GLOBAL CITIZENSHIP

in the Scottish Health Service

The value of international volunteering

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

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FOREWORD

Many NHSScotland staff give their time and expertise to volunteering work in healthcare settings across the world. I am delighted to welcome this timely report which reviews and analyses volunteering activity by NHSScotland staff. Many of you will have been involved yourselves or will know someone who has. It is common for Scottish staff to experience significant personal and professional growth from time abroad. When a health service worker steps outside their normal environment it frequently leads to better cultural sensitivity and an openness to doing things differently. I believe there is much to learn from healthcare colleagues working in lesser resourced environments, who often show great ingenuity and a healthy pragmatism in their service delivery.

This review has taken into account a broad range of perspectives, including input from all of Scotland's Health Boards as well as charities, professional organisations, subject experts and volunteers themselves. I welcome the findings that there are mutual benefits where NHSScotland staff choose to volunteer abroad. Successful development work in partner countries occurs on both long and short term visits by Scottish staff, but sustainable and meaningful change is made more likely where the principles of effective partnership are carefully followed, including, for example, alignment with existing priorities.

This review faces challenges inherent in international activity head-on, taking into consideration the challenges of maintaining a high quality of service to Scottish patients during employee absence, financial costs and the need to consider personal health and safety risks. Health service concerns about service gaps may explain the experience of some volunteers, who report a lack of support for their international work and this review rightly considers the varied access to opportunities around Scotland.

I am keen that the evidence based recommendations that the College makes for improving our engagement with global health needs are considered in depth by NHSScotland and the Scottish Global Health Committee I chair. The Scottish Government has a clear commitment to Global Citizenship, and to the attainment of the UN's Sustainable Development Goals both domestically and internationally. This report outlines how the health service can play its part in this commitment, with the articulation of a distinctive Scottish approach to global health engagement. We need to recognise and appreciate the value of international volunteering and commit to the principles of effective partnership and mutual development. I would encourage all those who are considering a period of volunteering, or who are responsible for colleagues who might wish to volunteer, to take the time to read this report and consider the recommendations within.

"We will meet in the developing world a level of will, skill, and constancy that may put ours to shame. We may well find ourselves not the teachers we thought we were, but students of those who simply will not be stopped under circumstances that would have stopped us long ago." (Don Berwick)

Dr Catherine Calderwood
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Chief Medical Officer for Scotland

INTRODUCTION

"As long as poverty, injustice and gross inequality persist in our world, none of us can truly rest… overcoming poverty is not a gesture of charity. It is an act of justice."

Nelson Mandela spoke these words to the 20,000 people gathered in Trafalgar Square on 3rd February 2005, but his wider audience included the leaders of the world's largest economies as they met to determine their response to severe and persistent global inequalities.

That year also marked the publication of the first international development policy of a devolved Scottish administration, which set out to promote *"the positive contribution that Scotland can make to the world, and in particular to developing countries*[1]*."* This policy set key priorities for international development efforts, in alignment with the UN's Millennium Development Goals. Health has remained a critical component in the new Sustainable Development Goals (SDGs) and in December 2016, the Scottish Government launched its refreshed International Development Strategy, 'Global Citizenship', reaffirming its belief that Scotland *"can play a unique role in finding solutions to the common challenges facing our world*[2]*."*

This report from the Royal College of Physicians and Surgeons of Glasgow outlines how Scotland's health service can deliver our national commitment to good global citizenship, and we explore the value of this to our country. We are pleased to have secured the views of all Scotland's territorial and special Health Boards to inform this assessment, alongside many other key organisations and individuals. This report focuses on international volunteering by Scotland's health service workers but necessarily we speak to the broader context of global health engagement. We contrast our current approach with neighbouring countries and conclude that action is required to place Scotland at the forefront of best practice.

In committing to both domestic and international implementation of the SDGs, First Minister Nicola Sturgeon stated that *"we need to grasp the opportunity that following this path offers to create a fairer Scotland and a better world both now and for generations to come*[3]*."*

We urge the Scottish health service to 'grasp the opportunity', embracing a culture of global citizenship which initiates and supports international health partnerships with less developed economies. We contend that such a culture reflects Scotland's heritage and values, and in turn offers substantial benefit to Scotland's health sector workers, our healthcare services and our nation.

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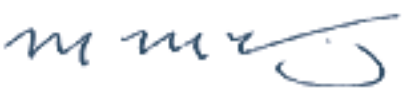

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April 2017

EXECUTIVE SUMMARY:
Findings and Conclusions

Global citizenship is viewed by the Scottish Government as a core national value. It is the title of the Government's new International Development Strategy[2], and has a key position in our national schools programme 'Curriculum for Excellence'[4]. Global citizenship is both a concept and an attitude which welcomes diversity, global solidarity, and which pursues justice both at home and abroad. The Scottish Government has expressed this value by embracing the UN's Sustainable Development Goals[5] as a dual commitment to tackling inequalities at home and to helping developing countries grow in a fair and sustainable way. In addition to Scotland's contribution to the UK aid budget, the Scottish Government currently distributes a further £11 million per year towards international development and on efforts to reduce the impact of climate change on the world's poorest communities.

Engagement of the Scottish health service in improving health and healthcare around the world is a necessary reflection of these policy commitments. Quite apart from a moral commitment to global citizenship are two further compelling reasons for Scotland's health service to engage in global health work:

- **common challenges:** disease epidemics, drug-resistant infections, and non-communicable disease burdens do not respect national boundaries and need to be tackled with international cooperation.
- **mutual learning opportunities:** engagement in global health work brings proven benefits to our health workers and our healthcare system.

Evidence for the mutual benefits of global health work is accumulating steadily in the academic literature and in the experience of health systems that have combined the development of global health work with training and service delivery. Benefits to individuals can accrue in a range of domains including:

- leadership and management skills
- communication and teamwork
- clinical skills
- policy awareness and experience
- academic skills
- patient experience and dignity
- personal resilience, satisfaction and interest

> ***Engaging in international volunteering will broaden an individual's views and present different challenges... with increased exposure to differing healthcare environments comes a greater understanding and creativity in solving problems.***
> - Clare McKenzie, Postgraduate Dean, East Region – Scotland Deanery.

Benefits to NHSScotland include:

- enhancement of recruitment and retention
- system learning and capacity building
- professional development of the workforce
- improved Scottish patient experience
- reputational development

VIEW CASE STUDY

> ***Seeing health care delivered under such pressure encourages me to think about what aspects of care are really critical and which can be done without, if need be.***
> - Consultant Paediatrician Charlotte Wright describing her visits to the Children's Hospital and Institute of Child Health in Lahore, Pakistan.

The challenges and risks that can be associated with global health work include:

- maintaining NHS service delivery during employee absence
- financial costs to individuals and services
- personal health and security risks
- opportunity costs (for example professional or family sacrifices)
- issues with professional regulation
- reputational risk to NHS services

Global health experience appears to be widespread in UK health workers. A large cross-sectional study of health workers in the North-West of England found that 42% of staff had experienced at least one overseas placement, with 80% of these experiences in a low- or middle-income country.

A survey by the Scottish Global Health Collaborative of 391 NHSScotland employees (see Remit and Approach for details) included 105 respondents who had undertaken recent global health work. Of these 105 respondents:

- 88% of respondents delivered their global health work on a 'fully' or 'partly' voluntary basis.
- 63% of respondents had no experience or awareness of support from their Health Boards.

> ***Although there was great enthusiasm and support prior to my visit, there were small but vocal pockets of lack-lustre senior management support at the same time... I was left with a guarded and embarrassed feel on return. It was as though I had done something wrong or had enjoyed a 'jolly' at the expense of other colleagues.***
> – Anonymous staff member

In their direct response to our stakeholder engagement, senior management teams from Scottish Health Boards provided the following key information:

- Boards do not have bespoke policy provisions for the support of global health work.
- Boards are unable to quantify the extent of international volunteering in their organisations since this information is not routinely collected.
- Boards suggest that the current NHSScotland approach to international volunteering can be improved through greater national coordination and support.

Global health activity is being formalised and coordinated in other administrations:

- **England** has published a number of strategy and guidance documents, and have established the 'Global Health Exchange' in Health Education England to support workforce development.
- **Wales** has legislated on the UN's Sustainable Development Goals, established an 'International Health Coordination Centre' and agreed a 'Charter for International Health Partnerships'.
- **The Republic of Ireland** is establishing a global health office within the Health Services Executive and have developed codes of best practice in volunteering.

International health partnerships are of proven value to health systems with lower resources than our own. In an era of financial stringency and challenging performance targets, careful consideration needs to be given to how Scotland can strategically share some of its substantial human resources and intellectual capital with partners in the developing world. Such an approach should enhance benefit to both Scotland and its international partners, and should also avoid stifling individual efforts or innovation.

Global health work can sharpen and motivate our workforce in their primary task of delivering healthcare to the people of Scotland, and when undertaken thoughtfully and respectfully can be a powerful international statement of Scottish character and values.

EXECUTIVE SUMMARY: Recommendations

Many Scottish health service workers are currently undertaking high quality international development work in the health domain, predominantly on a voluntary basis. These individual efforts are in tune with the Scottish Government's dual commitment to the Sustainable Development Goals, implementing domestically and contributing internationally. This also brings clear benefit to these health service workers and our health service. Our task has been to suggest how the Scottish health service can better encourage, support and coordinate this commitment and activity. A summary of our eight recommendations is provided below. A fuller explanation and exploration of each is found in Section 4. These suggested areas for action take into account the views we received from each of Scotland's Health Boards, our extensive stakeholder engagement exercise, the Collaborative survey and our literature review.

1 **DEVELOPING A STRATEGIC APPROACH:**
NHSScotland should consider articulating a strategic approach to global health engagement which embraces global citizenship in the Scottish health service.

Elsewhere in the UK, and beyond, administrations have laid out their vision for global health engagement and the time is right for Scotland's health service to do the same. This will reflect a continuation of Scotland's devolutionary journey and be a statement of her international outlook. Articulating a strategic approach can bring focus and enhanced effectiveness to existing international health work, ensuring that we deliver value for money abroad, mitigate risks and capitalise on the benefits to our NHS. Many Health Boards expressed the view that our approach to international volunteering by NHS workers can be improved through clearer guidance that can be applied consistently to all staff across Scotland.

Articulation of a Scottish approach to global health work might result in a focus of resource and expertise in keeping with the current Scottish Government International Development strategy[2], with its sub-Saharan project base of Malawi, Zambia and Rwanda, and educational links with Pakistan.

2 **PROFESSIONALISING COORDINATION AND SUPPORT:**
The Scottish Government should consider professionalising and resourcing coordination and support of global health work at a national level.

Enhancing our global health work requires capacity and a modest investment in professionalising support and development. This capacity could be provided by a Scottish Global Health Coordination Centre, which might have the following purposes:

- Developing and articulating global health policies and strategy.
- Providing practical and policy expertise to individuals and organisations on the planning and delivery of global health activity.
- Identifying and publicising funding opportunities for global health work.
- Providing a central point for liaison with Scottish Government departments and with jurisdictions elsewhere.

3 **MAXIMISING BENEFIT:**
NHSScotland should consider exploring how the potential personal and professional benefits of global health work could best be maximised in the Scottish health service.

One of the anticipated benefits of a renewed health service commitment to global citizenship and international engagement is more proactive capitalisation of the benefits of global health work. Our report explores examples of how international placements have been used to boost recruitment and retention, and enhance development of professional and leadership skills. We can learn from these initiatives. We believe that there is scope to better capture and recognise the value of existing international work. Supporting health service workers in global health work is an intelligent investment in staff development and can boost morale.

4 **ENSURING EFFECTIVENESS:**
NHSScotland should support global health work which is needs-led and follows principles of effective partnership working.

A strategic Scottish approach to global health work should include an institutional commitment to established principles of effective partnership and reflect the Scottish Government's policy commitment in its 2016 International Development Strategy to the "beyond aid" agenda. This will reinforce best practice and curtail ineffectual interventions, and could measure success in this area by consistent evaluation of global health work. While formal institution to institution partnerships have proven an effective model of co-development, we suggest that smaller scale individual partnerships should also be supported, as they can also be of mutual benefit and may lead to larger collaborative efforts.

5 **VALUING COLLABORATION:**
NHSScotland should consider committing to collaborative engagement and advocacy on global health issues.

Consistent and collaborative institutional engagement on global health work will help to address barriers and challenges in international activity, will share Scotland's considerable expertise in development work, and will provide advocacy for our interests. It is important that the Scottish health service is aware of and involved in wider UK international development policy developments and able to take advantage of all funding streams. Within Scotland, the various elements of the health service and the academic community should seek opportunities for information sharing and collaborative working.

6 **EXPRESSING LOCAL COMMITMENT:**
NHSScotland should consider asking all Health Boards to articulate a focused organisational commitment to global citizenship.

We believe that tangible delivery of global citizenship values in the Scottish health service depends on them being valued and expressed in individual Health Boards. This report outlines how some Boards and individual hospitals have formalised international health links and reaped the benefits of long-standing partnerships. We recognise that the first priority of Boards must remain high quality local service delivery, but suggest that staff and service development through proportionate, considered international work complements rather than hinders this objective.

7 **DEFINING SUPPORT MECHANISMS:**
NHSScotland, in partnership with Health Boards, should consider defining support mechanisms for international volunteering.

Most Health Boards responding to our call for views and evidence suggested a "once for Scotland" approach which applied consistent guidance to all staff. Most global health visits are undertaken in annual leave. Some organisations are allowing more flexible use of study leave in international development work, reflecting the element of personal development that is often occurring on such visits. Unpaid leave, sabbaticals and career breaks offer another route to undertaking work abroad. Policy development in this area could direct health workers towards focus areas for Health Boards or NHSScotland, but should avoid stifling more ad-hoc relationships which are often a springboard for later development of formalised partnerships.

8 **SETTING EXPECTATIONS:**
NHSScotland should consider articulating its expectations of Scottish health service workers when engaging in global health work.

While the focus in this report is on institutional opportunities and responsibilities, it will be Scottish health service workers who represent Scotland internationally. We believe that a clear statement of employer expectations in this area of activity will inform staff, support best practice and mitigate against reputational risk from poorly conducted volunteering.

CONTENTS

REMIT AND APPROACH

This report by the Royal College of Physicians and Surgeons of Glasgow has been supported by the Scottish Global Health Collaborative, an interest group established in October 2015 and chaired by Scotland's Chief Medical Officer. The Collaborative's aim is to work with the Scottish Government and partners in the wider health community to promote effective and coordinated health sector involvement in global health.

The Collaborative asked the College to produce a report which would:

- define and describe current international volunteering by Scottish health workers
- evaluate the benefits and challenges of international volunteering to the Scottish NHS
- appraise the current approach by NHSScotland to international volunteering by its staff
- suggest what actions would deliver improved benefit from global health work to Scottish health workers and the Scottish health system, and improved benefit to partners abroad

From January 2016 to March 2017, the Collaborative gathered evidence on the attitudes and experiences of Scottish health workers through an online survey administered by the Tropical Health and Education Trust (THET). This was distributed through Health Boards and international development networks. A total of 455 responses were received from all sectors, and 391 were NHSScotland employees. Of these 391 NHSScotland employees, 105 had undertaken global health work within the last 5 years. Data from this survey is used to inform the report.

This report has also been informed by a review of key reports, existing policies from Scotland and elsewhere, published academic literature, non-published literature and a wide-ranging stakeholder engagement exercise.

We formally sought opinions from senior management teams in all territorial and special Health Boards in Scotland, all of whom provided a response. We also consulted Scottish Government policy teams, key academic, professional and charitable organisations operating in Scotland, and individual subject experts from Scotland and beyond. Grateful acknowledgment to the many participants and supporters of this work is given at the end of the report. Their input is fully integrated into the report and occasionally quoted verbatim. Where anonymity was requested, this has been respected.

Photo courtesy of THET

1. SETTING THE SCENE

1.1 GLOBAL CITIZENSHIP IN SCOTLAND

"Scotland cannot act with credibility overseas if we are blind to inequality here at home. And our ambitions for a fairer Scotland are undermined without global action to tackle poverty"
- First Minister Nicola Sturgeon[6].

Scotland is a small nation which has exerted a disproportionate influence on modern culture, philosophy and science. It takes pride in its warm welcome to visitors and in its vibrant international connections, which include many productive academic partnerships[7]. The concept of 'global citizenship' captures Scotland's understanding of interconnectedness, global solidarity, respect for diversity, and passion for addressing injustice- whether encountered in our own nation, or around the world. The importance that Scotland places on global citizenship is exemplified by its position as a key theme in our national schools programme 'Curriculum for Excellence'[4].

Global Citizenship is also the title of the Scottish Government's new International Development Strategy, which identifies areas of Scottish expertise in which we have potential to contribute to global achievement of the UN's Sustainable Development Goals ("global goals")[2]. Health is one such area. In the following section, we explore recent background to Scottish international development work in health, uncover the policy frameworks under which NHS staff currently undertake international work, engage with staff perspectives on their experience of this work, and contrast our current approach with those elsewhere in the UK and further afield.

1.2 THE IMPORTANCE OF GLOBAL HEALTH TO SCOTLAND

Scotland's international commitment to meeting the global goals[3] has been made in a world where there is gross inequity in healthcare resource distribution worldwide. As a case in point, the African continent carries 24% of the world's disease burden, but employs only 3% of the world's healthcare workforce, and spends less than 1% of the world's financial resources for health[8].

The NHS in Scotland directly employs approximately 160,000 staff[9] and delivers a health service to Scotland's 5.4 million people[10] with a budget of £12.2 billion (2015). Healthcare in Scotland has been the responsibility of the Scottish Parliament since devolution in 1999, and it accounts for 40% of the Scottish Government's total expenditure[11].

Although a commitment to partnership with less developed countries is partly a moral decision, there are other strategic reasons for healthcare systems in highly developed economies to engage in mutual learning with systems in developing countries. There is much commonality in the healthcare challenges faced by high-income countries (HICs) and low- or middle-income countries (LMICs)[12], such as in:

- **Infectious diseases:** disease epidemics and drug-resistant infections do not respect international boundaries and solutions require transnational ideas and cooperation.
- **Non-communicable diseases:** both HICs and LMICs face an increasing burden of cardiovascular and respiratory disease, cancer, diabetes and mental illness, and have similar challenges in prevention and chronic disease management[13].

- **Rising costs of care provision and competition for skilled care workers:** in many countries, populations are aging, use of technology is increasing and there is competition for skilled health service workers, making achievement of equitable, affordable care difficult[14].
- **Providing equitable services to remote and rural communities:** there are worldwide difficulties in recruiting and retaining staff for rural areas, and providing health equity to these populations[15].

In the face of these shared problems, mutual learning and innovation sharing can occur between countries of varying resource levels. Indeed, in such circumstances the term 'international development' has been thought better replaced by the idea of 'co-development', which reflects genuine partnership[12].

In recent years, the concept of 'global health' has come to encapsulate the complexity of addressing global inequalities in health and their root causes. The most widely used definition is: *"Global health is an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide. Global health emphasises 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[16]."*

This definition encompasses concerns of equity, the question of causes and solutions, the delivery of intervention to individuals and whole populations, and the 'global' conceptualisation of health[17]. A global understanding of health is distinct from 'international' health in that it ignores borders and focuses on vulnerable populations wherever they may exist. Global health acknowledges the need for more multi-professional, cohesive policy in tackling the many causes of ill health and healthcare inequity[18].

Scotland has been able to demonstrate imagination and resourcefulness in advancing healthcare at home. We are well positioned to help deliver those same advances where they are most needed – in the world's poorest countries.

1.3 INTERNATIONAL DEVELOPMENT AND HEALTH – A UK PERSPECTIVE

The UK is the third largest provider of official development assistance (ODA) in the world[19], and by 2013 had achieved its long-stated target of spending the recommended 0.7% of Gross National Income (GNI) on aid[20]. The UK Government describes our aid commitment as a *"a moral imperative... a crucial part of the UK's place in the world[21]."* The £12.1 billion budget for ODA (2015)[22] is managed predominantly by the Department for International Development (DFID), with assistance from other UK Government Departments.

Health has always been a crucial area of interest in UK international development. In 2015, DFID spent a total of £1.6 billion on health work* (13% of their total spend)[22]. Over recent years, DFID has allocated a small portion of its budget to partnership working between UK health organisations and collaborating organisations in the developing world, an approach which places great emphasis on the use of UK volunteers. This development followed a 2007 report by the former Chief Executive of the English Department of Health, Lord Nigel Crisp[23].

* This figure combines £1,003 million in bilateral health aid and £582 million in imputed multilateral aid for health work.

Figure 1: Health Partnership Scheme in Numbers[24]

His 'Global Health Partnerships' paper reported on how UK expertise and experience in health might best be used to improve health in developing countries, and suggested that in doing so, the UK could:

1. *Learn a great deal for itself about how to meet its own health needs*
2. *Broaden the education of health professionals in the UK*
3. *Build stronger relationships across the globe that will stand the UK in good stead in a changing and risky world*

That 2007 report was welcomed by the UK Government which accepted the report's recommendations. One of the key responses of DFID was the formation of the International Health Links Funding Scheme, which was succeeded by the Health Partnership Scheme (HPS). Since 2011 the HPS has provided £30 million funding for health partnerships, administered by the Tropical Health and Education Trust (THET) [24]. Figure 1 illustrates some of the achievements of this scheme.

Scottish-based academic and health service institutions have collectively received 13 of 198 HPS grants, totalling 11% of the monetary value of funds awarded (personal communication).

THET describe health partnerships as *"a model for improving health and health services based on ideas of co-development between actors and institutions from different countries. The partnerships are long-term but not permanent and are based on ideas of reciprocal learning and mutual benefits*[24]*."* The health partnership movement has been seen as addressing some of the short-comings of traditional aid, which is sometimes viewed as distorting local economies and priorities[25].

At a UK level, the All-Party Parliamentary Group (APPG) on Global Health was established in 2011 and has proven an influential think-tank with Lord Crisp as co-chair. In 2013, the APPG published a report 'Improving Health at Home and Abroad' which outlined how international volunteering from the NHS benefitted the UK and the world[26]. They made recommendations about spreading good practice, creating a movement and sustaining success, although they were focused on the English context.

1.4 INTERNATIONAL DEVELOPMENT AND HEALTH – A SCOTTISH PERSPECTIVE

In the UK, international development remains a 'reserved' responsibility of the UK Government, funded through UK-wide taxes, rather than being a devolved policy area of the Scottish Government. However, as outlined in the consultation document[27] for their new International Development Strategy, the Scottish Government explains that *"Scottish Ministers may under the Scotland Act*

1998 assist Ministers of the Crown with international relations, including international development assistance". Through this provision, the Scottish Government has developed its own international development footprint since 2005 which aims to complement the work of UK agencies. Scottish Government international development spend, whether under its International Development Fund, Climate Justice Fund or humanitarian donations, is counted towards the UK's overall official development assistance targets.

The Scottish Government published its new International Development Strategy ('Global Citizenship') in December 2016, which states the vision that Scotland *"contributes to the fight against global poverty, inequality, injustice and promotes sustainable development by embedding the Global Goals* [UN Sustainable Development Goals] *in all that we do*[2]*."*

The Scottish Government's current priorities in international development are to:

- *Encourage new and historic relationships*
- *Empower our partner countries*
- *Engage the people of Scotland*
- *Enhance our global citizenship*

The Scottish Government has decided to direct its resources towards four partner countries: Malawi, Zambia, Rwanda, and Pakistan. Thus far, Scotland's development efforts have particularly focused on Malawi, with whom strong historical links existed and with whom an inter-governmental cooperation agreement was signed in November 2005.

The International Development Fund established by the Scottish Government currently dispenses £9 million per year. This is distributed to a variety of programmes and through core funding of three networking charities: the Scotland Malawi Partnership, the Network for International Development Organisations of Scotland (NIDOS) and the Scottish Fair Trade Forum.

The Scottish Government also has a separate Climate Justice Fund which is used for international work. In the future, Scotland's International Development Fund will be directed towards three separate funding streams:

1. Development assistance
2. Capacity strengthening
3. Investment

The Scottish Government has committed to a "Beyond Aid" approach in its international development work, noting that the Beyond Aid agenda *"takes a holistic approach to sustainable development, requiring all – government, local government, public bodies, private sector, communities and individuals – to adapt their behaviour in support of the Global Goals*[2]*."*
The Scottish Government's International Development Strategy (2016) has been shaped by its existing International Framework[28] (2015), which states:

Our internationalisation agenda is twofold:

- *To create an environment within Scotland that supports a better understanding of international opportunities and a greater appetite and ability to seize them; and*
- *To influence the world around us on the issues that matter most in helping Scotland flourish.*

Health work has traditionally featured heavily in Scottish development assistance, with over £16 million of Malawi Development Programme funds awarded to health projects from 2005-2015. The Scottish Government's commitment to a capacity strengthening funding stream will present an opportunity for improving health systems and supporting health service workers in partner countries.

However, the Scottish Government does not have any current health-focused policies in relation to international development, beyond a 2006 Health Department Letter which refers to a now-concluded volunteering scheme (see section 1.5.1), and a commitment to ethical recruitment of international healthcare workers.

The Scottish Global Health Collaborative was formed in October 2015 as an interest group with representation from the Scottish Government, the Scottish NHS and third sector organisations, with the intention of promoting effective and coordinated health sector involvement in global health.

1.5 VOLUNTEERING FOR GLOBAL HEALTH WORK

While considering all types of international experience, this College report focuses on international partnership opportunities for health sector volunteers. This reflects the fact that most global health work originating in Scotland is undertaken in a voluntary capacity[†], and reflects the request of the Scottish Global Health Collaborative when they initiated this report.

Volunteering was defined by the Scottish Executive in 2004 as, *"the giving of time and energy through a third party, which can bring measurable benefits to the volunteer, individual beneficiaries, groups and organisations, communities, the environment and society at large. It is a choice undertaken of one's own free will, and is not motivated primarily for financial gain or for a wage or salary*[29]*."* This definition is used throughout the remainder of the report.

Global citizenship may be expressed by health service workers in a variety of ways, and does not only equate to personal visits abroad. However, our national commitment to good global citizenship does require a willingness to share some of our substantial human resources and intellectual capital. Our health sector workers can share (and gain) expertise internationally in a wide range of opportunities, which, in terms of personal compensation, encompass a spectrum from salaried positions to entirely self-financed volunteering.

A 2013 report of international volunteering by NHS workers by the UK's All-Party Parliamentary Group on Global Health described various approaches to volunteering[26]:

- **coordinated – uncoordinated:** although formal institutional links are becoming common, most volunteering happens more informally.
- **short-term – long-term:** for reasons of sustainable impact, many volunteering organisations focus on longer-term placements, but it is accepted that well-coordinated shorter trips can still be highly effective; very successful partnerships often use short trips in the context of longer-term volunteers being present.

[†] In our mapping survey, 53% of healthcare workers reported undertaking global health work on a fully voluntary basis, and 27% undertook it on a "partly" voluntary basis.

- **grant funded – self funded:** very few programmes receive direct funding from the NHS and mainly rely on endowment funds, charities, donations, the Health Partnership Scheme and other sources. Some UK Trusts and Health Boards who have demonstrated success in small grant use have been successful in winning bids for international funding.
- **capacity-building – gap-filling:** gap-filling, such as in short service provision trips, has been the more traditional model of global health engagement and remains widespread but there is now more development of projects that aim to leave behind a more sustainable impact.
- **'lunch-break' volunteering – in-country volunteering**: many workers assist in capacity-building while based in the UK, such as through remote project support, mentoring, and fundraising.

> One doctor gave an experience of extensive 'international' volunteering while still being based in Scotland:
> **[Our project team]** ***meet every two to three months, usually on a Saturday or in an evening. On-going work includes data analysis, project report writing and developing teaching materials and networking to increase burn injury awareness in country - all this work goes on during my 5.30am starts, or late at night! I guess it's difficult to capture this type of 'volunteering'.***

An interesting example of "lunch-break" volunteering is provided by the UK-based charity Virtual Doctors. Virtual Doctors are providing remote clinical decision-making support to paramedical Clinical Officers in rural Zambia through a bespoke smartphone-based system which has the support of the Zambian Ministry of Health. This system engages a bank of UK-based volunteer doctors to review clinical scenarios and high quality photographs which are uploaded securely by Clinical Officers. Initial evaluation of this service[‡] suggests that in 80% of cases, the expertise accessed through Virtual Doctors prevented unnecessary (and expensive) onward referral and in 85% of cases, advice had improved clinical conditions.

The most substantial recent effort to quantify the spread of international experience in the NHS was undertaken in 2015 by Dr John Chatwin and Professor Louise Ackers[30], who interviewed a cross-section of 911 NHS staff from the North West of England. This cross-section included all staff groups in approximate proportion to their workforce contribution. The staff members were asked, 'have you had any periods in another country, either as an employee or volunteer?' and they found:

- 42% of all staff had experienced at least one overseas placement;
  - 58% of these experiences were in a low-income setting;
  - 22% of these experiences were in a medium-income setting.
- Length of time spent overseas was distributed as follows:
  - Short-term (less than 2 weeks) – 17%
  - Medium-term (2 weeks – 3 months) – 50%
  - Long-term (3 months – 1 year) – 21%
  - Settlement (over 1 year) – 8%
  - Other – 4%

[‡] Personal communication

Although international development policy is formally a reserved responsibility of the UK government, health is a matter which is wholly devolved, and therefore policies for health care volunteering in Scotland, Wales and Northern Ireland are determined by their own administrations. The Scottish experience of healthcare volunteering will now be described in some detail and then contrasted more briefly with policy developments and practices in sister UK nations and other European nations with similar social attitudes and developmental status.

1.5.1 Global health and volunteering in Scotland

In 2006, NHSScotland announced funding for a two-year pilot volunteering programme which harnessed the expertise of Voluntary Service Overseas (VSO) with money from the Scottish international development fund. This scheme aspired to recruit 20 health service workers as long-term volunteers in Malawi and other Sub-Saharan African countries.

The scheme was announced by the Chief Nursing Officer and Interim Human Resources Director in a Health Department Letter (HDL (2006) 8), and although the scheme was not continued, the letter states the value of international volunteering to the Scottish NHS, so is still being used as a policy reference in this area.

Our stakeholder engagement exercise revealed that no Scottish NHS Board has policy specific to international volunteering by its staff, either in relation to release arrangements or expectations. Existing volunteering policies are largely focused on the use of volunteers within NHSScotland. In response to our questions about volunteering policy, Boards made reference to some non-specific provisions that may be used by staff who spend time working abroad, such as occasional use of special leave, study leave or sabbaticals. An extract of sabbatical arrangements for medical and dental consultants in Scotland is provided in Appendix 1. The 2013-2016 Ebola outbreak in West Africa necessitated the issuing of bespoke guidance to boards who were advised to use existing leave policy to facilitate volunteering, where this could occur with safe maintenance of staffing levels in Scotland.

The existing 'Safer Pre and Post Employment Checks in NHSScotland' policy (2014) makes reference to 'secondary work activity', which it defines as potentially including volunteering or unpaid work. This system-wide policy states that Boards should be satisfied that secondary work activity does not:

- *Present an actual or potential conflict of interest;*
- *Have health and safety implications for the employee, their colleagues or patients/service users;*
- *Have an adverse impact on their ability to maintain a satisfactory level of attendance at work; or*
- *Have an adverse impact on their ability to perform to the required standards of their role.*

The respondents to our mapping survey who had undertaken global health work (105 NHSScotland employees) were asked how they normally make the time for this activity. The results (Figure 2) show that most volunteering takes place during annual leave. These volunteers were also asked, 'Do you have or are you aware of any support from your Health Board for your global health work?' and 63% said no. Those that did declare support from their Health Boards reported some of the following assistance:

- provision of special/study leave
- equipment provision
- space to publicise their work
- management of the international partnership
- agreement for rapid deployment when "on-call" for sudden humanitarian disasters (as part of the UK's Emergency Medicine Team)

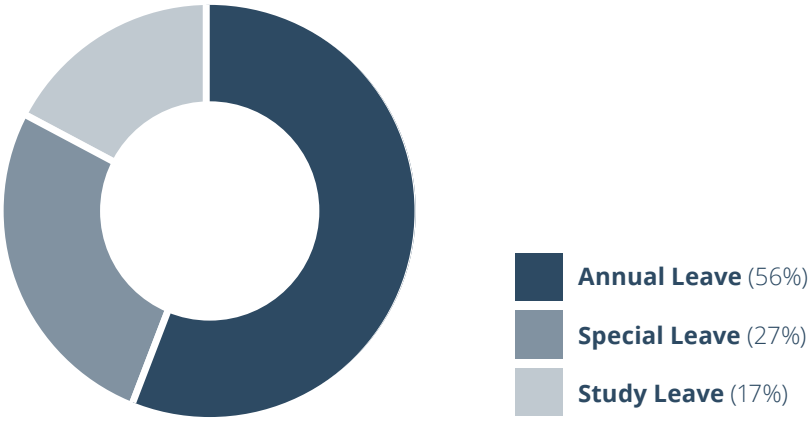

Figure 2: How Scottish health worker volunteers make time for overseas activity (not including "lunch-break" volunteering)

> ***I've had a mixed experience of the logistics. When I worked for*** [a university] ***leave was straightforward and required no use of annual leave. When I worked for the Health Board it was more complex and on two occasions I took unpaid leave and on other trips I took annual leave. It was never straightforward or welcomed.***
> – Anonymous staff member

> ***Although there was great enthusiasm and support prior to my visit, there were small but vocal pockets of lack-lustre senior management support at the same time. Although this did not detract from the success of the visit, I was left with a guarded and embarrassed feel on return. It was as though I had done something wrong or had enjoyed a 'jolly' at the expense of other colleagues. I do plan on returning but am almost certain to take annual leave and pay for my own travel and accommodation, than to feel the same way again.***
> – Anonymous staff member

It was clear from our wider stakeholder engagement exercise that many Scottish health service workers engage in global health work. However, there was a lack of information about this available to Boards. Boards do not systematically collect details of international volunteering activity, so none of them could provide an exact description of the number of international volunteers in their organisation or their spread of activity. Some Boards were aware of specific volunteering activities and there are several well-developed links between Scottish hospitals and partner institutions abroad, some of which have been supported through the Health Partnership Scheme and through Scottish Government International Development grants. These links mostly utilise clinical staff, but non-clinical staff also participate.

Gary Mortimer was the General Manager of Facilities and Estates in Aberdeen Royal Infirmary when he joined a volunteer delegation to Felege Hiwot Hospital in Ethiopia, as part of a growing institutional link. He describes his experience as follows:

> ***Feedback from the junior doctors indicated that whilst they were making great inroads to education and strengthening the relationships, their efforts were often hampered by the daily loss of power, water and the general poor state of infrastructure. As hospital engineers with about 70 years experience between us, it seemed reasonable to assume that we could help fix things and to equip the Felege Hiwot team with the necessary skills and confidence to sustain this for themselves... We left Felege Hiwot humbled by the experience. Whilst we fixed a lot of things and left them with a lot of skills, we were privileged to learn much from our Ethiopian colleagues.***

Medical staff who volunteer during a formal specialty training programme may do so using annual leave, study leave or special leave, but only where placements are short. If they wish to spend longer abroad, they will require permission to go 'out of programme'. We determined that at least 3.6% of out-of-programme events in Scotland occur in low- or middle-income countries (LMICs) but given the number of events where location is unknown, this may be a significant underestimate, and it should again be emphasised that this number does not include volunteering by trainee doctors who are not in a training programme (e.g. between the initial 'Foundation Programme' and the start of specialty training, or those who are not in a formal training programme). A more detailed analysis of out-of-programme events is included in Appendix 2. Individual evidence submitted to us suggested inconsistency of access to out-of-programme experiences in LMICs, and for some this lack of support from their training programme was a deeply negative experience.

> A hospital specialty trainee describes their experience of trying to arrange a year 'out of programme' for a placement as a visiting Clinical Lecturer:
> ***No one in the department* [in Scotland] *specifically supported me, and it was suggested that this was not a good idea in terms of career progression.***

1.5.2 Global health and volunteering in sister UK nations

England

Lord Crisp's seminal 2007 paper on 'Global Health Partnerships' was written at the invitation of then Prime Minister Tony Blair and resulted in a UK government response in 2008, welcoming the report suggestions and outlining 16 recommendations[31]. These were directed at DFID and the English Department of Health (DH), providing a framework for *"how NHS agencies and individuals can best maximise their potential to contribute in a sustainable and appropriate way to capacity building in developing countries".*

The English NHS has produced a number of global health policies and guidance documents in recent years; a selection is presented below:

- International humanitarian and health work: Toolkit to Support Good Practice (DH, 2003)
- Health is Global: UK Government Strategy 2008-13 (DH, 2008)
- Framework for NHS Involvement in International Development (DH, 2010)
- Health is Global: An outcomes framework for global health 2011-2015 (DH, 2011)
- Engaging in Global Health: The Framework for Voluntary Engagement in Global Health by the UK Health Sector (DH and DFID, 2014)
- Toolkit for the collection of evidence of knowledge and skills gained through participation in an international health project (Health Education England, 2015)
- Supporting NHS staff who are Volunteers (NHS Employers, 2016)

Health Education England set up a new coordinating organisation, the Global Health Exchange (GHE), in October 2015 with the aim to *"improve the quality and volume of the NHS workforce through global learning and exchanges, and as a consequence, build health education capacity in low and middle income countries*[32]*."* The GHE has approximate core costs of £100k with additional funding obtained for specific projects. It has defined the following objectives:

1. Create opportunities for global education and training for NHS current and future workforce.
2. Promote general overseas volunteering.
3. Participate in the development and delivery of collaborative international projects to address current workforce shortages.

Wales

In 2006, the Welsh Government instructed all the Chief Executives and Human Resources (HR) directors in the Welsh NHS to ensure that their organisation achieved the following actions[33]:

- Demonstration of institutional commitment to overseas links and achievement of the Millennium Development Goals
- Amendment of policies to facilitate and recognise international visits and exchanges as options available to their staff.

Building on this commitment, the Welsh Government published 'Health within and beyond Welsh borders: an enabling framework for international health engagement' in 2012, aiming to more systematically coordinate its international health work. Their four key intentions were:

- *NHS Wales staff will be empowered to be global citizens.*
- *Our international health links will be strengthened.*
- *Wales will have a higher international profile that promotes and reflects our expertise and values.*
- *We will have the knowledge and intelligence to benchmark and compare our health against a range of international indicators.*

To deliver these intentions, the Welsh Government created an International Health Strategy Group, to create, review and inform the overall strategic direction for Welsh action on international health, and lead on international relationships. It also created an International Health Coordination Centre (IHCC) which is part of Public Health Wales. It describes its function as follows:

Photo courtesy of Public Health Wales

The IHCC provides a focal point for health related international work across the NHS in Wales where previously there was no overall coordination of international health engagement within the Welsh health community. Therefore, the aim is to maximise the potential gains for Wales and its partners, reducing financial, human and political resources which could be wasted in the duplication of efforts. By having a coordinated approach, there is the possibility for new opportunities to arise, including the strengthening of applications for funding[34].

Following an extensive two-stage stakeholder consultation, the IHCC consolidated the Welsh commitment to excellence in international work by establishing a Charter for International Health Partnerships (2014). All Welsh NHS boards publicly committed to the charter principles which were:

1. Organisational responsibilities
2. Reciprocal partnership working
3. Good practice
4. Sound governance

The IHCC has supported Welsh Health Boards and Trusts to implement the Charter and embed its principles as a standard practice. The IHCC has also developed a Global Citizenship training resource, tailored specifically to health professionals. These actions have supported the implementation of the Well-being of Future Generations (Wales) Act 2015 and its 'Globally Responsible Wales' goal. The role of the IHCC continues to develop but as a case in point, Appendix 3 describes the 2016/17 Operational Plan delivered by the IHCC and the International Health Division of Public Health Wales.

1.5.3 Global health and volunteering in other European nations

The Republic of Ireland[§]

The Health Services Executive (HSE) runs all the Irish public health services. International volunteering is mainly supported by the HSE through three types of leave: career break, special leave (with nominal pay), and leave for deployment with the Rapid Response Corps. Since Ireland's economic difficulties arose in 2008, it has been more difficult to obtain management approval for use of these mechanisms, and back-fill can be a challenge.

[§] Information from Professor David Weakliam, Global Health Lead, Health Service Executive.

In common with Scotland's experience of the Ebola crisis, Ireland's HSE needed to introduce emergency provisions to enable staff to deploy with response teams, since a suitable mechanism for staff release was not previously available. Staff were deployed on full pay for up to 3 months, and release arrangements for this kind of work have since been formalised.

The HSE set up a global health programme in 2010 and is in the process of setting up a formal global health office to support this work. Ireland has not yet articulated an overarching policy for global health engagement but supports a number of organisational commitments and agreements. Many of these agreements support global health engagement undertaken by staff while based in Ireland. HSE's global health efforts include:

- A memorandum of understanding with Irish Aid, to allow provision of technical expertise on request.
- Membership of the European 'ESTHER' alliance, which twins European healthcare organisations with partners in low-/middle-income counties. HSE has subscribed to the ESTHER alliance Charter for Quality of Partnership[35] which sets a standard for engagement.
- An institutional agreement with the Government of Mozambique, allowing HSE staff to collaborate on quality improvement initiatives.
- Development of statements of best practice: the Comhlámh Code of Practice for Volunteering Agencies and the Comhlámh Volunteer Charter

The Netherlands**

The Dutch Government spends 0.75% of Gross National Income (GNI) on international development[19]. In the health domain it focuses on sexual and reproductive health and rights, where they have an established track record. In the wake of the Ebola crisis, the Dutch Ministry of Health hosted a Global Health Security Agenda conference in October 2016 where representatives from 39 countries discussed how to improve global preparedness for future disease outbreaks.

Unlike the other countries referenced in this section, the Netherlands has had a specific medical training programme for global health work for many years. This 27-month training programme is offered to doctors from the point of graduation, and involves hospital placements in obstetrics and gynaecology, and surgery or paediatrics. Trainees spend 3 months on a residential course and receive targeted specialist training days throughout the programme. Their training concludes with a 4-6 month placement abroad in a diverse range of countries including India, the Democratic Republic of Congo and Tanzania.

This training is coordinated by an independent training institution, the Netherlands Society of Tropical Medicine and International Health, and is accredited by the Royal Dutch Medical Association (KNMG). Trainees are paid by the employing hospitals during clinical placements and receive a local salary while working abroad. At present the trainees have to meet the costs of their additional training courses from personal funds. The training scheme has capacity for 20 trainees per year and is usually substantially oversubscribed. After this training, doctors receive the title 'Medical Doctor in Global Health and Tropical Medicine KNMG (AIGT-KNMG) and in most cases, apply for a job abroad for a longer period of time. The AIGT doctors are paid a local salary only. After a few years they often return to the Dutch healthcare system where their enhanced skill set proves attractive to other postgraduate training schemes.

** Information from Dr Ankie van den Broek, Chair of the NVTG (Netherlands Society of Tropical Medicine and International Health).

Scandinavia[††]

Scandinavian countries have historically spent a higher proportion of income on international development than many other developed countries. Norway is a country with a very similar population size to Scotland, and in proportional terms, its official development assistance budget is the third most generous in world[19], representing 1.05% of its GNI. In terms of proportionate budget allocation, Sweden is the most generous (1.40% of GNI). Table 1 shows a comparison of proportionate allocation of budget to Official Development Assistance (ODA, i.e. aid) in 25 high-income countries which are members of the OECD (Organisation for Economic Co-operation and Development).

Scandinavian countries are also well-known for their employee-friendly working practices. Many hospitals in Sweden and Norway have established outreach programmes with sister institutions for training or research purposes. Such programmes usually have staff time set aside for maintaining and developing the collaboration, funded from a variety of sources. Hospital consultants in Norway are entitled to a four-month period of paid sabbatical leave for every five years of work. These sabbaticals are used in a variety of ways and can include voluntary global health work with partner institutions or aid organisations. To our knowledge, neither Sweden or Norway has formally integrated global health experience into postgraduate training programmes.

Table 1: Proportion of Gross National Income (GNI) spent on Official Development Assistance (ODA) - OECD countries[19]

Country	% GNI spent on ODA (2015)
Sweden	**1.40**
United Arab Emirates	**1.18**
Norway	**1.05**
Luxembourg	**0.95**
Denmark	**0.85**
Netherlands	**0.75**
United Kingdom	**0.70**
Finland	**0.55**
Germany	**0.52**
Switzerland	**0.52**
Turkey	**0.50**
Belgium	**0.42**
France	**0.37**
Austria	**0.35**
Ireland	**0.32**
Australia	**0.29**
Canada	**0.28**
New Zealand	**0.27**
Iceland	**0.24**
Italy	**0.22**
Japan	**0.21**
Malta	**0.17**
United States	**0.17**
Portugal	**0.16**
Estonia	**0.15**

[††] Information from Dr Kjetil Søreide and Dr Hampus Holmer.

1.6 CONCLUSIONS

Scotland has a significant history of healthcare innovation and international health partnerships in clinical and academic domains. It is an outward looking nation which has been a major contributor to international development work in resource-challenged countries. Scotland is committed to good global citizenship and there are examples of how Scottish NHS structures have supported staff in their volunteering efforts.

Scotland does have potential to learn from policies and procedures used by other similar nations to foster enhanced co-ordination and support of health worker volunteering. There is currently no system-wide strategy or guidance on international volunteering, or indeed on global health engagement, which has been specifically developed for the Scottish health service. Much strategic material on global health that is written in UK terms is largely focused on the English NHS, reflecting the difference between reserved and devolved powers.

Other nations with similar outlooks on the world are investing in mechanisms for coordination, training and quality assurance of global health work. The next section of the report explores how expression of global citizenship can bring mutual benefit to partnering healthcare systems.


PATEL SHOPPING
CENTRE
Citizen

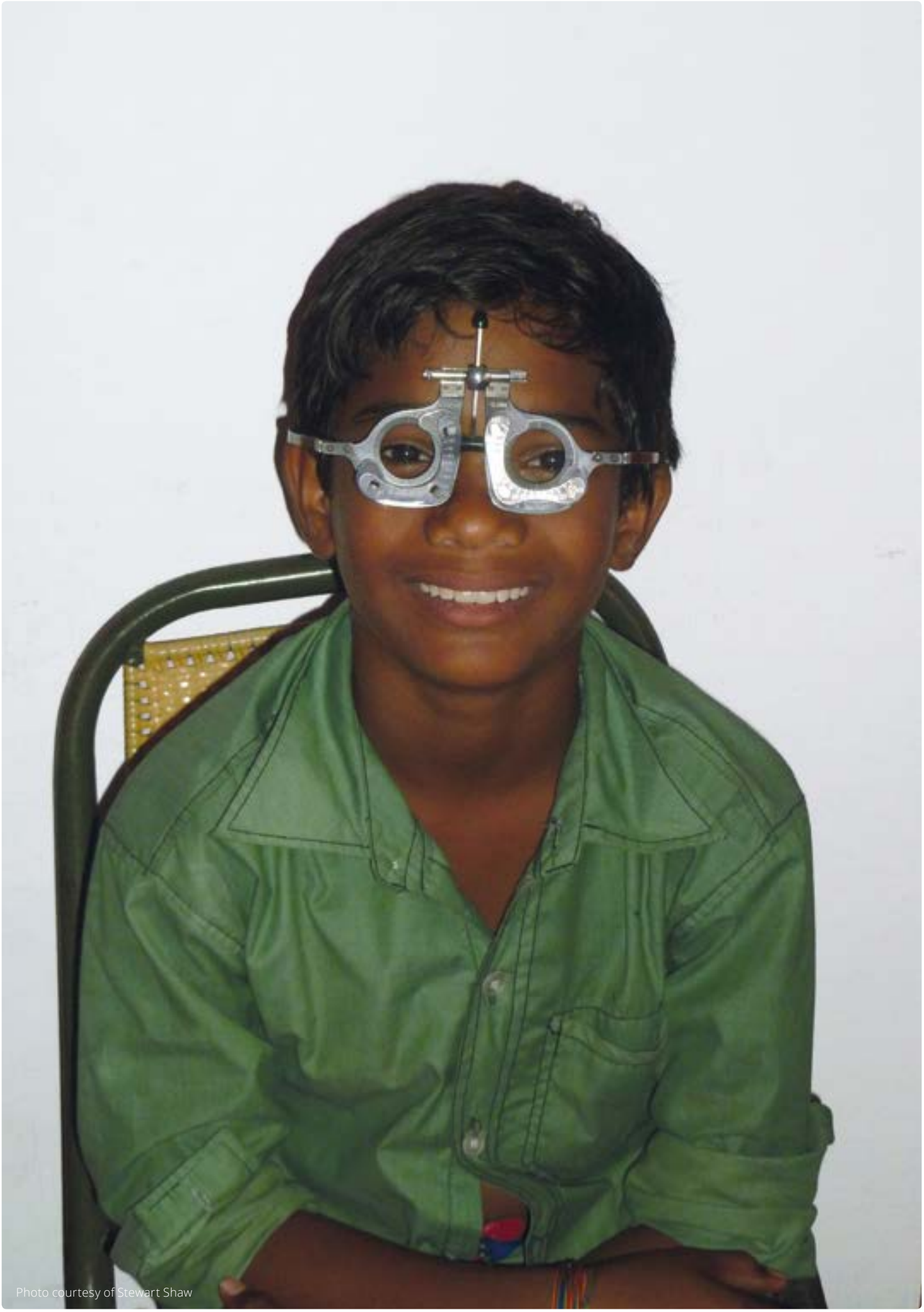

Photo courtesy of Stewart Shaw

2. RECOGNISING BENEFITS

It has long been promoted that engagement by developed countries in global health agendas brings benefits to individuals, organisations and at a national level. In this section, we review the evidence for personal, organisational and national benefits from international partnerships between high income countries and low- or middle-income countries (LMICs). The content of this section and the next (which considers the challenges inherent in international activity) is informed by a review of primary and summary literature, and responses received from Scottish Health Boards, academic institutions, third sector organisations, individual health sector workers and subject experts.

As outlined in section 1.3, much recent UK health worker volunteering has occurred in the context of health partnerships. In 2013, Felicity Jones and colleagues from King's College, London, published a systematic review of the benefits and costs of single institution health links to UK partners[36], and the domains of benefits and costs that they identified are used to frame sections 2.2 to 2.4 and section 3, with minor modification. Their search strategy found 9 relevant published papers and 32 additional pieces of 'grey' literature (not formally published in peer-reviewed sources). They found that the large majority of available primary literature consisted of expert or individual opinion, although a small number of studies had employed more rigorous academic methodology. Since this systematic review was published, several qualitative studies of volunteer benefits from international experience, with good methodological quality, have added substantively to the evidence base in this area[37-42].

Before assessing the potential benefits of global health work to Scotland, we begin by reviewing the evidence for the impact of health partnerships in LMICs themselves.

2.1 DEVELOPING COUNTRY BENEFITS FROM DEVELOPED COUNTRY PARTNERSHIPS

SUMMARY:
Although evidence for developing country benefits from partnerships with developed country institutions is limited to date, encouraging outputs have been noted:

- reduced morbidity and mortality
- improved knowledge, skills and confidence of health workers
- improved quality of care and new services
- enhanced training and education capacity
- improved institutional governance, policy development and system change

Following the Crisp report (2007)[23], there has been a burgeoning interest in partnerships between the UK and the developing world. It is important to ask whether such partnerships are effective in achieving system development and outcome improvement in partner institutions and countries.

This question was addressed in 2013 systematic review by Dr Chris Smith[43] which specifically assessed partnerships involving single UK institutions with single LMIC institutions. At the time of his review, 7 relevant peer-reviewed journal articles and 2 internal reports were available to answer this query. The collected data provided "fair to poor" quality evidence of LMIC benefit from UK partnerships but the author comments that these papers were not focused around this question, and that broad trends suggested benefit. One paper reported a reduction in mortality, several reported reductions in morbidity, and none reported adverse health outcomes.

By their very nature health partnerships are complex, dynamic and highly variable interventions, and therefore in practice it is difficult to produce clear evidence that links them with long-term changes in health outcomes[44]. In a recent review[45], Kelly and colleagues suggest that while clinical interventions should (and can) be assessed by studies of the highest evidential quality (randomised controlled trials), the question of how organisational and personnel improvement might best be delivered in LMICs will need to be answered through the alternative disciplines of management science, implementation science and social science.

The Health Partnership Scheme (HPS), managed by THET, was given £30 million by DFID from 2011-17 to invest in institutional health links (see section 1.3) and has recently been independently evaluated through a total of 350 interviews, 4 country visits and 3 online surveys[46]. Findings included:

- *HPS projects have improved the knowledge, skills and confidence of health workers and in many cases this has contributed to increased quality of care or new services.*
- *Training and education capacity; accreditation and curricula have been improved in several countries, and on occasion this has impacted on a whole health cadre, but wider human resources outcomes are not apparent.*
- *Some projects have influenced wider level change in hospital systems with equipment, record keeping and infection prevention and control (IPC), and sometimes this extends to several hospitals.*
- *Rigorous evidence of impact is scarce, but there are enough examples of improvements in service delivery and quality of care to assume that the HPS projects are impacting the delivery of quality health services, even if it is not being measured.*

Following the conclusion of the current funding round for the HPS, THET reviewed its learning from the programme and interviewed several partners based in LMICs[24]. They found the following themes were regarded by LMIC practitioners as crucial if partnerships were to be effective:

1. **Addressing country need:** UK partners need to understand local contexts- both institutional and national, and not impose their own priorities.
2. **Transparency:** if lacking, can result in resentment and confusion.
3. **Ownership:** LMIC partners need to be co-producers of all aspects of strategy as well as delivery.
4. **Sensitivity:** careful respect of cultural values and clearer alignment with national plans.

> ***The biggest challenge was that the core aim for the project was not set by us, but imposed on us by our UK partner and we were somehow going to have to make it happen... this came to haunt us, especially when it came to evaluating the impact of the project***
> – LMIC country partner in a Health Partnership Scheme project[24].

The focus of this report is on the UK side of partnership working, but a fuller exploration of the positive and potentially negative impacts of volunteers in LMICs can be found in Professor Louise Ackers' book 'Mobile Professional Voluntarism and International Development'[25].

2.2 BENEFITS OF INTERNATIONAL EXPERIENCE: TO SCOTTISH HEALTH SERVICE WORKERS

SUMMARY:
Benefits experienced by individuals from international experience can be summarised under the following domains:

- leadership and management
- communication and teamwork
- clinical skills
- policy awareness and experience
- academic skills
- patient experience and dignity
- personal resilience, satisfaction and interest

2.2.1 Leadership and Management skills

Prominent amongst responses from individual health sector workers was their description of enhanced leadership and management skills as a result of international experience. Leadership and management skills benefits summarised by Jones et al[36] included:

- resourcefulness, innovation and problem-solving
- adaptability, flexibility and ability to cope in different environments
- prioritisation of limited resources
- self-awareness, self-reliance and understanding of personal limits

> ***For my work as a GP partner in the West of Scotland the overseas experience was invaluable... I am more comfortable taking on responsibility at an organisational level both within and out-with the practice, from my experience of being a senior decision maker in the overseas placement***
> – A volunteer in Bwindi Community Hospital, Uganda, who undertook clinical work, quality improvement and service development.

The formal evaluation of a mental health partnership between Sheffield and Uganda[39] found significant opportunities for UK staff to develop expertise in service and project management, with UK staff commenting on how much they had learnt by the deep involvement of Ugandan patients in the development of the service.

Photo courtesy of Gillian Calder

2.2.2 Communication and teamwork

Cross-cultural work in unfamiliar environments places exacting demands upon the communication and teamwork skills of health workers and the subsequent benefits include[36]:

- Improved skills of negotiation with multiple stakeholders
- Enhancement of team-working skills
- Increased appreciation of relationships and skill in building them
- Opportunity to learn and use different languages

VIEW CASE STUDY

Physiotherapist Gillian Calder has visited Malawi to support a burns prevention and care partnership and has hosted Malawian physiotherapists in Glasgow. She describes the benefits to her own department's team working skills:

[We] ***have had to identify ways that we as a physiotherapy department in Glasgow can support the Burns Unit in Blantyre - through email communication, Skype calls and teaching both here and Malawi. We have also been trying to fundraise, locate equipment and transport the equipment to Malawi! This has involved our department working together to collect equipment, fundraise to buy new equipment and take the equipment to... the shipping container. When arranging the*** **[Malawian]** ***physiotherapists' visit, I had to engage with a range of departments in NHS Greater Glasgow and Clyde and out-with (e.g. the UK Visa agency, the Chartered Society of Physiotherapy) which was a challenge!***

2.2.3 Clinical skills

An obvious individual benefit of working and volunteering internationally is exposure to conditions and advanced or unusual presentations that are rarely encountered in UK practice, and exposure to environments where less technology-dependent solutions to clinical problems may need to be found[40]. Another advantage to Scottish health sector workers can be exposure to a volume of clinical activity that is not readily accessible at home.

A formal assessment of a GP training scheme which sent doctors to South Africa, Zambia and India[37] found that trainees were exposed to far more complex situations and procedures than they would be in the UK, and their trainers judged that they were better able to cope with acute situations. One trainer in this study commented that their trainee had a *"good mix of clinical skills because the doctor got to do far more than any of their peers at that stage of training. Learnt a lot about acute medical skills which may have taken a couple of years of general medicine in the UK."* Care needs to be taken that volunteers are not given inappropriate levels of responsibility, although standards need to be interpreted with cultural sensitivity.

For 'craft' surgical specialities, clinical experience abroad can give concentrated opportunities to consolidate technical skills in a high-volume situation. In the US literature, participation of surgical trainees in short-term humanitarian surgical missions has been shown to afford a wide variety and high number of cases[47].

2.2.4 Policy awareness and experience

Several Scottish health boards indicated that the development of policy understanding and perspective would be a valuable benefit to them and to individuals, suggesting for example that this could result in *"new approaches which can be adopted within NHS Scotland"* (NHS Dumfries and Galloway). Health boards also made mention of the opportunities afforded to *"contextualise our challenges against the challenges others face"* (NHS Lanarkshire). One of the island boards commented: *"in some remote areas innovative solutions may have been developed from which we in NHS Orkney could learn... in international volunteering there can be a genuine sharing of knowledge and expertise which is not one-way."* Academic sources also identify this benefit[36,38].

The Royal College of Midwives (RCM) was one of the recipients of a Health Partnership Scheme grant (see section 1.4), and they ran midwifery twinning projects spanning African and Asian countries. They undertook a survey of the experiences of the 75 RCM members who had participated as volunteers or consultants, and found that the most frequently cited personal benefit from their involvement was increased flexibility or adaptability in response to change (52% of respondents).

> ***Volunteering has given me personal and professional experience of working alongside midwives and mothers in poor resource settings, which has broadened my perspective, given me understanding of how to deal with challenging circumstances, and allowed me to view a world beyond the protection/constraints of the NHS.***
> - Midwife involved in the RCM twinning project (Health Partnership Scheme).

2.2.5 Academic skills

Many individual respondents spoke of how international experience had given excellent opportunities to develop their educational, training and research skills. In our survey, education, training and research represented three of the four most common areas of volunteer activity, and respondents made mention of the personal benefits here. Some health care workers have spoken of how teaching experiences in lower resource settings have made them less reliant on technology and more adept at keeping group interest[40].

Photo courtesy of Northumbria NHS Trust

Fiona Gifford, a renal medicine trainee working in NHS Lothian, had the opportunity to volunteer in Sri Lanka where she focused on teaching and research, and led a team of local medical students in designing and delivering a cohort study. She says:
The challenges of clinical research were magnified in a country with very different culture, language and working styles. This... enabled me to publish both the results of the cohort study, and a narrative review on my return to the UK. Moreover, preparing regular teaching for Sri Lankan doctors and students challenged me to be clear, concise and audience-specific in my teaching, and forced me to brush up on my statistics!

2.2.6 Patient experience and dignity

Jones et al[36] highlight two attitudinal benefits related to patient experience which may be obtained by international experience:

- Greater appreciation of factors influencing health in other countries
- Increased knowledge and appreciation of other countries

An evaluation of several links between UK partners and developing countries[48] reported that,
At one link, the overseas partner was located in a region from which many of the local minority community originated. The staff on exchanges returning to the UK had an increased cultural awareness that they could immediately apply to clinical encounters with their patients. The link coordinator referred to this as a 'good icebreaker' and found that patients built up a good rapport with these health professionals as a result.

A qualitative study of volunteer experiences in a link programme with Somalia[42] provides a volunteer's perspective on their enhanced cultural understanding: *"Well it makes you more reflective in dealing with*

people from different cultures, with the Somali population it means you can immediately understand them so much more than before and so if, for example, there was a Somali patient in the hospital I'll be asked to see them. Somali expert!" This kind of cultural competence learning is possible within the UK but is certainly enhanced when immersed in new environments.

2.2.7 Personal resilience, satisfaction and interest

Quite aside from a desire to benefit from the individual professional opportunities in international experiences, are the very strong motivations of health service staff to use their skills in making a tangible difference in other environments. Health workers frequently refer to returning to UK practice reinvigorated, enthused by being able to apply their skills to new and exciting challenges[49].

> Jason Leitch, National Clinical Director of Healthcare Quality and Strategy at the Scottish Government, has organised health provision trips to a large orphanage and school in Andhra Pradesh, India, for more than 20 years, and comments:
> ***I initially went to learn and see healthcare in another setting and to maybe offer some help. Now I go selfishly to recharge and focus on what's important in healthcare – the compassion and care we are privileged to be able to offer. I give very little, I gain a huge amount.***

> Tony Redmond of UK-Med observes that international volunteering gave health service workers...
> ***the opportunity to express the altruism that attracted them into the health service in the first instance, increased job satisfaction, a sense of achievement, reinforcing the sense of professional capability.***

For health service workers who graduated overseas, international volunteering can present a valued opportunity for them to benefit their home setting while remaining in NHS practice.

> ***I have done post-graduate training in orthopaedics both from India and the UK... and have been practicing as a Consultant in the NHS for the last 4 years. I always felt that I could make an even bigger difference if I applied the same skills in India, especially in remote rural areas. It would be an opportunity to give something back to my home country from where I have received subsidised education and not returned the favour.***
> - Kalpesh Shah, Consultant Orthopaedic Surgeon.

Another identified personal benefit of global health work is increased personal resilience[50]. The Royal College of Surgeons of Edinburgh stated the following in their submission to this report: *"International volunteers are likely to have a greater capacity for resilience and innovation which will ultimately benefit their work. Depending on the context that the volunteering takes place, even experienced clinicians mention that the 'back to basics' approach that they experience in low-resource settings allows them to reawaken old skills, and to appreciate the opportunities and resources of the NHS on their return."*

2.3. BENEFITS OF INTERNATIONAL EXPERIENCE: TO NHSSCOTLAND

SUMMARY:
Benefits experienced at an organisational and national level from engagement in global health can be summarised under the following domains:

- recruitment and retention
- system learning and capacity building
- professional development of the workforce
- improved Scottish patient experience
- reputational development

2.3.1 Recruitment and retention

Opportunities for global health engagement are attractive to many health service workers, and have the potential to lead to a workforce that is more appreciative of the NHS[36]. When Audit Scotland appraised the Scottish NHS in 2016, they concluded that difficulties in recruiting and retaining staff are putting the service under pressure[11]. Audit Scotland's report demonstrated that rising sickness absence, turnover and vacancy rates are contributing to an increase in NHS Boards' spending on high-cost agency staff.

Within the context of medical training, there are reasons for concern that the current training framework is proving unattractive to recent graduates. Of the over 7,000 doctors who completed the UK's two-year Foundation Programme (for new graduates) in August 2015, only 52% progressed directly into UK specialty training, and 25% of programme graduates did not express an intention to work in any clinical or clinically-related UK job[51]. This 52% progression rate represents a steady five-year decline from an equivalent figure of 71% in 2011. There has been a steady increase in the number of doctors who are taking a career break, from 4.6% in 2011 to 13.1% in 2015. This data is only available at a UK level but is thought to accurately reflect the situation in Scotland.

Using current systems of data gathering, it is not possible to be clear about what doctors are doing within career breaks. However, some recent research by Dr Sam Smith and colleagues at the universities of Edinburgh, Glasgow and St Andrews into the reasons why Foundation Programme graduates leave UK medicine is illuminating. They found that prominent among reasons given was the feeling of "wanting something different," and wanting a clearer sense of "doing some good"[52]. Such feelings are typical characteristics of the "Millennial" generation born in the 1980s and 1990s[53]. For some trainees contributing to our stakeholder engagement exercise, the non-acceptance of requests to volunteer was such a negative experience that it led to their resignation from training posts, or threats to do so.

In the English and Welsh NHS, global health experience has been regarded as a promising strand in a wider recruitment strategy. In the current (2017) GP recruitment round, England and Wales have offered up to 160 "Global Health Fellowship" posts to applicants to GP training who wish to extend their three-year training programme into a four-year programme with a built-in year of experience in South Africa. This scheme is being run in partnership with Africa Health Placements and fellows will be paid a salary. While this undertaking is therefore not traditional unpaid volunteering, it could be placed within the broader Scottish Executive definition of 2004, *"a choice undertaken of one's own free will… not motivated primarily for financial gain or for a wage or salary*[29]*."* The hope is that this approach will allow "Millennial generation[53]" doctors global health experience in a relatively controlled setting while keeping them within a UK training programme. At the time of writing, this scheme had received 162 applications, suggesting a considerable appetite for this approach.

A positive view of volunteering as boosting employer attractiveness was given in a number of health board responses. NHS Dumfries and Galloway suggested that international volunteering led to *"improved perception of the service due to supporting volunteering; improved satisfaction of staff and retention of the same if allowed to volunteer without needing to resign."* One geographical Health Board stated that they were actively considering an increase in contract flexibility to permit longer periods of volunteering as a means of improving job attractiveness. For individuals with strong global health interests, an employer's receptiveness to volunteering opportunities can be enticing.

> ***I have engineered my career around people with similar interests. I was attracted to a consultant post at the Borders General Hospital in part because of its openness to international work... My current international fistula surgery work has given unprecedented opportunities for inter-disciplinary and international collaboration.***
> - Kate Darlow, Consultant Obstetrician and Gynaecologist.

2.3.2 System learning and capacity building

Those returning from experiences of health care provision in LMICs frequently refer to their fresh, better informed perspectives, and recognition of transferable lessons for the NHS – both through their clinical encounters and by exposure to creative policies and practices in a different environment. Successful international health partnerships are not one-way transfers of knowledge. Rabkin and colleagues write of how the early years of HIV treatment in Africa were dominated by a "North to South" transfer of ideas, expertise and resources, but suggest that in recent times, there is great potential for "South to North" transfer of lessons learned through the remarkable achievements of HIV treatment and research programmes in Africa[54].

> John Gillies, retired GP from Selkirk and current Deputy Director of the Scottish School of Primary Care, reflected on how the transnational lessons from the recent Ebola outbreak echoed the lessons he learnt in AIDS from his time in Malawi in the 1980s:
> ***Towards the end of our time there, we started seeing people with oropharyngeal thrush, with resistant TB, with weight loss, with Kaposi's sarcoma, and we didn't know why they were dying. Then, in 1984, we came back to the UK and we realized we had seen the beginning of the HIV/AIDS epidemic. Working as a GP trainee in Edinburgh, I saw a young man who had travelled widely and who had oropharyngeal thrush, cough and weight loss. After testing, it became clear that he was one of the first people to develop HIV/AIDS in Scotland. Ebola and AIDS are completely different diseases but it brought home to me in a very visceral way that the world was shrinking, that people travel to all parts of it and that infectious disease is no respecter of boundaries. It also illustrates that clinical experience overseas is of great use in the UK.***

Lessons in HIV/AIDS care are set amongst many examples of so-called "reverse innovation[55]" learning opportunities between low and high income countries[56]. In a 2004 edition of the British Medical Journal dedicated to learning from developing country experience[57], authors wrote of lessons in Kangaroo Mother Care (skin-to-skin care of preterm infants by mothers themselves)[58,59], health reform[60], and rationalisation of medication provision[61].

Experience in LMICs has been a key foundation of many careers in infectious diseases, and we came across many examples of how many people engaged in the challenge of providing extended generalist care in Scotland's rural communities have built up many of their skills and can-do attitudes through international experience.

> Jessica Cooper is completing her training as a rural GP, and spent two previous years in Zambia, stating:
> ***I have now returned to practice in the UK with new skills that I am putting to use in working as a rural GP, where a wider skill set is demanded... I worked out that over the first year of volunteering I had assessed over one thousand children, as well as general medical and surgical experience. I have seen children have seizures, have terrifying respiratory distress, have empyemas, tension pneumothoraces, cardiac failure. I have made decisions in the middle of the night with no help and seen and felt the effect of both good and poor outcomes. Now as I am called in the middle of the night as the only GP on call for an island population, faced with an acutely unwell child, I have experience and feeling to draw on, not just a knowledge.***

> Gordon McFarlane is a Consultant General Surgeon in the Shetland Islands and spent nine years working in Chogoria Hospital, Kenya. He describes how this has been a crucial enabler in his provision of a broad-based surgical practice to this remote Scottish community:
> ***Although I spent*** **[four years in general surgical training after my return from Kenya, and then]** ***a year in surgical specialties before taking up a consultant post in Shetland, there is no doubt my main training ground for rural surgical practice was Africa...*** **[My African obstetric experience]** ***allows an occasional call from maternity to be a pleasure... emergency orthopaedic surgery in Shetland has remained broad based... Transurethral Resection of the Prostate has also continued in Shetland drawing on my African experience... Neurosurgical trauma is not commonly seen in Shetland but there is no option when the transfer time is at least four hours. Overseas experience has again allowed four procedures to be safely undertaken*** **[by me]** ***over the last 10 years. It is not impossible to train a rural surgeon in the UK... but there is no doubt that the huge variety of conditions seen and operations undertaken provides invaluable experience for these posts.***

Operating in a lower-resource environment than the NHS has often inspired health service workers to take a more critical look at the wastage which can be commonplace. The avoidance of unnecessary, unhelpful, harmful and wasteful practices is a key aim in the Scottish health service, as articulated in the Chief Medical Officer's 2016 report 'Realistic Medicine'[62]. Health systems in LMICs have much to teach the Scottish NHS about a 'Realistic Medicine' ethos. The University of Edinburgh recently completed a qualitative and quantitative evaluation of a multi-country intervention to strengthen and integrate palliative care in African health care systems, which includes this quote:

"The reliance on clinical skills and assessment of benefit vs burdens, without the dependence on radiology and blood tests is always a salutary lesson to incorporate in our work in the UK. [The UK has an] *over reliance on investigations rather than clinical skills.*[63]*"*

Finally, partnerships in the developing world offer Scotland's health service significant potential for fruitful academic collaboration. The need for research system strengthening in the developing world is well documented[64] and Scotland is well placed to assist. It should be noted that there is substantial public funding available for global health research; in 2015 the UK government announced a £1.5 billion Global Challenges Research Fund with the aim *"to ensure UK science takes a leading role in addressing the problems faced by developing countries,"* and announced a £1 billion "Ross Fund" to support research into infectious and tropical diseases[21].

2.3.3 Professional development of the workforce

In a recent review of the mutual value of UK global health partnerships, Chief Medical Officer of England Professor Dame Sally Davies wrote, *"not only is this good for countries overseas, who deserve our support to overcome the poverty they face, it is also good for the UK. Those who travel overseas bring home fresh ideas about leadership, innovation and service delivery, which directly benefit our work in the UK*[24]*"*. Involvement in assessing and addressing health needs in LMICs contexts provides Scotland with a cadre of health service workers with enhanced ability to lead and deliver high quality care to our own citizens[65]. These generic benefits are in addition to a workforce more informed about globally relevant threats, as was made clear in the Ebola outbreak.

VIEW CASE STUDY

> ***From a professional perspective, I have probably developed in ways I would not have done had I only worked here in a developed country, in the NHS, that is resource-rich. The challenge over there is that you are often working in isolated settings with a lack of technology, a lack of skilled professionals around you from other professional groups. You learn to be incredibly creative in your use of resources. You learn to make effective and timely decisions so that there are better outcomes in the care that you provide, and you also learn to appreciate much more the cultural influence on health-seeking behaviours and how to communicate effectively even when you don't share the same language.***
>
> - Tracy Humphrey, Professor of Midwifery and Dean of Health & Social Care, Edinburgh Napier University, discussing her learning from a programme of education and research which she led in Malawi.

There are some examples of organisations that have more substantially capitalised on the potential for international experience to yield enormous benefit for leadership development.

Since 2008, Thames Valley and Wessex have involved over 150 health workers in a leadership development programme that is based around placements in Cambodia, Myanmar or South Africa. They describe this as, *"an unparalleled opportunity to develop a set of leadership skills in UK participants, which are generally not achieved through standard clinical training*[66]*."* A recent evaluation of the scheme alumni[67] revealed that:

- 91% said the programme changed how they approach their current role
- 83% of respondents see themselves as a leader since completing the programme (32% before)
- 93% would recommend the programme to colleagues

Funding for this scheme has been provided by DFID through the Health Partnership Scheme and by the Thames Valley and Wessex Leadership Academy.

2.3.4 Improved Scottish patient experience

The stated intention of the Scottish health service is to provide *"safe, effective and person-centred care*[68]*."* A workforce that is more globally aware and experienced is arguably better able to deliver personalised, culturally appropriate care to patients from many backgrounds[36].

The Royal Hospital for Children, Glasgow (previously 'Yorkhill') has had a formal institutional link with the Children's Hospital and Institute of Child Health in Lahore, Pakistan, since 2001. The Glasgow link lead describes this as, *"equally beneficial to the service provided at Yorkhill. The Pakistani origin community (Glasgow's largest single ethnic minority) are substantial users of Yorkhill and come mainly from the area around Lahore. The twinning increases staff knowledge and understanding of the cultural origins of this quite vulnerable group as well as enhancing relationships with the community."*

For employing organisations, the *"personal and career satisfaction"* that can be experienced in international volunteering (NHS Forth Valley) might be expected to lead to a more motivated workforce that are better enabled to provide high-quality care. NHS Borders observed that benefits extend beyond the individual volunteers: *"undertaking fundraising or delivering projects in support of international volunteering can have a tangible benefit for team cohesion."*

> ***The biggest gain the NHS has had on my return is a motivated and committed Paediatrician who understands the need to educate and train herself so she may be useful in resource limited settings. Prior to this project I was ready to quit training. Now I feel less demoralised about my training (particularly with being in Scotland for 8 years away from family) and feel strongly that the need to be trained is imperative so I can provide the best care possible here at home and further afield.***
> - Natasha Basheer, Specialty Registrar in Paediatrics, who volunteered her time in mobile medical clinics in earthquake-affected regions of Nepal.

2.3.5 Reputational development

At a local level, engagement in global health work can have significant reputational benefit for individual health boards and departments. NHS Borders commented that international work gives *"an enhanced reputational impact through publicity highlighting the wider corporate social responsibility of the organisation,"* sentiments that were echoed by other boards.

Scotland has an opportunity to learn rapidly from the patterns of global health engagement around the developing world and has the intellectual and resource capacity to become a global centre of excellence in international health partnerships. Scotland's healthcare expertise is a resource of international significance and better capitalising on this would be a very effective projection of Scotland's "soft power"[23] and values around the world.

> Epidemiologist Alison Potts, based in Health Protection Scotland, volunteered with the WHO in 2015 in South Sudan and Sierra Leone and reflects on her experiences supporting Ebola outbreak work:
> ***We are going out on missions as ambassadors for Scotland and our actions and behaviour on mission reflects on Scotland and the UK.***

> ***Any success has been due to building up trust. Over the last 10 years we have had over 40 Indonesians come and stay with us in our home. We have become firm friends, and in a country where the colonial legacy has fostered a suspicion of foreigners, hopefully my Indonesian colleagues realise that "I am only trying to help", and that I have no hidden agenda.***
> - Consultant Ophthalmologist Andrew Pyott from Raigmore Hospital, who has spent over 10 years as a medical advisor to the charity CBM for their work in Indonesia.

NHS-24 stated that international volunteering can lead to *"the fostering of good relations between communities and nations"*, contributing *"to improve the life chances of the people located in the area that the volunteering is taking place."*

2.4 CONCLUSIONS

Our literature review and extensive stakeholder engagement exercise make clear that international volunteers from the Scottish health service appreciate the opportunity to use their expertise and enthusiasm to benefit colleagues and patients in more resource-challenged parts of the world.

> ***To use the skills gained within our NHS and transfer them to some remote village on the other side of the world is beneficial to both parties whilst extending your skill set and stretching you out with the confines of our system to make you more adaptable to all situations.***
> ***The travel can be tiring, the accommodation is basic, the queues can be long but the smile from the recipient of that care you can provide, is overwhelming.***
> - Stewart Shaw, optometrist in Ayrshire and Dumfriesshire, on delivering regular eye care to children of an Indian orphanage.

Well-designed projects can result in substantial benefits to partners, in addition to personal professional benefits and significant benefits for employing organisations. The primary asset of the Scottish health service is its staff, who also represent by far its largest expense. Global initiatives enhance NHSScotland staff development, supporting the delivery of safe, efficient and effective care to the people of Scotland and so must be taken seriously in a forward-looking healthcare system. Such initiatives must be cognizant of the risks and challenges that are associated with global health work, which are explored in the next section.

Photo courtesy of NHS Borders

3. ACKNOWLEDGING CHALLENGES

SUMMARY:
Global health experience can be associated with challenges in the following domains to individuals, organisations and the nation:

- maintaining service delivery during employee absence
- financial costs
- personal health and safety risks
- opportunity costs
- regulatory issues
- reputational risk

3.1 MAINTAINING SERVICE DELIVERY DURING EMPLOYEE ABSENCE

At an institutional level, the most frequently cited challenge to international volunteering was the resultant temporary loss of staff from Scottish health boards. The Golden Jubilee Foundation board stated, *"there is always a risk of balancing operational need within the board* [and] *the ability to provide a service, but that should be managed locally."*

NHS Grampian's response expanded on this: *"although recognising the benefits of international volunteering, a main risk would be the ability to release staff if specific leave was in place for international volunteering, given the current financial constraints and increased workload... this would be difficult to implement along with the full range of other paid and unpaid leave from the workplace... the introduction of leave for international volunteering could be perceived as unfair for those that do not volunteer and feel that they are covering for the colleague on volunteering leave."*

Greater Glasgow and Clyde board commented, *"given our staffing pressures, releasing staff (with or without pay) can have consequences and impact on staffing and service delivery."* NHS Lanarkshire suggested that *"backfill for absence isn't always possible, suitable or can come at higher cost."* This difficulty may be exaggerated in areas of high specialisation or of low volume; NHS Orkney's Chief Executive remarked that, *"particularly in the smaller island boards... there is limited cross-cover of functions and release of an individual may have significant service impact."* While uncommon, some volunteers return with illness or injury, which may make them unavailable to their employers for an extended period of time.

Some individual respondents to our stakeholder engagement exercise reported difficulties in achieving management approval for their international activities, often for the reason of backfill difficulties. However, many did report significant management backing.

> Consultant ophthalmologist Andrew Blaikie maintains links with colleagues in Tanzania and Indonesia, and has had good institutional support from NHS Fife :
> ***I've had no problems from NHS Fife in receiving support for my international activities; I think it helps that we are a dynamic, hard-working department, we 'ask nicely', and have a good plan with clearly articulated benefits to us and our overseas partners; we acknowledge as a department that we have different strengths and there is buy-in from everyone for our international activity, whether or not they go abroad personally.***

Notwithstanding this challenge, some Boards have formalised overseas commitments, such as NHS Borders, which in 2009 signed a twinning arrangement with St Francis Hospital in Zambia. At this time, NHS Borders' chairperson Mary Wilson stated: *"This is not simply a symbolic gesture but is aimed at promoting co-operation and understanding between the two institutions."*

UK-Med is a charitable organisation that is contracted by DFID to provide the UK response teams for disasters and emergency relief, and it maintains a register of appropriately qualified and trained volunteers, which includes NHSScotland employees. UK-Med volunteering is facilitated by a release agreement with employers and volunteers typically deploy for 2-3 week periods. This occurs with full maintenance of salary and pension benefits to individuals, and the payment to employers of the cost of back-filling places. One of UK-Med's Ebola response team in Sierra Leone was a Scottish paediatric trainee, Rod Kelly, who described to us that *"organising my deployments was relatively easy."*

While UK-Med's financial ability to enable continuation of service may be ideal, it is very unusual. Nonetheless, some individuals still manage to commit to considerable lengths of time abroad through contract flexibility, such as less than full time contracts where the unpaid time could be taken in blocks, allowing longer periods away from the UK.

3.2 FINANCIAL COSTS

For employers, financial concerns related to volunteering were focused around the potential for the employee's absence to result in additional service provision cost. There were a small number of examples of boards directly contributing financial resources towards volunteering projects, such as provision of immunisations or prescriptions to departing staff.

For individuals, financial issues were generally not mentioned in the context of short term volunteering, but started becoming a concern for longer periods of volunteering, which usually implied the loss of UK salary and pension benefits. In a survey of 439 UK General Practitioners who had undertaken international work in their role as a doctor, loss of earnings was viewed as a potential barrier by 21%[69]. Long-term volunteers are usually provided with a local salary or regular stipend, which will represent a significant drop in income, and are likely to lose pensionable pay. The THET-managed Health Partnership Scheme did contain a provision to maintain the pension contributions of those who were abroad for more than six months, but awareness of this provision appeared to have been poor and it left short-term volunteers uncovered, together with those who were not part of a formal Health Partnership Scheme link[26]. Lack of pension cover has been for many years a recognised disincentive to longer term volunteering[26].

Photo courtesy of Rod Kelly

Some trainees volunteering abroad have been provided with honorary NHS contracts in order to avoid some of the financial penalties resulting from a loss of continuity in NHS service but it is not clear how widespread this practice is.

The cost of travel, accommodation, subsistence and any training materials are considerations to be made when volunteering, and unless fundraising efforts are made to try and meet these costs, these costs may exclude lower-paid health service workers from volunteering.

3.3 PERSONAL HEALTH AND SECURITY RISKS

Concerns for the health and safety of international volunteers were prominent amongst health boards, although serious harm to volunteers is rarely reported. Health problems that have been encountered by international volunteers include accidents, infectious diseases and psychological issues.

In view of the high degree of publicity given to the case of Pauline Cafferkey, a community nurse working in Blantyre who contracted Ebola while working in Sierra Leone, infectious disease concerns are prominent in employer's minds. However, issues such as stress, exhaustion and burnout are more common. Some individuals struggle with culture shock, and reverse culture shock. One volunteer described: *"since returning to Scotland, whenever I think of Malawi my overriding emotion is a sense of unfairness, why do we have such comfortable lives whilst others struggle so terribly?"* The psychological impact of encountering unfamiliar suffering and injustice may be unavoidable but in their submission to this report, NHS Education for Scotland mentioned the possibility that some individuals had *"lack of preparedness for the challenges they would encounter, insufficient personal resilience and lack of awareness of risks in terms of their own health."*

Safety and security risks were not high for most international volunteering described, but are more prominent in some locations. These risks include robbery, acts of violence, and hostage-taking. We heard of how the development of some health partnerships had been limited by security concerns. The visits between Childrens' Hospitals in Glasgow and Lahore, Pakistan, are an example: *"visits have been very limited in recent years by the unstable political situation and Foreign Office advice against travel, meaning that the hospital could not officially support visits."* To some extent, telemedicine links can overcome such

restrictions and provide continuity of contact where travel is difficult. Personal health and security risks highlight the need for responsible volunteer recruitment and management protocols, where individuals are volunteering with an organisation.

> Tony Redmond, Director of the UK International Emergency Trauma Register, explained the UK-Med approach to these issues:
> ***We try to mitigate* [against health and safety problems] *through pre-employment health screening, post-deployment health screening, full health and safety briefings including security in the field with a comprehensive health/travel/medical indemnity insurance package.***
> This fulsome approach remains aspirational for many volunteering initiatives.

3.4 OPPORTUNITY COSTS

One of the unavoidable and obvious costs of international volunteering is that time spent abroad, or spent preparing for periods abroad, is not spent on other activities that might otherwise take up that individual's attention. This can mean sacrifice in the some of the following alternate areas:

- core health service work
- alternate professional development opportunities
- leisure time or annual leave
- time for family and friends

Amongst respondents to our survey, a commitment of 6-15 days abroad was the most common length of stay, and the majority spent less than 30 days abroad. This reflects the known shift in international work towards shorter, more focused placements, compared with the 'settlement' stays in previous eras. This may mitigate against some of the opportunity costs of longer stays.

> Roelf Dijkhuizen was formerly the Medical Director of NHS Grampian. He has had a lifelong interest in tropical disease and as a doctor has spent some short periods abroad. He comments:
> ***Twenty to thirty years ago, tropical medicine felt like a one way ticket. Doctors who had worked overseas for a number of years would find it difficult to return to medicine in the UK. Departments were hesitant to take on a returning doctor because of fear they would appoint a 'jack of everything, master of none' type of medic.***

In terms of other opportunity costs, a number of survey respondents did mention that significant loss of annual leave and loss of family time was a substantive disincentive to volunteering. For some individuals, this was mitigated by use of special or study leave for their time abroad.

Photo courtesy of NHS Borders

> Deputy Charge Nurse Gordon Elliot from University Hospital Ayr has undertaken several trips to India where he delivers lectures on surgical care and runs a dressing clinic for disadvantaged children in an orphanage. He counts these trips as ***a privilege and a humbling experience*** but they do have family implications:
> ***I had a great desire to be involved within the team... However, this presented challenges within my own personal circumstances, as I had three young children... when going to India the team goes for two weeks and annual leave has to be taken to do this, sacrificing time normally allotted to family.***

3.5 REGULATORY ISSUES

Some health service professions are formally regulated at national level. Doctors are one such professional group. One of the concerns expressed by some doctors was the difficulty of maintaining a UK licence to practise from the General Medical Council (GMC) if volunteering for longer periods abroad. In order to hold a UK licence to practise, it is necessary for doctors to undertake an annual appraisal of their practice and a more detailed process of revalidation every five years.

Appraisal and revalidation are normally supported by a UK-based 'designated body,' which includes some UK voluntary organisations. Doctors who do not have a designated body or, alternatively, a GMC-approved 'Suitable Person' have to directly supply evidence to the GMC demonstrating how they are meeting revalidation requirements, and they may be required to undertake a 'revalidation assessment' test. This can have very significant professional and financial[‡‡] implications which particularly affect doctors who intend to spend extended time abroad, or who wish to volunteer following retirement from a substantive UK post. Revalidation assessments are currently available in 12 difference specialties, but these do not clearly match all areas of medical practice.

[‡‡] The current fee for a GMC revalidation assessment is £1,100 (sourced from http://www.gmc-uk.org/doctors/fees.asp on 09/04/17).

The GMC recommend that doctors may wish to temporarily relinquish their UK licence to practise while abroad. They have produced guidance for overseas regulators and overseas organisations about revalidation and the licence to practise for doctors working wholly outside the UK. However, many international medical organisations such as Médecins Sans Frontières (MSF) continue to require that their medical volunteers maintain a licence in their home country.

> One senior doctor, now retired from regular UK clinical practice, gave us the following opinion on regulatory issues: ***I know many other colleagues who have been unable to secure revalidation and consequently are unable to work overseas as a volunteer after retirement. This is a huge barrier to individuals and NGOs, and is having a seriously detrimental effect on Scotland's long history of providing experienced humanitarian medical aid overseas. Also, using retired NHS practitioners for humanitarian support has no workforce or financial cost to the NHS, so it would seem sensible to put structures in place to facilitate this.***

For nurses and midwives, maintenance of UK registration requires revalidation every three years and requires the input of another professional registered with the Nursing and Midwifery Council[70], but there is not currently an equivalent need for a 'revalidation assessment' test after a certain period away from UK practice. In our stakeholder engagement exercise, no nurses or midwives cited regulatory issues as a barrier to short or long-term international work.

3.6 REPUTATIONAL RISK

Whilst there are reputational gains for organisations and countries that undertake well-regarded, thoughtful and mutually respectful international development work, the converse is also true. Poorly run schemes with inappropriate, unskilled and culturally insensitive volunteers can result in negative perceptions of sending countries and institutions affiliated with those volunteers.

This was articulated by the Scottish Ambulance Service, *"if the volunteer is not competent or not adequately supported they would become a burden on other agencies which would damage our reputation and credibility."*

Addressing the reputational risk of poorly delivered international development will require alignment of Scottish policy and practice with the agreed principles of aid effectiveness which were articulated in the 2005 Paris Declaration on Aid Effectiveness and 2008 Accra Agenda for Action[71]:

1. ***Ownership:*** *Developing countries set their own strategies for poverty reduction, improve their institutions and tackle corruption.*
2. ***Alignment:*** *Donor countries align behind these objectives and use local systems.*
3. ***Harmonisation:*** *Donor countries coordinate, simplify procedures and share information to avoid duplication.*
4. ***Results:*** *Developing countries and donors shift focus to development results and results get measured.*
5. ***Mutual accountability:*** *Donors and partners are accountable for development results.*

3.7 CONCLUSIONS

Although there are clear benefits derived from international work, it is not without some risk and challenge. This is normally fully understood by individuals, health care institutions and by organisations facilitating this work, but some naivety exists and appropriate preparation is essential. Mitigation against risks will require appropriate preparation and safeguarding of its staff.

Partners in LMICs also experience significant benefit from the work of Scottish health service volunteers. To maximise mutual benefit, plans of engagement need to be thoughtfully aligned with principles of best practice. The next section considers how this might be best achieved, and how Scotland might maximise its potential to benefit from global health work.

Photo courtesy of THET

4. REALISING OUR FULL POTENTIAL

Scotland's health sector workers currently invest significant time and energy in global health work, and this is of established mutual benefit. We believe that maximal mutual benefit from global health partnerships can only be realised with a system-wide commitment to global citizenship, based on an agreed strategic approach.

Having taken account of the evidence reviewed, and our stakeholder views, we recommend that action is required in the following areas:

1. Developing a strategic approach
2. Professionalising coordination and support
3. Maximising benefit
4. Ensuring effectiveness
5. Valuing collaboration
6. Expressing local commitment
7. Defining support mechanisms
8. Setting expectations

4.1 DEVELOPING A STRATEGIC APPROACH

1

RECOMMENDATION:
NHSScotland should consider articulating a strategic approach to global health engagement which embraces global citizenship in the Scottish health service.

When we asked Health Boards how the current NHSScotland approach to international volunteering might be improved, most suggested issuing clear and consistent guidance that would apply to all staff across Scotland. NHSScotland may wish to consider an organisational commitment to each of the actions suggested in this report, with an articulation of how they will be accomplished and within what time scale.

Elsewhere in the UK, there have been extensive policy developments defining system-wide approaches to global health and this is now required in Scotland too. We believe that such an emerging strategy should clearly reflect Scotland's existing International Framework (2015), which stands as a guide to all Government activity and casts the vision that *"our people:*

- *are better skilled and equipped to engage in a global world.*
- *are open to international exchanges and learning opportunities.*
- *are able to understand the international environment and Scotland's place in the world."*

Given the Scottish Government's decision to concentrate International Development Fund resources on a sub-Saharan project base of Malawi, Zambia and Rwanda, and on educational links with Pakistan[2], it may be appropriate for a Scottish global health strategy to echo this approach. It is noted that many current Scottish health links do already focus on these four countries, but a substantial number of partnerships and volunteering opportunities have been established elsewhere and we do not recommend trying to curtail this work.

4.2 PROFESSIONALISING COORDINATION AND SUPPORT

2

RECOMMENDATION:
The Scottish Government should consider professionalising and resourcing coordination and support of global health work at a national level.

We believe that Scottish commitment to global citizenship requires to be demonstrated through the professionalisation of volunteering coordination and support at a national level. Many respondents to our stakeholder engagement exercise reported difficulties in accessing relevant information on global health opportunities and mechanisms of individual volunteering. NHS Tayside stated in their response: *"It would be useful for those contemplating global health volunteering to have a single point of contact, which would preferably be web based, which would provide information and guidance. It would also be useful for employers to have a similar resource."*

We are impressed with the breadth of policy development and support that the International Health Coordination Centre in Wales has been able to achieve and believe that adaption of this model to the Scottish context could achieve similar results.

Scotland's international development approach already recognises the value of centralising and professionalising the collection and then dissemination of expertise. The major focus of Scottish Government international development to date has been in a country-to-country partnership with Malawi, and part of its budget is spent in resourcing the Scotland Malawi Partnership.

The Scotland Malawi Partnership is a national civil society network with over 1,000 member organisations and key individuals which exists to *"inspire the people and organisations of Scotland to be involved with Malawi in an informed, coordinated and effective way for the benefit of both nations."* The Partnership received £290k from the Scottish Government in 2015-16 and over this time delivered over 100 meetings and engagements, reaching approximately 2,300 people. It arranges forums, networking events and training programmes, provides advice and support to individual members, liaises with a sister organisation in Malawi, maintains active communications and engages in political advocacy. This model has been very effective in supporting wider public engagement, with every £1 of Scottish Government funding in Malawi being matched by £10 raised by civic society.

Against this background, we suggest that a Scottish Global Health Coordination Centre could fulfil a facilitating purpose in the health domain. This would not replicate existing networking effort, but provide much-needed capacity and expertise to the coordination of health work. Such a Centre could be nested within an existing national organisation or set up as an independent unit. The purposes of such a professionalised support service could include:

- developing and articulating global health policies and strategy
- providing practical and policy expertise to individuals and organisations on the planning and delivery of global health activity
- identifying and publicising funding opportunities for global health work
- providing a central point for liaison with Scottish Government departments and with jurisdictions elsewhere

4.3 MAXIMISING BENEFIT

3 **RECOMMENDATION:**
NHSScotland should consider exploring how the potential personal and professional benefits of global health work could best be maximised in the Scottish health service.

As this report makes clear, global health experience offers considerable benefits to Scottish health service employees and employers. Risks also need to be considered and it is recognised that different approaches have met with variable success in achieving transferability of learning and benefit to Scottish institutions. A renewed strategic approach to global health in Scotland must consider how benefits can be maximised and risks minimised. Healthcare systems elsewhere have supported global health experience with some of the following objectives:

- boosting recruitment and retention
- integrating into professional development programmes
- capturing and capitalising on learning
- sharing experience
- developing synergies with the academic sector

Boosting recruitment and retention

As identified in section 2.3.1, integrating global health experience into training and a UK career has potential to increase employer attractiveness, boosting recruitment, maintaining staff morale and keeping staff motivated to stay in their current positions. Scotland should also seek to capitalise on widespread interest in global health work and consider developing bespoke programmes that combine international experience with UK training and practice.

Integrating into professional development programmes

Many respondents to our stakeholder engagement exercise highlighted the opportunities for professional development inherent in international partnerships. Section 2.3.3 gives an example of a successful leadership development programme which focuses around an international placement, and is part-funded by DFID. We suggest that NHSScotland should develop its own programmes of professional development that harness its existing expertise in quality improvement, leadership and management training and combine this with global health experience.

Capturing and capitalising on learning

The Academy of Medical Royal Colleges, an advocate for the value of international volunteering[72], has recently published the results of an expert review process which identified key areas of capability which are particularly pertinent to global health[73]. While we welcome this work, we believe that most professional learning on the international stage is more generic. In their review of UK benefits from international partnerships, Jones and colleagues provide a clear demonstration of how many skills enhanced by global health work link clearly to established UK professional development frameworks, but they also state the need for a clearer documentation of benefits and costs experienced by individual volunteers[36].

Formal analysis of a volunteering scheme linked with Somaliland[42] identified some of the issues that influence transfer of learning to NHS practice:

Individual factors:

- Extent of volunteer commitment
- Volunteer ability to extrapolate learning between contexts

Placement factors:

- Links between roles while volunteering and within the NHS

NHS factors:

- Organisational capacity for learning and change

A toolkit for capturing evidence of knowledge and skills gained through global health experience was published by Health Education England in 2015 and this appears to provide a useful framework for evidencing benefit to organisations and individuals. Scottish international volunteers should be encouraged to document their experiences in this way, which could underpin accreditation of global health work for continuing professional development purposes.

Sharing experience

We recommend that NHSScotland should support the sharing of expertise gained in global health work. The Scottish Global Health Collaborative is becoming established as an important and effective national vehicle for this conversation. Web-based platforms could provide an ideal framework for dissemination of learning.

Developing synergies with the academic sector

Global health is a developing interest area for many Scottish higher education institutions. The growth of international academic interest groups such as the World Federation of Academic Institutions for Global Health and the Consortium of Universities for Global Health reflects this trend. Higher education programmes for health workers in training, such as nurses[74] and medical students[75], note benefit from allowing international experience and some universities have developed and resourced student link programmes at scale[76]. Many successful UK health partnerships have combined expertise from the health service with the academic sector. Scotland should aim to maximise such synergies.

Just as England's Global Health Exchange has facilitated the development of their Global Health Fellowships, a Scottish Global Health Coordination Centre could provide capacity and expertise to support the actions suggested here, by helping develop new programmes and disseminating best practice.

Photo courtesy of Gary Mortimer

4.4 ENSURING EFFECTIVENESS

4 **RECOMMENDATION:**
NHSScotland should support global health work which is needs-led and follows principles of effective partnership working.

We suggest that a strategic approach to global health should involve a service commitment to respectful partnership which is led by the needs of the partner institution.

Much NHSScotland global health activity will be conducted in the context of institutional partnerships and in this context we commend use of the eight principles of effective partnerships which were developed by THET[24]:

1. ***Strategic:*** *Health partnerships have a shared vision, have long-term aims and 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 local and national plans and complements the activities of other development partners.*
3. ***Effective and sustainable:*** *Health partnerships operate in a way that delivers high-quality projects that meet targets and achieve long-term results.*
4. ***Respectful and reciprocal:*** *Health partnerships listen to one another and plan, implement and learn together.*
5. ***Organised and accountable:*** *Health partnerships are well-structured, well managed and efficient and have clear and transparent decision making processes.*
6. ***Responsible:*** *Health partnerships conduct their activities with integrity and cultivate trust in their interactions with stakeholders.*
7. ***Flexible, resourceful and innovative:*** *Health partnerships proactively adapt and respond to altered circumstances and embrace change.*
8. ***Committed to joint learning:*** *Health partnerships monitor, evaluate and reflect on their activities and results, articulate lessons learned and share knowledge with others.*

THET are currently developing a self-assessment toolkit that will allow partnerships to assess their vision and activities against these eight principles, and this should be of widespread use.

In relation to the management of potential volunteers, we commend the recommendations of Louise Ackers and colleagues in their thorough analysis of learning from a large-scale capacity-building volunteering project in Uganda[77]:

- **Transparent and equitable recruitment process:** volunteering opportunities should be advertised to all eligible staff groups and should to assigned without discrimination.
- **Age and seniority of volunteers:** there is a need to balance NHS interests (which would favour the placement of junior health service workers) and partner institution interests (which would favour senior worker placement).
- **Matching volunteer with institution:** an intention to build capacity entails that volunteers are prevented from simple labour substitution and negotiations between sending and host organisations should be marked by high contextual understanding and mutual trust.
- **Supervision, risk and the co-presence principle:** every volunteer should work alongside a counterpart in the host organisation, thus reducing risk, and the possibility of dependency.
- **Supporting volunteers from induction to debriefing:** volunteers should be provided with cultural and professional context in a tailored fashion, with linkage to existing project volunteers, and deployment in clusters where possible.
- **Risk mitigation and administrative issues:** the volunteering programme should conduct risk analysis of placements, avoid lone working, ensure that volunteers are appropriately registered, have effective health insurance and professional indemnity.

Global health activity from NHSScotland should be mindful of these principles of best practice. We believe that they are a helpful guide to many kinds of global health work, but it is recognised that mutually beneficial international work may not always conform to the partnership model and we do not favour a restrictive approach.

4.5 VALUING COLLABORATION

5 **RECOMMENDATION:**
NHSScotland should consider committing to collaborative engagement and advocacy on global health issues.

NHSScotland staff and associated professional and charitable organisations in Scotland possess considerable expertise in global health issues, and the Scottish Government has received considerable international acclaim for its approach to co-development with LMIC partners. It should also be recognised that the NHS is Scotland's largest employer, with over 160,000 staff.

For these reasons, we consider it important that Scotland seeks opportunities to be an active participant in the formation of UK global health policy and in sharing best practice with existing networking organisations.

The Scottish Government should be proactive in ensuring that the mutuality of benefit from international development work is fully realised in Scotland. Effectiveness in this endeavour will be enhanced by pooling of resource and expertise between NHS structures and other elements of the health system, including universities, professional organisations and charities. The Scottish Government should also be proactive in tackling system barriers to global health work such as professional regulation issues (see section 3.5). This requires high level support and commitment.

4.6 EXPRESSING LOCAL COMMITMENT

6

RECOMMENDATION:
NHSScotland should consider asking all Health Boards to articulate a focused organisational commitment to global citizenship.

While the Scottish Government may articulate a national global health strategy, tangible delivery of the global citizenship philosophy will depend on acceptance and implementation at Board level. Many of the benefits (sections 2.2 and 2.3) and challenges (section 3) of global health engagement were identified by Boards themselves in their submissions to our review. Some Boards or hospitals already have formal twinning agreements, such as the NHS Borders link with St Francis Hospital in Katete, Zambia and the Royal Hospital for Children, Glasgow link with the Children's Hospital and Institute of Child Health in Lahore, Pakistan. Boards should consider appraising their resources and connections in deciding how they may play their part as global good citizens. For smaller Boards, this may mean combining resources.

An inspiring example of what a Board-level global health programme can achieve is found in the Northumbria Healthcare NHS Trust. Since 2001, this Trust's board have made annual plans of international engagement and currently support about six overseas visits per year on core funding from the board of £17,500. Actual costs are met with additional personal and team fundraising activity, and the donation of large amounts of personal time. The Trust regards the Tanzania partnership as a workforce development initiative.

These projects involve many staff groups, who typically deploy in their normal teams. The Trust have won a number of national awards for their activities and have been essential partners in delivering highly regarded innovations in service delivery, such as the establishment of an independent laparoscopic surgery service and endoscopy unit in Kilimanjaro Christian Medical Centre, Tanzania.

Boards may wish to consider identifying suitable staff to act as local coordinators and local champions of international partnerships, and should consider ways of celebrating local success in global health work. Some Boards already provide financial assistance towards volunteering in the form of free travel medicine advice, vaccinations and prescriptions, and such support could be extended. Boards may also consider further practical support that could be given to volunteering programmes such as providing accounting and administrative support.

4.7 DEFINING SUPPORT MECHANISMS

7

RECOMMENDATION:
NHSScotland, in partnership with Health Boards, should consider defining support mechanisms for international volunteering.

As highlighted in section 1.5.1 of this report, most Scottish health service workers undertaking global health work will do so as volunteers and using annual leave. UK-Med, a charity contracted by DFID to provide the UK's emergency medical response teams, provides an unusual example of a charity which is able to directly supply Boards with the finance required to meet locum costs for an absentee employee. Very few organisations will be in the position to offer this level of support and Boards will rightly prioritise the needs of the population they are serving directly, rather than needs elsewhere.

However, we believe that there are sustainable mechanisms by which Boards could become employers that are more supportive of global health engagement. Northumbria Healthcare Trust, cited in section 4.6, has modified its volunteering policies to allow staff to take up to five days of study leave towards international projects that are Trust priorities, providing staff also commit at least the same number of days of annual leave and follow the procedures that are outlined in the policy extract below. As Jones and colleagues have stated, *"volunteering at least partially within study leave would protect volunteers' annual leave, and thus help prevent burnout*[36]*."*

NORTHUMBRIA HEALTHCARE NHS TRUST – VOLUNTEERING POLICY
International Partnership Volunteers

- The trust has a commitment to support the development of healthcare services in less developed countries as part of agreed partnership programmes. Members of staff who wish to volunteer their time to support international projects, and who are eligible for the agreed programme of activities, as set out in the annual business case, are expected to commit to the use of annual or special leave to take part in projects.
- It is to be noted that all absences must be agreed in advance with the operational manager who will ensure that any planned absences will not impact on service delivery.
- The trust has agreed that members of staff will be able to take up to five days of study leave to undertake specific project activities. In order to qualify, the member of staff must be prepared to commit at least the same number of days from their annual leave entitlement, or more. Staff volunteers must also agree to undertake pre-departure interview briefings and training, including participation in risk assessment, prior to engagement in international volunteering.
- Members of staff returning from international project work are expected to submit feedback reports to the international project manager and provide feedback, in terms of a presentation, to their business unit.

Photo courtesy of Linda de Caesteker

For staff that are particularly committed to international work, flexible or less than full time contracts will be an attractive way of freeing up more time for global health work without resigning an NHS post. On rare occasions, a leave of absence has been granted to allow a temporarily full-time international commitment.

VIEW CASE STUDY

Dr Linda de Caestecker, Director of Public Health at NHS Greater Glasgow and Clyde for 10 years, has recently returned from a one year leave of absence where she was Director of Projects with the International Federation of Obstetrics and Gynaecology (FIGO). She comments:

It was a wonderful opportunity and experience. There was personal cost involved... but the benefits far overwhelmed these... I came back to my role as Director of Public Health, refreshed and re-motivated to improve health and feeling very fortunate to work within our NHS system with its commitment to equality and universal access.

Another mechanism which could be more often utilised to support global health work is sabbatical leave provision. The Scottish consultant contract contains an example of a sabbatical leave policy which has been used by some clinicians to facilitate global health work (see Appendix 1 for full policy). Some staff[60] have made creative use of sabbatical leave provision by spreading this time out over a number of years; an example is given below.

VIEW CASE STUDY

Dr Adrian Stanley is a Consultant Gastroenterologist and together with other clinicians, has had a major role in training and equipping endoscopy units in Malawi. He explains how this long-standing commitment has been achieved, and its personal benefits:
I took holiday leave for my initial visit, then Greater Glasgow & Clyde allowed me 6 weeks sabbatical leave [spread out] ***to help undertake annual visits over the subsequent 4 years (I swapped or time-shifted my core clinical commitments when away). This project has been incredibly rewarding for me. It is a humbling experience being able to work with Malawian clinicians, who practice under very difficult circumstances and are extremely grateful for the help we can provide. My training visits refresh me professionally and provide me with a balanced perspective on the challenges faced when working in Glasgow.***

Health workers in training positions may have alternative opportunities to spend some of their time gaining international experience in low and middle countries and some professional organisations such as Royal Colleges offer funded international fellowships. Our health service as a whole should value these staff training opportunities.

4.8 SETTING EXPECTATIONS

8 **RECOMMENDATION:**
NHSScotland should consider articulating its expectations of Scottish health service workers when engaging in global health work.

While the focus of this report is on institutional actions that could improve Scotland's global health contribution, we believe that an articulation of NHSScotland's expectations of its employees when undertaking international volunteering would also be useful. Scotland's health service workers will carry its reputation abroad and should be directed towards ethical and thoughtful engagement with international partners.

NHSScotland may wish to develop its own code of practice or could adapt an existing framework[78-79]. World Orthopaedic Concern (UK) sends both consultant and trainee staff abroad as volunteers and has developed a charter on minimal ethical standards for volunteering by trainee surgeons. Although contextualised to this situation, their advice and standards would appear relevant in many international volunteering situations. It is replicated below.

"The Visiting Trainee Surgeon's Charter: travelling to a less developed country"[80]
Intention to treat approach

- Ensure that all that you do is primarily for the benefit of the recipient country.
- Ensure supervision from a trusted senior is available in your placement.
- Do not tackle cases which you think are beyond your capabilities.
- Do not compete with local doctors, students and clinicians for operating time- form partnerships instead.
- Accept if no actual benefit has been achieved in terms of training from your visit- use the experience to better plan future visits.

Pre-trip preparation

- Make prior contact with destination hospital, including head of department, hospital director etc., especially if travelling with an agency/NGO which arranges everything for you. It is customary in the UK to go through these formalities, so it should be common courtesy to do the same abroad.
- Have a plan of what you will do and come prepared to your placement.
- Read up about the health care system and common pathology you will encounter in your placement.
- Look for courses that will equip you with some of the knowledge and skills useful to work in these different and often challenging environments.
- Research what materials/drugs etc will be useful for you to bring.

General cultural advice

- Respect local culture.
- Make an effort to learn basic language skills.
- Try and learn a little about the history and traditions of the country.
- You can read up about wider issues affecting less developed countries- aid, trade, history, colonialism, slavery, etc. This will often make you more sensitive about subtle issues and help you with connecting with local people.
- Be polite, patient, courteous, punctual, appropriately dressed, etc. as per local culture, just as you would expect of visitors in the UK.

Work attitude - "To understand all is to forgive all"

- Work ethics will invariably be different from the one you consider normal or appropriate. Remember work ethic is determined by many factors, including pay, promotion, job security, and other incentives which we pretty much take for granted here, let alone stringent managerial pressures. This can be very different abroad and one should take extreme care when criticizing people. You might want to criticize the system instead but again with care and tact. The appropriate thing is to enquire politely and try and understand the other point of view, while sharing with them your own work ethic. You can demonstrate the value of it through your own good example and through convincing accounts of it working from your own past experience.
- Be aware of the gap in wealth between you and your colleagues potentially. Revealing your expensive equipment might not be appropriate, especially if you do not intend to leave them behind for the benefit of the hospital.
- Planning what you bring should also reflect that and indeed you might find yourself carrying equipment that is not compatible with the health care setting you discover once out there.
- Question the relevance of applying "western" standards of healthcare to the recipient country. It might not be applicable for a number of logistical and cultural reasons.
- Be generous, but be careful not to create a culture of dependence. The latter can be frustrating to yourself and indeed end up being counter-productive to your mission. Giving to local projects and grassroots initiatives which you find attractive while abroad might be a more sustainable way of sharing your money with the community.

Organisations that send workers abroad should themselves carefully align their volunteer management protocols with best practice, which will support volunteers in their delivery of ethical, effective partnership work. Standards of good practice for supporting health worker volunteers were outlined in the 2014 document 'Engaging in Global Health' (Department of Health/Department for International Development)[81], which advocates the following hallmarks:

- effective health, safety and security procedures
- a clear and transparent volunteer selection process
- pre-departure preparation
- appropriate support in the host country
- support for continuing professional development
- continued support on return

The Royal College of Paediatrics and Child Health runs a Global Links programme which facilitates 6-12 month-long capacity building placements. Prior to their deployment, volunteers receive a 2-week training course which addresses practical preparation issues and cultural training as well as addressing potential knowledge gaps. Generic practical guidance on volunteering abroad is available from the British Medical Association[82] and the Royal College of Nursing/Royal College of Midwives[83]. A Scottish Global Health Coordination Centre could potentially provide pre- and post-deployment advice.

4.9 CONCLUSION

The publication of "Global Citizenship", Scotland's new International Development Strategy[2], provides an opportune moment for the Scottish health service to consider its approach to global health engagement. The Scottish Government has committed to achieving the UN's Sustainable Development Goals both domestically and internationally, and the thoughtful contribution of NHSScotland towards Goals 3 and 17, "Good Health and Well-Being", and "Partnerships for the Goals" will be an important factor in delivering this commitment.

The primary task of NHSScotland will remain the health and wellbeing of the people of Scotland. However, a health service with an internationalised outlook, valuing and supporting its employees who represent Scotland's best characteristics abroad, will reflect our national commitment to the common good and stands to reap the extensive benefits that global health experience can bring to its people and its service.

Mutual benefit can best be assured by a coherent national policy, which should galvanise our resources in a coordinated and proportionate way while not stifling individual excellence. Health Boards in Scotland have suggested that some national leadership and coordination would enhance our current approach to global health. We hope that the evidence in this report, the examples of good practice, and our suggested areas for action will provide a useful platform for taking this agenda forward. Scotland has a strong heritage of high-quality healthcare provision. We have much to offer our colleagues who undertake a parallel task in the developing world with far fewer resources than are available to us. We also stand to be inspired and informed in our service to the people of Scotland.

APPENDIX 1: SABBATICAL LEAVE PROVISION IN THE TERMS AND CONDITIONS FOR CONSULTANTS IN SCOTLAND

7.4 Sabbatical Leave[§§]

7.4.1 After 7 years service in the consultant grade, a consultant will be eligible to apply for one period of sabbatical leave of up to 6 weeks or after 10 years service, a consultant will be eligible to apply for up to 3 months sabbatical leave. If either of these options is granted with pay, no further period of paid sabbatical leave will be granted until retirement.

7.4.2 Sabbatical leave has clear benefits for the individual and the service, enabling a period of development and refreshment. It will be granted where it can be demonstrated that the consultant proposes to use the leave in furtherance of a project that is in the interests of the NHS and contributes to his/her continuing professional, clinical or leadership development.

7.4.3 The consultant applying for such leave must set out a stated case explaining how the leave will be used and how the sabbatical will benefit the NHS.

7.4.4 Sabbatical leave will only be granted subject to approved arrangements having been made to cover the absence of the consultant.

7.4.5 An application must be made a minimum of 6 months in advance of the intended date of leave to be taken. Where an application for sabbatical leave is rejected, a period of 12 months must elapse before a fresh application can be considered.

7.4.6 Applications will be considered by the Medical Director / Director of Public Health and must have the written support of the Clinical Director / manager.

7.4.7 Where travel and accommodation expenses will be incurred, the employer has discretion to meet these in part or in full.

7.4.8 Sabbatical leave may be granted without pay in circumstances other than those set out above. The paid period of 6 weeks / 3 months may be extended by a further unpaid period at the discretion of the employer. Any such extension will be considered on the same terms as the original sabbatical leave agreement.

7.4.9 When sabbatical leave has been granted without pay, an employer has discretion to grant additional periods of sabbatical leave at intervals of no less than seven years after the first period.

7.4.10 All employment rights will be preserved during periods of sabbatical leave.

[§§] Extracted from: National Health Service. Hospital Medical and Dental Staff and Doctors in Public Health and the Community Health Service (Scotland). Consultant Grade. Terms and conditions of service. Scottish Government Health Directorates. (2007 update)

APPENDIX 2: ANALYSIS OF OUT-OF-PROGRAMME EVENTS BY JUNIOR DOCTORS IN SCOTLAND, 2006-2016

Junior doctors who wish to deviate from the normal course of a specialty training programme (i.e. GP training or hospital doctor training) in a particular area need to ask their training programme director and post-graduate dean for permission to go 'out of programme.' In the context of international volunteering, this kind of permission will be required for periods abroad that extend beyond annual leave/study leave/special leave. Permission to go out-of-programme is given on one of four bases:

- career break
- experience
- research
- clinical training

A geographical exploration of how Scottish trainees have used types of out-of-programme opportunities from 2006-2016*** is shown below in Table 2. Data was kindly provided by NHS Education for Scotland.

The location of these opportunities was missing in 15% of cases, so at least 3.6% were in LMICs but the true proportion may be higher. It should be noted that this analysis only captures data from doctors who are both in a training programme and likely spending ≥3 weeks abroad. It is not possible to describe the extent of international experience or volunteering which may occur in other circumstances, such as the end of the initial 2-year Foundation Programme and the beginning of specialist training.

TABLE 2: Out-of-programme types and destinations of Scottish trainee doctors, 2006-2016

Location	Career Break	Experience	Research	Training	All Types
Scotland	6	70	418	105	599
Other UK country	2	23	53	79	157
Australia	2	19	12	32	65
Canada/USA	4	6	9	9	28
Low-/middle-income country	0	26	7	6	39
Other high income country	0	11	8	13	32
Unknown	123	24	5	4	156
Total	**137**	**179**	**512**	**248**	**1076**

*** Low numbers obtained from 2006-2009 suggest incomplete data from this period.

APPENDIX 3: OPERATIONAL PLAN OF THE INTERNATIONAL HEALTH DIVISION AND INTERNATIONAL HEALTH COORDINATION CENTRE (PUBLIC HEALTH WALES), 2016/17

1) Improve knowledge, understanding and use of international policies, evidence and good practice to improve health and well-being, reduce inequalities and support sustainable development and global citizenship in Wales through delivery of two briefings and two engagement/training initiatives.

2) Enhance Wales' impact on UK/European health policy and practice and raise our profile through showcasing Welsh achievements and success internationally and contributing to the work of our UK & international networks and partners, in particular EuroHealthNet, the World Health Organisation Regions for Health Network.

3) Work with Welsh Government, universities and other stakeholders to build capacity and facilitate partnerships to enable European income generation in Wales through delivery of series of local information/trainings events across the Health Boards and Trusts.

4) Work with World Health Organisation Europe and other European regions towards achieving excellence in 'Sustainable Development and Health' and preparing to apply for a World Health Organisation Collaborating Centre status, starting with the delivery of a joint publication and study visit.

5) Strengthen sound governance, reciprocal partnership, organisational responsibility and good practice in international work and global responsibility through supporting and monitoring the implementation of the Charter for International Health Partnerships in Wales across all Health Boards and Trusts.

6) Increase coherence, coordination and communication of international and global health work and strengthen our divisional role as a focal point and centre for excellence through establishing a virtual network of internationally active staff across Public Health Wales and the NHS.

7) Strengthen our national and international collaborations and sharing with related Welsh, UK and European organisations and similar regions through facilitating events, organising reciprocal visits, establishing synergies and Memorandum of Understandings, participating in joint grant applications and projects, working groups and publications.

8) Plan and start the development of a Public Health Wales International Health Strategy through consultation and dialogue across the organisation and with other relevant stakeholders and partners.

This information kindly supplied by the International Health Coordination Centre, Wales.

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NHS Borders
NHS Dumfries and Galloway
NHS Fife
NHS Forth Valley
NHS Grampian
NHS Greater Glasgow & Clyde
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Healthcare Improvement Scotland
National Services Scotland
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NHS Education for Scotland
NHS Health Scotland
Scottish Ambulance Service
State Hospital Board for Scotland

Organisations

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Christian Medical Fellowship
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