve and what they did achieve in terms of skills and knowledge.

With this in mind, the main focus of this thesis was to discover how the SVP volunteers achieved their objectives in Uganda. Particularly looking at whether the volunteers were met with any ethical issues or tensions in their quest to carry out their placement, whilst managing the combined prospective objectives; their own, their sending organisations and the Ugandan health system.

This section investigates the experiences relating to tensions and ethical issues encountered by the SVP volunteers during their placements and gives specific examples of how some objectives created such tensions. As well as discussing how these findings compare with other current research.

The analysis of the data collected illuminated specific area themes or influential factors in which 'tensions' were felt by the SVP volunteer and by the author as the social science volunteer of the SVP. These themes have been categorised into five areas; altruism vs. self-interest, Ugandan peer relationships and staff motivation, expectations vs. authority, new experience vs. competency and unforeseen circumstances.

To illuminate the suggested tensions within the context of the SVP, the following subheadings discuss each theme relating to a tension encountered by the volunteers as well as myself (as the SVP social science volunteer and as the researcher of this thesis).

## 9.1 Altruism vs. self interest

This theme underpins the broader theme of ‘benefit to the volunteer (as an individual) vs. benefit to the host nation (in this instance, Uganda)’. This was an apparent theme throughout the authors experience with the SVP volunteers as well as an issue felt by most of the volunteers themselves. Upon reflection, I note that this was a consideration I had personally felt aware of prior to my arrival in Uganda. Therefore, my awareness of it was stronger than some of the volunteers, which did influence my judgement on some volunteer activity undertaken. However, as discussed in the methodology section, my position as the researcher was both a positive and a limitation in this instance.

The principal of this theme stems from the volunteer’s motivation to conduct the placement and what their objectives were, which has been discussed earlier in this thesis.

The ‘vs.’ is a challenge or ‘tension’ between what their set objectives intend to achieve and whether they are aimed at achieving altruistic outcomes (for the benefit of Uganda) or self-interested outcomes (individual benefit), the intentions of their objective are what may cause the suggested tension. To illustrate how a specific objective may result in a tension, an example of a volunteer’s objective centred on a ‘self-interest’ outcome is given below;

*‘I want to go home having done breech deliveries and I’ve done a lot of uterine rupture repairs which I am focusing on now, that will be two things on my CV that I won’t have had unless I’d done something like this’*

The perceived and realised outcome of ‘benefit’ after fulfilling this particular volunteer’s very clear objective, is clearly centred around the volunteer themselves and therefore raises some interesting questions. ‘Who’ other than the volunteer is gaining from this type of placement objective? Having such specific objectives relating to clinical skills gain is not health development centred. Therefore, if a placement is centred on developing a (UK based) individual volunteer’s specific clinical skills, this raises questions as to how such placements would benefit the Ugandan health care system.

Looking at some of the outcomes the volunteers feel they have gained during their placements, it could be argued that there is little that the Ugandan health system will gain

from such narrow and specific objectives that are based on individual gain. Gains such as specific *clinical skills, enhanced communication and leadership skills etc.* will not have a direct or indeed any sustainable impact on Uganda's health care system.

The objectives could be seen 'box ticking' exercises, which for the volunteers might be necessary in terms of their training programme and what they need to achieve in order to improve their CV or training portfolio. As the BMA stated, UK doctors are under increasing pressure to improve their training portfolios and continue to update their clinical knowledge and experiences, especially when conducting placements that are classed as 'time out' of their training, such as the SVP voluntary placements.

Further to the above objective, another example of a 'box ticking' objective potentially creating tensions came from a volunteer application form in 2013. The applicant was a consultant obstetrician who applied for a 6 month placement with the SVP. The potential volunteer had a specific objective they wanted to fulfil which they stated clearly in their application:

*'I want to treat 50 ruptured uterus cases only'*

In terms of sustainable change and co presence, this objective has no long term benefit or impact on the Ugandan health care system. It is a benefit for the volunteer to 'tick' this objective off and return to the UK up skilled in this particular clinical case, but does not leave any lasting impact on Uganda. For that reason, this application was rejected.

This objective in particular may have created tensions such as; making Ugandan staff feel uncomfortable: If the volunteer is so one dimensional in their objective what would the need be for Ugandan staff to work alongside? This may have made the Ugandan staff feel uncomfortable, unwanted or even unnecessary. There would certainly be no sustainable impact to this objective.

Such specific objectives may be able to be fulfilled without any issue or tension. However, the author found that within the SVP that this suggested tension was a factor for many of the volunteers.

Arriving with such specific self-interest focused objectives was common amongst the SVP volunteers, as understandably, they all wanted to gain experience.



However, it was interesting to note how opinions on this matter changed, and the consideration of how these objectives will benefit Uganda became more apparent throughout the placements, which was heavily discussed in Hudson and Inkson's research (2006). One volunteer discussed this issue during an interview mid placement;

*'I think you're really selfish if you come out here as a junior doctor and want to enhance or do clinical situations that you've never done, you're basically saying I want to practice on people in the third world and I really disagree with, if there's no alternative then maybe but I think its immature and they don't understand the complexities'*

This particular volunteer was ST4 and was slightly more senior than other volunteers within the SVP at that time. It seems it is the balance of how to manage the objectives is what is important and it is how these objectives are considered.

*'I'd never thought about the fact that you might have animosity towards you when you were here, certain local people don't want things to change or the hierarchy, the politics'*

## 9.2 Ugandan peer relationships and staff motivation

Through interviews and observational work, I was able to capture how the volunteer's objectives impacted their daily work during the placements. As discussed, the self-interest focussed objectives created the most tensions and challenges. However, objectives that appeared to have Uganda's needs at the forefront were seen to still be met with tension.

As the SVP holds a strong focus on co presence, it is important that the volunteers maintained a good working relationship with their Ugandan counterparts. This will enable the SVP aim of maintaining co presence as well as allowing the volunteers to have a comfortable work environment in which they can conduct their placements and their planned objectives. However, some of the objectives were met with challenges.

In many LMIC's there are many international volunteers coming in and out of healthcare settings conducting placements. The local staff may have seen several volunteers come and go, it is understandable that they may assume these placements are short and might not be very useful, particularly if a volunteer arrives with an self-interest objective such as *'I want*

*to treat 50 uterus ruptures only*, which is not going to directly help or benefit the local staff in any sustainable way.

It is also considered and understood that local staff might not have a huge amount of enthusiasm when 'another' volunteer arrives to carry out a placement, for various reasons as discussed in the VSO reports i.e. lack of pay etc. This lack of motivation and enthusiasm was encountered by some SVP volunteers.

One volunteer had embarked on a project in a small health centre, the project aimed to increase the amount of blood pressures taken during the daily antenatal clinic as the blood pressures were often not taken or taken incorrectly, the data collection for the blood pressures taken at the HC was unreliable and incorrect. This was noted by the Foundation for Sustainable Development (FSD); *'It is claimed that statistics have been distorted through the inaccurate extrapolation of data from small urban clinics to the entire population'* (2013).

The volunteer doctor arrived, full of enthusiasm to motivate the staff to use the blood pressure machines (of which she provided) and encourage the use of the machines by confirming the benefits this will have to the pregnant women as well as how using the machine will make the staff's workload less and easier. Over time, it became clear that not using the machines was simply the way it worked at this centre and the staff were not very enthused by the idea of changing their routine of not doing the blood pressures. The volunteer became frustrated, as did the local staff by her insistence that the midwives and nurses comply with her project. During an interview with this volunteer, she explained the situation and her frustration;

*'I went into the clinic today and noticed blood pressures were not being taken other than the ones I did, so I asked the Sister in charge;*

*'Why aren't the blood pressures being done today?'*

*'I'm tired'*

*So how do I work with that?'*

This objective can be viewed as both altruistic and hold self-interest values. In terms of Uganda's needs, this objective would hugely benefit the pregnant women at the clinic and

have only positive outcomes. The self-interest value, is that this volunteer can return to the UK and explain on her portfolio that she managed a clinical project that was implemented and (if all goes well) was sustained after her departure, showing management skills as well as communication for developing a project with the local staff (if all went well and they complied). However, this is not the way the project turned out, and as stated above, the volunteer was met with animosity and the project was unfortunately not sustained.

The SVP volunteers do have flexibility in terms of what they do during their placements, and the activity undertaken differs per volunteer depending on their individual interest. Some volunteers like to be very hands on, and have as much clinical work as possible. Whilst others choose to stand back and observe for a while and prefer to keep clinical/hands on work to a minimal. This was an issue which also created some tensions with Ugandan staff. One volunteer did work clinically as a doctor in one of the health centres, but there were elements to her role that she chose to stand back with. In this instance, it was delivering a baby without any gloves on. For infection risk purposes, the volunteer decided not to deliver a baby one day and asked that the midwife take over, unfortunately this was a very busy day in labour ward and the midwife encouraged the volunteer doctor to deliver. When the volunteer explained that the reason she didn't want to deliver was because there were no gloves and she was unsure the expectant mother was HIV positive; she was met with an uneasy response;

*'She was basically saying why are you ducking out of it, you are supposed to be working with us why can you duck out of this and we can't'*

The volunteer was upset by the reaction but stood by her decision to protect herself from a potential infection. This difficult situation was apparent on several occasions for the SVP volunteers and presumably for many other volunteers working in a LMIC.

The co presence element of the placements also created some tensions for the volunteers, as discussed in the VSO reports; Ugandan health care workers are often under enormous pressure, working hours and often not getting paid. Therefore, an enthusiastic volunteer arriving may seem like an opportunity to relax and let them take off some of the pressure.

This can work well for both parties. However, when the SVP volunteers are working within the co presence principle, they cannot be left to work alone, which during busy times with many patients to see and not enough staff, may be inconvenient for the Ugandan staff to uphold as well. In some cases, it became an area of concern for the SVP volunteers as it became impossible to have co presence. One volunteer explains how she felt about maintaining co presence and how it impacted her relationship with the Ugandan staff;

*'I became less bothered to be honest, it's unrealistic, they never see you as pulling your weight if you refuse to work alone, if you show you work and you graft then they have respect for you and they come at you with problems but if they see you as a slacker who is not supporting them they won't and you won't build that relationships'*

This volunteer found that the tension created by trying to incorporate co presence into their daily working routine and relationships with staff was not sustainable or realistic, therefore they seemed to deflect their efforts away from the SVP objective, which had the catalyst effect of creating tensions between the volunteer themselves and their organisation.

Another volunteer also found the local staff difficult to work with and focussed their efforts on the students. This volunteer went on to explain how she found co presence to work well;

*'I found students easiest to work with, they are motivated, they are present, they're a pleasure to work with because it's hard to work with people are not interested in change or learning, most of the time I worked with someone but I just became less bothered who that was'*

By working alongside the students, this volunteer is not only complying with the SVP value on co presence but also potentially adhering to the wider aim of creating sustainable change by working with the students, the future health care staff of Uganda.

Despite the staff relationships appearing difficult at times, some volunteers were increasingly aware and understanding of the reasons why they may have been met with animosity or lack of enthusiasm. A volunteer sums up this tension simply but effectively;

*'I'd be annoyed if someone turned up started telling me what to do'*

### 9.3 Expectations vs. authority

Skills gain and experience was proven to be the largest motivating factor in the SVP volunteer data. However, the commitment to achieving these gains sometimes found the volunteers stepping outside of their boundaries and not conforming to the SVP aims and objectives. This was the case with the 'hearing project' which was discussed earlier. The post F2 doctor embarked on a project focussing on new born screening for hearing, which does not relate directly to the SVP core focus of maternal and new born health. The volunteer continued with the project despite being told by the SVP that this was not a relevant project to the SVP core objectives. This created tensions between the volunteer and the SVP in the UK. Discussions about the projects relativity continued for some time until it was decided that the volunteer must conduct this project in their own time. The volunteer followed this advice and continued outside of normal working hours.

Further to this and relating again to staff relationships, volunteers were also met with tensions outside of their 'work' based objectives. Issues surrounding working hours and time off also became apparent and it was noted that some of the Ugandan staff commented on the hours he volunteers were working. Although the SVP stipulates volunteers do not work nights (due to risk) they are expected to work a 'normal' working day. Volunteers also have free time on the weekends and are entitled to holidays, which are often used to travel around Uganda, go on safari etc. However, if this was seen as too often it was noted by some Ugandan staff who took the impression that the volunteers were doing the bare minimum.

#### 9.4 New experience vs. competency

This subject relates to an issue raised in the 'staff relationships' theme, how much volunteers want to engage in activity they would not otherwise, either due to contextual reasons and environment or because of their current level of competency.

Volunteers vary in terms of how much they want to engage in activity that is 'beyond' their competency, it is a potential risk for the SVP and themselves but not one that can really be monitored and it is up to the volunteer themselves to manage that. At times, it was noted during observational work that some volunteers may have conducted activity that was a unique and clinically, a great experience but one in which was potentially dangerous as it was far beyond their level of training.

Another volunteer was able to deliver her first baby as an F2 doctor in Uganda, which at her level in the UK she may not have had the chance to do until further into her training, this was a positive experience and supported by local midwives.

Working beyond clinical competency was not the only level of competency that was challenged within the SVP and resulted in tensions. As mentioned throughout this thesis, there are many other international volunteers from various countries, organisations and stages in their careers working in Uganda, and it was common for SVP volunteers to meet and work alongside other international volunteers. However, this can create a tendency for the international people to stick together, which may compromise the overall aim as well as the SVP value of co presence.

During an interview with a post F2 volunteer, a discussion about why she chose to spend more time with other international volunteers and less time with Ugandan staff drew out some interesting views.

*'Working with people who are so different it's easier to work with the international volunteers it's easier. I enjoy my time at the HC and the NRH a lot more when the UK students are around'*

## 9.5 Unforeseen circumstances

Hospitals and health centres around the world are unpredictable and circumstances can change dramatically in any scenario. This is no different in Uganda, and the SVP volunteers found themselves in sometimes dramatic and challenging scenarios.

As a 'westerner' in Uganda, it is often difficult to endure challenging and distressing situations, often relating to poverty, poor health care, lack of resources etc. And it is common for volunteers to want to help beyond their role within the health care system, whether it be giving money, buying food or providing holistic support to a Ugandan patient etc.

However, such situations of going 'beyond the role' have caused the volunteers to become engaged with tensions. One particular situation stood out as an example of how unforeseen or unpredictable circumstances can influence the volunteer position to go beyond their role, which potentially causes contentions.

This situation took place at a HC where a post F2 volunteer doctor had been working for around 4 months. At the time, the HC had no blood, which was restricting in terms of the care and treatment that could be provided. A distressed, labouring woman came into the HC and was bleeding heavily, it was decided she would need an ambulance to take her to the national referral hospital. The ambulance was not available, and despite the volunteer calling for it several times there was no sign of it arriving on time. The volunteer decided to drive the patient in her own car, along with another SVP volunteer. The woman became more and more distressed, the volunteer took her to the hospital and ensured she was taken to the correct department. Her waiting time was minimal, she was treated promptly and delivered a healthy baby. Despite a 'happy ending', the decision to take the patient by herself posed a lot of risk; for the volunteer themselves as they did not follow the 'co presence' principal. The woman was totally in the volunteer's hands and care, which was a lot of responsibility. It was unclear how the staff at the HC felt about the SVP volunteer taking the woman directly to the hospital and it was only when the volunteer returned that she was applauded for her efforts. However, if the patient had not have been so luck or had such a positive outcome, the reaction may have been very different as 'blame' may have been put on the local staff.

This was a difficult situation for the SVP as the volunteer had technically put themselves and the project at risk. However, volunteering does allow autonomy and it was the volunteer's decision to make.

All of the suggested tensions stem from the desire to carry out specific objectives which in most cases were 'individual focused' rather than 'Uganda health system focused'. In order to avoid such tensions or at least minimise them, it might be a consideration that volunteers pre arrival in an LMIC spend some time researching what the current challenges are within the context of their placements, for example, find out what the current state is at the HHC they will be spending six months at, make contact with the local staff if possible or even contact previous volunteers to allow scope for continuity and sustainability in voluntary services and impact at the centre.

A positive outcome of this research into tensions and ethical issues was the volunteers who discussed a change in their views and a realisation that their objectives must meet the needs of the Ugandan health system as well as their own to allow mutual benefit between this partnerships. I believe that if the appropriate understanding of what these placements intend to achieve and a balance in terms of mutual objective benefits is set out prior to the volunteer's arrival, such placements will create optimum outcomes. A final quote from an SVP volunteer perfectly sums up the experience:

*'My experience was humbling, challenging and totally eye opening. I think I would have benefitted from having previous knowledge of the challenges but they were not something I didn't figure out myself over time, and they are what have made this experience so unique'.*



## 10. Conclusion

### 10.1 Introduction

This research on professional volunteering in an LMIC offers a moment of insight into the subjective experiences of professionals conducting a voluntary placement through the SVP in Uganda, and identifies their motivations, what they hoped to gain from it and most importantly what they learned and what tensions they felt when trying to achieve their objectives. This concluding chapter will draw the findings together and also discuss considerations and recommendations for future research and global health focussed volunteering projects.

### 10.2 Summary of main findings

The initial research into the motivations and outcomes of the SVP placements strongly suggests that clinical skills gain is the main benefit the volunteers strived to achieve during their placements as well as being the area which causes contention and ethical issues.

The study identified five key areas of contention that was apparent in the volunteer's experiences. Most of which, related to the desire to achieve their objectives which they had set prior to their arrival in Uganda.

The discussion throughout the thesis suggests that doctor volunteers are on a career path and are initially driven to complete these placements by a desire or pressure to improve and gain further experience which as the BMA suggests is becoming increasingly integral to a doctors career; *'it is more important than ever before that UK doctors are able to access opportunities to gain international experiences more and more important for a doctors career'* BMA, (2014).

However, as Hudson and Inkson (2006) found in their study on volunteers, they have a *'strong identity but are also adaptable and open to experience which may lead to greater self-awareness and openness'*. In relation to this finding, most of the SVP volunteers did acknowledge a degree of changed opinions and a realisation that their objectives may not be fulfilled so easily or at least not without such emerging tensions.

This was an important finding and an area of interest which could be taken forward in further research.

### 10.3 Considerations and Limitations

A methodological consideration might be the limitation of my position, being considered an 'insider researcher' Brannick, T., & Coghlan, D. (2007). As mentioned in the methodological section, I was immersed within the sample as a fellow volunteer, living and working amongst the SVP volunteers. Therefore, there may have been some 'responder biases', Mason (1996). However, as noted earlier, this has also been suggested to provide benefit that arguably outweighs the limitations, for example, the ease in which the sample was chosen and accessible. Also, I believe there was an element of myself (as the researcher) being considered an outsider as I was the only 'non-medical' volunteer in Uganda working on the project. Therefore a really important part of the analytic procedure was engaging with my supervisor and co-ordinator of the SVP to discuss the emerging themes and interpretations from the data collected to ensure that they were grounded within the participants' accounts.

Another methodological consideration might be the homogeneity or similarity of the sample, although the aim was to focus on doctors specifically, perhaps for future research other cadres of medical staff who volunteer might be chosen as the sample and future research could look to restrict the sampling criteria further in order to explore the experience for particular samples in greater detail. This limitation was considered after a midwife pointed out in the focus group that midwives have a different experience to the doctor volunteers during these placements. The idea to focus on another cadre of medical professionals in future research relates to the ideas of Onwuegbzie and Leech (2007), who highlight the importance of homogeneity within the sample, whereby 'all participants possess similar characteristics or attributes and have membership of a subgroup necessary for fulfilment of the research aims'.

An ethical consideration was again related to my position as the researcher, most specifically in relation to my ethnographic style when conducting participant observations. Sometimes observations took place during difficult medical situations, which at times were uncomfortable, although very important to observe the volunteers experiences. The ethical implications of observing volunteer activity have direct reference to the patient, the staff as well as the volunteer, whom are all being observed during sometimes stressful and difficult

situations. Of course, I was there purely to observe and not to judge clinical activity and this approach did prove extremely beneficial for the research and understanding of a voluntary experience.

#### 10.4 Future research

In terms of extending this research topic further, I put forward a research proposal which will focus on student elective placements in Uganda. The title of the proposed study is:

*'Improving the outcomes of elective placements in low resource setting for health care professionals'*

This thesis is focused on doctors only, and as mentioned I feel that the experiences and impact of 'other' medical professionals and students as volunteers within an international context should be explored in detail as well. I would like to look into international placements of other NHS staff, such as nurses, midwives and even the non-clinical staff such as Bio Medical Engineers. I am keen to investigate the motivations of other NHS staff, understand what is expected of them and what they hope to achieve from an international placement.

I believe the area of Medical/ Health Volunteerism in the form of doctors has been researched extensively, which is why I would like to explore the more neglected cadres and research this area more broadly.

Taking into account all of my experience in Uganda and my understanding/ knowledge of the country's health system and its relationship with UK/NHS volunteers, as well as my connections, the planned study would be based Uganda as a setting to carry out my empirical work. Over the next two years, Health Education North West are planning to fund 40 undergraduate students to complete a placement in Uganda. The project will be sending students out in November 2015, and I hope to use the scheme as the basis of my study, and carryout a longitudinal evaluation.

## 10.5 Concluding thoughts

The research conducted for this thesis has enhanced the current understanding of a voluntary experience for a medical professional (doctors) and examined the tensions or ethical issues volunteers face during these placements. The results and discussion will contribute to the existing limited literature available in this area of global health.

Volunteering is a rapidly growing phenomena and with such steady increase in international global health volunteering projects it is important to ensure continued evaluation and research is continued. To ensure the benefits and costs to such projects are shared for all involved, creating a standard understand of the growing field as well as ensuring ethical implications and tensions suggested in this thesis are minimised to create positive outcomes for both the LMIC and the partnered country. Continued research will also encourage professional development, and gains to the NHS. As well as enriching the student experiences and enhance a graduate's skillset prior to starting their career.

## 11. Appendix

### Interviewee demographic information

<b>Interviewee</b>	<b>Date and Location</b>
Post F2 doctor	January 2015- UK, London
Post F2 doctor	January 2015- UK, London
Post F2 doctor	June 2014 - Kampala
Post F2 doctor	June 2014 - Hoima
ST3 Obstetrician	July 2014- Hoima
ST5 Obstetrician	November 2014 - Fort Portal
ST5 Obstetrician	November 2014 - Fort Portal
ST5 Paediatrician	November 2014- Kampala
Consultant Obstetrician	May 2014 - Kampala
Consultant Anaesthetist	May 2014- Kampala
Midwife	May 2014- Kampala
Midwife	January 2015 - UK , London
Neo Natal Nurse	September 2014- Kampala
Focus group - <i>including other SVP volunteers and clinical leads from various UMNH sites</i>	May 2014- Kampala

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