# Study on Volunteer Placement Design in Zambia

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Commissioned by Health Education England in relation to their international volunteering work stream.

# Executive Summary

The potential to scale-up UK volunteering in Zambia is considerable. Current levels of volunteering through the DFID Health Partnership Scheme, which has been the main source of funding to support volunteering in the health sector to-date, amounts to just 11 people per year – a total of 86 people over six years. Further afield, VSO has also been placing people in the health sector in recent years but in small numbers.

Volunteering can play a useful role both with regard to training and assisting in the shortfall of health workers, especially in more specialised roles as Zambia introduces the Speciality Training Programme (STP). The Zambian Human Resources for Health Planning and Development Strategy Framework Strategic Plan (2018-2024) sets out the scale of the human resourcing challenges that the country faces and the impact this has on millions of Zambians who are denied access to basic and specialist care. It is estimated that Zambia will need to train and recruit an additional 37,644 health workers by 2025 to meet these needs. Recognising that "the human resource capacity remains one of the weakest components of the health system in Zambia"[4], the Plan identifies pathways to improve the situation, one part of which places a greater emphasis on a new STP which will decentralise the training of specialist doctors to the ten regions of Zambia.

Numerous studies over the last ten years have suggested that volunteering overseas provides significant benefits to the National Health Service who engage in the practice. The benefits range from strengthening their problem-solving, leadership and interpersonal skills to improving their motivation and developing their clinical skills. While much of the present literature provides some recommendations for placement design, there does not seem to be a definitive guide to supporting volunteer placements for mutual benefit, as much of the literature comes from the perspective of sending organisations, institutions or returned volunteers. This creates a danger of a paternalistic approach to placement design.

In order to gain insights into the needs of the Zambian health system regarding volunteer placements, THET undertook semi-structured, one on one and group interviews with individuals at key institutions throughout the health system and country, including with the Ministry of Health (MoH), District Hospitals, Specialist Hospitals, Health Service Training Institutions. A total of 13 individuals provided in-depth insights from eight facilities and institutes of higher learning, across three provinces of Zambia. Surveys asked interviewees to provide information on their level of experience with facilities, the facilities' need as well as challenges and recommendations for the design of volunteer placements within their facilities. We also talked to other placement agencies such as VSO and volunteers and staff involved in HEE's Improving Global Health programme.

Based on the results of this research THET makes the following recommendations for the design of a volunteer placement project:

1. The setting up of a national steering committee and facility-based bodies at each facility to promote better coordination between relevant stakeholders and ensure maximum benefit from placements.
2. Volunteers should be recruited through a coordinating organisation with links to the MoH and the NHS. Cadres and specialities required should be designated by the receiving facility and the coordinating organisation and facilities should work together to select the most appropriate candidates.
3. A Memorandum of Understanding (MoU) should be signed between the MoH to help ensure national ownership of the placement approach. This will be useful in addressing challenges issues such as visas and professional registration fees.
4. There should be further MoUs with each institution receiving volunteers and the coordinating organisation clearly setting out the roles and responsibilities of each party.
5. Volunteering must be carefully managed to ensure that the mutual benefits are felt by both partners; one key method of ensuring this noted in several studies is the placement of volunteers through long-standing, collaborative and equal institutional partnerships.
6. Facilities should have a capacity assessment before placements and be supported to provide appropriate hosting facilities.

7. A fund should be developed that supports the accommodation of volunteers, travel to the communities in which the volunteers are placed and small improvement projects that may be implemented to ensure that volunteers are well supported and able to access items and equipment required for their placement.
8. Placement programmes should be long-term, wherever possible, and co-developed with facilities and a maximum number of volunteers should be agreed with the facility. Placements should not be less than one month with six-month placements being the norm.
9. No more than two volunteers should be placed in the same department at the same time.
10. All volunteers should have a clearly defined Terms of Reference (ToR) which are mutually agreed and clearly define the scope of each volunteer placement in a facility. These should set out the responsibilities of each party and be signed off before departure. A handover guide should be produced by all volunteers to ensure sustainability of impact.
    a. A draft ToR should be clear in the role of the volunteer in terms of the role they are to play, whether that is clinical, capacity building or system strengthening and to enable a balanced role that will create sustainable positive outcomes for the facility and the volunteer.
    b. A draft ToR, developed with facilities before recruitment, should provide a person specification to ensure that the needs of the facility are met by the volunteer and that the expectations of the facility in regard to the volunteer are fair.
11. All volunteer placements should involve an element of capacity building for local staff to ensure sustainability of impact, as it has been shown that volunteers can learn just as much from the staff in their receiving institution.
12. While challenging to ensure, given the pressures on the UK workforce, wherever possible, a continuous flow of volunteers should be maintained for a period of not less than two years for each facility; and a maximum of two volunteers should be assigned to any department depending on the needs and capacity of each facility.
13. Support mechanisms are put in place to support volunteers and facility staff before, during and after their placement. This should include:
    a. Thorough two-stage inductions should be available for all volunteers to ensure that they are well briefed on what to expect and what will be expected of them.
    b. A designated focal person within the facility who the volunteer will work with to support their integration in the facility and provide a key point of contact for their learning.
    c. Volunteers working in medical settings are required to be supervised by local staff members however, co-working and co-mentoring should be embedded into a placement.
    d. A volunteer house is maintained at or near each facility.
    e. Stipends should be calculated to ensure that volunteers from all financial backgrounds are able to access a volunteer placement opportunity. However, it is necessary that this is calculated to be appropriate to the setting without being far above the wages of staff within facilities.

# Introduction

The Zambian Human Resources for Health Planning and Development Strategy Framework Strategic Plan (2018-2024) sets out the scale of the human resourcing challenges that the country faces and the impact this has on millions of Zambians who are denied access to basic and specialist care. It is estimated that Zambia will need to train and recruit an additional 37,644 health workers by 2025 to meet these needs. Recognising that "the human resource capacity remains one of the weakest components of the health system in Zambia"[4], the Plan pathways to improve the situation, one part of which places a greater emphasis on a new Specialist Training Programme (STP), which will decentralise the training of specialist doctors to the ten regions of Zambia.

The new Specialist Training Programme (STP) is an in-service training initiative to decentralising the training of specialist doctors to each of the ten provinces of Zambia. The programme is a very good example of where support to the Ministry of Health (MoH) is urgently needed. It is the first programme focussing on post-graduate medical specialisation outside of the university setting. During the first year of the initiative 314 places were offered at 13 facilities. The programme was successful in delivering specialist volunteers placed in Chilonga (Muchinga Province), Lewanika (Western Province) and Solwezi (North Western Province) hospitals. However, it was not possible for the government to offer any places in the Muchinga, North-Western or Western provinces due to the lack of specialists in those provinces.

Volunteering can play a useful role both with regard to training and assisting in the shortfall of health workers, especially in more specialised roles as Zambia introduces the STP.

To understand these roles more thoroughly, The Tropical Health and Education Trust (THET) has undertaken an assessment that looks at how such a programme of placements could be applied in Zambia. The assessment aims to provide an overview of current approaches and priorities to volunteer placements in Zambia; identify the priority needs for volunteer placements in partnership with the MoH; give insight in to the volume of placements available and make recommendations on how such schemes can be deigned to achieve mutual benefit for the UK, Zambia and other host countries.

## Health volunteering in Zambia

The placing of volunteers at different levels of the health system in Zambia is commonplace. All the facilities that took part in this study had experience of hosting international volunteers. Sending countries included the United Kingdom, the United States, Germany, the Netherlands, Japan Canada, Ukraine, Argentina, India, Kenya, the Czech Republic and Cuba and ranged from *ad hoc* individually organised trips and project specific placements to long term, co-ordinated placement programmes run by development organisations. Clinical placements in facilities, undergraduate and post-graduate teaching, and mentoring and capacity building on the job are some of the various forms such volunteering placements have taken.

The UK is sending volunteers through several mechanisms. We examined three for the purposes of this study:

- The 2011-2017 Health Partnership Scheme, which saw at least 86 placements made, amounting to over 2600 volunteer days.[5]
- VSO is running four volunteer models in three rural areas - Nyimba in Eastern province, Serenje in Central province and Samfya in Luapula province. Through the International Volunteer Programme, the Community Model Volunteer Model, the Youth International Citizenship Service and the National Volunteers programme VSO receives approximately 90 volunteers per year, although at present they have no active volunteers in health facilities.
- In 2018 the Improving Global Health Fellowship programme, run by the Thames Valley Wessex Leadership Academy/Health Education England, started placing volunteers in Zambia, initially with two fellows. They had previously placed a volunteer in 2011 who volunteered in the Zambia Anaesthesia Development Programme in 2011.

We were unable to identify however, any systematic review of the impact of volunteers in Zambia. Our evidence that volunteers are making a positive contribution is therefore based on the interviews carried out in this study and on THET's own grey literature from seven years of health partnership reports, reinforced by the findings from a body of supporting evidence which is attached at the end of this report.

## Benefits of Volunteering – Review of Existing Literature

Numerous studies over the last ten years have suggested that volunteering overseas provides significant benefits to the National Health Service and other high-resource country staff who engage in the practice, from strengthening their problem-solving, leadership and interpersonal skills to improving their motivation[i] and developing their clinical skills.[ii,iii,iv,v, vi] In one set of interviews with returning volunteers, 78% suggested that their placement had provided them with experience that was not possible elsewhere and 100% of interviewees (n=28) "recognised improvements in their ability to problem solve ".[vii] However, volunteering must be carefully managed to ensure that the mutual benefits are felt by both partners; one key method of ensuring this noted in several studies is the placement of volunteers through long-standing, collaborative and equal institutional partnerships.[viii] Memoranda of Understanding have been suggested as a method of formalising the relationship to mutual benefit.[ix] It has also been suggested that the involvement of diaspora members can be highly beneficial as they "tend to have a deep understanding of the culture, language, systems and social conditions of both the UK and their indigenous countries and are often key players in supporting the development network."[x]

As travel becomes easier and the prevalence of previously unseen conditions such as dengue fever, malaria and tuberculosis increases in the United Kingdom (UK),[xi] the need for health professionals to have experience of their treatment has become more acute and volunteering overseas can provide these vital skills. It has also been argued that increased cultural awareness can be "immediately [applied]" on volunteers' return to the UK.[xii] Process improvements and frugal innovation have also been noted in volunteers returning from low resource volunteers and through the partnership model. Examples of frugal innovations include oral rehydration therapy, the kangaroo mother care and the Ponsetti method of club foot correction.[xiii]

Other areas of benefit to the UK found have included creating "new perspectives on patient-centred care."[xiv] For partners in low- and middle-income countries (LMICs), health partnerships or links have been found to provide training and sustainability as well as material benefits of equipment and pharmaceutical support.[xv]

However, volunteering in low resource settings can provide a number of challenges for those who engage in it. One commonly cited issue is the steep cultural learning curve for underprepared staff. Which can lead to frustrations for the volunteer and the healthcare workers in the facilities. This highlights the need to ensure that all volunteers are provided with an induction or training before travel and that partner institutions are provided with a mechanism to feedback to their partner institution and/or to ensure the benefits are maximised and harmonised for all involved.

This highlights the importance of the equal, long term relationship between sending and receiving partners has an impact on sustainability, communication,[xvi] equity and cross-cultural learning.[xvii,xviii] There is also evidence that suggests that the health partnership model supports a trend of institutionalising partnerships: moving from individually centred collaboration to a multi-disciplinary approach.[xix] This can bring a multitude of benefits, including increasing sustainability of impact. Links can remain implementing improvements despite staff turnover and can create an enabling environment within facilities in the low- and middle-income country (LMIC) institution as benefits begin to spread through departments and areas of collaboration, for example from in-service training to research and curriculum development.[xx]

Clear guiding recommendations for volunteer placements have been provided by a number of sources, including Ackers,[xxi] most are from sending organisations or UK based organisations, for example the forthcoming Volunteering Standards that are being produced by THET and the UK's Department for Health's "Engaging in Global Health: The Framework for Voluntary Engagement in Global Health by the UK Health Sector."[xxii] The direction of guidance from the UK or other sending countries understandably focuses on the context, for example in "Engaging in Global Health" the suggested "sources of support" for ensuring effectiveness, organisational commitment and support for volunteering are all UK based organisations.[xxiii]

While many articles reviewed present similar recommendations, there does not seem to be a definitive guide to supporting volunteer placements for mutual benefit, as much of the literature comes from the perspective of sending organisations, institutions or returned volunteers.[xxiv] This creates a danger of a paternalistic approach to placement design.[xxv]

## Study

In order to gain insights into the needs of the Zambian health system and how volunteer placements can support the Zambian government to meet them, THET undertook semi-structured interviews with individuals at key institutions throughout the health system and country, including with the MoH District Hospitals, Specialist Hospitals, Health Service Training Institutions. A total of 13 individuals provided insights from 8 facilities and institutes of higher learning, across three provinces of Zambia. Surveys asked interviewees to provide information on their level of experience with facilities, the facilities' need as well as challenges and recommendations for the design of volunteer placements within their facilities. Of those interviewed, four were medical doctors, two nurse tutors/administrators, one facility nurse, one senior non-physician anaesthetic officer from the MoH, one anaesthetist, a principal and a training manager at higher learning institution, one was Dean in the School of Medicine and one a pharmacist

All but two respondents had had previous experience with local and international volunteers and 50% highlighted the lack of specialists and/or a skilled workforce as a key challenge for their institution.

## Findings and Recommendations

Our interviews resulted in a range of insights regarding preferred length of placements, strategies for volunteer management in terms of recruitment and challenges faced by participants. On the basis of these findings we have developed a series of recommendations for future volunteer placements in Zambia.

Judging from our interviews, Zambia's experience of hosting volunteers is overall positive. 100% of people we interviewed felt volunteers were having a positive impact on the Zambian health sector, particularly on their ability to fill skills gaps across health themes and facility levels. They were also all keen to facilitate the future placement of volunteers within their institutions.

However, it was also clear than to ensure that placements are designed to ensure mutual benefit for volunteers and the facilities they are working within. Frequently heard concerns included the lack of sustainable impact in the case of short-term volunteers which was exacerbated by a lack of continuity and follow up; and the need to ensure that volunteers are well prepared before travelling to minimise culture clashes or expectations of the ability of staff to implement rapid change.

### Coordination of Placement Programme

Our interviewees had strong views on how volunteers should be managed. Collaboration and coordination were seen as being vital. 70% of interviewees suggested using an MoU so that roles and responsibilities are clearly defined and understood.

> *"It is important to first get to know the priority areas of a given health facility before placing volunteers"*

Several interviewees highlighted the involvement of the MoH other key national bodies such as professional associations and regulatory bodies such as the Health Professionals Council of Zambia (HPCZ), as a factor to support appropriate placements and the sustainability and scope of impact. For certain areas such as Anaesthesia there were readily identifiable positions that could take the lead in national level coordination. Roles suggested for the MoH included defining need and coordinating placements across the country, and the coordination of data collection from volunteers. Coordination at the facility level was emphasised to ensure that the placement of volunteers is both need-driven and strategic, although an individual holding the partnership relationship or full responsibility for the programme was seen as detrimental as in several facilities high staff turnover was mentioned as a problem.

Although the needs of each facility are well understood within those facilities, there is currently no mechanism to feed this information up through the necessary channels to the national level. The National Steering Committee would fill this gap. It is recommended that a coordination mechanism is set up, with an initial one-day stakeholder meeting convened with facility heads, provincial health officers, the Ministry of Education, representatives of professional associations and MoH. This should be repeated at the end of each year of programme implementation to review

priorities of all institutions involved. This will ensure that any placement scheme meets the need of the country and also ensure a spread of volunteers throughout Zambia rather than a concentration in areas such as Lusaka and Ndola.

There is also a need to strengthen the facility management of volunteers, it was noted in one case that the relationship with the volunteering sending body was held by one individual, which led to the supply of volunteers drying up when this individual moved to another facility.

This committee should consist of facility management representatives, including Chief Medical Superintendents or Principals and Human Resource Departments depending on the type of facility and the Head of each Department within the facility. The role of this Committee would be to provide strict guidance on the type of placements required within the facility to both the MoH and the coordinating organisation, to support the development of placement design, to facilitate volunteer logistics in-country, to assign each volunteer with a facility point-of-contact and to be the first port of call for volunteers in the case of in-country challenges. This would ensure engagement of the staff who would be involved on a daily basis with volunteers and oversight of placements and their impact on the facility. This approach, it is hoped, would safeguard against volunteers being placed in departments where staff do not have the capacity to support volunteers or learn from them, as well as ensure that the facility needs are met democratically, thus reducing likelihood of misunderstandings or resentment with staff.

Recommendations:

- THET recommends the setting up of a national steering committee and facility-based bodies at each facility to promote better coordination between relevant stakeholders and ensure maximum benefit from placements.
- An MoU should be signed between the MoH and the coordinating organisation.
- There should be further MoUs with each institution receiving volunteers and the coordinating organisation clearly setting out the roles and responsibilities of each party.

## Placement Design

Interviewees were able to clearly articulate the departments in which volunteers would be particularly appreciated but support is required across most cadres, including with doctors, nurses and medical educators. In line with the decentralisation of clinical training approach that the MoH is now taking, many requests were made for doctors who were able to transfer skills to existing staff. Heath training institutes were keen to see more lecturers available for postgraduate training. While the emphasis of the placements considered by most interviewees was on capacity development in terms of clinical and teaching/supervisory skills, it must also be acknowledged that several interviewees felt that volunteers should be able to undertake clinical practice while on placement.

While elements of service delivery, especially when combined with capacity building of local staff can have significant health system strengthening gains by increasing patient access to services and allowing volunteers to provide hands on guidance and support in patient care; this must be carefully defined to ensure that that volunteers are not expected to fill on going gaps unsustainably and patients are not left in a position where they are unable to receive follow up care. The balance should be agreed with the facility before recruitment to ensure that expectations are met and that volunteers do not face undue pressures when on placement.

It should be noted that facilities outside of Lusaka were particularly keen to ensure a more equitable distribution of volunteers across the country. This must, however, be balanced with the support available to volunteers while placed in Zambia. Facilities may not have the infrastructure, such as housing or required staffing numbers available to adequately provide for the needs of the volunteers. It is therefore vital that any sending organisation work with facilities to ensure the safety, security and well-being of volunteers during their placements.

Recommendations:

- Placement programmes should be long-term, wherever possible, and co-developed with facilities and a maximum number of volunteers should be agreed with the facility.
- Volunteering must be carefully managed to ensure that the mutual benefits are felt by both partners; one key method of ensuring this noted in several studies is the placement of volunteers through long-standing, collaborative and equal institutional partnerships.

- No more than two volunteers should be placed in the same department at the same time.
- All volunteer placements should involve an element of capacity building for local staff to ensure sustainability of impact, as it has been shown that volunteers can learn just as much from the staff in their receiving institution.
- All volunteers should have a clearly defined ToR which are mutually agreed and clearly define the scope of each volunteer placement in a facility. These should set out the responsibilities of each party and be signed off before departure. A handover guide should be produced by all volunteers to ensure sustainability of impact.
    a. This ToR should be clear in the role of the volunteer in terms of the role they are to play, whether that is clinical, capacity building or system strengthening and to enable a balanced role that will create sustainable positive outcomes for the facility and the volunteer.
    b. A draft ToR, developed with facilities before recruitment, should provide a person specification to ensure that the needs of the facility are met by the volunteer and that the expectations of the facility in regard to the volunteer are fair.

## Volunteer Recruitment

Recruitment of volunteers was seen as a crucial area for collaboration between the sending organisations, MoH and host facilities. Two benefits are derived from this: volunteers are recruited with the right skills, and with the right attitudes. The value of volunteers to a facility is linked to the skills they can impart to local staff; mentoring was considered crucial. Several hospitals for example, referenced their lack of specialists (in one facility nearly all doctors on staff were general practitioners) and talked about how this led to physicians working outside of their area of training. Volunteers with specialist skills were therefore at a premium.

All interviewees were clear on the need to ensure that volunteer placements were designed to respond to the clearly articulated areas of support within their respective facilities or nationally.

*"…look at the qualifications of the volunteer and match them with priority areas. The qualifications must be tailored to the gap."*

An example of where joint recruitment would be beneficial is ensuring the volunteers are personally well suited to the placements. Disputes and tensions between individuals often arose, in the view of interviewees, as a result of attitudinal positions taken, sometimes made worse by language barriers and communication. Volunteers need to be mindful that their presence often increases the workload of staff who are mostly already working at maximum capacity. While volunteers were generally well regarded and their involvement was highlighted as a motivating factor for staff, it is vital that they are selected to fit well with the existing staff and culture at the facility.

*"Remember these volunteers will also have to learn the way of working of local staff"*

At one facility a volunteer placement had to be terminated early as the volunteer who was placed to teach had insufficient English language skills to be effective. This clearly gives UK placements an advantage. But while English is ubiquitous, staff struggle when volunteers do not always take into account accents and speed of conversation.

*"We are aware that most volunteers are experts in their own areas, but [they] should not undermine the local staff as they are also experts in their own way."*

### Recommendations:

- Volunteers should be recruited through a coordinating organisation with links to the MoH and the NHS. Cadres and specialities required should be designated by the receiving facility and the coordinating organisation and facilities should work together to select the most appropriate candidates.

## Length of Placement

90% of interviewees expressed a preference for long term volunteers.[1] It was felt that this type was most beneficial for both the volunteer and the facilities involved, because it gave both sides enough time to adapt to the context,

[1] Defined for the purpose of the study as lasting six months or above

allowing for follow up and capacity building, and thus increasing likelihood of mentoring and ensuring the sustainability of impact. On the other hand, short-term placements were considered particularly beneficial when they had a narrow focus, for example teaching a specific module, or when combined with a long-term volunteer so both placements could add value to each other. They were also regarded as being a valuable way of familiarising new host institutions with the challenges of volunteers.

Continuity was also mentioned as a necessity for well-designed placements. In some facilities the lack of planning sustainability placed them in a worse position than before the volunteer was in place. For example, when a volunteer worked on a specific project, such as information systems without a structured handover, staff and processes were left more confused than before the intervention.

A continuous placement rotation would ensure that volunteers and their projects are embedded in the facility and that their impact is maintained in the long term. It would provide continuous learning opportunities and skills transfer for both the volunteers and facility staff they are working with and ensure that volunteers benefit from a deeper cultural understanding. It will also support the value for money of the programme by allowing for volunteer housing to be maintained rather than a reliance on hotels for accommodation. However, where this is not possible there could be scope for remote mentoring and support.

Recommendations:

- Placements should not be less than one month with six-month placements being the norm.
- While challenging to ensure, given the pressures on the UK workforce, wherever possible, a continuous flow of volunteers should be maintained for a period of not less than two years for each facility; and a maximum of two volunteers should be assigned to any department depending on the needs and capacity of each facility.

## Volunteer support

Respondents expressed concern over the lack of cultural understanding and sensitivity that they had experienced with volunteers previously placed in their facilities and suggested that culture shock and cultural misunderstandings could be damaging to both volunteers and facility staff. It was suggested that without this, volunteers may not be prepared for a low resource setting, something which can in turn lead to frustration and disappointment for volunteers.

Two types of preparations were suggested: firstly, orientation before arrival to provide an overview, and then a deeper contextual induction upon arrival. It was recommended at one facility that orientation include facility staff who would be working with the volunteers to cement relationships and orient staff on the roles of volunteers and their expectations. Preparation for placements should be made well in advance so that both parties can plan for the placement and having a well-defined, co-developed terms of reference was mentioned by one interviewee as key to the success of placements.

Other areas of support for volunteers that were suggested were providing accommodation, support to register with the relevant authorities and provision of transport options. However, this was not financially feasible for most of the respondents who requested that volunteer placements come with no financial cost to the receiving organisation.

The issue of stipends was similarly complex. There was an example where volunteers received a large stipend from their sending organisation and were working fewer hours than staff on less pay whose workload was increased due to the support and supervision the volunteers required, ultimately leading to demotivation of the facility staff.

On the other hand, the lack of stipends also created challenges for a facility when volunteers then expected support such as accommodation and transport from the host institution which if given created tension with local staff who did not receive the same benefits. The issue presented by stipends was also echoed by VSO Staff in Zambia, who have encountered similar problems when approaching volunteer support.

Recommendations:

- Support mechanisms are put in place to support volunteers and facility staff before, during and after their placement. This should include:

a. Thorough two-stage inductions should be available for all volunteers to ensure that they are well briefed on what to expect and what will be expected of them.
b. A designated focal person within the facility who the volunteer will work with to support their integration in the facility and provide a key point of contact for their learning.
c. Volunteers working in medical settings are required to be supervised by local staff members however, co-working and co-mentoring should be embedded into a placement.
d. A volunteer house is maintained at or near each facility.
e. Stipends should be calculated to ensure that volunteers from all financial backgrounds are able to access a volunteer placement opportunity. However, it is necessary that this is calculated to be appropriate to the setting without being far above the wages of staff within facilities.

### Support to Facilities

Aside from logistical support to the volunteer it was also highlighted that there should be maximum benefit to both parties, facilities may also need support to cater for volunteers. It is ineffective and frustrating for both parties to place a specialist in a hospital where they do not have the supplies and equipment to practice their area of medicine, therefore a thorough assessment of both need and capacity should be taken at all receiving institutions.

Respondents felt that one to two volunteers per department was the optimum to provide maximum benefit without increasing the workload of staff to an unacceptable level. The cost to the facility for supporting the volunteers was also a factor for interviewees when calculating the number they could support at one time, although two institutions suggested that they would be in a position, or currently, provide volunteers with accommodation. Further financial support may be required by facilities to ensure that the duty of care to volunteers is met.

**Recommendations:**

- Facilities should have a capacity assessment before placements and be supported, including financially, to provide hosting facilities.
- A fund should be developed that support the accommodation of volunteers, travel to the communities in which the volunteers are placed and small improvement projects that may be implemented to ensure that volunteers are well supported and able to access items and equipment required for their placement.

## Conclusion

Workforce challenges and crises are not unique to Zambia and the UK is also facing one. The response to this crisis need not be a zero-sum game.[1] Well- designed, co-developed, mutually beneficial volunteer placement programmes can provide at least part of the solution, strengthening the skills of health workers both at home and abroad.

However, while generally the individuals interviewed were very positive about the prospect of future volunteers to support individual and organisation capacity development the issue is much more nuanced when practicalities of involving volunteers temporarily in the Zambian Health System. Scaling-up UK volunteering requires careful planning. We interviewed Zambians across the health community, from the MoH to a small clinic in Ndola in the Copperbelt Province and this message was expressed most strongly to us.

Recommendations took various forms but can be summarised in one word: alignment. Alignment with MoH and host institutional requirements is regarded as being vital. This allows not only for better coordination with other sending countries such as the United States, Germany, the Netherlands, Japan, Canada, Ukraine, Argentina, India, Kenya, the Czech Republic and Cuba. It also means that the expectations placed on host institutions by volunteers can be more effectively absorbed. It will also ensure that the cadre of volunteers and the role they will play in the facility in which they are placed meet the needs of the health system.

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[viii] Balandin, *op. cit*. p.872

[ix] Department for International Development and Department for Health and Social Care. 2014. "Engaging in Global Health: The Framework for Voluntary Engagement in Global Health by the UK Health Sector" https://www.gov.uk/government/publications/supporting-international-volunteering-in-the-health-and-care-sector (last accessed 3rd October 2018). p.38

[x] Department for International Development and Department for Health and Social Care. 2014.*op. cit.* p.31

[xi] Baguley, *op. cit.* p.152

[xii] Baguley, *ibid.* p.152

[xiii] Syed et al. 2012. "Developed-developing country partnerships: Benefits to developed countries?" *Globalization and Health.* 8:17 p.2

[xiv] Baguley, *op. cit.* p.151

[xv] Baguley, *ibid.* p.152

[xvi] Which is particularly important when designing placements and ensuring realistic expectations are developed and met for both the host institution and the volunteer.

[xvii] Balandin, *op. cit*. p.872

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[xxiii] Department for International Development and Department for Health and Social Care. *ibid.* p.38

[xxiv] Rozier et al. *op. cit. p.1*

[xxv] Taylor, *op. cit.* p.52