CHAPTER 2

The Ethical Educational Placement Project

Introduction

In the introduction, we highlighted that international health electives have been a growing feature of medical education since the 1980s (Banerjee 2010) and that these are now viewed as important contributions to a diverse range of health-related undergraduate programmes. It is widely accepted that electives are beneficial to and popular with students (see, for example, Hastings et al. 2014), and that they have positive impacts on skills acquisition, personal and professional development, and knowledge of medicine and healthcare systems in different contexts. Electives are also considered to be important for students to learn about preventative health and social responsibility, so there are identified humanitarian as well as academic, professional and clinical benefits (Ackerman 2010). However, we emphasised that there are limited meaningful assessments of the outcomes gained on placements. Importantly, little attention has been paid to the ethical issues faced by students and, in particular, the impact of electives on host organisations, communities and countries.

The Background

The development of the Ethical Educational Placement (EEP)project originated from the experiences of the Liverpool-Mulago Partnership (LMP). In 2010, LMP held a workshop in Liverpool inviting

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representatives of other UK-Uganda health partnerships. This resulted in the setting up of the Ugandan Maternal and Newborn Hub (HUB)[1] whose role it was to support individual health partnerships through knowledge sharing and, where appropriate, volunteer mobility. One of the first actions we undertook was a HUB-wide benchmarking process to capture, as accurately as possible, facility-based data on admissions and services. This provided our first opportunity to trial student placements and we deployed 12 students from the University of Liverpool, placing them in pairs in HUB facilities and tasking them to work with local records managers to build capacity in records management and data collection. This provided the basis for our first HUB-wide benchmarking Report. Both Ackers and Ackers-Johnson accompanied the students on this ambitious project.[2]

At this time, and building on our successful model of professional volunteer deployment, we successfully applied for funding to set up the Sustainable Volunteering Project (SVP).[3] The SVP was a professional volunteering project funded by the Department for International Development (DfID) through the Tropical Health and Education Trust (THET). The SVP deployed 55 long-term Professional Volunteers[4] (PVs) from medical, nursing, midwifery, engineering and social science backgrounds to nine health facilities spread across Uganda over a three-year period between April 2012 and March 2015. Each PV engaged in knowledge exchange and capacity-building activities, such as classroom training sessions, workshops and on-the-job mentoring in order to share skills and make improvements to their personal practice and the Ugandan Public Healthcare System.

Throughout the SVP, PVs frequently reported instances of poor practice relating to the organisation and implementation of international – usually medical – student elective placements in their facilities.

[1] The Tropical Health and Education Trust provided financial support to establish the HUB.

[2] The results of this are reported in Ackers-Johnson (2010).

[3] For more detailed information on the SVP and the impact of professional voluntarism on LMICs, see Ackers and Ackers-Johnson (2016).

[4] We have used the term 'Professional Volunteer' to refer to qualified professionals deployed for periods of three months to over three years. We critique the use of the term 'volunteer' to accurately describe these roles in Ackers et al. (2016).

Students would often arrive seemingly unannounced at health facilities and engage in unsupervised, unstructured and often risky activities. Many were reported to be acting over and above their level of training and competency, potentially putting themselves and their patients at risk. Some students worked unpredictably, appearing only sporadically between various safari excursions and mountain treks, reinforcing the negative and often damaging 'voluntourism' stereotype. Others struggled to build relationships and integrate into the local facilities, leading to unproductive and disappointing placements. On many occasions, PVs found themselves supervising and supporting international students during their placements, despite them making financial payments to private and host organisations for such services. During the SVP, a number of students approached the LMP directly for assistance in organising medical elective placements in Uganda; many had discovered the LMP's activities online and wished to get involved in ongoing projects. The LMP assisted in organising the logistics of these placements, the majority of which were self-funded. PVs played a key role in assisting in the placement planning process and providing mentoring and supervision during the placements.

The impacts of the students' placements were monitored in terms of their effects on the PVs, the hosting facilities and their personal placement satisfaction and learning outcomes. The results were very positive; students benefitted greatly from having the PV to guide, supervise and educate them which improved learning outcomes. The PVs appreciated having the students working with them as they often offered fresh insights, inspiration and motivation. Any potential damaging effects on the hosting facilities were minimised; patients were put at less risk and the students conducted concrete, meaningful placements devised in conjunction with the LMP and the local facilities which were of mutual benefit to all parties. These overwhelmingly positive results formed the basis of the EEP; linking structured short-term student placements to long-term professional volunteer placements to design and implement sustainable interventions.

Despite the success of the SVP and the positive impacts of the PVs on the Ugandan Healthcare System, the project came to an end in March 2015 as continuation funding could not be secured. This is a problem associated with project funding which is often relatively short-term and unpredictable. However, through the student placements an opportunity to create a self-sustaining model which was not reliant on

precarious funding streams was identified. The vast majority of international student elective placements are funded by the students themselves and are organised through private organisations such as 'Work the World'. As indicated in the introduction, very little research has been conducted into the impact of educational placements; including their ethics, learning outcomes, sustainability and value for money. This highlighted a gap in the international student placement market for supervised, risk assessed and effective educational placements which focused on mutual learning, safety, sustainability, ethics and positive local impact.

The Concept

A concept paper was written by members of the SVP project management team based at the University of Salford (UK), in collaboration with colleagues at Mountains of the Moon University (MMU) in Uganda and trustees from a UK based charity, Knowledge for Change (K4C).[5] The objectives of the EEP concept were to establish, operationalise and develop ethical and sustainable undergraduate educational placements, capable of enhancing public health services in Uganda, whilst also providing optimal placement experiences and learning outcomes for British and Ugandan undergraduates and the professionals working with them.

Fort Portal was selected as the primary Ugandan placement site because of K4C's ongoing relationship with Kabarole Health District, Buhinga Regional Referral Hospital, Mountains of the Moon University and the University of Salford. This relationship had been formalised two years previously, with a Memorandum of Understanding in place outlining expectations, roles and responsibilities. Fort Portal was judged to be one of the safest places in Uganda to host student placements in terms of its location, road safety and the local environment. Additionally, there were relatively few international organisations working in Fort Portal, compared to places such as Gulu, Kisiizi and Kampala, which meant not only could our project (including PVs) have more of an impact on the local area but also any impacts on the students or local area would be more easily attributable.

[5] K4C is a registered charity (registered charity no. 1146911) in both the UK and Uganda, committed to stimulating improvements in well-being and livelihoods in Uganda by strengthening public services and systems through partnership and the mutual exchange of knowledge.

The first phase of the project aimed to build directly on relationships established and experienced gained during the SVP and focused on public health systems. This would include improving public access to health services, improving the quality of services and patient outcomes, improving referrals systems in order to reduce delays in accessing health services, and reducing patient congestion in referral hospitals. A comprehensive evaluation of the SVP had previously identified a number of key challenges facing the Ugandan Healthcare system, which included:

- Human resource management systems were characterised by high levels of absenteeism, 'moonlighting' and very low levels of employee motivation.
- Improvements in initial degree level education.
- Increased opportunities for, and equitable access to, relevant continuing professional development.
- Management of physical resources such as infrastructure, transport, drugs and other consumables.
- Empowerment of patients through improved information and communication systems.
- Improved evidence-based approaches based on evaluation, record-management and audit.
- Identification of tools to improve accountability and good governance.

To achieve the aforementioned objectives, the organisation of the EEPs was aligned with a holistic framework of priorities. The first priority was to enhance patient wellbeing through improvements in the referral systems. This would be achieved by targeting local facilities at key points in the public referral system which were not fully functional, but whose functionality could be restored with minimal resource intervention. The overall goal of this intervention was to reduce congestion in larger health facilities further down the referral pathway, such as the regional and national referral hospitals. The second priority was to support continuing professional development (CPD) for local staff and students; this would be achieved through the deployment of experienced professional PVs to provide and sustain CPD (known as Continuing Medical Education or CMEs in Uganda). PVs would contribute to initial education by co-teaching on local degree programmes to invest in the current workforce. This linked to the first priority of enhancing patient well-being through increasing referrals, as functioning facilities are essential to effective

volunteer engagement and to ensure co-presence with local staff. The third priority was to support Higher Education systems in Uganda. The project would support a local partner, Mountains of the Moon University (MMU), in the delivery of undergraduate and graduate level education and the design and operationalisation of new degrees in Nursing and Midwifery to invest in the future workforce. Again, having functional facilities is critically important in enabling effective education and training, especially in placement settings. The locations highlighted in priority one would be carefully selected to ensure that they could act as effective placement training sites for MMU students.

The fourth priority was to provide structured educational placements with enhanced learning outcomes. The knowledge and experience gained during the SVP provided the basis for the operationalisation of a programme of student placements. These were to be structured and managed to minimise risk and enhance learning outcomes and were negotiated to ensure that they supported local services and objectives including: local health facilities, MMU education programmes and capacity-building in evaluation. The placements would be operated on a not-for-profit basis and would be jointly managed by UK and Ugandan institutions and partners with full co-ownership and co-stewardship in place. The fifth and final priority was to support evidence-based policy transfer; ensuring effective evaluation and dissemination to encourage similar initiatives in other areas of Uganda and elsewhere.

A funding application, along with the EEP concept paper, was submitted to Health Education England's 'Global Health Forerunner' fund, proposing the aforementioned EEP model for international educational placements for Nursing, Midwifery and Allied Health Professional students and funding was requested to pilot 40 such placements in Fort Portal, Uganda, over a 12-month period. Negotiations with HEE led to the inclusion of an additional 40 elective placements in India to be used as a comparison setting.[6] It was also decided that the placement opportunities should be opened up to Universities from across the North West of

[6] Although we supported the organisation and delivery of the India placements, these were included at the request of the funding body. K4C had no prior engagement or experience with projects in India. The placements were organised on an observation-only basis in a private not-for-profit facility. We extended our evaluation system to these placements to provide an element of comparison.

the UK and, on this basis, the funding was approved. The initial placement location selected for India was New Delhi, however risk assessments carried out during staff scoping visits judged this location to be too dangerous for students, in terms of both the city itself and the huge congested hospital facility. A smaller and safer city and hospital facility were selected; MS Ramaiah Hospital in Bengaluru. Bengaluru was identified as one of the safest and cleanest cities in India which made it more appropriate for hosting a large number of UK students. The placements were to be evaluated in terms of the students' learning outcomes and the impact of the placements on Uganda and India and their respective health systems. The end result was to devise a cost-effective model for student placements in low-income settings that could be up-scaled in Uganda and India, and potentially replicated elsewhere.

Project Setup

The EEP project began on the 1 April 2015 with an official end date for the first phase of 31 March 2017. The initial stages of the project included various stakeholder meetings with partners in the UK, Uganda and India to discuss, negotiate and confirm the viability of the placement project and ensure the necessary levels of buy-in and support. As experienced during the SVP, strong and mutually beneficial relationships with clear reciprocal expectations are crucial when developing and sustaining projects of this nature in LMICs. The relatively hierarchical nature of organisations in Uganda and India increased the need for effective communication at multiple levels. In India, this included most importantly the director of M.S. Ramaiah Hospital and the principals of M.S. Ramaiah's Schools of Medicine and Nursing. In Uganda, where we had already established relationships, negotiations were made at health district level with the Kabarole District Health Secretary and District Health Officer. Negotiations were also made with the directors of the various health facilities and organisations which would be hosting the students. These included: Mountains of the Moon University, Buhinga Regional Referral Hospital, Mulago National Referral Hospital, Virika Hospital, Bukuuku Health Centre, Kibiito Health Centre, Kagote Health Centre, Kataraka Health Centre, Kyaninga Children's Development Centre, SOS Children's Village, Good Shepherd School, the Agency for Community Development and Welfare, the Youth and Women Empowerment Foundation and Baylor Uganda.

Risk Assessment

Whilst stakeholder meetings and negotiations were taking place, comprehensive risk assessments were carried out at each of the proposed placement locations. These assessments updated and built upon a risk assessment of the SVP locations in Uganda completed by the Chief Risk Officer and Head of Global Health at the University Hospital of South Manchester in 2012,[7] highlighting and analysing risks to inform mitigation strategies for personal risks for the students and organisational risks for the University of Salford and K4C. The risk assessments for Uganda and India yielded relatively similar results, with road traffic accidents being identified as the greatest risk to the health and well-being of students and vicarious liability[8] being the greatest organisational risk. Other risks identified included assault and theft, illness resulting from unsafe food and drink, exposure to infection and tropical diseases, terrorism, civil unrest, the risk to students arising from unsafe or unsupervised clinical activities, getting lost in unfamiliar surroundings and excessive sun exposure.

The risk assessment was key to the design and implementation of the EEP, leading to the implementation of a variety of measures to mitigate the risks highlighted. For example, risk assessed accommodation was selected to host the students, safe and reliable transport was arranged for students between the airport, their accommodation and their placement locations. Also, rules regarding student travel outside of placement time were introduced to reduce the risk of road traffic accidents. To reduce the organisational risk of vicarious liability, policies were drawn up governing student placement activities and the required levels of supervision. The risk assessment advised that a single comprehensive insurance policy cover all the staff, PVs and students involved in the project to ensure an adequate level of cover for all parties and avoid them having to trawl through multiple different policies in the case of an emergency which may cause confusion and delays. Fortunately, the University of Salford's insurance

[7] The risk assessment is discussed in more detail in Ackers et al. (2016) and is available on the K4C website: www.knowledge4change.org.uk

[8] Vicarious liability refers to a situation where someone is held responsible for the actions or omissions of another person. In a workplace context, an employer can be liable for the acts or omissions of its employees, provided it can be shown that they took place in the course of their employment.

policy was judged to be suitable for this purpose and was able to provide the necessary cover.

Over the course of the EEP, there has been only one instance in which the insurance policy was required; this occurred when a student in India aggravated an existing back injury, possibly whilst driving on a bumpy road or carrying luggage up a flight of stairs to their accommodation. The insurance policy worked well; the student received the necessary treatment at a high-quality private hospital in Bengaluru before being returned to the UK with a medical escort. We had not been aware of the back injury prior to the placement commencing; this led to the implementation of a written medical questionnaire, given to students prior to their placements, requiring the disclosure of any physical or mental health conditions that they are aware of. It was made clear that failure to do this could cause serious individual problems, destabilise the whole placement group and potentially void the insurance policy putting the individual and organisation at risk.

Where a pre-existing medical condition was declared, advice was sought from both the insurers and the PVs on the ground in the placement location as to the suitability and viability of the placement. The opinion of the PV was particularly important as they had experience and knowledge of the local health system and would also often be the first port of call in any emergency situation. We took careful steps to support a number of students who disclosed health problems, for example autism and deep vein thrombosis, and the placements passed successfully. There was only one instance in which a student was refused a placement; this was due to a complex long standing heart condition which, although insurable, was judged by the PV to pose excessive risk as it could not have been treated locally should the condition have worsened during the student's placement. Naturally, the principle of equality of opportunity was always respected despite any disclosures and placements were only refused as a last resort. Both risk and insurance formed core elements of the student induction process which is explained in greater detail below.

Student Recruitment and Selection

Once initial stakeholder meetings and negotiations had been completed, information on the project was circulated to the programme leaders for each discipline at each university; it was their responsibility to share this information with necessary staff and students within their respective

institutions. Students were initially invited to attend an information day, during which they were given more general information about the project including what it would involve, our expectations, logistics and the timeframes of the placements. There was a great deal of interest and, almost immediately, large numbers of applications were received from students.

The application and selection process comprised three main stages; the first stage involved each student submitting a completed written application form consisting of three main sections, the first being basic personal information. The second section asked students to answer three questions in no more than 250 words each. The first question related to their reasons for applying for a placement, the second question asked what they hoped to achieve and experience during their placement, and the third question asked how they believed the placement would impact on their learning and future employability. The final section of the application form required students to select their preferred placement dates which varied from cohort to cohort. The candidates who submitted the highest quality application forms and suited the eligibility criteria relating to their university, study discipline and level of study were invited for interview. Achieving a representative sample of students from the multiple different institutions, disciplines and study levels was extremely challenging given that each group had conflicting 'mobility windows' (times in the year at which they could travel) and the need for the project to begin immediately and be completed within an 18-month period. Midwifery students in particular struggled to find time within their academic and UK placement timetables to be able to complete a four-week placement and some had to use some of their annual leave allowance. The need for flexibility increases further when placements are part of the curriculum and are assessed. Rather than sticking to rigid placement timings, the EEP placements offered flexibility throughout the year to try to accommodate as wide a group of students as possible.

Although the EEP evaluation strongly suggests that all students, at any stage in their degree programme, have benefitted hugely from their placement, the optimal placement timing was found to be towards the end of their penultimate year of study. These students tended to have a better attitude towards learning than less advanced students and were better able to share their learning and experience with peers upon their return to the UK (students completing placements at the end of their final year would tend to move straight into employment roles). These students were also

better able to contribute to the low resource setting as a result of their higher level of academic knowledge and workplace experience. Many of the students were mature students who had previous experience and/or degrees; these students tended to show greater resilience and confidence and were able to contribute more to local facilities. Therefore, in terms of the selection process, students in their second year of study onwards (with the exception of Masters' level students) were preferred.

The interview processes consisted of both individual and group interviews which were moderated by members of the project management team. The main qualities sought during the interviews were communication skills, team working skills, leadership skills, resilience and motivation. Again, building on SVP experience, these skills were deemed to be the most important in ensuring that students were able to cope emotionally and work efficiently during their placements. As a final stage of selection, the relevant programme leaders and/or personal tutors for each student were contacted to ensure that the student was able to travel on the selected dates and that there were no circumstances unbeknown to the project management team that would prevent the student from undertaking a placement, or expose the student or project to unacceptable levels of risk. Such circumstances expressed during the project included potential exam resits, outstanding coursework submissions, poor academic performance, poor attendance and health issues which had not been disclosed by the students themselves. Not all of these circumstances led to placement offers being withdrawn; for instance, some coursework deadlines were extended to enable students to complete the placement.

Over 350 application forms were received from students over the course of the project, and over 200 students were interviewed. The selection process was far more competitive for certain disciplines than others depending on the number of applications received, the dates of travel and the number of placements available. The most competitive discipline was usually adult nursing; one particular round of selection saw over 40 applications for just four placements. Other courses, such as podiatry, received very few applications which meant the majority of applicants were successful. There were a number of other factors which affected the number of applications received, the main being the methods and timing of information dissemination about the project within each institution and discipline, and the course structures and mobility windows available.

Student Induction

A formal induction process was held for successful applicants, and this began approximately ten weeks before their placement start date. The first stage of this process was the dissemination of a comprehensive 'Induction Pack', 'Local Guide', a short film and a local phrase book which contained detailed information about many aspects of the placements including the locations, logistics and travel arrangements, health and safety, emergency contact details, code of conduct and disciplinary procedures, insurance, leisure activities, finances, language, food and drink, dress and cultural sensitivity. Similar topics were covered again during a compulsory 'Induction Day' which was four hours in duration and run approximately six weeks before the placement start date. The Induction Day provided further information to the students and enabled them to ask any questions they had. Where possible, visiting colleagues from the LMIC hosting institutions were invited to provide input and advice. The induction session gave students the opportunity to meet the placement group with whom they would be placed prior to travelling. This was greatly appreciated by the students who often formed groups on social media to stay in touch, offer peer support and arrange weekend activities, as the following quote illustrates:

> It has been nice to have that support since the induction, [our group] have been talking for a few weeks now and we have a good grasp of each other's personalities. It's good that we are going out as a team now as opposed to getting there and having to become a team (Nurse, Uganda)[9]

Students were also provided with 'EEP Placement Agreements' (Appendix 1) to read, sign and return. These formally outlined our expectations of them whilst on placement, such as hours of work and conduct. A final induction and orientation session was held for the students once they arrived at their placement location which involved a tour of the accommodation; local area and health facilities; the provision of a mobile phone and local sim card for emergency usage; an introduction to their long-term volunteer supervisors and local staff in placement facilities; and further information about the placements and what to expect.

[9] Sample characteristics are provided in Table 2.1. Where appropriate we give the discipline and location of the respondents in brackets after the quote. Unless otherwise stated, these refer to the students.

Placement Cohorts and Locations

All cohorts of students were accompanied on their flights to Uganda or India by a member of the EEP team; this proved important especially when small problems arose such as delayed flights and lost baggage. If flights arrived in the late afternoon or evening, students were accommodated at a secure hostel near the airport and travelled to their placement location the following morning. A number of students were anxious about travelling at night, even when accompanied by members of staff. Students were always collected from and returned to the airport by a known and trusted driver.

Over the course of the project, 111 students completed four-week educational placements in Uganda (n = 92) and India (n = 19). The number of placements in India was reduced from the proposed 40–19 due to logistics and timeframes; only one cohort could be run per year (in November) to coincide with M.S. Ramaiah's 'International Student Winter School Programme'. The remainder of the placements allocated for India were instead run in Uganda. The sample included students from 11 different Higher Education Institutions; University of Salford (n = 49), University of Central Lancashire (n = 19), Liverpool John Moore's University (n = 15), Edge Hill University (n = 12), Liverpool Hope University (n = 4), Lancaster University in partnership with Central Manchester Foundation Trust (n = 4), University of Cambridge (n = 2), University of Cumbria (n = 2), University of Glasgow (n = 2), Anglia Ruskin University (n = 1) and Queen Mary's University (n = 1).

The first three cohorts of students, 36 in total, completed four week educational placements in Uganda between June and September 2015. The fourth cohort of six students and the fifth cohort of 19 students completed placements in Uganda and India respectively in November 2015. Eight further cohorts, 50 students in total, completed placements in Uganda between March and October 2016. The students' disciplines and placement locations are provided in Table 2.1. With the exception of the Prosthetics, Orthotics and Biomedical Engineering students, all the placements in Uganda were run in Fort Portal. The placements for the Business /NHS Management Trainees were split between Kampala and Fort Portal. All the placements in India were run in Bengaluru and Kaiwara, as explained in more detail later.

The optimal size of each cohort was found to be between six and eight students. Larger groups can lead to financial economies of scale, however they tended to fracture internally resulting in tensions and the breakdown of relationships, which detracted from the overall placement experience.

Table 2.1 Students' disciplinary background, gender and placement locations

	Placement location			
	Uganda		*India*	
Discipline	*Male*	*Female*	*Male*	*Female*
Adult Nursing	5	17	2	13
Midwifery	0	14	0	2
Children's & Young People's Nursing	0	9	0	0
Business/NHS Management Trainees	2	6	0	0
Mental Health Nursing	0	5	0	2
Social Work/Social Policy	2	5	0	0
Physiotherapy	2	3	0	0
Medicine	0	4	0	0
Prosthetics & Orthotics (in Kampala)	1	3	0	0
Integrated Practice (Nursing & Social Work)	0	3	0	0
Occupational Therapy	0	3	0	0
Paramedic	0	3	0	0
Podiatry	0	2	0	0
Bioscience/Human Biology	1	1	0	0
Biomedical Engineering (in Kampala)	1	0	0	0
Sub totals	**14**	**78**	**2**	**17**
Totals	**92**		**19**	

Source: Created by the authors.

Multi-disciplinary (mixed) placement groups were found to work well and provide exposure to new ideas and problem solving both within the UK team but also in their engagement with local health workers and systems. However, such groups demanded more complex project planning and tighter logistical management on the ground across multiple facilities. There was inevitably a greater strain on accommodation with larger groups and often students were required to share one bedroom between two, each bedroom containing two double beds. Only a small number of mature students expressed concerns about sharing bedrooms, however other shared facilities such as washrooms and kitchen areas did come under pressure, often becoming messy and attracting ants and mice

despite the employment of daily cleaners. It is very important to ensure that accommodation is of adequate standard and that the students are comfortable, otherwise it can lead to disputes within the group and can have a strong effect on students' wellbeing and placement experience.

Placement Structure and Activities in Uganda: the Role of the Professional Volunteer

As noted above, all students were accompanied on their journeys to both Uganda and India. The Ugandan placements are also supported by the services of a full-time Ugandan Placement Manager who is on site at all times to support the students and the various K4C projects. In addition to regular visits by the UK team and the presence of a local placement manager, Professional Volunteers (PVs) play an important, complex and multifaceted role in the design and structure of placement activities in Uganda. First, they form a crucial link between the students, project managers and the hosting facilities and institutions, and are responsible for students' safety and learning whilst on placement. They were able to supervise students during their placements providing on-the-job training, debriefing and support their wellbeing. Although logistically they cannot be co-present with each student at every point in time, they are readily available. Regular (daily and weekly) debriefings take place with the Placement Manager, the PVs and the students. This is particularly important in cases where students encountered patient deaths or 'near misses'. Students based on the neonatal units all witnessed neonatal deaths; in two cohorts, this happened on their first day. Of course, such deaths are traumatic in themselves and the way of dealing with dead neonates in Uganda shocked students; there were clear cultural differences regarding the care of the newborn and the contact between the mother and her dead baby. Time was spent during induction sessions discussing this in order to prepare students, but the fact remains that this will happen and students will find it stressful at first, as the quote below illustrates:

> It was very hard to deal with, even though we were told what it would be like and to expect to see death. I don't really think we could be more prepared for it because even if you told somebody all about it, if it actually happens to you it's different. (Nurse, Uganda)

All students have coped well in these circumstances during their EEP placements as a result of the high level of support the model provides. It is important to add that the students also provided strong support for the PV in similar circumstances. Indeed it is clear that the presence of UK students contributed significantly to the learning, experience and support available to professional volunteers. For example, midwifery students working alongside PVs often assisted with complex deliveries and particularly with neonatal care and resuscitation (areas where skills are often found lacking in Uganda). The PVs have really enjoyed mentoring the students, gaining motivation from this experience in what are often quite difficult environments. Students also provide strong social support for them and the project as a whole which contributes in important ways to the overall (integrated) sustainability of the EEP model as the quote from a PV suggests:

> I've felt much less isolated over the last few weeks and having the students here has really helped with that. (Professional Volunteer, Uganda)

The second benefit of having PVs on the ground derives from the relative longevity of their placements which enables them to build and maintain strong relationships with local stakeholders such as the district health officers, facility in-charges and local staff. This not only leads to the mutual development of new and exciting project ideas with Ugandan stakeholders, but also expedites the students' transition into local organisations, health facilities and staff groups enabling them to begin their placements immediately on arrival in Uganda. This also avoids the problem observed during the SVP relating to local staff often being suspicious of – and occasionally unwilling to work with – unfamiliar foreign staff and students. Third, the PVs played an 'anchoring' function to sustain project activities in between cohorts of students, allowing one cohort to easily and effectively continue the work of their predecessors, thus maintaining momentum and improving the efficiency of development activity. Fourth, the PVs provided training to local staff and students within health facilities and by teaching on Mountains of the Moon University's nursing and midwifery degree programmes. This marked a positive ethical and sustainable step towards ensuring mutual benefit to both Uganda and the UK. Finally, the PVs played a useful role in project evaluation; providing feedback about the successes and challenges face by the students and the impact the project was having on the local health systems.

The EEP directly funded a PV midwife to supervise the first three cohorts of students travelling to Uganda in the summer of 2015. When the midwife completed her placement, an obstetrician took her place and remained in post for 12 months until the end of the EEP. Obstetric/midwifery focused PVs were recruited since the majority of care in Uganda, particularly in smaller rural health centre 4s, is maternity focused, and other ongoing K4C projects were predominantly focused on maternal and new-born health. Given that students were not continuously deployed on the ground in Uganda, it meant that PVs had the capacity to assist with these other K4C projects, boosting the development impact of the charity. Fortunately, K4C had other PVs based in Uganda but primarily working on different projects. These PVs included two biomedical engineers based in Kampala. All of these PVs were willing and able to assist in supervising the students whenever necessary. This was particularly helpful when the group of prosthetics and orthotics students travelled out to Uganda. The active engagement of our sister bio-medical engineering project (see www.knowledge4change.org.uk) provided excellent opportunities for prosthetics and orthotics students to spend time in Kampala under the direct supervision of our PV in the large prosthetics and orthotics departments in Mulago Hospital and Kyambogo University. This demonstrates the benefits of having a number of diverse ongoing projects and a wide-ranging network of knowledge and relationships within the host country.

Local Supervision

In practice, it is impossible in the Ugandan public heath setting to guarantee one-to-one supervision in all placement locations given the turnover of staff, shift patterns, absenteeism and also cultural attitudes towards the supervision of students.[10] We tried to work towards this over the course of the EEP through close engagement with local staff and facility management but by the end of the project it was still occasionally lacking. This is partly the reason why students were placed in pairs, wherever possible, and were required to report any incidences of lone working to the placement manager or PV as a matter of urgency. The level of local supervision received by students was monitored through the weekly reporting process, which required students to state how often (never, rarely, sometimes, usually or always) they had been

[10] Ugandan students rarely receive active supervision whilst on their placements.

working alongside Ugandan colleagues and whether they had any concerns about this. The most common responses for the first three cohorts of students in 2015 were 'rarely' and 'sometimes'. By the end of the project, this had improved to 'usually' with many students selecting 'always'. As a project, we successfully applied for a significant number of Commonwealth Professional Fellowships which enabled us to bring Ugandan colleagues working in these facilities over to the UK for periods of between one and six months. This has played a very valuable role in augmenting relationships[11] and exposing them to the environment in UK universities and hospitals. The Fellows continue to play a very valuable role in supporting student information days, awareness raising and induction processes.

In the evaluation, no students reported any concerns about the level of supervision they received from local staff since many received sufficient supervision from a PV. Students believed they could access supervision quickly should it be required as the following excerpt suggests:

> Obviously being a student and being unsupervised isn't ideal however if I ever had any questions or needed support I could always call [the PV] and she would inform me about what to do or come over if it was an emergency. (Child Nursing Student, Uganda)

In most situations, particularly during placement in the smaller health centres and community based organisations, students have worked alongside excellent local staff and other students in mutual learning contexts. Given the breadth of disciplinary backgrounds this has been a learning curve for the placement managers who are now in a better position to select placements and also anticipate situations where students may experience staff shortages and potential lone working. Responding to these situations has proved beneficial both to the students but also to local health systems enabling us to leverage improvements in staffing, in attitudes towards student supervision and staff behaviour. By emphasising the necessity of supervision during placements for the UK students we are pushing ahead a model of good

[11] We have received three Fellowships to support Ugandan midwives in one of our smaller EEP training sites.

practice for Ugandan students. Co-locating the students in training sites[12] is making this possible and efficient.

Flexibility versus Structure

The educational placements in Uganda offered considerable flexibility to students based on their study discipline and personal areas of interest. Following the induction session, each student was given the opportunity to describe their personal interests and the ideal type of placement they were hoping to undertake and the types of facility they would prefer to be based in. Although it was made clear that not all requests could be fulfilled and that all placements would be negotiated with the various stakeholders involved in the project, the students' preferences were taken into consideration during the placement planning process. The main factors influencing the students' placement activity were the needs of the health system requested by local stakeholders, informed by PV opinions and verified by K4C and University of Salford management to ensure activities rested within the longer term organisational objectives. Given the iterative nature of the project, we were able to make a number of changes over the lifetime of the project to ensure that the placements were optimised to best achieve our objectives.

There was a careful balance to be achieved between autonomy and structure, and the level of flexibility to allow the students within their placement schedules was often difficult to gauge. Nursing and midwifery students tended to expect higher levels of structure, support and supervision in line with their experience of placements in the UK. This contrasted with, for example, the NHS graduate management trainees who requested a higher degree of autonomy and medical students who expected – and often actively sought – more intense autonomous clinical exposure rather than wider systems-focused placements. Often students expressed a desire to be placed in many varying locations in order to gain as wide an experience as possible, but this caused a number of problems. First, it

[12] The concept of 'training sites' has come from the EEP. It has included the improvement of infrastructure and equipment in the health centres nominated so that students can be placed in contexts where there is at least basic functionality and, where possible, examples of and opportunities for good practice. In the process systems and services are also being improved for patients.

made it difficult for them to integrate into the local health teams and build up strong relationships and the level of trust required for efficient co-working. One local physiotherapist explained how they were able and willing to supervise two students coming for multiple consecutive days; however, when three or four students were coming on different days, they failed to build relationships and it took much more time and effort having to explain the same things repeatedly. In moving around frequently, students were perceived as 'voluntourists' rather than colleagues by local staff which made them more suspicious of new students and therefore less likely to engage.

A second problem caused by placing students in a variety of settings was the additional burden placed on the UK and Ugandan project management team. Communication became more difficult as did organising the resulting more complicated placement schedules, supervision and daily transport plans. Third, a number of students reported feeling disappointed that they had not achieved as much as they had hoped as a result of moving around too frequently and therefore not having sufficient opportunities to engage in useful, tangible and impactful projects. Finally, it was observed that giving students a certain level of timetabling structure meant they were better able to maintain a positive routine; students who moved placement locations on a regular basis often reported greater confusion and stress which negatively impacted on their wellbeing. Additionally, some of the student requests (to spend time in local schools for example) had tenuous links to their study disciplines. However, although the learning from such placements would not be as directly relevant to the students' courses, it was acknowledged that they could help improve the student's knowledge and experience of health, education and social systems in LMICs. A decision was made to allow students to have half a day on Fridays away from their formal placements to engage in such 'side placement' activities, providing they were beneficial for the students' learning and experience and did not lead to additional risks or expense.

Placement Timetabling

As emphasised in their 'EEP Placement Agreement', students are required to complete a normal working week of 36 hours. Most student placements begin at 09.00 and end at 17.00; however some also began at 08.00 and ended at 16.00 to fit with the timings of the PV, local doctors' ward rounds or NGO community visits. The students were allowed 45 minutes

for lunch each day. The importance of beginning and ending placements promptly was emphasised to the students as this served as a form of role modelling for local staff and students. Students were only allowed to complete placements at night if it was in their personal interest and adequate supervision and transport arrangements could be provided to minimise risk. The main risks of working at night, as highlighted by the risk assessment, include transportation to and from placement when it is dark and the increased aforementioned risks associated with students being left to work alone and without adequate supervision.

At the beginning of the project, students would be on placement for five full days per week. Report writing for the purposes of the project evaluation, group meetings and debriefing were conducted in the evenings and weekends. However, many students reported that they did not feel they had sufficient time to debrief and write their reports, particularly as they were spending relatively long hours on placement compared to the UK. In addition, they indicated that the placements were often more difficult and/or stressful as a result of increased numbers of traumatic experiences, more demanding working conditions and a more debilitating climate. Also, students often engaged in personal leisure activities or relaxation during evenings and weekends which put pressure on the free time they had. It was therefore decided that each Friday would be split, with the morning dedicated to the 'side placements' and the afternoon involving a team meeting between project managers, PVs and students, a reflection and debriefing session and time for report writing.

Student Placement Activities

The majority of nursing and midwifery students competed hospital and health centre based placements. These included observational elements on the wards and theatres, along with hands-on clinical training under the supervision of the local staff and PVs across multiple facilities. Students were not permitted to work on their own without local or PV guidance for a number of reasons: this could potentially put them and the project at risk of litigation following medical malpractice as noted within the risk assessment; it does not foster efficient and mutual learning between the students and LMIC partners; and it detracts from the relationship building and team working. Students were generally placed in pairs as this reduced the risk of lone working, improved integration and simplified arrangements for supervision and transport. One Ugandan midwife reported how larger

groups of students often found it more difficult to integrate into the local workforce as students tended to 'stick together' as a group. This midwife also explained how larger groups tended to be *a 'greater burden on both local staff and PVs in terms of their management and supervision'* and could *'occasionally intimidate local staff and patients who were not comfortable in dealing with large groups (of foreign students)'*.

Initially the physiotherapy, occupational therapy and podiatry students also began placements in the hospital facilities. However, these were not successful for a number of reasons, the main one being that these professions were not well recognised in Uganda and therefore the students had little or no support from local staff. Also, staff working in the public sector, particularly in these less recognised areas, are often poorly paid, poorly managed and as a result poorly motivated and frequently absent. This meant the students – particularly the physiotherapy and occupational therapy students – were sometimes left unsupervised and finished their placements early each day. The gaps in the Ugandan health service left by these poor or non-existent services were often filled by the non-governmental organisation (NGO) sector funded and/or wholly run by international individuals and organisations. Using existing relationships and networks, we were able to locate and approach a number of these organisations and successfully negotiate the possibility of them hosting students. 'Kyaninga Children's Development Centre',[13] for example, proved to be an extremely successful placement location for physiotherapy and occupational therapy students. Similarly, the 'Youth and Women's Empowerment Foundation (YAWE)' NGO was able to provide effective placements for Nursing, Integrated Practice and Social Work students.

Other organisations hosting students on non-health focused placements included the Fort Portal Juvenile Centre, Fort Portal Open Prison, Kyaka II Refugee Settlement, Kyambogo University and Mountains of the Moon University (MMU). These organisations were particularly beneficial in hosting Social Work and Business students. A number of students from various disciplinary backgrounds (including health) ran teaching sessions for MMU students. These teaching sessions

[13] Kyaninga Children's Development Centre (www.kyaningacdc.org) is an NGO in Fort Portal which supports children with physical and mental disabilities such as cerebral palsy, cerebral malaria and brain injuries. They hosted six physiotherapy and occupational therapy students over the course of the EEP.

were negotiated and arranged by the UK students in partnership with MMU staff to ensure the content was relevant for the Ugandan students and could be taught to an acceptable standard. The sessions included (amongst others) lectures run by Social Work students on the potentially harmful effects of drugs and alcohol, workshops run by Midwifery students on safe childbirth, lectures run by Nursing students on infection prevention and control and lectures by NHS management trainees on the principles of management.

Placement Structure and Activities in India

The placements in India were established and managed quite differently to those in Uganda, mainly due to the nature and history of the partnership. The partnership with M.S. Ramaiah Hospital was formed solely for placement purposes, rather than being an ongoing partnership focused on capacity building, health system development and sustainability. This meant that there were no existing networks, relationships, experience or knowledge to build upon. There were also no PVs on the ground to support the project's development or the students on their placements. The India placements offered more a more formal and rigid structure and far less flexibility for the students since the placement timetable, accommodation and transportation were all prearranged by M.S. Ramaiah Hospital with relatively little input from the UK project management team. In effect the placements were organised as a 'package' put together by the India leads and charged to the UK project.[14]

During the in-country induction, each UK student was paired up with an Indian 'buddy' whose role was to provide support and guidance during placements. The buddy system worked very well in most instances. All the buddies were studying similar courses to the UK students at M.S. Ramaiah Nursing School, and this enabled them to exchange knowledge and experience; they were particularly instrumental in overcoming language barriers and would translate conversations between doctors, nurses and patients. The UK students and their buddies often formed friendships, which gave them increased insights into each other's lifestyles and

[14] The package provided by M.S. Ramaiah was priced at £850 per student to include in-country accommodation, transport, supervision and food.

cultures. Socially, the buddies played a useful role in showing the students around the local area and advising them where to buy food and clothes.

The first two weeks of the placements were spent in M.S. Ramaiah Hospital, a large non-profit private hospital, where students observed on wards and in operating theatres alongside their buddies. Throughout the placements, the students were wholly supervised by local medical and nursing staff. Students were rotated through many varying hospital departments, offering wide ranging of clinical exposures. Students followed a prescheduled timetable whilst placed in the hospital, spending each morning in one location and rotating to a different location in the afternoon. Students were collected from their accommodation by bus at 08.15 each morning to begin their placements at 09.00. They were allowed 45 minutes for lunch then finished at 16.30 when they were returned to their accommodation. All the placements in India were observational only and the students were not permitted to engage in any hands-on care of patients. There were two main reasons for this; first, as the hospital environments were less familiar we could not guarantee a sufficient level of supervision for the students and therefore needed to avoid the risks related to lone-working. Second, the regulatory environment in India tends to be stricter than in Uganda. Both project management and Indian colleagues were keen to minimise the risk of litigation against the students arising from medical negligence or malpractice. This was made clear to the students during the induction process. However, the vast majority students expressed a strong desire in their feedback for hands-on clinical placements, stating its anticipated benefits for their own learning and their sense of efficacy and desire to 'make a difference' as the following quote illustrates:

> I just feel I could have contributed so much more if we were allowed [to engage in hands-on practice], it felt awkward just standing and watching when we could have been helping at least with basic, routine care like wound dressings and changing beds which we do all the time in the UK. (Adult Nursing student)

The second two weeks were spent attending the Gokula Education Foundation 'Winter School'. This was a formal residential school which took place in a rural town called Kaiwara. The 19 UK students were split into groups of four or five, within which they worked alongside a large number of medical students from M.S. Ramaiah's School of Medicine to

conduct a wide range of projects designed to benefit the local community. Such projects included designing hand hygiene protocols and conducting training in infection prevention and control; devising plays and fun activities to deliver healthcare messages to small surrounding villages and schools; assisting local clinicians with patient assessment and treatment during health camps and assessing safe water collection and storage protocols. All the students appreciated being able to experience both placement locations and being able to compare and contrast the urban and rural settings. Each location offered differing placement activities, health facilities, cultures, environments, accommodation, placement groups and patient demographics. As with the placement in Bengaluru, all the accommodation, transport arrangements and placement activities were organised by M.S. Ramaiah through their Gokula Education Foundation.

Leisure and Free Time

It was made clear to all students in both Uganda and India that the evenings and weekends could be used for their personal leisure and free time. The activities that the students completed during these times depended on their location, personal preferences and finances. In Uganda, the majority of students completed tourist activities such as safari trips, mountain hiking, touring crater lakes and visited a variety of sights and attractions. In India, the students went on an organised visit to a temple at Mysore, attended a traditional Indian wedding and visited local tourist attractions within Bengaluru. The students were allowed to take part in any activity provided it was covered by the insurance policy, was not judged to put them at risk and did not negatively affect their formal placements. Completing such leisure and tourist activities was found to be greatly beneficial to the students as it allowed them to relax, experience more of the culture and environment within the LMIC and generally improved their happiness and wellbeing. The only instances in which the project managers were required to intervene concerned students consuming excessive amounts of alcohol whilst socialising in bars and clubs in the local towns. On two occasions, students were warned that their behaviour put them at personal risk and that continuing to engage in such behaviour might lead to disciplinary action. As a result, an additional clause was added to the student placement agreement regarding the

consumption of excessive amounts of alcohol and the potential risks and consequences.

Some students wanted to prolong the duration of their placements to allow for personal holiday time and this was permitted and flights were arranged accordingly. However, the students were required to pay any additional airfare and had to agree that any extra time spent in the placement country before or after their official placement was undertaken completely at their own risk and expense since the project would take no responsibility for them and they would not be covered by the University's insurance policy.

Placement Costs and Student Contributions

The first five cohorts of students who completed their placements in Uganda and India over the course of 2015, with the exception of the self-funded students, received full funding. This covered the cost of flights, accommodation (including free Wi-Fi), visas, 'in country' airport transfers, placement transport, insurance, supervision and pastoral support, an emergency mobile phone with a local sim-card and a small amount of airtime and, in the Ugandan placements, a direct investment of £150 per student into the local host health facility. The only costs that these students faced personally were for vaccinations, antimalarial prophylaxis, UK airport transfers, food, drink, tourism and leisure activities. Only one student out of 52 in this group reported experiencing difficulties in raising sufficient funding to be able to complete a placement, although this was mainly as a result of family circumstances and them having to support a dependent family member using the income from their part-time job.

A decision was made in January 2016 to ask students to contribute £395 towards the cost of their placements. This decision was made following student feedback which indicated that the students themselves thought they should be required to contribute something towards the placement costs. The figure of £395 was determined by the students as they deemed this amount to be affordable and fair given the experience they were having and the relatively small costs they were incurring. Of course, the introduction of a student contribution improved the project's cost efficiency and meant placement opportunities could be offered to a greater number of students. It was also felt that asking the students to make a relatively small

contribution would dissuade those students who were more interested in exploiting the attractive offer of a 'free' international trip without actually being committed to the objectives of the project. A number of complaints were received – from both a local host organisation and fellow UK students – about some students (who did not make a contribution towards the cost of their placement) who did not seem to care much about their placements and instead were more interested in taking photos with children for their social media pages or engaging in tourist activities. It was found that students who did make a contribution towards the cost of their placement demonstrated higher levels of interest, motivation and engagement with the project which led to improved outcomes both in terms of students' learning and also the impact they had on the hosting facilities.

Students in the nursing, midwifery and allied health professions were generally less able than medical students to draw on personal and family resources to fund electives; they were a more diverse group and many had families and undertook paid work to support their education. A small but significant number of these students could not have engaged in the placement if they had to contribute large amounts, although even these students said they would be able to fund £395 if they had around six months' notice and/or support with fund raising and applying for travel bursaries.

In total, 86 of the 111 students had their placements funded by Health Education England; of these 52 were fully funded and 34 made a contribution of £395 to K4C. The remaining 25 students completed the placements on a self-funded basis at a cost of £1495; however, 13 of these received bursaries of £1000 from the aforementioned contributions received by K4C, meaning they each contributed only £495. A large number of the self-funded students and the students who made a contribution are known to have received bursaries or travel grants from external sources, such as University student support services, to fund all or the majority of the cost of their placements. The figure of £1495 has been assessed to cover the full cost of each student placement in both Uganda and India based on a group of eight students travelling on four-week placements every month (not including the cost of UK project management time). Larger group sizes can achieve cost savings as a result of economies of scale in relation to student induction, airport transfers, in-country transport and accommodation (plus PV supervision in Uganda). However, the main cost of each placement is the flight cost which remains fixed between £450 and £650, becoming higher at peak times in the year (Fig. 2.1).

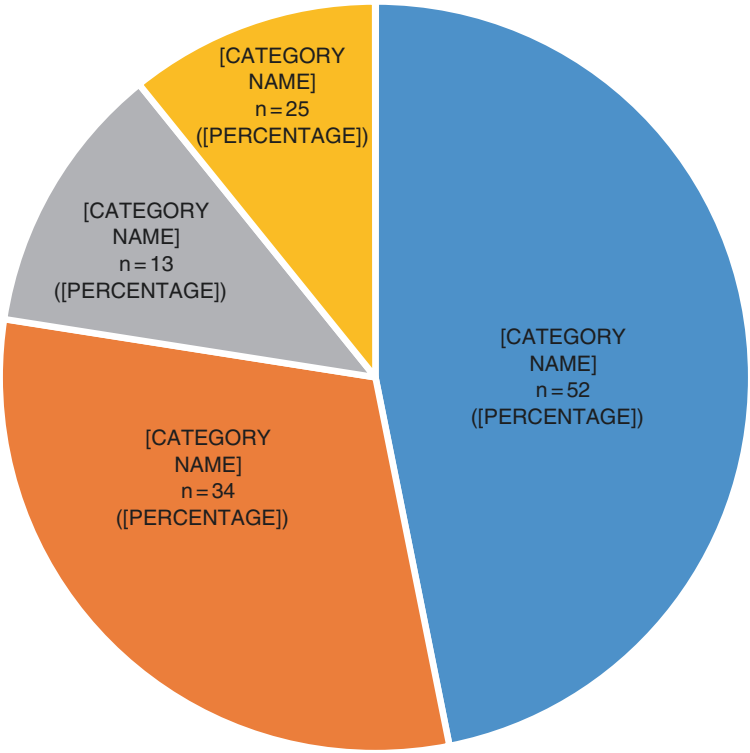

Fig. 2.1 Placement funding. *Source*: Created by the authors

Project Evaluation

The fact that both the educational placements project and the wider health systems intervention in Uganda is based in an established research group (Knowledge and Place) at Salford University has supported high-level evaluation. The evaluation has taken a complex multi-method approach combining qualitative and quantitative methods. All of the data collected has been anonymised, coded and analysed using Nvivo10 software. A grounded approach was followed in generating a node framework, into which all qualitative data was imported and coded. The main sources of data collected during the EEP evaluation are summarised below:

- Weekly reports during placements.
- Comprehensive end of placement reports by all students.
- Pre-, mid- and post-placement interviews with all students.
- Post-placement survey sent out to all students.
- Interviews with UK HEI programme leaders.
- Interviews with Professional Volunteers (Uganda only).
- Interviews with staff in hosting LMIC facilities.
- Reports from staff in hosting LMIC facilities.
- Observations by UK and LMIC project management, evaluation staff and post-doctoral researchers.
- Transcribed focus groups, meetings and workshops with students, LMIC hosts, PVs and project management.
- Email communications between project management and PVs, students and hosting LMIC staff.

The pre-placement interviews aimed to assess how the students thought they would benefit from the placements and how these expectations related to their programme of study. They also focused on the financial implications of the placements and identified any areas where students may require additional support. The mid-placement interviews addressed practical issues such as placement logistics, supervision and student wellbeing; this informed the evaluation of the difficulties faced by students whilst on placement and the nature of pastoral care required to remedy any concerns. As the mid-placement interviews were carried out after just two weeks of the students being on placement, they did not focus so closely on learning outcomes or the impact the students perceived they were having on the LMIC. The post-placement interviews were carried out roughly a month after the students had returned to the UK from their placement. A month was found to be an appropriate delay before conducting the post-placement interviews as it gave the students the opportunity to settle back into regular life and reflect more clearly on their placements. Before, during and immediately after placements, students were sometimes overly focused on the short-term problems and stresses experienced over what was often a highly emotional four to six-week period for them, such as group dynamics, traumatic experiences and fatigue. Many students explained how their thoughts and feelings about their placements had changed hugely once they had had time to think and reflect properly, usually becoming more

positive and continuing to do so the longer the time that elapsed after the placement.[15]

The weekly reports included questions about the students' general wellbeing, their roles and activities completed during the week, their learning and personal development, the extent to which they had been working under supervision and alongside UK and LMIC colleagues and any issues of concern they might wish to raise. The purpose of the weekly reports was two-fold; they informed the overall project evaluation and also provided an opportunity for students to raise any concerns which then enabled project management to take immediate action or make changes to placements. Many students used the written reports as useful form of reflection on the challenges they had faced during the preceding week and the actions they planned to take the following week to prepare for, avoid or overcome them. Similarly, the comprehensive end of placement student reports prompted the students to think back over their placement as a whole to summarise successes, achievements and challenges, and to provide productive feedback to inform necessary changes and improvements to the EEP.

The post-placement survey was designed using Survey Monkey and was disseminated to students over WhatsApp by means of a web link (Appendix 2). The survey was relatively short, comprised of only seven questions which aimed to collect quantitative data on the impact that the placements had on the students' learning, their future career and employability and on the LMIC. The survey also asked the students to rate their overall placement experience. Sixty-five responses were received in total when the survey was circulated in October 2016, which represented a response rate of 59% of the 111 students that completed placements.

Interviews were also conducted at regular intervals throughout the duration of the project with PVs and local hosting LMIC stakeholders. The main focus of these interviews was to establish the impact the student placements were having on the hosting LMIC and their constituent facilities, staff, health workers and patients. Interviewees were asked about both personal and professional impacts, as well as the impact they perceived the EEP to be having on their organisations and the health system

[15] Further research on the long-term impacts of midwifery placements is currently underway as part of Natalie Tate's doctorate; this will involve repeated interviews at six and twelve months post-return.

in general. The impact on the PV in terms of their learning, professional development and the impact their placement might have on the UK NHS was also evaluated (see Ackers and Ackers-Johnson 2016).

Summary

This chapter has described in some detail the operationalisation of the undergraduate educational placements that we have been involved with. The EEP model has evolved over time in an evidence-based fashion building on the experience of the Sustainable Volunteering Project and our experience then of managing a placement whilst also observing students on placement from other institutions across the world and the UK. We have included in this discussion the organisation of placements in India specifically requested by Health Education England. Having outlined the organisation of these placements and students' response to this, the following chapters move on to consider the outcomes and impacts associated with these kinds of placement.