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What are the main influences on short-term international
healthcare volunteering in two sub-Saharan African countries?
An ethnographic approach.

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PgCert (MedEd), BDS (Hons), LLM

Submitted in fulfilment of the requirements for the Degree of
PhD

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Abstract

Introduction: Short-term international healthcare volunteering (IHV) in sub-Saharan Africa (SSA) is an under-researched area within academic literature. Much study of the IHV phenomenon in the region focusses on a Global North perspective underpinned by reflections, stories and case studies written by returning volunteers and donor organisations. IHV is a multi-faceted phenomenon which has had a mixed response (Green *et al.*, 2009) with contention from some that it does more harm than good (Bauer, 2017).

Methodology: The IHV phenomenon in two SSA countries was studied by an ethnographic approach in which I as primary researcher used an interpretive paradigm and hermeneutic methodology to give a “thick description” (Geertz, 1973, p.6). Data collection was primarily by participant observational study on four fieldtrips located in the two SSA countries mostly observing IHV programmes with two different IHV non-governmental organisations (NGOs). Data was analysed using thematic analytical principles as first described by Braun and Clarke (2006) and enhanced by Kiger and Varpio (2020). Reflexivity was embedded into the research by maintenance of comprehensive reflective field notes during fieldtrips. There were no pre-defined themes. Data was open coded and themes identified, which following recursive reflection selected three groups of inter-linked themes that best answered my research question given the compromises, exclusions and limitations of the research.

Results: The main influences on IHV in the two SSA countries are the interlinked themes of collaboration, sustainability and dependency; cultural competence and cultural tension; power, hierarchy, respect and neo-colonialism. Three chapters of this thesis discussed and critically analysed each of the interlinked themes in detail.

Conclusions: Several conclusions were identified for each of the interlinked themes including seven principles for cultural competence and cultural tension for use in IHV in SSA. My research gave general recommendations together with recommendations that may raise awareness of and better embed an African perspective in IHV in the two SSA countries. Many areas of the IHV phenomenon in the two SSA countries require further research for which recommendations are suggested.

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Preface

I have written this thesis titled *What are the main influences on short-term international healthcare volunteering in two sub-Saharan African countries? An ethnographic approach* following several years of research in this area and based on many years of involvement within short-term international healthcare volunteering (IHV) in sub-Saharan Africa (SSA). I will provide full reasons why I undertook this research and how I developed my research question in *Chapter 2* of this work. For now, I will tempt the reader with an African proverb that helped stimulate my research journey:

Why be a goat when you can be a cow?

The source of this proverb is unknown. It was recounted to me, in conversation, by a wise and revered African¹ in a different context. They appeared to hope that the proverb would act as a *call to action* for me. The origin of the proverb is most likely from the Maasai people of Kenya and Tanzania. In the Maasai religion *Engai*, the Maasai deity, gave all cows in the world to the Maasai. Maasai can and do survive off goats, but cows are both revered and are a symbol of success for the Maasai. Many other cultural groups in SSA have adopted this differing construct of the relative importance of goats and cows and apply it to many aspects of life. For me I had to undertake this research otherwise I would remain a goat when I felt that I and the proverbs speaker believed that I had potential to be a cow.

My thesis takes an appropriate structure for the type of interpretive approach to research that was undertaken. In consequence there is no standard literature review nor is there a separate results section. I have done this as my raw data was subject to informal analysis from the start and more formal analysis later and as indicated by Cohen (1987) the selection of data is a form of analysis. Furthermore, there is a lack of firm boundaries between data and analysis as:

¹ This refers to person SEM1B. Please note that I am using a person-indexing system throughout this thesis that is explained in Appendix 1.

There is no *hermetic* seal between data and analysis, since data is only meaningful insofar as it has been in some way analysed. (Dowie, 2002, p.10).

My engagement with relevant literature is mostly located in *Chapter 1* titled *International healthcare volunteering*. *Chapter 1* also sets out the detailed aims and objectives of my thesis in Section 1.12. There are further significant interaction with published works being related to my methodology in *Chapter 2* titled *Background and methodology*. *Chapter 2* additionally addresses the formulation of my research paradigm and development of my research question. Literature features in other chapters as necessary but from the outset in *Chapter 1* my data and results findings are stitched and weaved through all chapters with appropriate discussion and analysis except for *Chapter 2* where results feature minimally. That said my main engagement with the results of my interpretation of the IHV phenomenon in the two SSA countries, which look at the main influencing and interlinked themes, appears in *Chapters 3, 4 and 5*. These three chapters are derived from my interlinked themes and represent a large part of my account which answered my research question. See a brief chapter synopsis of the remaining chapters below:

Chapter 3: This chapter presents the interlinked themes of collaboration, sustainability and dependency as they influence IHV in the two SSA countries . The chapter discusses the coexistence of sustainability and dependency in the IHV phenomenon in the the two SSA countries. It suggests the importance of collaborative networks in IHV and the two SSA countries to *inter alia* better enhance sustainability and better tolerate dependency. It gives suggestions on how to better embed sustainability in IHV in the the two SSA countries.

Chapter 4: This chapter discusses the interlinked themes of cultural competence and cultural tension as main influences in answering my research question. This chapter will give a significant amount of context regarding African culture to better situate these themes. As well as discussing cultural competence, and its counterpoint cultural incompetence, links to cultural tension are an important part of this chapter. The chapter debates some potentially inflammatory areas like ethnicity and racism in IHV together with dealing with aspects of trust

and suspicion. The chapter highlights the importance of good relationships amongst IHV actors and collaborators and explores how to improve them.

Chapter 5: This chapter presents the interlinked themes of power, hierarchy, respect and neo-colonialism as main influences on IHV in the two SSA countries in this chapter. The chapter gives context for the reader in all these areas but is particularly focussed on giving context regarding hierarchies in IHV and in African health services. Similarly, I give significant context around neo-colonialism. The chapter discusses the intimate links between these themes and how respect, which permeates African culture, underpins these interlinked themes. The chapter concludes with evidence and suggestions regarding decolonization strategies for IHV in the two SSA countries .

Chapter 6: My final chapter presents my research conclusions, implications, recommendations, suggestions for further research and how to better embed an African perspective in IHV. In addition, I present a critical reflection on thesis findings. My conclusions should be considered as a partial answer to my research question. They do not show a complete interpretation nor claim to list *all* the main influences of the IHV phenomenon in the two SSA countries. To give the reader a preview of my conclusions and recommendations the findings of my research lead me to suggest the formation of collaborative networks, the adoption of inclusive and collegiate leadership and promotion of positive interactions within the IHV phenomenon. I recommend the need to embed sustainability into IHV programmes and adopt key principles regarding cultural competence and cultural tension. Furthermore, I suggest that IHV interest-holders try to redress power imbalances and reflect on perceptions of neo-colonialism in the IHV phenomenon. When considering further research areas, I have had to be selective as IHV in the two SSA countries is an under-researched area. Thus, my suggestions represent my analysis of the priority areas based on my conclusions, implications and recommendations of this work.

This thesis has seven appendices. The first five appendices arise from the audit-related criterion of rigour set out by (Lincoln and Guba, 1985) which I will return to in Section 2.3.2. *Appendix 6* gives evidence of my ethical approval for this study from the University of Glasgow College of Medicine, Veterinary Medicine

and Life Sciences (MVLS) ethics committee for this research. Ethical considerations are further discussed in Section 2.3.1. *Appendix 7* relates to a set of principles derived from one of my interlinked themes which represents a *coda* to my work as a whole. *Appendix 1* details a list of participants, who are the subjects I observed and who were quoted or referred to in this thesis or in an appendix. This gives an indexing system meaning speech and reported speech can be attributed to an actor or their role(s). The person whom I am quoting or referring to is indicated by their identifier in the footnotes. Furthermore, in this appendix I list the persons that I purposively sampled for closer observation and my reasons for observing these individuals in more depth. *Appendix 2* details my document indexing system and inventory for data. Reported or quoted speech or where I paraphrase data will be indicated as footnotes so the document, page, and line numbers or footnote number of where this can be found in the *data corpus* are indicated. *Appendices 3, 4, 5, 6 and 7* set out how these interlinked themes were arrived at. *Appendix 3* gives the reader an example of how I coded my data and of my reflexivity as the coded data contains reflective coded field notes. *Appendix 4* shows how I organised my coded data around a specific code. In the example provided I use the code *respect* which later became an integral part of answering my research question (see Sections 5.2 and 5.5). *Appendix 5* gives my list of codes that I derived from the data. The list of categories together with the workings of my deductive approach to arrive at potential themes can be found in Section 2.3.7 together with several tables that concisely illustrate the workings.² How I arrived at my final selection of interlinked themes is also seen in Section 2.3.7 again showing more evidence of my deductive approach to final theme selection and further illustrative tables.³ These appendices and detailed workings and tables show my progression from data to codes to categories to themes and to a final selection of interlinked themes. This will give not only an audit trail but hopefully this will further enhance the validity and dependability of my study for the reader. *Appendix 7* presents, in a shortened pictorial form (for ease of display and dissemination), seven principles for cultural competence and cultural tension in IHV in the two SSA countries. These are presented in Section 6.3 in full. Finally, there is a *Glossary* which translates for the reader words in this thesis, including appendices and within footnotes, that are written in non-English languages.

² See Tables 5, 6, 7, 8 and 9.

³ See Tables 10, 11, 12, 13 and 14.

My first chapter provides a focused background to the research question and interacts with relevant literature sources. However, my interaction with literature is not comprehensive as there are gaps within the literature and I have had to make decisions to limit engagement to those aspects of the literature that are most relevant to my research question. I chose to highlight an African perspective when studying the IHV phenomenon in the two SSA countries for reasons that I will discuss in Chapter 2, and this has meant that some data collected and analysed that is more relevant to other aspects of the IHV phenomenon has been discarded from the final write up. However, an African perspective is only one feature of the IHV phenomenon in the two SSA countries, so where relevant other important influences are discussed at length.

My study was affected by the Covid-19 pandemic both directly and indirectly by cancellation of a fieldtrip and opportunity to further study the IHV phenomenon in the two SSA countries in a much-changed world where IHV faced much uncertainty. Where appropriate my thesis will include aspects of the IHV phenomenon from during and after the Covid-19 pandemic that are pertinent to answering my research question.

As is evident from my preface thus far, it is my intention that this whole thesis will be written in the first person. Writing in the first person enhances my subjectivity and reflexivity in the writing process and brings to the project my perspective as the researcher more clearly. The empirical research in this study was based on a hermeneutical approach to interpretation as I had increasing and significant insider leadership roles within the IHV phenomenon in the two SSA countries. This meant that for me my methodological approach was that I, as the researcher, aimed to produce a valid and reflexive partial account in answering my research question given the role conflict, limitations, exclusions and compromises that I had to make to opportunistically study the IHV phenomenon in the two SSA countries primarily by fieldtrips to those countries. This methodology will be discussed deeply in *Chapter 2*.

My main data collection method was by participant observation with neither ethnographic interviews nor focus groups being conducted, the reasons for which I

will discuss in *Chapter 2*. This meant that much of the reported speech is constructed from memory. I took great care to write up this reported speech every day during fieldtrips to ensure accurate transcription and data validity. Inevitably there will have been some minor lapses. Therefore, reported speech will generally be in *italics* with an *absence of quotation marks*. On occasion, I had access to some direct speech⁴ which will be in *italics with quotation marks*. I will return to the validity of reported speech in Section 2.3.5. In some other situations, for example *Zoom* meetings, I took handwritten notes at the time of speech. This was usually impossible during fieldtrips given the onerous nature of my participant role.

For confidentiality and other reasons, I have gone to considerable lengths to disguise and perhaps even confound the reader by not identifying many things that would usually be identified. For example, the two SSA countries that were the loci of the fieldtrips are not specifically identified. The two countries had much commonality in terms of rural-urban split, health services and structure and interactions with IHV. Where there are variations in the data between the countries, I refer to *Country 1* and *Country 2* but otherwise I do not identify them. I acquired a minimal amount of data from three other SSA countries⁵ that I briefly refer to in this thesis. They are identified as *Country 3*, *Country 4* and *Country 5*.

Additionally, I predominantly⁶ use non-gendered pronouns such as *they* and *them* save for a small section in *Chapter 5* where I specifically discuss gender equality in IHV. I did this to reflect that many African languages do not have genders at all, and others use genders minimally⁷ as people were defined by their community roles, age or respect rather than gender in African society (The African Alliance, 2025). Gendered pronouns were imposed on Africans by colonial masters within a Western-styled education system who felt that one reason Africans were considered primitive was that they did not conform to Western gendered norms (Jallow, 2025). Over time binary pronouns have become more used in Africa which

⁴ Usually from video recordings made by IHV actors or interest-holders for use on social media or websites.

⁵ This data was acquired by participants informing me of the efforts of a non-study IHV NGO in *Country 3*, a pilot project that NGO 1 had undertaken in *Country 4*, and an NGO working in a similar field to NGO 1 in *Country 5*. Whilst small in quantity the data was rich in quality.

⁶ On some occasions I use gendered pronouns for the necessity of accurately reporting speech. I additionally use them in Appendix 3 and 4 which contains some of my actual raw data and coded raw data.

⁷ For some examples: *Yeye* (Swahili), *En* (Luo), *Ó* (Yorùbá), and *Yena* (isiXhosa) refer to both he and she (The African Alliance, 2025).

could be seen by some as a product of colonialism or later neo-colonialism. In highlighting an African perspective in this thesis, I felt it helpful to foreground the African perspective in my writing style. I do identify male and female in my list of participants which can be found in *Appendix 1* with the third letter of the unique identifier being *F* or *M* for *female* and *male* respectively.

In this thesis I refer mostly to health and health workers rather than the specific health profession of study. I use ranks such as *senior*, *middle grade* and *lower* to identify hierarchies rather than profession specific titles such as *consultant* or *specialty doctor* or *student nurse*. Many quotations or paraphrases of quotations will have the word *redacted* somewhere in a sentence, for example *redacted surgical procedure* and the organisations primarily studied remain unidentified with variations in data being identified as *NGO 1* and *NGO 2*. That said, I provide both a more detailed explanation justifying this and other redacted elements in Section 2.3.1 of this thesis. This does mean that the flow of the thesis can sometimes be interrupted by, for example, the inherent clumsiness of redactions and longer role titles of those observed which may irritate the reader. I feel that these modifications are entirely justified to facilitate considerate, culturally appropriate, and confidential discussion of potentially controversial subject matter that helped me answer my research question.

I give sufficient background and context regarding my own participant (non-researcher) roles (see Table 1). I detail further contextual information regarding the study IHV NGOs (see Table 2), basic details regarding the two countries that were the loci of my fieldtrips (see Table 3) and contextual information regarding the four main fieldtrips in this study (see Table 4).

My project involved opportunistic study, and the data is weighted more heavily in terms of both Country 1 and NGO 1 as three of my four fieldtrips were located in Country 1 where I participated in IHV programmes with NGO 1. Additionally, I had more participant roles within NGO 1. The fieldtrip I had cancelled due to the Covid-19 pandemic should have been in Country 2. That said most of my post-Covid-19 data is from Country 2, where I was involved in a collaboration with both NGOs. Additionally, I had more opportunities at a higher strategic level in IHV, for example, meetings with government decision makers in

Country 2, including senior representatives from Country 2 visiting the fourth fieldtrip in Country 1.

I refer in my study sometimes to Africa(n) and sometimes to SSA. These are strictly speaking not interchangeable terms, and I define SSA in Section 1.1. However, I use the term African as a person does not call themselves a sub-Saharan African in daily conversation. The reader should be aware that when I refer to Africa(n) or SSA my meaning relates to SSA, unless specifically stated and makes no claim to include the United Nations (UN) region of Northern Africa.

One nuance that is important to understand is that some IHV actors whom I observed, particularly but not exclusively Africans⁸, had multiple roles within health services, IHV, regulators, health professional associations and government etc. In some cases, they separated their roles entirely. I call this the *Local Hero effect* which relates to the film *Local Hero* (1983) where the character Gordon Urquhart⁹ separates his roles as *inter alia* hotelier, taxi driver and accountant, adopting at times a different persona and/or approach for each role. I have reflected this change in persona/approach in the IHV phenomenon in my list of participants so the person and their role, at the time of observation, is noted (see *Appendix 1*).

All citations and references in this thesis are written in the Harvard referencing style. Specifically, citations and references are based on the guide used by the University of Sheffield (2023) which in turn is based on advice given by Pears and Shields (2016) in their tenth reviewed and expanded edition regarding citations and references in academic writing. In this thesis I make considerable use of footnotes. This is largely to attribute participants to speech and reported speech and to signpost where data can be found in my indexing system.¹⁰ The style of my footnotes is based on the Chicago manual of style (University of Chicago, 2017). I commonly refer to myself in this account as AP (Andrew Paterson). This occurs frequently within footnotes.

⁸ I, for example, had multiple roles in IHV in the two SSA countries during this research. See Table 1.

⁹ The character Gordon Urquhart was played by the actor Denis Lawson. The role separation is best viewed between 22 minutes to 25 minutes into the film although it is seen at various times throughout the film thereafter.

¹⁰ See Appendix 1 and Appendix 2.

I hope that the reader finds this account of the IHV phenomenon in the two SSA countries clear and interesting with enough context and background to understand my research perspectives. Above all I hope that this account does justice to answering my research question and adds to better and deeper understandings of the complexities of the multi-faceted IHV phenomenon in the two SSA countries.

Dedication

To Libby, my wife, to my children, Calum, Matthew, Ross and Sarah and to my grandchildren, Cameron and Blair.

To the memories of my father, James Paterson, and my mother, Marjorie Paterson who raised me in Africa and inspired me to serve.

Acknowledgements

Professor Al Dowie (Medical Ethics and Law) and my supervisory team were extremely supportive, constructive and patient supervisors to a (very) mature student who have my utmost respect and gratitude. Professor Andrea Sherriff (Epidemiology and Statistics) and others who reviewed my progress gave me much moral and practical support during difficult moments which was much appreciated. I would like to thank one of my current work colleagues for taking some of my workload and thereby granting me the precious commodity of time to complete this thesis, and in doing so, burdening them. I would like to thank many colleagues and professional services staff from the University of Dundee and NHS Tayside (my former employers) and the University of Glasgow and NHS Greater Glasgow and Clyde (my current employers) for their help and support in the facilitation of this research.

I am very grateful to the Royal College of Physicians and Surgeons of Glasgow who granted me an award which helped me with travel expenses for one of my fieldtrips to SSA. Much of the inspiration that I had to undertake this research came from informal discussions with other IHV actors from throughout the Global North and SSA before, during and after previous IHV programmes on ways to improve the IHV phenomenon in the region.

Above all I am extremely grateful to the many individuals and organisations in both the Global North and in the two SSA countries who were involved in the IHV phenomenon during my studies for their openness, hospitality, support, knowledge, encouragement and wise counsel and for making my research journey and experiences enjoyable. Confidentiality does not permit me to name them but despite being nameless in this thesis you all have my thanks. I am thankful to Ross Paterson for supporting and improving my information technology (IT) knowledge and skills. I am grateful to Sarah Paterson and Matthew Paterson for formatting advice, proof reading and constructive comments that enabled me to improve. Finally, I would like to thank my family for always being supportive and keeping me in good spirits throughout the duration of this research.

Author's declaration

I confirm that this thesis is entirely my own work except when I refer to the work of others or quote from the work of others.

Andrew James Paterson

17th May 2026

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AP	Andrew Paterson, Author of this thesis and researcher in this study
CAQDAS	Computer Assisted Qualitative Data Analysis Software
CBO	Community Based Organisation
CEO	Chief Executive Officer
Country 1	SSA country which was a locus of study in this research in 3 fieldtrips
Country 2	SSA country which was a locus of study in this research in 1 fieldtrip
COVID-19	Coronavirus Disease 2019
CPD	Continuing Professional Development
CSR	Corporate Social Responsibility
FBO	Faith Based Organisation
FOCAC	Forum on China - Africa Cooperation
GNHV(s)	Global North Healthcare Volunteer(s)
GDP	Gross Domestic Product
HEI	Higher Education Institution
HIV-AIDS	Human Immunodeficiency Virus-Acquired Immune Deficiency Syndrome
HV	Healthcare Volunteering
IHV	Short-term International Healthcare Volunteering
IT	Information Technology
LMIC(s)	Low-and Middle-Income Country/Countries
MDG(s)	Millenium Development Goal(s)
MOU	Memorandum of Understanding
MSF	<i>Médecins Sans Frontières</i> [also known in the anglophone world as: Doctors Without Borders]
MVLS	College of Medicine, Veterinary Medicine and Life Sciences, University of Glasgow
NCD	Noncommunicable diseases
NHS	National Health Service
NGO(s)	Non-governmental Organisation(s)

NGO 1	Non-governmental Organisation whom the researcher studied in this research
NGO 2	Non-governmental Organisation whom the researcher studied in this research
PEPFAR	President's Emergency Plan for AIDS Relief
PPE	Personal Protective Equipment
RHMT	Regional health management team
Rio	Political Declaration on the Social Determinants of Health
SDG(s)	Sustainable Development Goal(s)
SSA	Sub-Saharan Africa
TB	Tuberculosis
UEHV(s)	United Kingdom and European Healthcare Volunteer(s)
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV-AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UoA	Unit of Analysis
US	United States
USA	United States of America
VGS	Volunteer Graduate Scheme
VPO(s)	Volunteer Partner Organisation(s)
VSO	Voluntary Service Overseas
WHO	World Health Organization

Additional abbreviations within the footnotes of this thesis:

Fn.	Footnote
l.	Line
p.	Page

Please note that *Appendix 1 (List of participants)* and *Appendix 2 (Document indexing system)* have their own separate explanatory key to abbreviations used, to generate unique identifiers, at the start of each respective appendix.

CHAPTER ONE - International healthcare volunteering

Chapter Introduction

This chapter forms the basis of an account which dovetails with parts of the literature around the IHV phenomenon. Whilst this is the main interaction with published works, literature will be referred to throughout other chapters as necessary. Interaction with the literature will in part be by means of a commentary based on some of my findings from my research. The literature is by its nature incomplete with both continuities and discontinuities (including lacunae in the literature) as the phenomenon has many facets and nuances. I have had to be selective in including and exploring those areas that I feel are most pertinent to allow as full and complete appraisal of the phenomenon as possible balanced by the need to be concise within a thesis. For example, I have minimized significant discussions on international treaties and guidance pertaining to IHV as I have mentioned much on regulation within this forthcoming chapter, and this is likely to add little to further understanding.

Within this chapter some sections will refer to my own research and others infrequently or not at all as my research sheds light on only some sections discussed in the literature. Some of my findings discussed here, whilst important, do not warrant inclusion in my main theme chapters but are included as it helps for better interpretation of the phenomenon.

1.1 Definitions

There are many definitions of volunteering with no one consensus as to the most appropriate definition. Volunteering is one facet of a cohort of helping activities which include spontaneous help, volunteering and caring. It can be distinguished from spontaneous help which tends to be reactive whereas volunteering is proactive (Wilson, 2000). According to Snyder and Omoto (1992)

caring indicates a more obligatory relationship in a private sphere whereas volunteering is thought of as more formalized and public.

Wilson (2000) defines volunteering as:

Any activity in which time is given freely to benefit another person, group or organization (p.215).

This is an important broad definition as it presents volunteering as a predominantly altruistic act. More importantly it does not preclude the volunteer from benefitting from the volunteering.

The International Labour Organization (2008) define volunteering more specifically as:

Activities or work that some people willingly do without pay to promote a cause or help someone outside of their household or immediate family (p.16).

This reasonably well accepted definition can be criticised as it presents a Western cultural construct of volunteering which fails to fully consider cultural contexts in Africa. Firstly, it fails to consider the element of compulsion due to community and religious expectations and customs of service in African society (CIVICUS: World Alliance for Citizen Participation, 2011). Secondly, the notion of what constitutes a household or immediate family is variable within different cultures. Finally, volunteer work is work without monetary pay or compensation as were this to take place it would be paid employment. This has been qualified to allow some forms of monetary compensation, and the test is essentially as to whether compensation is *significant*. Thus, in some contexts, expenses, a stipend to cover living expenses, and symbolic compensation are permitted (International Labour Organization, 2008). This leaves grey areas as to whether the compensation is *significant* or not, which may vary in different locations. For example, food provision in a low-income area, which are commonplace in Africa, may be *significant* compensation.

With no consensus on definition and inadequate understandings of cultural differences volunteering may likely mean something different to individuals, communities, and policy makers in different parts of the world as can be seen by my research. Individuals from volunteer teams I have been part of during this research sometimes vocalise the notion between themselves that people from Africa do not volunteer and mostly expect something in return, usually money.¹¹ The view of some health workers and officials in the two SSA countries in this study is expressed as a belief that the international healthcare volunteer cannot really be a volunteer¹² as they even pay for their own food so must be being paid or even bribed¹³ because they themselves would not do this. Misunderstanding thus permeates the volunteer persona itself.

Healthcare volunteering (HV) is my preferred term to describe volunteering within the wider healthcare sector. Initially, medical volunteering, which is a term used widely, described volunteering undertaken by physicians and surgeons but nowadays encompasses the healthcare sector. I have used healthcare to be inclusive of volunteering from nurses, pharmacists, midwives, dentists, opticians and similar healthcare providers. I have however limited my study to look at formal HV where the volunteering is associated with an organisation or institution and where the main objective is focused on healthcare improvement or delivery or capacity building. This is similar to the limitations of definition proposed for a national HV study in the UK (Naylor *et al.*, 2013). I have however included capacity building, which was not included in that study as capacity building is both a focus of IHV in the two SSA countries and a prime objective of volunteering to aid implementation and planning of the UN Sustainable Development Goals (SDGs) (Moon, 2014).

The use of the term international implies that the volunteering takes place in a different country than the normal country of practice of the volunteer or volunteering organisation. This distinguishes the volunteering from national volunteering within health services of donor countries. It has been necessary for me to explore some aspects of national HV within SSA as these volunteers often

¹¹ Person SPM5 reports this in document F1M (p. 14, Fn. 36). Please note that I am using a document-indexing system throughout the thesis that is explained in Appendix 2.

¹² Person SYF1 reports this. See document F1M (p. 34, l. 3).

¹³ Person GVM4B informs this in document F1M (p. 38, l. 34-35).

interact with international healthcare volunteers and/or organisations who are working in their countries to obtain a more complete picture of the phenomenon.

SSA is defined as the region of Africa that is geographically located south of the Sahara Desert (McKenna, 2025). It comprises the UN geopolitical regions of Western Africa, Middle Africa, Eastern Africa and Southern Africa (UN Statistics Division, 2025). It does not include Northern Africa which has more Arab cultural influences. It is an ill-defined region as, for example, Sudan is partially in Northern Africa. Whilst SSA is a very diverse region culturally, politically, economically, and linguistically, it has commonalities of African culture and values.

There is no consensus on the difference between short-term and long-term volunteering. Some consider short-term volunteering to be up to a month (Volunteer World, 2025) whilst Loiseau *et al.* (2016) define short-term to be between 7 to 90 days. Loiseau's broader definition is more inclusive, and I have taken this to be more appropriate and relevant to the types of IHV that commonly occur and can be distinguished easily from long-term volunteering. There is some blurring in definition as often short-term volunteers will volunteer repeatedly or volunteer for IHV NGOs in longer-term projects that do not necessarily require presence within SSA, for example, production of training resources. I have included these activities within my definition.

1.2 Inequality in healthcare

It has been widely accepted for many years that health inequality between the Global North and Global South is huge as expressed by many health indicators such as life expectancy and infant mortality (World Health Organization (WHO), 2011a). Health inequality is at its most profound in SSA where the need for basic healthcare is significant as it has a burden of nearly 25% of global disease but only 2% of global health workers (Scheffler *et al.*, 2008).

This inequality remains in much of SSA despite the major initiatives of the UN setting Global SDGs, which include specific health goals that aim to ensure healthy lives for all (United Nations General Assembly, 2015). This is evident by looking at increased disease burdens for both communicable and noncommunicable

diseases (NCDs), which in the case of communicable diseases shows an increase in deaths of 23.8% in 2021 compared to 2010 (Global Burden of Disease Collaborative Network, 2021). Furthermore, health spending is lower in SSA than any other region of the world (Apeagyei *et al.*, 2024). Indeed, health spending is one fifth of the next lowest region (Middle East and North Africa) and is predicted to go down *per capita* over the next 25 years (Global Burden of Disease Collaborative Network, 2023).

It is however too simplistic a notion to talk simply of inequality in numerical terms. SSA has made great strides in tripling its health workers in the last 10 years (Ogodo, 2024) but poor employment prospects, lack of and/or poor facilities and poor retention rates of personnel means this capacity building is often not translated into the health improvements envisaged by the SDGs. In this study across all fieldtrips I undertook in the two SSA countries, without exception and at all levels of health services from regional hospitals to rural health posts, I found significant evidence of poor facilities, such as lack of basic infrastructure, pharmaceuticals and equipment.¹⁴ There were poor retention rates of staff of different cadres and health professions and in some cases evidence of lack of job prospects.¹⁵ The evidence was most concerning within rural areas where retention rates of staff were particularly poor with the recruitment situation often being desperate. In addition, health facilities in rural areas sometimes lacked clean running water, a reliable source of electrical power and buildings that were in disrepair. My experiences are not unique with similar in-country inequality in rural areas noted by Munga and Mæstad (2009) as extreme.

It is against this background of health inequality that affects SSA negatively that IHV can find a current legitimate role and purpose. This is because Section 45 of the SDGs empowers volunteer groups to work with governments and other interest-holders to help in the implementation of programmes that contribute to achieving the SDGs (United Nations General Assembly, 2015). I will now go on to

¹⁴ For an example see in document F2M the images (p. 43-44) and the comments (p. 42) of person GVM2A (p. 42, l. 12-13 and 33-34), person GVM5A (p. 42, l. 26-27) and person XVM1 (p. 42, l. 37-38) together with AP's summary comments (p. 44, l. 26-27) regarding the daily working conditions of person SHM3B. For a further example see my reported comments of a hospital manager (person SYM1) in document F4M (p. 36, l. 9-14).

¹⁵ For example, person SHM1B reports this in relation to senior health workers in document F4M (p. 75, l. 27-28); Person SHM4 reports this in relation to lower grade health workers in document F4M (p. 42, l. 19-20).

look at the history of IHV in Africa together with a brief overview of colonial history in Africa as this helps understanding of why IHV has developed the way it has today in the two countries and wider SSA.

1.3 A brief history of international healthcare volunteering in SSA

Before I examine historical aspects of IHV in SSA it is important to frame this within a brief overview of the colonial history of Africa. This is an immense subject so I have discussed only those aspects of colonial history that are important to my research question¹⁶. Colonialism is defined as the annexation and control of a nation or nation(s) by another nation (Ahmed, Umaru and Yusuf, 2022).

In the case of Africa all nations except Ethiopia¹⁷ and Liberia¹⁸ were subjected to colonial rule by Western European countries meaning that the colonial power dominated all socio-economic and political aspects of the colonised nation (Kastfelt, 1976). The driver for colonialism was primarily born in the industrial revolution and was likely the need to exploit Africa for raw materials and other resources (Ake, 1980). Whilst colonialism in Africa started around 1800, to reduce competition between nations the European colonial powers at a conference in Berlin in 1884-1885 decided to partition African territories with minimal reference to African interests (Brownlie, 1979). They paid scant attention to traditional authority or ethnic territories resulting in at least 177 ethnic groups being separated (Asiwaju, 1985). For example, the *Yorùbá* groups were split between French and British areas of West Africa (Asiwaju, 1976). It is estimated that only one-sixth of colonial borders in Africa accounted for ethnic demographics (Foucher, 2020).

¹⁶ For readers who wish to explore colonial history further a comprehensive account can be found in volumes 1 and 2 of the books edited by Gann and Duignan (1969).

¹⁷ Whilst there were strategic, geographical and cultural reasons that Ethiopia avoided colonization the most important reason was its military victory over the Italian colonial army at the Battle of Adwa in 1896. It was however occupied between 1936-1941 by the fascist Italian regime, being liberated with British support.

¹⁸ Liberia was established in 1822 by the American Colonization Society as a home for freed African American slaves becoming independent in 1847. It avoided colonization partly as it had limited economic interest for European colonisers and had a degree of political protection from the USA.

As colonialism split the African continent, the colonial powers ruled under different systems. For example, the British operated an indirect rule system to exploit African resources whereas the French and Portuguese tried to assimilate Africans into their cultures (Ake, 1981). The Germans and Belgians operated direct and paternalistic approaches emphasizing their belief of European racial superiority whilst trying to civilize Africans (Ake, 1981). After the first world war, Germany lost its territories, for example German East Africa¹⁹ became a British colony and Rwanda became a Belgian colony. The Belgians in Rwanda discriminated regarding relative racial superiority between *Hutus* and *Tutsis* creating divisions that were thought to be a later catalyst in the 1994 genocide (Schimmel, 2021). When African countries became independent in the 1960s, they inherited colonial systems in every aspect of life. They had borders that did not reflect traditional nations and experiences of colonial injustices that had left many people underdeveloped, impoverished, inadequately educated, and with distrust of foreigners. Whilst colonialism ended for most Africans in the 1960s neo-colonialism²⁰ remains an ongoing challenge in Africa (Murrey and Pouo Moutsouka, 2024).

Health was similarly dominated in colonial periods by colonial powers who set up health systems to meet the needs of European colonisers with indigenous peoples receiving inadequate and minimally funded healthcare (Bolt and Cilliers, 2025). Colonial health systems generally did not design or build larger scale health infrastructure with the first decades of colonialism failing to improve public health systems (Bolt and Cilliers, 2025). Later developments in public health did take place in some colonies with the reduction in tropical disease mortality being one of the few positives of the colonial period (Warren, 1980). Even when later colonial administrations tried to progress more comprehensive health policies many focussed on urban areas with a non-uniform approach to improvements across Africa (Patterson, 1981). It was within colonial rule and inadequate colonial health systems that IHV in SSA was first seen in the 1850's. I will now briefly explore the history of IHV in SSA.

¹⁹ Known after the first world war by the British as Tanganyika this forms along with Zanzibar the modern day United Republic of Tanzania.

²⁰ Neo-colonialism was found to be a major influence in IHV in the two SSA countries in this research. It is discussed at length in Sections 5.6, 5.6.1 and 5.6.2.

It is generally accepted that modern IHV in SSA has its roots with medical missionaries in the 1850's (Olanmi and Perry, 2006). The small numbers of medical missionaries at that time found that providing basic healthcare to indigenous populations allowed them access to populations that would then engage with their primary purpose as messengers of the gospel (Hastings, 1994). However, Cardinal Lavigerie, in the 1860s, is credited as the first to attempt to train Africans to meet the health needs of their own communities by sending indigenous students to study medicine in Malta (Hastings, 1994).

Volunteering spread slowly but Foster (2010) informs that during 1896 the Church Mission Society established a Ugandan hospital which he believed signalled the start of scientific medicine in Africa. By 1910, there were around 1000 medical missionaries in Africa (Hastings, 1994). Hastings (1994) further reports that many missionaries founded small mission hospitals which increased local capacity a little. Concurrently medical students started volunteering for overseas missions giving historical precedent to student volunteering (Olanmi and Perry, 2006). According to Bauer (2017) the profile of volunteering to SSA was raised by Albert Schweitzer who, in 1913, founded a hospital in Gabon in the belief that:

It was the Christian duty of a civilised society to send and support volunteering doctors in large numbers to *do good* among *the natives* (Bauer, 2017, p.1).

Schweitzer was a fervent promoter of volunteering to SSA, and Bauer (2017) further contends that his celebrity²¹ and romantic notions of adventure, fortitude and heroism encouraged many to volunteer.

However, I contend that volunteers, mission hospitals and economic development were unevenly and thinly spread and often directed paternalistically with little or no account for local needs. In my study I found examples of one-time mission hospitals being in sparsely populated areas leaving some more populated areas with no or minimal facilities, indeed one of my fieldtrips was partially based

²¹ Which included the Nobel Peace Prize in 1953.

in such a hospital.²² Furthermore, I observed that the effect of this historical development is evident by the frustrations of senior SSA health officials as they inform that many different IHV NGOs focus on the area closest to one-time mission hospitals. This is because they act as a safe base with reasonable facilities as they still receive funding from religious organisations. Thus, these areas are saturated with NGOs with some work duplicated, whereas neighbouring areas have minimal coverage yet more need.

For individual remote and rural communities, I argue that it was and sometimes remains often a matter of moral luck whether their community has access to appropriate healthcare. Olakanmi and Perry (2006) argue that this historical lack of volunteering focus in SSA is a factor in current lack of capacity in rural areas and has further led to many states having only one medical school and few public health resources.

As Christianity took hold in parts of Africa many Christian missions delegated evangelical activities to indigenous priests and instead focused more on medical and community development work (Olakanmi and Perry, 2006). In consequence there are many examples today of religious organisations being more involved in medical and community development rather than evangelism with *inter alia* Jewish, Muslim, and Christian charities actively promoting volunteering (Tevel b'Tzedek, 2025); Muslim Aid, 2025; International Christian Medical and Dental Association, 2025).

Governments started to become involved in medical work in Africa in the 1920's although this was not volunteering. The drive for these initiatives appeared to be that following formation of the League of Nations there was developing insight that some diseases were of international concern. Therefore, some governments started to coordinate international global public health initiatives (Bashford, 2006). Little changed in SSA until after the second world war when the creation of the UN and the WHO gave new direction to volunteering against priority healthcare issues, often disease specific measures towards diseases such as malaria and smallpox (Stern and Markel, 2004; Bhattacharya and Dasgupta, 2009). Additionally, researchers identified the need to extend research efforts, often in co-

²² See document F4M.

existence with volunteering programmes, to African populations. A classic example of this was Dennis Burkitt's seminal research which firstly linked Epstein Barr virus and malaria in what came to be later known as Burkitt's lymphoma (Burkitt, 1958).

Bauer (2017) contends that it is uncertain when secular medical volunteering commenced in SSA. Sobocinska (2017) though argues that it originated from the government supported secular development model of volunteering typified by the Australian Volunteer Graduate Scheme (VGS) in 1951. It is apparent that government supported IHV became widespread in the early 1960s in the form of *inter alia* the United Kingdom (UK) organisation, Voluntary Service Overseas (VSO) and the United States of America (USA) organisation, The Peace Corps (Sobocinska, 2017). Unfortunately, transnational cooperation was poor as each nation claimed credit for the development volunteering model with donor state interests sometimes taking precedence over recipient interests (Sobocinska, 2017). Whilst the USA recognised there were other countries involved in government supported development volunteering the Peace Corps, according to Hoffman (1998):

Symbolized what America wanted to be, and what much of the world wanted America to be: Superhero, protector of the disenfranchised, defender of the democratic faith (1998, p.1).

In this era the language around and naming of volunteer organisations started to construct a military feel to volunteering. The VGS founder was described as a "pioneer" and recipient countries were described as "frontiers" (Sobocinska, 2017, p.53 and p.56). This continues today, to an extent, and as I will discuss later in this thesis that this type of language in the IHV phenomenon may be perceived as neo-colonialism (See Section 5.6.1).

This plethora of organisations provided volunteers and finance to facilitate health education, support services and direct healthcare in Africa. Yet host countries such as Nigeria regularly criticised VSO and VGS and even set up an anti-Peace Corps movement (Sobocinska, 2017). This was the first overt sign that IHV can produce tensions between hosts and donors in SSA. At the time there was

uncertainty as to why IHV received this poor response, but I suggest that there are several common threads that may be involved. Firstly, volunteers who were often young and inexperienced were placed in positions of authority, secondly the notion that Western society is an ideal for all nations to aim for exhibits cultural discrimination and finally the distinction between developed and undeveloped left accusations of neo-colonialism. However, in this era volunteering priorities were primarily being directed by the Global North with interest-holders in SSA having minimal input into its health needs. Undoubtedly, organisations like the Peace Corps have evolved to better address current priorities and remain active in addressing SDG priorities like human immunodeficiency virus/acquired immune deficiency syndrome (HIV-AIDS) and maternal health but they perhaps remain partly tainted by their past.

In the 1960s many nations in SSA gained independence with concurrent conflict issues, with often negative consequences for health services. Olakanmi and Perry (2006) inform that for humanitarian reasons the WHO together with international groups like the Red Cross/Crescent filled healthcare vacuums. However, in a post-independence Africa there was a growing realisation that health was dependent on many factors other than targeting specific diseases. Global North government driven models and volunteering began to falter as in both the Global North and South opinion started to regard them as inefficient and sometimes morally dubious (Fox, 1995).

In consequence in the early 1970s small groups of individuals started to set up smaller NGOs with *Médecins Sans Frontières* (MSF) being an example of the first cohorts (Olakanmi and Perry, 2006). The formation of these organisations exemplifies the frustrations felt towards government-led volunteering at the time. MSF was established, initially in Nigeria, partly due to the Red Cross and the WHO's inability to manage public health and partly as the founders believed that the Red Cross had not taken a neutral stand during civil war (MSF, 2025). Free from government constraints and with inspirational leaders offering direct action these types of NGOs inspired many health workers to volunteer, and many NGOs grew rapidly throughout SSA.

I argue that NGOs like MSF started to conceive a more discerning form of secular volunteering that tried to dismiss political, cultural and religious boundaries and instead tried to prioritise the welfare of the needy. As co-founder Bernard Kouchner reportedly stated on later reflection regarding the founding of MSF in 1971:

It's simple really, go where the patients are. It seems obvious, but at the time it was revolutionary (MSF, 2025, <https://msf.org.uk/founding>).

Indeed, the appeal to health workers of this type of NGO volunteering model grew not least because it appealed to a diverse range of potential volunteers. For example, *Africare* was an African American led NGO, founded in 1970, which attracted many volunteers from the African diaspora (Denis, 2014). Whilst there was a rapid increase in numbers of NGOs in SSA, during this time problems soon began to surface. Some health needs were duplicated, and others simply were unaddressed. For example, Chambers (2010) argued that the lack of NGO interest in mental illness was awful.

With the HIV-AIDS pandemic of the late 20th century there was a global health crisis of unparalleled proportions with the disease burdens being predominantly in under-resourced communities in Africa (Joint United Nations Programme on HIV-AIDS (UNAIDS), 2006). I contend that HIV-AIDS starkly demonstrated global health inequalities by exposing the lack of health resources, capacity, and public health programmes in SSA for the rest of the world to see. The consequent international response to HIV-AIDS involved formation of supranational organisations like UNAIDS, national organisations such as the United States Global AIDS Program and the President's Emergency Plan for AIDS Relief (commonly known as PEPFAR) and an increase in private sector philanthropy of *inter alia* the Bill and Melinda Gates Foundation. HIV-AIDS in my view allowed predominantly government driven and funded volunteering to have a more influential role once more in Africa which had been more occupied for a time by NGOs. In many ways the HIV-AIDS pandemic allowed better coexistence of government funded and NGO volunteering. The effects of the more recent Covid-19 pandemic on IHV have yet to be fully assessed. It may though have altered the volunteering landscape with more virtual and less in-country programmes together

with funding difficulties, as throughout the Global North nations prioritise their own post-pandemic issues at the expense of international development.²³

The history of IHV in SSA is characterised by good intentions, paternalism and neo-colonialism modified by other factors such as conflict, structural political and socio-economic change, emergent disease, health inequality and cross-cultural tensions. Moreover, the history of IHV has involved a multitude of different types of government, NGO, secular and religious groups, and individuals being involved to varying degrees in IHV, in different historical periods. Throughout the history of IHV, there has regularly been a failure to understand and dovetail with the health priorities of local communities and governments in Africa. This historical development has resulted today in a multitude of actors being involved within a complex patchwork of organisations and individuals rather than being part of a purposeful collective with shared goals. I further contend that the modern potential volunteer is faced with a large choice of organisations competing for their skills. However, a lack of reliable information may mean that, in some cases, volunteers may choose programmes without either an adequate understanding of their aims and objectives or their potential harms and benefits. It is imperative therefore to examine volunteering organisations and networks in SSA.

1.4 Volunteering organisations and networks

Currently IHV in the two SSA countries and wider SSA predominantly takes place associated with government agency or NGO based organisations, although some government agency volunteering is long-term volunteering. An example of government agency-based volunteering is the Peace Corps which has a director appointed by the USA government, direct funding from government, and oversight from both United States (US) Senate and Congress committees who oversee its activities and direction (Peace Corps, 2023). There is no consensus on what constitutes an NGO except that it is generally considered to be:

A voluntary association of individuals who coalesce around common aims to promote collective benefit. It operates independent of government

²³ Both study IHV NGOs in my research are involved in online programmes that did not exist before the Covid-19 pandemic.

oversight or representation and usually operates on a not-for-profit basis
(adapted by me from Yaziji and Doh, 2009, p.4).

This definition does not preclude an NGO being in receipt of government funds usually by way of grants. Indeed, the study NGOs that I observed had received at some point either directly or indirectly grants from donor country governments.

Volunteering organisations operating in healthcare in Africa vary greatly. They range from the very large such as the UN Children's Fund (UNICEF) where healthcare and indeed volunteering is a relatively small part of their agenda to the small where a few individuals focussed on a specific issue in a specific area may be involved, such as the oral health NGO Smileawi, operating in Northern Malawi (See Smileawi, 2023; UNICEF, 2023). NGOs usually have specific areas of interest such as health education or resource allocation (Olahanmi and Perry, 2006). Some NGOs will operate on a cross specialty basis within healthcare, for example Mercy Ships whose model provides Western healthcare, training and capacity building for the indigenous population from large well-equipped hospital ships anchored off ports in Africa. Contrast that with the Vine Trust who operate a boat on Lake Victoria providing primary healthcare with limited resources to remote lakeside communities (See Mercy Ships, 2023; Vine Trust, 2023). Other NGOs focus on a specific disease such as HIV-AIDS (Phaswana, *et al.*, 2008) and others on specific specialist skill sets such as Smile Train Africa, which focuses on surgeries and training for cleft lip and palate (Smile Train Africa, 2023). The reality is that IHV NGOs are a heterogeneous collection of organisations that encompass a significant number and variety of healthcare skillsets. Most UK and European health workers will be able to relatively easily and successfully find an NGO to volunteer with in Africa. It was within NGO-based IHV in two SSA countries where this study was primarily located.

Confusing the literature is terminology relating to what constitutes an NGO. In healthcare volunteering (HV) within SSA an organisation can sometimes be primarily referred to as a Community Based Organisation (CBO) or Faith Based Organisation (FBO) rather than an NGO (Zihindula, *et al.*, 2019). A CBO is an organisation that generally targets a specific community or community group and a FBO is one that either is funded by or draws volunteers from or targets a particular

religious grouping. This does not preclude CBOs or FBOs from being NGOs given the broad, albeit not accepted by all, definition of an NGO seen above. For the purposes of this study the term NGO has been used with reference to community, faith and religiosity. I occasionally use the term FBO to add to specific interpretation.

Government based volunteering has the advantage of having designated budgetary funding for programmes rather than reliance on grants and donors. Using the Peace Corps as an example, the USA Government decides funding annually which is usually around 1% of the USA foreign operations budget (Peace Corps, 2023). It is unclear how governments make decisions as to where resources are targeted and the extent of host country involvement in those decisions, although there is evidence of local partner involvement. The Peace Corps for example targets five SSA nations for their *Advancing Healthcare Program* (Steindl, 2021).²⁴ This programme aims to focus resources on training and strengthening capacity in indigenous healthcare systems in these nations with volunteers going on one-year placements (Smith, 2020).

There are situations in Africa where volunteering is located within both a government and NGO network. To better explain this, it is important to look at an example that I observed. Scotland has a development assistance programme and small grants programme which targets four countries, three of which are in SSA (Scottish Government, 2016).²⁵ A funding allocation is given to Scottish based organisations such as NGOs, universities, National Health Service (NHS) boards and local authorities to fund projects via a respectful partnership/collaboration with partner countries. One of these projects was the MalDent project, which aimed to produce and implement an oral health policy for Malawi and set up and support an undergraduate dental course in Malawi. Whilst funding was from Scottish Government to a Scottish university, the MalDent project became a multi-sectoral collaboration involving *inter alia* other higher education institutes (HEIs), royal colleges, health boards, dental bodies in Malawi and IHV NGOs with the Scottish university managing the grant.

²⁴ Eswatini, Liberia, Malawi, Tanzania and Uganda.

²⁵ Malawi, Rwanda and Zambia.

There are various means by which a multi-sectoral collaboration operating in Africa can find collaborators such as IHV NGOs. I observed in this study that collaborators may become involved through informal word of mouth means rather than there being a defined network or database of NGOs.²⁶ This potentially means that there may be an untapped NGO resource that may not have the chance to input their skills into a multi-sectoral collaboration of this nature because their existence is unknown to others in the collaboration. In my observation of NGOs there have been chance meetings in the field which have sometimes led to later potential collaborations and at other times have led to realisations that there is duplication of effort.²⁷ Adequate information of the possible existence and operations of potential collaborators is often unavailable or if available is hard to find. Other means of finding collaborators are by groups that involve linking specific nations together for support and coordination of effort. An example of this is the Scotland-Malawi Partnership that has a searchable database of many organisations involved in health directed towards Malawi (Scotland Malawi Partnership, 2025). Some countries offer larger databases of organisations involved in International Development such as Scotland who have a searchable database via Scotland's International Development Alliance (2025), but this is not the case for many countries. UN Volunteers (2023a) has some resources and country specific data but, as data input is voluntary, it is significantly lacking for African nations. IHV lacks any form of meaningful international network to put NGOs in touch with other interest-holders to better explore opportunities for collaboration or sharing of ideas. This is despite the evident need that IHV would benefit from a collaborative approach (Caldron *et al.*, (2015). Whilst incomplete in global health research the US Government funded Fogarty International Centre (2023) keeps a database of NGOs operating in global health research. Something similar for IHV would likely be of great benefit to more effective collaboration in SSA. Some authors have even called for the setting up of an international organization, recurrent congresses, and a dedicated academic journal to act as a driver for quality improvement in IHV (Caldron *et al.*, 2015). This though has not yet become a reality. I must agree with the statement that volunteering in 2013 was then a fragmented environment (Academy of Medical Royal Colleges, 2013). I contend this remains true over one decade later.

²⁶ Which includes their known area of operation.

²⁷ For an example see document C3 (p. 3, l. 8-11) where collaboration with a non-health NGO was explored in a meeting between AP, person GOM1B and person SYM2.

1.5 North-South volunteering

Towards the end of the twentieth century the terms Global North and Global South became the predominant term to describe global world order (Braff and Nelson, 2022). This is largely a socio-economic and political construct putting wealthier predominantly *developed* nations in the Global North and poorer predominantly *developing* nations in the Global South rather than a geographical one. For example, Australia and New Zealand are usually considered to be in the Global North (United Nations Trade and Development (UNCTAD), 2025) despite their geographically southern situation in the world. Similarly powerful countries such as China are classified in the Global South rather than the Global North (UNCTAD, 2025) despite its economic wealth and political power. All SSA countries are in the Global South. Whilst this simplistic definition does not take account of variations between nations it is a useful term in IHV as the predominant direction of volunteering is volunteers from the North volunteering in the South (Lough, Tiessen and Lasker, 2018). Given this direction of travel of IHV use of Global North and Global South are my preferred terms in this study as opposed to the *valuing* nature of the term developing (Oluwafemi Mimiko, 2012, p.49) or use of visualisations to depict world inequality like the Brandt line (Brandt, 1980). Generalisations like Global North and Global South are suboptimal but remain useful as they function as tools for analysis and as meta-categories in many research outputs in academic literature. In my study most volunteers on programmes with the study NGOs came from the UK and Europe so were Global North healthcare volunteers (GNHVs). As my study involves data from UK and European healthcare volunteers when I refer to volunteers from the Global North I usually refer to them as UK and European healthcare volunteer(s) (UEHV(s)) to define that it was this subset of GNHVs who predominantly appear in the data. I do however refer to GNHVs also in this thesis particularly when citing others or where generalisation is necessary.

Within the Global South there is a high demand for HV (UN Volunteers, 2023b). This is largely due to a critical shortage of health workers particularly in 36 SSA countries (Jensen, 2013). There is minimal data on the extent of IHV in Africa however, in a study published over 15 years ago, it was estimated that volunteer health workers from the Global North comprised a maximum of 5000 in SSA, with

25-30% of these being medical doctors (Laleman *et al.*, 2007). Whilst this seems a large number to put this in context the health worker shortage in Africa is estimated in the hundreds of thousands (Chen *et al.*, 2004). It seems then that at best IHV from the Global North can only play a limited role in filling gaps and in consequence may be perceived as a measure of final resort by African health services (Laleman *et al.*, 2007). Where GNHVs appear to be crucial to African health services are in those nations where there is an absolute lack of health workers, particularly in remote and underserved areas (Laleman *et al.*, 2007). My study fieldwork took place primarily in two SSA nations, both of which had an *absolute lack* and were in the 11 nations in the world with the lowest health worker density (Jensen, 2013). I am conscious that my interpretations may be different were fieldwork to have taken place elsewhere in SSA.

What is unknown is the true extent of IHV from smaller NGOs and voluntourism from the Global North on health services in SSA, as the very limited data that there is available largely relates to larger NGOs and is out of date. Pezzella (2006) estimates that from the USA alone 500 organisations are involved in sending volunteers on around 6000 programmes annually to the wider Global South. It is unknown whether this is increasing or not at present and how much is currently taking place in SSA.

1.6 South-South volunteering

South-South IHV is less frequent in SSA perhaps because in the region most nations face a lack of healthcare professionals, capacity and resources so are more focussed on issues in their home nation. However, African governments have affirmed the need for mutual assistance between nations to strive to fulfil SDGs with the release of the Nairobi Outcome Documents of 2009 and 2016 (UN General Assembly, 2009; Global Partnership for Effective Development Co-operation, 2016). Not only do these documents call for South-South cooperation they call for a wider triangular cooperation between nations, NGOs, the private sector and philanthropy towards achievement of SDGs (Organisation for Economic Co-operation and Development, 2019).

South-South IHV is prioritised in in the 2009 Nairobi Outcome Document, and an example of good practice is Nigeria's South-South healthcare delivery programme (UN General Assembly, 2009). Unfortunately, little is known about that programme, and I have been unable to find other examples in the healthcare sector of South-South volunteering between African nations. However, South-South cooperation in the form of development aid rather than volunteering *per se* between China and the African Union is well-developed. The seventh triennial summit of the Forum on China–Africa Cooperation (FOCAC) had goals to capacity build by, for example, creation of an African Centre for Disease Control and to strengthen public health systems (Gao and Ngengasong, 2019). In my fieldwork I have witnessed examples where it is evident that Chinese aid has strengthened capacity mainly by provision of healthcare equipment or building rural health facilities.²⁸ Through FOCAC, China undoubtedly has an increasing role within healthcare in Africa.

The intention of South-South IHV has great potential within SSA as volunteers are likely to have similar culture, face similar problems, work in similar health structures and have, in some cases, a common language. Unfortunately, other than important development aid examples like FOCAC there is no convincing evidence in SSA that much South-South volunteering occurs between SSA nations. In other parts of the world, examples of successful South-South volunteering between nations that are close to each other in terms of geography and culture are seen such as Cuban doctors volunteering in Venezuela (Laleman *et al.*, 2007). What is evident in my fieldwork are many examples of in country HV or *outreach* by indigenous health workers and community volunteers in SSA.²⁹

1.7 Funding and underfunding

IHV is an expensive pursuit. For the volunteer there are usually costs of air travel, overland travel and accommodation to factor in. UEHVs frequently incur further costs, for example NGO training days and vaccinations. In longer term volunteer placements, some may be disadvantaged regarding continuous

²⁸ In my second fieldtrip, the 2nd rural health centre study locus was having a new maternity unit and circumcision clinic added by Chinese funding and provision of Chinese construction workers.

²⁹ Examples of *outreach* are seen in document F2M (p. 33, l. 1-2) as evidenced by person SPM5 and document F1A1 (p.3-4, photographs) as produced by person SHM1A.

employment benefits (Cochrane, Chisholm and Tomlinson, 2014). In addition, volunteers incur hidden costs that are somewhat opaque when signing up to a programme. For example, my research has found that some host nations in SSA define volunteering as a business activity thus mandating volunteers to pay a significantly higher cost for an entry visa.³⁰ Furthermore, most ethical volunteering organisations will require volunteers to register temporarily with the host nation health professional regulators of their health profession, if the volunteering involves clinical work. This can be costly as can the requirement for indemnity insurance.

In this study, I observed that some volunteers found the costs of funding or fundraising for a programme difficult particularly if they were a member of a less well-paid healthcare profession or if they wanted to return on further trips and this acted as a barrier to further volunteering in SSA.³¹ I found this was important to the volunteer programmes I observed in the two SSA countries as having experienced volunteers to act as mentors to the inexperienced can give a better skill-mix and a more resilient team. On the programmes I studied, some volunteers were funded or partially funded by individual grants from various organisations. Others by employers donating a fee to the NGO running the programme that covered some of their employees to volunteer in SSA.³² Feelings of guilt amongst those on grants was not uncommon with their realisation that others on the same trip had paid fully for the trip themselves, although I found no evidence that this affected volunteer team dynamics.

For most volunteering organisations operating in the two SSA countries there are many general costs such as maintaining an office, staff costs and good governance practices. Larger organisations may have staff whose primary role is volunteer or programme management, whereas in smaller organisations this role may be undertaken by volunteers.³³ Much cost within volunteering organisations is geared towards writing grant applications, pursuing healthcare industry contacts at home and in SSA, promoting and marketing programmes, and maintaining a

³⁰ Noted in document F1M (p. 75, l. 22-26) by person SPM5; the fee was later reduced by government in Country 1 for further fieldtrips.

³¹ See document F1M (p. 84, l. 6-9) as discussed by person GVF6.

³² In fieldtrip 1 this was the case for person GVM1 and in fieldtrip 4 for person GVM3.

³³ Volunteer project and UEHV management occurred in NGO 2; this occurred also in NGO 1 after the onset of the Covid-19 pandemic.

positive website and social media profile. Further cost in volunteering occurs to develop links and collaborative partnerships with other NGOs in both donor and African countries together with local partners/collaborators, community representatives and central, regional and district governments.³⁴ In addition, the volunteering organisation may require an in-country implementation partner in SSA together with links to national professional healthcare associations, other institutions and academic or professional personnel. Forging these links and working in Africa will add to the costs particularly if additional planning trips are necessary to SSA from organisation staff.³⁵ Additional costs are incurred if any implementation partner must visit sites where programmes may operate, to seek permissions from key local government and community contacts and to logistically plan the programme. To successfully run HV programmes often requires specialist medical devices and other equipment, personal protective equipment (PPE) and drugs. Availability of these supplies in SSA can often not be guaranteed and costs can vary dependent on availability. Essential items that are unavailable locally then require to be transported from donor to recipient country either by volunteer teams or separately. Both methods are expensive and sometimes incur excise duty charges in SSA. In the organisations I observed during my research these were the typical activities that regularly incurred significant cost.

Unless a volunteer organisation is directly government funded most volunteer organisations must obtain funding from donors. For IHV NGOs funding often comes from healthcare interest-holders who are most closely aligned to the area of interest of the NGO. Many commercial healthcare organisations will fund NGOs as part of their Corporate Social Responsibility (CSR) strategy. In the NGOs I studied CSR was a significant source of revenue and was marketed by commercial organisations. Funding of this type was used to sponsor volunteers, sponsor health workers in recipient countries, provide equipment, provide *pro bono* services such as legal services, digital services and the installation and maintenance of equipment in recipient countries. The difficulty with CSR in the study NGOs was that provision of funding was sometimes erratic, leading to cash flow issues. Additionally, if the commercial organisation themselves were less profitable or

³⁴ Trips to the two SSA countries from NGO leaders occurred during my time of study for these purposes in NGO 1 (in Country 1 and 2) and NGO 2 (in Country 2).

³⁵ This was necessary for both NGOs during my time of study.

faced with crisis such as the Covid-19 lockdown, then funding sometimes ceased without warning.

IHV NGOs compete for grants from a variety of sources ranging from government to small trust funds. Grant funding is essential to the continued existence of most IHV NGOs. Grants can either be unrestricted, where the NGO can use these for their activities as they see fit or restricted to, for example, a specific project. I found that this means sometimes a project that the volunteering NGO considers particularly important is not funded. However, other projects are funded because they appear more attractive to a donor in terms of marketable outcome measures. In my study one NGO received mainly restricted rather than unrestricted income for a significant time, meaning there was an income shortfall to run the NGO. This led to considerable financial strain which required cost cutting measures and restructuring to a mainly volunteer-led NGO to ensure NGO survival. Inevitably one knock on effect of this was major delays to undertaking planned activities in the two SSA countries which both threatened to disappoint collaborators and risked reputational damage.

There is sometimes an uneasy relationship between the large donor and the NGO who may feel that a programme must be made to suit donor requirements rather than NGO or community priorities (Banks, Hulme and Edwards, 2015). Donor requirements can sometimes threaten the existence of an NGO itself, for example, in Malawi donor prioritisation of HIV-AIDS led to a reduction in other healthcare projects and disappearance of some NGOs in that country (Simon Morfit, 2011). Grant applications can be onerous with many hurdles to overcome. For smaller healthcare NGOs grant regulations for larger grants often require an annual income greater than they have, so the smaller NGO is barred from application, and is thus unable to compete for the larger potentially transformative grant that may allow them to make real differences in SSA. Governance regulations act as a potential barrier to some grant applications as smaller NGOs often do not have the support of dedicated teams to comply with all regulatory requirements.

IHV NGOs use many other innovative methods to increase their funding streams. In the NGOs I observed sources of income came from returning volunteers being encouraged to give regularly, sponsorship of activities and events, match

funding with other organisations, card schemes with banks and collaborations with other IHV NGOs to seek joint funding for programmes. Additionally, to run programmes effectively and efficiently the healthcare NGOs often receive volunteer contributions towards programmes. In effect they hold the volunteers' cash, and this is sometimes used to manage cash flow problems. This can be a risky strategy as seen in the Covid-19 pandemic when I observed that one of the NGOs in this study had several programmes cancelled. The volunteers then required refunds as they had paid towards programmes that no longer existed, but the NGO had already spent some of their cash. This led to a significant detriment to the NGO which then changed protocols to prevent this happening again, the downside being that it is harder to run programmes in the two SSA countries as all funding must be in place prior to the programme.

An additional issue of funding is the perception of the financial wellbeing of the IHV NGO amongst collaborators in Africa. My studies in the two SSA countries found that the donor NGO is sometimes perceived as having almost unlimited funds amongst SSA interest-holders. There are frequent requests to fund out of programme costs, postgraduate education abroad for individuals and to expand operations in SSA to an unmanageable level.³⁶ Even when explanatory attempts are made misunderstanding persists, so the NGO often has a large disappointment gap to fill regarding realistic funding with SSA colleagues. However, another source of potential income for IHV NGOs is to compete for grant funding from commercial organisations within SSA either directly or indirectly. There are many multinational companies working in Africa within the healthcare sector. Sometimes applications for CSR type funding to these organisations that come directly from an IHV NGO, usually to sponsor equipment or materials are successful. Alternatively, an IHV NGO can assist SSA NGOs or a volunteer partner organisation (VPO) so that they are directly funded for programmes rather than the IHV NGOs, which indirectly reduces programme cost.

IHV NGOs operate in a very challenging and competitive funding environment such that budgetary restrictions mean many NGOs cannot run all the programmes that both they and African collaborators want to meet their shared

³⁶ For example, in document F1M funding requests are made from person SYF1 (p. 38, l.2-3) and person SHM5B (p. 56, l. 37-38).

goals. With many NGOs being underfunded they are destined to remain small-scale enterprises, and it is difficult to see how they can be *scaled up* within current economic and funding structures as was the hope of the House of Commons International Development Committee (2014).

1.8 Harms and benefits of volunteering in SSA

The harms and benefits of IHV are controversial as there is little widespread agreement as to what exactly constitutes harms and benefits when focusing on this phenomenon. This in part is that there is insufficient data to back up claims that some programmes are well-intentioned but poorly informed whilst others make an enormous difference within IHV (O’Neil Jr., 2009). This may be because monitoring and evaluation is often inadequate in IHV in the two SSA countries and wider SSA. Additionally, in recent decades discourses on volunteering largely related to Africa have been played out within wider journalism. These include polarised views backed by inadequate evidence. For example, some views accuse NGOs of enabling privileged volunteers to use IHV as a leisure pursuit, whilst seeking to atone for past injustices in Global South nations (Mohamud, 2013). Others give opposing views that indicate that IHV has a huge impact on the lives of GNHVs and those whom they help (Blackledge, 2013). Academic literature in this area is often programme focused and specific to a single context. In effect, the literature often uses case report(s) or reflections on a programme with a paucity of empirical evidence to back up a claim. This part of the literature may be fundamentally flawed by having to draw upon inadequate data, although I will attempt to fill in gaps with my own evidence from my research. I have focused harms and benefits on those related to the effect of IHV on SSA interest-holders to draw out an African perspective rather than those related to GNHVs and sending organisations which are already well documented by Lasker (2016).

1.8.1 Harms of volunteering in SSA

It is generally accepted that mostly NGOs and GNHVs seek to do good in recipient countries and harm is often unintended. Many journal articles report in introductory paragraphs the types of harms that may occur, but little is known regarding incidence, distribution and indeed how many of these harms are historic.

In my study I came across some harms, and indeed reflecting on my own past experiences as an UEHV I now realise that I may have been the perpetrator of unintended harm myself through ignorance. For example, undermining local health professionals by not inviting them to participate in programmes in their communities.

IHV in SSA frequently occurs where there is a combination of poor resources, political and socio-economic instability and dynamic health needs (Banatvala and Zwi, 2000). Within this challenging environment the GNHV requires some cultural competency of local cultural perceptions of health and disease, and how they dovetail with local traditional and modern medicine (Hunt, 2011). It is no surprise that harms can arise in these circumstances, such as the inability of the GNHV to assess risks or manage appropriately some conditions, like malnutrition, that are more advanced and seen less frequently in the Global North (Wall, 2011). Furthermore, the GNHV is often faced with a lack of basic diagnostic equipment considered essential in their usual practice like X-ray equipment, and sometimes volunteer teams lack experienced colleagues or have no or lack knowledge of local referral networks (Bauer, 2017). This may lead to harmful treatment and reductions in standards posing ethical dilemmas for GNHVs. In my study I was fortunate that the study NGOs had good referral networks, and an appropriate skill mix so this minimised potential harms, but on rare occasions lack of equipment led to suboptimal management.³⁷ The list of medical harms published is too long to detail, but an example reported is gastric ulceration due to dispensing non-steroidal anti-inflammatory drugs to people who were malnourished and had inadequate access to food and water (Roberts, 2006).

In my study I identified concerns from higher grade SSA health workers that the occasional lower grade SSA health worker trained on IHV programmes for additional tasks were inadequately prepared for independent practice of those tasks. They reportedly caused harm and more work for others to provide remedial treatment.³⁸ Similarly, one middle grade health worker reported their experiences of UEHVs providing surgical clinical treatment that resulted in an unexpectedly high

³⁷ On fieldtrip 2 basic supplies were critically low. See document F2M (p. 65, l. 2-3) as reported to AP by person GVF7, person GVF8 and person XVF2.

³⁸ See document F1M (p. 14, l. 30) where person SHM5B reported this to AP who in document F1M (p. 15, Fn. 38) indicates that the matter was discussed privately between person SHM5B and AP.

complication rate. This was felt to be due to inexperience of the local setting and extent of disease such that the local health workers:

*Spent months attending to complications.*³⁹

Both these situations represent an important point for improvement from an African perspective. Many UEHVs volunteer on volunteering programmes that are short-term and sometimes there is little thought from IHV NGOs on how complications are managed or when new skills are taught how they are reinforced and supervised after the programme moves away from the area.

I found that there are significant financial disparities between remuneration that a SSA health worker receives particularly from government employment to the funds that can be offered to work with an IHV NGO or an IHV NGO funded VPO. This can destabilise areas in the two SSA countries where health worker recruitment and retention are difficult. For example, in my study a particularly competent senior health worker who worked in a rural area was induced financially by an IHV NGO to work for them, and to give up their government employment.⁴⁰ Wages with the NGO were considerably higher, and this ultimately left an entire district with no trained staff for several years. Whilst this was of financial benefit to the SSA health worker, individually, this was harmful for public health in hard-to-reach areas. This experience was reported to me by others as a not uncommon experience. Indeed, some SSA health workers were keen to work with an IHV NGO in the hope that there would be future economic advantages and employment.

In my study I found one senior SSA health worker who expressed that it was not uncommon for IHV NGOs to put in programmes that were unwanted in particular local communities as they did not address local health priorities, and discussion from IHV NGOs with communities had been minimal. In these circumstances sometimes the local community backed down and thus received inadequate healthcare sometimes believing that anything is better than nothing even if it is inappropriate for them. This resulted in SSA health workers often being

³⁹ Person XHM1 reports this in document C3 (p. 3, l. 15).

⁴⁰ Person SPM2.

unable to access their own health facilities to undertake their usual work leaving patients untreated. Put simply by the health worker:

*One of our biggest problems are NGOs.*⁴¹

Undermining confidence in a local SSA health worker is another unintended harm that can happen in IHV NGO programmes in SSA. Take an example from my study where one NGO leader⁴² discussed the predicament of a middle grade health worker. Some GNHVs had attended their district with lots of high-tech equipment and offered Western-type health services to a rural population without including the local health worker. After two weeks they left never to return but the population lost confidence in that person as they were unable to provide the same services. Ultimately their health worker, who previously had a good reputation, became disillusioned and left the district and a replacement was not found.⁴³ The harm here was that the district no longer had local healthcare available.

Finally, one significant harm that does occur in the IHV phenomenon in SSA with very negative consequences is that a change of government or lack of a donor grant to an IHV NGO or even a change in IHV NGO management can bring sudden change or different priorities to IHV. All SSA actors are powerless to prevent these types of external decisions harming health projects in Africa. An unwelcome example was when a new government in Denmark in 2004 changed their aid policy and with only three months' notice community health initiatives in Malawi were abandoned without any exit strategy (Barber and Bowie, 2008). In my study I found no examples of this except during the Covid-19 pandemic. Here programmes were abandoned in study NGOs as travel was not permitted with the most harmful effects being seen amongst VPOs in the two SSA countries as their income stream dried up overnight.⁴⁴ Without any government support, unlike IHV NGO counterparts, their existence was threatened.

⁴¹ AP interprets person SEM1B in the preceding paragraph in document F3M (p. 88, l. 6 - p. 89, l. 24). The reported speech occurs in document F3M (p. 88, l. 8).

⁴² Person GVM4B.

⁴³ See document C3 (p. 4, l. 31-34).

⁴⁴ See document C2 (p. 6, l. 31 - 44; p. 7, l. 1 - 3) where person GNF2 encapsulates the situation for VPOs.

1.8.2 Benefits of volunteering in SSA

Determining long-term benefit in recipient countries in SSA is difficult to determine partially because there is no agreement on who determines what constitutes a benefit, who should receive the benefit, and what is an appropriate amount of the benefit (DeCamp, 2007). An additional issue is that benefits are often seen through the lens of the NGO or donor rather than what local communities and health professionals view as important (Anderson, Brown and Jean, 2012). There is a shift to assessing benefits that are framed within local community perceptions of their needs, and what they believe constitutes health and wellbeing (Anderson, Brown and Jean, 2012). This though, in practical terms, is difficult to ascertain at community level. In my study the NGOs involved all actively sought perceptions and views on benefits from national, regional and district interest-holders together with community involvement. However, even when doing this it was often the national or regional view that won over the local community. I found that what was important to interest-holders higher up the pyramid was benefits that involved quantitative measurements. Examples included the numbers of a certain health intervention undertaken or the numbers of health workers in a district trained to undertake a procedure.⁴⁵ In my study I found that ultimately the important views of community elders⁴⁶ expressing gratitude for advising or treating their often health illiterate communities with dignity and respect were not viewed as a benefit. This was likely because they are not quantifiable nor useful to governments or NGOs for future funding. Similarly, managing anxiety and cultural myths⁴⁷ sensitively during preventive and medical interventions was not quantifiable. Stories of benefits, it seems are less important than numbers in the volunteering phenomenon despite an increasing view that qualitative research is an imperative to measure benefits (Bauer, 2017; DeCamp *et al.*, 2014).

Benefits commonly expressed within the literature on IHV in Africa include the provision of life saving procedures and measures that have improved quality of life of individuals (Bauer, 2017), expectations of sustainable partnerships

⁴⁵ The importance of numbers is seen in documents F2M (p. 51, l. 10) as reported by person SPM1 and document F4M (p. 62, l. 27-28) as reported by person SPM6.

⁴⁶ See for example in document F4M (p. 125, l. 18-23) the gratitude of person SCM1.

⁴⁷ See for example in document F2M (p. 70, l. 9-16) as reported by person GVF7.

(McCauley, Raven and van den Broek, 2021), improved knowledge and skills (McCauley, Raven and van den Broek, 2021), and increased insight into best practice (McCauley, Raven and van den Broek, 2021). However, it is uncertain in some of the literature as to where the data has come from and thus this questions its validity and reliability. For example, in the thought-provoking paper by (McCauley, Raven and van den Broek, 2021), a mixed methods study looked at volunteers from the UK and a variety of Low-and Middle-Income Countries (LMIC) most of which were in SSA. Qualitative data came from UK volunteers only, with quantitative data taken from both. The authors indicate a limitation of their study was not having qualitative data from LMIC volunteers. I agree with this limitation as to know in more detail the views of LMIC volunteers independent of UK volunteers would give assurance of benefits from an LMIC perspective. Nevertheless, my fieldwork would largely agree with the benefits expressed above. However, from my results I am sceptical regarding expectations of sustainable partnerships. I found that IHV produced initially robust multi-sectoral collaborations between individuals, institutions, NGOs, governments, inter-professional organisations and health associations, but I also found that some of these were unsustainable. In both SSA countries where I undertook fieldwork governments, whilst supportive, ultimately and likely through lack of funding and resource together with more immediate pressing priorities were unable to sustain progress made. For example, I observed an NGO undertake a task-shifting model (with full approval and encouragement from a Ministry of Health) whereby lower grade health workers were first trained by UEHVs to undertake a specific health procedure. Then local trainers were trained to train their own lower grades by the NGO, with the sustainable phase being the NGO withdrawing and the local trainers cascading the programme as part of government health policy. However, this model failed to become sustainable as the cascading was not taken forward locally.⁴⁸ I will discuss this further in Section 3.8.

Finally, and largely unreported within literature, I found another benefit for recipient countries in my study. I observed during fieldwork in both study countries that over the many interactions between UEHVs and local health professionals that every so often an individual local health professional, usually in a leadership role, would use the UEHV(s) as a sounding board for their own ideas to improve health

⁴⁸ For example, person GVF4B reports this in document F1M (p. 80, l. 40-4).

in their community, district or region. In these few cases, interaction continued remotely for long after the programme was over by way of information exchange, facilitation, advice and mentoring. The individuals concerned often went on to set up, sometimes with support or collaboration or assistance from the NGO, their own projects which were successful, sustainable and later received support from their own governments and communities. One example involved an individual who went on to address by way of training a harmful traditional medicine practice throughout a region of over two million people.⁴⁹ Another example was of an individual who set up a course where village volunteers were trained to give specific preventive health advice and cascade this throughout local remote communities.⁵⁰ The first example is currently being expanded into other regions of the same country, and the second example was used by the WHO as an example of good practice with the individual later contributing to the WHO setting up an online training course for other SSA countries. This facilitation of ideas to allow highly competent local health professionals to help bring their ideas to fruition is worthy of further study and encouragement. Perhaps this is a better approach to achieving sustainability in volunteering and a real benefit.

1.9 The healthcare volunteer

When studying IHV it is imperative to try to understand the motivations and persona of the healthcare volunteer. Drawing out an African perspective is problematic here as literature is concentrated on GNHVs. Nevertheless, in Africa it is these GNHVs that must interact with indigenous communities. Thus, to give an African perspective requires understandings of the major currency and frontline actor in the IHV phenomenon being the healthcare volunteer.

Volunteering is perceived as an important aspect of an application for any person hoping for admission to a healthcare professional training course. Elseed (2012) informs that compassion and societal service are key components of medical school admissions. In consequence, it is apparent that volunteering is an appropriate way to demonstrate core values to help gain admission to study. Furthermore, regulators express that healthcare professionals *must* exhibit

⁴⁹ Person SHM1A.

⁵⁰ Person SEF1B assisted by person SHM2A and others.

compassion as a core standard (General Dental Council, 2013, Standard 1.2.3). One way of reflecting compassion is by volunteering, although I would argue that there is no evidence that volunteering does indicate the level of any individual's compassion or desire to serve society. Whilst some may consider it cynical to think that volunteering is used merely to secure admission to a health profession there is undoubtedly a motivation to volunteer which has little to do with altruism.

The problem in trying to assess motivation to volunteer is that when volunteers are asked why they volunteer, a common response is "to help others" (Shye, 2010, p.185). This is an overly simplistic response which does not reflect the complexities of the volunteering phenomenon. It is however a common notion that I have come across throughout my exploration of volunteering amongst fellow volunteers.⁵¹ Perhaps it is simply an easy answer to give or perhaps the volunteer themselves does not understand why they volunteer. What motivates individuals to volunteer is likely of paramount importance to volunteering organisations, but in my view is poorly understood by many who compete to recruit and retain a limited volunteer pool. This is even more limited in the HV area as usually specialist healthcare knowledge, qualifications and experience are required. To address this, I will examine in turn several factors as to what may motivate healthcare professionals to volunteer.

Much of the groundwork as to why people volunteer was based on social research undertaken by House (1981) who examined social support in general with volunteering being a small part of social support. Based on research from House (1981), Wilson (2000) argues that there are two distinct perspectives on volunteering. The first perspective is a subjective one where volunteering is believed by the potential volunteer to be a socially responsible thing to undertake, but for what the person volunteers for is perceived by them to be less important (Wilson, 2000). The second perspective is a behaviourist approach where the potential volunteer rationally weighs up the individual and social risks and benefits to them of volunteering dependent on the context (Wilson, 2000). For example, a junior doctor may choose to volunteer or not for a specific programme based on whether they perceive it to be beneficial to their career progression. I contend the

⁵¹ For example, this is seen in a survey NGO I did of their UEHVs (see the appendix of document V2).

first perspective may have elements of naivety and the second can hardly be considered altruism.

However, in both perspectives social responsibility seems to be a common thread and according to Faulkner and McCurdy (2000) social responsibility is thought to influence how healthcare professionals behave. Many regulatory frameworks inform health workers that they have a duty to place other's health above self-interest, and this is based on principles such as integrity, compassion, courage, and justice (Kenny, 2006). Twohig and MacDonald (2004) further assert that it is these principles that allow health workers to be trusted and have privileged roles in society, and this drives their social responsibility. However, they further argue that modern medicine has been criticised that it has lost its role in wider society (Twohig and MacDonald, 2004). Verma (2005) contends that for the healthcare professional social responsibility is almost obligatory. If volunteering is a manifestation of social responsibility, then there is an argument that if social responsibility is obligatory it ceases to be volunteering, as some may feel coerced to volunteer.

It seems that wherever the health worker turns they are being informed of the importance of social responsibility. The WHO reminds physicians of the requirement for social responsibility (Boelen and Woollard, 2009). Indeed, the WHO provides direction for that social responsibility by suggesting that efforts be directed towards vulnerable or marginalised individuals and groups (Boelen and Heck, 1995; Boelen, 2012). Combining the relative ease of international travel in the modern era with the contention of Bloche (1999) that promoting health within a wider community is an imperative for physicians, I would argue that the world has become that wider community. This view of what constitutes a wider community is enhanced by increased global media coverage (Snyder, Dharamsi and Crooks, 2011). This allows the potential volunteer to directly see some of the health issues facing the Global South, albeit edited and packaged as the media deem appropriate. I suggest that the notion that volunteering is both a manifestation of social responsibility and a type of global citizenship has considerable merit as to why health workers are motivated to volunteer (Whitehead, 1991).

Others argue that motivation to volunteer can simply reflect the principles of healing and service that characterise healthcare professions (Langowski and Iltis, 2011). This motivator may have some validity as healthcare professions seem to select individuals into them for whom these principles are important. In the same vein influential charismatic people can themselves provide motivation to volunteer. For example, in the USA some were motivated by the words of Edward O’Neil Jr.:

It is only through direct involvement with the poor in the developing world (or here at home) that... the medical profession at large will find reasons to care and, ultimately, find ways to change the health of the world’s most vulnerable (O’Neil Jr., 2006, p.848).

Whilst secular volunteering predominates in the modern era, religious motivation is still involved for many. For example, modern crises and conflicts such as recurrent internal conflict in South Sudan/Sudan have motivated Muslim organisations to become more involved in IHV (United Muslim Relief, 2025). In this study religious motivation of volunteers was a full or partial motivational factor for some volunteers despite volunteering with secular organisations.⁵² Some IHV NGOs encountered in my studies describe themselves as having for example, a Christian ethos, however this is sometimes not made explicit to the new volunteer. This can lead to potentially uncomfortable situations where a volunteer can feel excluded or feel they must participate in faith-based activities, like praying, that they have no desire to do.⁵³ Some IHV NGOs though are expressly faith based and appear to select from an exclusive volunteer pool only, where a specific faith, rather than other motivators are a requirement for acceptance to a programme.

Often overlooked as a motivator for the potential volunteer is adventure. There has been much recent criticism of some IHV programmes being more akin to adventure tourism or voluntourism (Occhipinti, 2016). However, Hudson and Inkson (2006), building on work by Campbell (1949), assert that a motivator can be the combination of adventure and altruism and they describe that most volunteers fit into the “hero’s adventure model” (Hudson and Inkson, 2006, p.304). This model is like one for business expatriates (Osland, 1996) and for academic

⁵² For example, person GVM2A. See document F2M (p.10, l. 33-34).

⁵³ For example, person XHM1. See document C3 (p. 3, l. 16).

expatriates (Richardson, 2003) both of whom reported similar results. In these constructs motivations are commonly the need to describe trials and tribulations, acquisition of new skills, and personal transformation. In the modern world such experiences are played out on many personal and organisational social media platforms. This need to describe to others the volunteering experience may be at the core of volunteering motivation. Penner (2002) argues that the desire to be depicted in a certain way by others and the desire to feel good about it is at the root of volunteering. In this study, NGO 1 undertook an unscientific survey of their volunteers which included motivation. Whilst over 65% simply wanted to help, around 10% admitted that adventure was an important motivator.⁵⁴ Indeed, returning volunteers, throughout the course of this study, commonly posted experiences of volunteering involving themselves on social media sites or in reports with depictions of adventure and overcoming adversity.⁵⁵ This could be construed as casting the author of the post as a hero. I would agree with published studies that the hero's adventure model is a potential motivator of volunteering, but the extent of this is debatable.

Clary *et al.* (1998) took volunteering theory further and described six primary functional motives behind volunteering namely *values*, *understanding*, *social*, *career*, *protective*, and *enhancement* motivations. They describe the values motive as one that expresses their altruism and humanitarian concern. The understanding motive expresses a desire to use previously unused skills. The social motive is like that described by Penner (2002) and involves the need to fulfil the expectations of others but also adds the desire to build social relationships. The career motive involves the need to acquire new skills or enhance *curriculum vitae*. The protective motive is described as the desire to protect from negative feelings or emotions or personal problems by doing something good. Finally, the enhancement motive is thought to be a desire for personal growth by volunteering (Clary *et al.*, 1998). Applying this theory to IHV in the two SSA countries is an interesting concept, which indicates that many volunteering motivators are about the volunteer's desires and needs rather than the needs of African communities.

⁵⁴ See the appendix of document V2.

⁵⁵ For example, person GVM1. See document F2A8 (p. 5, l. 5-15).

For each volunteer some motives will be more important than others. In a study of over 200 potential volunteers, it was shown by Finkelstein (2010) that people who exhibited individualism were motivated by career-based motives whereas those who exhibited collectivism seemed to be motivated by social and charitable motives. The main motivator behind repeat volunteering was the need to continue fulfilling the unique individual needs of the volunteer (Clary *et al.*, 1998).

Demographic data of GNHVs can illuminate volunteer motivation and what potential barriers there may be to IHV. Healthcare clinical experience inevitably increases with time spent working clinically in a profession post-graduation. Exchange theory suggests that as people become part-time or retire, they swap paid employment for volunteering to seek social and psychological benefit (Fischer, Rapkin and Rappaport, 1991). Yet surprisingly retirement does not draw people into volunteering, but those who do volunteer spend more time volunteering (Caro and Bass, 1995). Whilst many IHV programmes depend on the recently retired, my findings indicate that modern regulation means that indemnity insurance is harder to acquire for the retiree's potential clinical acts and omissions.⁵⁶ There is a significant risk that soon UK retired healthcare professionals may be unable to volunteer in clinical roles. The younger person is more likely to volunteer if the programme is perceived as high-risk (Wilson, 2000). This reinforces the notion that adventure may be a significant motivator for the younger clinician. Of course, it is too simplistic to think of chronological age as a demographic indicator. People's values and beliefs change throughout life and an example of this can be seen in a study of volunteering in a primarily religious based context where Caro and Bass (1995) felt that increased religiosity with age increased volunteering.

In simple terms there is minimal gender difference in volunteering although there is variation in some donor countries (Hall *et al.*, 1998). There is no clarity as to why there are gender differences from country to country (Hall *et al.*, 1998). Exploring gender further indicates that men are more likely to volunteer to make friends whereas women link their volunteering to existing friendships with other women (Gallagher, 1994). Based on this contention it is thus unsurprising that men tend to seek out volunteering opportunities individually (Sundeen and Raskoff,

⁵⁶ UK indemnity organisations mostly do not cover a retiree in an overseas health volunteering capacity from anywhere between two and five years after registration has ceased with their specific health professional regulator.

1995). Race differences in volunteering have been minimally researched. White people account for more volunteers than black people (Hodgkinson and Weitzman, 1996), but black people are much more likely to be influenced to volunteer by religious organisations (Musick, Wilson and Bynum Jr., 2000). My own research has shed no further light on these aspects of the volunteering phenomenon.

There are many other contextual factors that influence volunteer motivation. Physical and mental health of volunteers, family commitments, socio-economic status, education, and political activism are all factors to be considered as motivators or barriers to volunteering (Wilson, 2000). Many of these factors vary throughout an individual's life and it is unclear precisely what influence they have on an individual volunteer. In my research socio-economic and health status has played a part acting as a potential demotivator to the volunteer. Many NGOs rely on volunteer contributions for expenses such as air fares and living expenses which one study NGO identified as being problematic for volunteer nurses.⁵⁷ The same study NGO as part of a duty of care required a reasonable standard of health amongst its volunteers given the demands of volunteer work in rural areas in SSA.⁵⁸

1.9.1 The international healthcare volunteer

North-South IHV relies on the limited human resource of the GNHV. Most studies of GNHVs focus on short-term volunteering giving descriptions of volunteers who have significant paid healthcare roles in their home countries (Mitchell et al., 2012). Despite this short-term commitment Lough, Tiessen and Lasker (2018) found that the short-term GNHV is two years older and more highly skilled than their long-term equivalent. For many potential GNHVs IHV is impractical as work commitments and family responsibilities often preclude this. I found this to be mostly the case in this study but with some exceptions. GNHVs at the start of their career sometimes took gaps between jobs allowing commitment to IHV.⁵⁹ The downside of this was sometimes relative inexperience and thus need for

⁵⁷ See the thoughts of person GVF6 in document F1M (p. 84, l. 6).

⁵⁸ In document F1M (p. 33, l. 19-20) one UEHV, whose person identifier I redacted due to the sensitive nature of the data, has hidden a health condition exacerbated by stress which became an issue in fieldtrip 1.

⁵⁹ For example, person GVF7. See document F2M (p. 21, l. 4).

supervision by others.⁶⁰ I found that the recently retired UEHV had more time, and some volunteered for multiple short-term trips each year.⁶¹ These volunteers were often in leadership roles and offered valuable experience and mentorship to others. However, this was not problem free. Take for example a conversation with a recently retired serial returning volunteer who exhibited burnout and stopped volunteering as:

*All these difficult trips and the politics around them take a toll.*⁶²

Time was not the only factor that I found in limiting the UEHV volunteering for more trips. For those, particularly in lower income healthcare professions or at the start of their career, economic reasons meant returning more frequently than they wished was impossible.⁶³ My study had limitations in that the UEHVs I encountered were predominantly short-term volunteers, so the study did not explore the long-term volunteer in sufficient quantity to make any valid observations. However, a study of VPOs found that they considered the highly skilled short-term volunteer more effective than the marginally less skilled long-term volunteer (Lough, Tiessen and Lasker, 2018). The reasons for this are unclear but differences in skill level perhaps warrants further study.

Often the GNHV participates in a volunteering trip as part of a group of varying levels of experience and sometimes drawn from different healthcare professional groups. This was typical of the NGOs in my study. The achievement of positive team dynamics was highly valued by the NGOs studied. Much time and efforts were made to produce a team with effective leadership, an appropriate professional skill-mix, and a mix of returning and new volunteers. This included trying to get to know new volunteers well in pre-trip orientation and training sessions together with those in leadership roles exploring with team members their hopes, fears and expectations of the programme before the trip.⁶⁴ Mostly this worked well such that during most programmes there would be remarks regarding

⁶⁰ For example, person GVM7. See document F2M (p. 20, l. 4 and p. 52, l. 26-27).

⁶¹ For example, persons GNF1B, GNF3B, GNM3B, GVF3A, GVF4A and GVM5A.

⁶² Person GVF4A. See document T1 (p. 9, l. 5).

⁶³ For example, person GVF6. See document F1M (p. 84, l. 6-8.)

⁶⁴ See for example, document F2M (p. 9, l. 5 - p. 21, l. 18) and document F4M (p. 10, l. 5 - p. 17, l. 10). Reported by AP (documents F2M and F4M), person GVF1B (document F2M) and person GVF3B (document F4M).

the volunteers that *they're a great team*.⁶⁵ Similarly, a VPO senior administrator indicated:

*There really are no problems...this team is great.*⁶⁶

Whilst this positive teamwork was the predominant view in this research, in the highly pressurised setting of a volunteering trip when individual UEHVs clashed, and this was unresolved, negative consequences usually resulted. On occasion individuals were sent or went home early from trips leaving the team short.⁶⁷ Sometimes poor cooperation meant trip activities were at times shambolic, and whilst ultimately programme objectives were completed the standard achieved was sub-optimal. Despite an insider knowing that there were problems, social media from the IHV NGO remained entirely positive so an outsider would be unaware of any issues.⁶⁸ It remains unclear to me as to why, despite best efforts, some team dynamics were problematic, however one factor may relate to the combination of the nature of the programme and the UEHV. Many programmes in my study involved primary healthcare yet UEHVs are drawn from both primary and secondary healthcare with a variety of professions and hierarchies involved. When individuals are placed in a volunteering team the rigid pyramidal hierarchy of Western healthcare can be altered by the needs of the programme. This means hierarchies can be inverted with sometimes those in leadership roles at home being replaced by others who would be lower down the hierarchy.⁶⁹ Most individuals and teams manage this well but if they do not tension can result.

The GNHV is a highly skilled health worker but in most cases, I found in this study that their skill set was an imperfect fit for the combination of the African setting and the programme that they had volunteered for. Rapid in-programme learning was an imperative. However, the UEHVs in my study mostly proved to be resilient quick learners. Often though they had feelings of a combination of being

⁶⁵ Person GVM2A reported this in document F2M (p. 29, l. 31).

⁶⁶ See for example, person SPM6 reports this in document F2M (p. 55, l. 4).

⁶⁷ See for example, person GVF4B indicates this in document F1M (p. 81, l. 28 - p. 82, l. 3).

⁶⁸ See for example, in document S1 (p. 12, l. 10 – p. 13, l. 26) person GVM6 gives a positive interview for NGO social media regarding an IHV programme. AP was aware of significant issues with this IHV programme.

⁶⁹ For example, in fieldtrip 2 person GVF1B is in an IHV programme leadership role but is considerably lower in the UK health hierarchy than new volunteer, person GVM2A.

overwhelmed and worried which necessitated much support from team leaders and other local interest-holders throughout the programmes.⁷⁰

1.9.2 The SSA healthcare volunteer

I have defined the African HV as a skilled health worker who volunteers within their own nation in the healthcare field.⁷¹ This is an important definition as it is commonplace to find these individuals working for VPOs or working in healthcare roles that interact or collaborate with IHV NGOs. On several occasions in my research, I have observed them talking about their own volunteering activities in their own nations.

Higher education institutions in Africa are increasingly embedding community-based service in rural areas as compulsory components of their curricula (Amalba *et al.*, 2020). This community-based service is not just embedded into medical and dental curricula but is being used in institutional curricula where middle grade health workers are trained (Couper *et al.*, 2018). This student experience is known simply as *outreach*. I observed that this gives an African healthcare professional an appreciation of health inequality amongst underserved and disadvantaged groups within their own nation. For example, this is seen in rural areas and urban shanty towns near training institutions. I found SSA health workers recall of their student volunteer *outreach* experiences to be predominantly religiously motivated with examples of the student collaborating with a local religious group to provide simple primary healthcare or preventive advice.⁷²

These student experiences seem to act as a catalyst for further volunteer *outreach* during their working lives although this is varied. I found SSA health workers sometimes provide *outreach* as a group activity around specific events. For example, during healthcare conferences *outreach* to the local area is common or as

⁷⁰ See for example, in document F2M (p. 52, l. 7- 8) this affected person XVF2 and also in document F2M (p. 93, l. 25- p. 94, l. 7) this affected person GVF8 .

⁷¹ For example, persons SEF1B, SEM1B, SHM1A, SHM2A, SHM5A, SHM8A, SPM2, SPM5 and SPM6 all are involved in some HV independent of roles that involve IHV NGOs.

⁷² See for example, in document F1A1 (p. 2-3, photographs with text) person SHM1A shows their student *outreach*.

part of initiatives led by healthcare professional associations.⁷³ Less common is individual *outreach* but when it occurs it appears to be predominantly religiously motivated. For those who undertake these activities much time and effort are put into volunteering. Take, for example, the senior health worker who took up cow fattening to fund HV activities to the poor and those with special needs as:

*It will be joyous in heaven through the little things we do for the needy.*⁷⁴

See Figure 1:



Figure 1: Fattening these cows funded one SSA health worker's *outreach*.

It is too simplistic to say that religious motivation was the only driver for SSA healthcare individual *outreach*. I found that the ethical and cultural notion of providing service to others and creating a better service was highly valued amongst individuals and communities, and this appeared to be a significant motivator for *outreach*.⁷⁵

However, for some SSA health workers their notion of healthcare volunteering conflicted with the Western definitions of volunteering. Some who were working on IHV programmes, and either being directly paid by NGOs or VPOs felt that such an activity was in effect *volunteering*. They appeared to think of *volunteering* as something that you choose to do which was different from your

⁷³ Reported by person SPM5 in document F2M (p. 33, l. 1-2). *Outreach* occurred around a national specific health profession conference in Country 1.

⁷⁴ Person SHM1A reported this to AP in document F4A10 (p. 4, l. 7-8).

⁷⁵ Person SEM1D uses *service* to others as a call to action to middle grade health workers to volunteer. See document F3M (p. 71, l. 11-20).

normal job with the expectation of payment for your time and talents.⁷⁶

Unsurprisingly I found a degree of tension between African health workers who had different views on volunteering. Take two religiously motivated SSA health workers, one who volunteered on a rest day during an NGO programme with no expectation of payment to help at a local health facility⁷⁷ and the other who refused as there was no payment.⁷⁸ The eventual volunteer indicates that Christianity is better served by helping poor people whereas the refuser would only contemplate *volunteering* if paid.⁷⁹ Tension persisted between the two individuals throughout the remainder of the IHV programme that they were both being paid for.

Commonly SSA health workers work for VPOs. I found instances of VPOs whose SSA health workers undertook *outreach* activities within local communities that were entirely independent of the NGOs that they usually collaborated with.⁸⁰ These activities usually took the form of *pro bono* primary healthcare or preventive activities within areas of need they had identified locally or amongst disadvantaged groups such as special schools. This was advantageous to both the VPO and individual health workers as it enhanced their standing within their local community. It also allowed them to achieve some sustainability by being able to raise funds of their own reducing dependency on the NGOs. Helpfully when a VPO did this I observed that the NGOs would offer support, expertise and advice in aspects of volunteering like grant applications⁸¹ which directly benefitted the VPO and facilitated the VPO programmes.

1.9.3 The white saviour and the voluntourist

White saviourism means different things to different people with no one accepted definition and is sometimes perceived as being an ideology or complex. *White saviourism* was first defined as “A big emotional experience that validates

⁷⁶ This is known as a *per diem*. This is discussed in detail in Section 4.6.

⁷⁷ Person SHM1A.

⁷⁸ Person SHM5A.

⁷⁹ See document F1M (p. 40, l. 9-10).

⁸⁰ For example, person SPM2 did this regularly near the VPO's base. See document F1M (p. 75, Fn. 263).

⁸¹ Person GNF2 reported this in document F2M (p. 23, l. 4-5).

privilege” (Cole, 2012, see⁸²). Others have defined a *white saviour* as it relates to global health as:

Any person or group, regardless of race, possessing an imbalance of power or privilege (Agarwal et al., 2020, see⁸³).

In trying to apply this to IHV I have taken *white saviourism* to be:

An ideology whereby a person in a position of power or superiority tries to help indigenous people or communities with beliefs that they are better placed to help than those in that community or that their approach to healthcare is superior to those from indigenous communities.

In IHV the *white saviour* is perceived as someone who will respond to a health need with little or no consultation with the indigenous people affected without taking time to reflect on the wider issues involved. This is not a new phenomenon with early white colonial medical missionaries in Africa, such as Nobel prize winner Albert Schweitzer, being accused of demonstrating paternalistic and potentially benevolent racist behaviour (Mazrui, 1991). With the benefit of hindsight such behaviour could be viewed with a modern lens as *white saviourism*.

White saviourism is considered as potentially harmful as it predominantly deals with an immediate issue rather than the underlying longer-term issues (Clavijo-Dias, 2025). In IHV this accusation can be levelled against many volunteers as it is common for UEHVs to participate in programmes that deal with immediate issues in SSA.⁸⁴ To avoid *white saviourism* Clavijo-Dias (2025) advises that an appropriate approach is to be prepared to let local leaders set their priorities and to show awareness of the issue. Whilst the UEHV is often powerless to individually deal with most underlying issues, I have observed some IHV programmes whereby community involvement is at the heart of the programme, with programme aims and objectives being led by local communities. There are exceptions and I have observed examples of IHV programmes where there is lesser

⁸² <https://www.theatlantic.com/international/archive/2012/03/the-white-savior-industrial-complex/254843/>

⁸³ <https://blogs.bmj.com/bmjgh/2020/03/11/the-white-savior-industrial-complex-in-global-health/>

⁸⁴ For example, NGOs 1 and 2 were heavily involved in training and capacity building, but they also were involved in clinical management of immediate issues.

regard for the views of indigenous communities. *White saviourism* has become more prominent in the media with numerous examples of celebrities undertaking philanthropic activities often criticised as being more self-serving and portraying Africa as having no voice or being helpless (Bell, 2013). In consequence, I have found NGOs being highly aware of potential negative consequences such as donors stopping contributions if they are viewed or perceived as *white saviours*. Indeed, defensive actions are sometimes taken simply from the fear of being potentially called out as *white saviours* and occasionally unnecessary changes made to programmes borne out of fear. Paradoxically I found the study NGOs to be highly aware of the wider picture in the two SSA countries and observed them take a backseat to VPO and local communities, trying to be the antithesis of *white saviourism*.

This study though has allowed me to reflect personally on whether I am or have been an example of a *white saviour*. As someone who has been involved in IHV for many years, I have participated in a variety of NGO programmes in the past in SSA, some of which on later reflection have been sub-optimal in their involvement of indigenous people in orchestrating programme activities.⁸⁵ At the time I thought merely helping was enough but in reality, I may inadvertently have been causing more harm than good and have been perceived as a *white saviour*. Now I understand better, as someone in a position of power in IHV programmes and with specific healthcare skills, what *white saviourism* is. This allows me to continually reflect to seek to avoid it, articulate its nature and try to avoid potential harms. Doing this may have the potential to make programmes and individuals have more impact as there is less chance that *white saviourism* is involved.

In my study I observed views about *white saviourism* from some African health workers during the course of IHV programmes in the two SSA countries. Views were mixed with the notion being expressed that the concept of *white saviourism* itself was insulting to African people and UEHVs. The reason given for this was that given the high healthcare need in SSA the ideology may disincentivise UEHVs from volunteering for desperately needed IHV programmes.⁸⁶ Contrast that with the view that I found that UEHVs are unwanted but necessary as health

⁸⁵ For example, my student elective.

⁸⁶ See the views of person SEF1A as reported by person GNM2 in document C3 (p. 3, l. 3-4).

services in the two SSA countries require both their skills and money given their lack of resources.⁸⁷ In effect I found that the *white saviourism* ideology seems to affect IHV interest-holders from donor nations and in Africa in a variety of ways having potential for positive change and empowerment amongst African people and VPOs, but at the same time risking defensive practices and disincentives to IHV. Raised awareness, openness and constructive discussion between interest-holders of the *white saviour* complex may be a way forward to better raise up fuller involvement of African people and communities in IHV to better eliminate *white saviourism* from IHV.

Voluntourism is a popular culture term originally and alternatively known as volunteer tourism. Like many terms in the volunteering phenomenon there is no consensus on an exact definition. I have defined *voluntourism* as:

An activity whereby holidaymakers fund and work on projects around the world as part of their holiday, the primary purpose being a holiday rather than volunteering (adapted by me from Wearing, 2004, p.209).

Voluntourism is a rapidly growing area of tourism (Germann Molz, 2016). It is important to distinguish *voluntourism* from IHV in which the primary purpose is the volunteering programme rather than a holiday, although inevitably some holiday may take place on days off or on programme completion.

I observed in my study that a minority of UEHVs either indicated or were called out by others that they had misjudged the volunteering programme which they thought was primarily a holiday rather than IHV. When faced with the actual reality of IHV in the two SSA countries I further found that some of these individuals were either ineffective or had sickness absence or left or were sent home from the programme early.⁸⁸ This often had a detrimental effect on team dynamics leaving volunteering teams short or frustrated by the would be *voluntourist* in their midst. Strangely though I observed situations where sometimes the adversity of having a potential *voluntourist* in the team bolstered the team dynamics and ultimately led to improvements in engagement of the budding

⁸⁷ Person SEM1A indicates this in document F3M (p. 32, l. 9).

⁸⁸ Person GVF4B reports these issues. See document F1M (p. 81, l. 28-31).

voluntourist who appeared to eventually transform into an effective UEHV.⁸⁹ My research shows no further evidence of *voluntourism* other than that discussed above perhaps because of the nature of the volunteering programmes that were observed in this study.

1.10 Regulation and IHV

Regulation, and sometimes lack of regulation, of IHV is complex with many potential influences and interest-holders being involved in both donor nations and in Africa. This can give practical problems, ethical dilemmas and potential delay or halt programmes for volunteering organisations, UEHVs, VPOs, local communities, host health workers and institutions.

The WHO (2022) make it clear that all governments have both a responsibility to achieve the SDGs in their respective nations and to support the health and wellbeing of their citizens. Thus, it is evident that to be lawful and to practice healthcare in SSA both volunteering organisations and GNHVs *must* obey the laws, regulations and guidance relating to healthcare in the host country. In addition, most NGOs are registered as *bona fide* organisations in the donor country with individual GNHVs being regulated by a healthcare regulator dependent on profession, with the resultant need to work within their regulations. Interest-holders in IHV are then affected by persuasive international resolutions and policy from transnational bodies such as the UN and the WHO. This means that different and potentially conflicting constructs of laws, regulations, policy and guidance will be a requirement for organisations and individuals involved in IHV.

With a wide variety of potential donor countries and potential host countries in Africa, for practical reasons, it was impossible in this study to consider all permutations. I have limited my study in this section to look at the UK as donor country and anglophone SSA as host countries. This is helpful because anglophone SSA mainly represents former British colonies whose legal system is foundationally based on English Common Law⁹⁰ with guidance from indigenous

⁸⁹ AP observed this transformation in person GVF13. See document F4M firstly at p.11, l. 31 and after transformation at p. 64, l. 23-24.

⁹⁰ English Common Law originated in England after 1066. It has mostly developed over centuries by case law and judicial precedent rather than by statute.

law (Charles, 2010). The locus of the fieldwork of my study was in two SSA countries that were anglophone and former British colonies. In these parts of SSA there is much commonality in healthcare ethics, law and regulation which is underpinned by common values of *principlism* (Beauchamp and Childress, 1979). As a typical example of the region, these principles are espoused in Tanzania as a Code of Ethics (Medical Council of Tanganyika, 2005).

Most healthcare professionals are required by host country law in Africa to register with the relevant regulatory body to legally practice their profession in the host country. For an example see Manyozo-Phiri *et al.* (2001) regarding regulation in Malawi. There are some exceptions where the cadre of health professional is not registerable in the host country, for example, dental nurses. I found that this requirement is known widely amongst NGOs who send UEHVs to SSA. However, I also observed that some reportedly highly reputable NGOs choose not to register their UEHVs with appropriate host regulators in SSA. When challenged responses indicated that non-registration was due to either expense or difficulties negotiating regulatory bureaucracy. Some claimed that they had permission but when explored this was usually an agreement with the individual local healthcare professional whose facility or district was to be used for the programme.⁹¹ It is evident that such informal arrangements do not meet regulatory requirements of SSA governments.⁹² However, I found examples of good practice where permissions were obtained at the highest level such as a Memorandum of Understanding (MOU) with Ministries of Health and regional and/or district authorities, formal agreement with relevant host healthcare associations, and temporary registration for UEHVs with relevant host healthcare regulators in SSA.⁹³ I observed that these formal arrangements took longer to arrange and much regulation to negotiate but had the advantage of embedding host community and interest-holder involvement in the programme. This importantly meant that the NGO and any UEHVs were operating legally and were held in high esteem by host interest-holders. Furthermore, in most cases I found that host healthcare regulators either waived or charged nominal fees for

⁹¹ AP observed person GNF2 report this after challenging person GNM4 (who led a different IHV NGO operating in Country 3) regarding governance. See document F2M (p. 108, l. 10-12).

⁹² See for example, where person GVM4B and person GNM5 only had local permission but were told not to return by an SSA Government (Country 4). See document F3M (p. 9, l. 25-32).

⁹³ This is expressed in the entirety of documents F1A2 (regarding an MOU in Country 1) and document F3A16 (regarding discussions around an MOU in Country 2).

temporary registration of UEHVs in these circumstances often embedded in a MOU.

The consequence of poor regulatory practices by NGOs are potentially far reaching for both NGO and UEHV. Take for example my observation of a senior health official in SSA who informed of an NGO sending UEHVs to practice without necessary permission and train a cadre of health professionals for whom the training would be out of their scope of practice and was unwanted by local health officials. The NGO chose to publicise this widely and on arrival to the country that NGO was asked not to run the programme. They refused and started to treat and train resulting in them being deported within a day. In this case, the individual UEHVs of this NGO were unaware that they were operating unregulated and without permission as they had assumed that the NGO would have done this.⁹⁴ I can only speculate on the damage to the NGOs reputation amongst its current and potential volunteers after their return home from an expensive and unproductive trip. The IHV NGOs I encountered in this study would all consider themselves *bona fide*, but a minority of NGOs did not always act and communicate with authorities to an appropriate standard that would be viewed as ethical and legal. Take for example an NGO that commonly seeks *permissions* to work in an area only from a local health worker, who is not empowered to give *permissions*, rather than district and national governments in SSA who are thus unaware of their presence. On challenge this NGO believes it is acting ethically and legally as it has sought some form of tacit approval, but I argue that it is not.⁹⁵

Additionally, I found that some individual UEHVs were well aware prior to and after programmes that they were operating illegally in host countries in SSA. Some felt that the regulatory environment was such in SSA that it was either unimportant to be regulated or unnecessary *red tape* or too difficult to be regulated or that permission from a local health worker was sufficient. Comments from UEHVs in this situation were that regulation in SSA was less regulated so nobody would find out anyway.⁹⁶ Other researchers have also identified gaps in good regulatory practice in the IHV phenomenon, with one systematic review on short-

⁹⁴ Reported by person SEM1A in document F3M (p. 89, l. 12-23).

⁹⁵ For example, person GVM9A is unaware of this when challenged by person GNF2 regarding programmes in Country 3. See document F2M (p. 108, l. 14).

⁹⁶ For example, see person GVF14 who discusses this with AP in document C3 (p. 13, l. 7-18).

term *medical missions* indicating that better oversight is required (Roche, Ketheeswaran and Wirtz, 2017).

The UEHV is extremely vulnerable if operating illegally in SSA, risking deportation and criminal charges in the host nation and investigation by their host country professional regulator on return. Host nations in SSA make it very clear that practising without registration is inexcusable and illegal (Kumpalume, 2016).⁹⁷ In my observations though I found an example of where an NGO was operating programmes in one study SSA country without appropriate permission with unregistered UEHVs in an underserved community. This was managed by a government official in a very forgiving and humane manner as their IHV programmes were considered needed and of a high standard. The person chose to educate, instil insight and remediate the NGO by helping them to negotiate the regulatory requirements indicating to me that it will:

*Not be easy as they have shown great discourtesy by not going through the proper channels.*⁹⁸

I sensed that being needed was important for the remediation of this NGO as opposed to recourse to charges and deportation. Furthermore, I interpreted that what was important to the health official was the disrespect shown by not obeying the regulations rather than the actual illegality of the NGOs omissions. Yet there was no defined pathway to deal with such transgressions. Take another example where a UK health worker recruited a team and embarked on a private clinical mission with no appropriate permissions to a study SSA country but without interpreters. When they arrived, they recruited interpreters by paying health students for the role during the students' exam period. As the financial incentive was high and the students were economically poor, they claimed they were sick and could not sit their exams. Members of the UK team chose to broadcast activities with photographs on social media. The students' teachers found out with negative consequences for the students. The UK team returned oblivious to the mayhem they

⁹⁷ See Kumpalume (2016) in this video at 1 minute, 50 seconds to 2 minutes 2 seconds. Note this video has some disturbing content and viewer discretion is advised.

⁹⁸ Reported by person SEM1A in document F3M (p. 102, l. 18-23).

had created for the students, with regulators⁹⁹ in the SSA country being unable or unwilling to find a way to address the situation with the UK team effectively or prevent repetition.¹⁰⁰ Undoubtedly a lack of consistency in dealing with these types of breaches means that they are likely to continue, but perhaps a blind eye is turned on occasion as some healthcare, even if unwanted, is sometimes considered better than none by SSA interest-holders.

In addition to regulations and law, UEHVs and NGOs operating in SSA have much good practice guidance to inform appropriate practices. As an example for UK volunteers, risk management when working abroad is extensively covered by UK guidance for NGOs (The Charity Commission, 2013). For UEHVs and NGOs there is significant guidance relating to many aspects of volunteering including cultural competence, *soft* skills and professional behaviours from healthcare interest-holders such as government and royal colleges (Department of Health, 2010; Fergusson and McKirdy, 2017). However, Roche, Ketheeswaran and Wirtz (2017) concluded that there remains a need for clearer guidelines to design global standards for the benefit of patients and recipient health services. This may be an aspirational notion given the cultural differences in recipient nations throughout the world. In the NGOs studied in this research much pre-trip orientation took place which tried to embed the main features of these sound principles within their UEHVs. However, I observed some UEHVs discussing experiences in previous volunteering trips with a variety of organisations where little or no attempt was made to inform UEHVs of either expectations or good practice guidance prior to an IHV programme.¹⁰¹ I argue that this omission risks the potential for poor practice and vulnerability for the UEHV as good practice guidance may be unknown and unintentionally not adhered to. Whilst not binding, robust guidance is something incumbent on a UK health professional registrant to both find out and pay attention to (General Dental Council, 2013).¹⁰² Failure to do so in IHV risks potential negative regulatory consequences for the UEHV from host country professional regulators.

⁹⁹ Person SYM4 took this to the SSA regulator but no action was taken. See document C3 (p. 5, l. 30-31).

¹⁰⁰ See document C3 (p.5, l. 19-31). See also Figure 12 in Section 3.6 of this thesis.

¹⁰¹ See for example, the report of person GVF4A in document T1 (p. 47, l. 23-24).

¹⁰² See GDC standard 7.1.

Guidance in IHV however also comes from transnational bodies such as the WHO which are highly valued in SSA. For example, NGO volunteer programmes in SSA commonly involve *task-shifting* indigenous lower and middle grade health workers by specific training to improve local capacity to undertake new tasks, for example, the provision of spectacles in rural areas. The WHO produce extremely robust and helpful guidance regarding this (WHO, 2008). Similarly, many NGOs donate healthcare equipment to LMICs as part of IHV programmes and these are also covered by good practice guidelines (WHO, 2011b). Unfortunately, I observed in my study a lack of awareness amongst NGOs and health workers in SSA of these guidelines so without awareness compliance is unsurprisingly poor. Furthermore, guidance from transnational bodies sometimes does not appear to be updated regularly so elements of it become outdated or less relevant. Take for example the *task-shifting* guidance which emanated primarily as a response to the HIV-AIDS pandemic, where much *task-shifting* took place in SSA (WHO, 2008). This guidance has not been updated since 2008 and thus has failed to take account of the needs of a broader range of current *task-shifting* interest-holders in SSA.

To summarise, I found that there is much room for improvement in the regulation of IHV to ensure that volunteering is as safe and effective as possible for all concerned in SSA. A minimum standard of compliance with local regulations by NGOs and GNHVs, in my view, is necessary to ensure respect and good relationships with African collaborators and to better underpin the universal values of professional ethical standards. Whilst negotiating regulation in SSA may take longer and be the cause of frustration for NGOs, GNHVs and SSA health workers, spending the time getting these matters right first time has many benefits for all involved in IHV in the two SSA countries.

1.11 Health services in SSA

It is necessary to explore health services in Africa to understand how IHV interacts with health services as this is where IHV efforts are primarily located. I have limited my discourse to anglophone SSA as this has been the main area of focus of this study, although there are many similarities in health services between anglophone SSA, francophone SSA, lusophone SSA and hispanophone SSA (Azevedo, 2017). As I have already discussed in Section 1.3, the initial foundation

of mission hospitals has left a historical distribution of health services in Africa leaving marked differences in coverage with some areas better served and other areas underserved in modern times.

Most government run health services in SSA commonly adopt a pyramidal structure of varying layers (dependent on nation) with the base layer primarily being village health services scattered across the country. Nomenclature will vary from nation to nation, but this bottom layer primarily consists of health posts or multi-purpose community-based centres staffed by village workers often nominated by the village with minimal health training. This layer offers primarily preventive advice. The next layer are the dispensaries staffed by a combination of nurses or medical assistants.¹⁰³ These will provide vaccination programmes, dispense common medications including anti-retroviral therapy for HIV-AIDS, and be involved in childbirth often having birth attendants. The next layer is found in larger towns who will have health centre facilities and often have clinical officers¹⁰⁴ in their staffing cadre, so simple surgeries and more complex births are managed here. It is only at the district hospital level that more advanced facilities appear such as eye departments, dental departments, radiology departments and operating theatres. Some more qualified staff will likely be in district hospitals like assistant medical officers,¹⁰⁵ dental therapists and in some but not all instances' doctors or dentists appear together with some specialists.

This district hospital layer is very important and a great demand on health budgets. In some instances, African governments enter into agreements with other interest-holders such as religious groups, and foreign governments to financially back these institutions. For example, during my various fieldworks I observed a government run district hospital funded by the Mennonites,¹⁰⁶ and another funded by a development fund of the Norwegian Government.¹⁰⁷ The final layers are the regional hospitals which will vary in facilities as regions in SSA can be predominantly rural with less facilities in their main town or city to quite urbanized regions with airport connections. Some will have much more robust facilities, which varies from country-to-country, and often involves considerable financial

¹⁰³ Typically, a person with two years formal medical training.

¹⁰⁴ Typically, a person with three years formal medical training.

¹⁰⁵ A clinical officer who has undertaken at least another year of formal training.

¹⁰⁶ The locus of fieldtrip 4 for the first week was in such a site. See document F4M.

¹⁰⁷ The locus of fieldtrip 2 for the first week was in such a site. See document F2M.

backing from the Global North. Finally, some but not all countries will have referral or national hospitals at the pyramidal apex with specialists, sometimes visiting surgeons from overseas, and a reasonable range of advanced diagnostic facilities. The two SSA countries in this study operated the pyramidal structure described above.

At first sight the pyramidal structure looks a laudable approach, but it is fraught with practical difficulties. Most health services in SSA are decentralized so it is the districts who usually hold the budget of which health is only one part. Health in a district can sometimes be at the mercy of one or two individuals, the local politician and the local council executive, people with many conflicting demands on a limited budget. On every fieldtrip, without exception, I observed that the VPO insisted that on day one the whole volunteer team must pay a visit and show respect to them. This inevitably resulted in a photo which was used to show what they were doing for health in the district.

On one occasion the local politician of a particular district decided to then visit the programme with a national television company crew to hold an event and inform the *nation* that the volunteer trip was an example of how he was improving health in the district.¹⁰⁸ This local politician and the local council executive had been underfunding health for a long time, so a volunteer visit was something of a political gift for the local politician that they wanted to publicise. On the day the local politician arrived, a visiting dignitary¹⁰⁹ was also visiting, and they were very unhappy with the local politician and local council executive who had allegedly failed to fund a particular cadre of health professional staff. They argued on live national television which caused the local politician and local council executive to feel disrespected with the volunteer team caught in the middle.¹¹⁰ I sensed the utility of the volunteer team was thereafter unimportant to the local politician. Future planned trips were cancelled by the district with health continuing to be underfunded as likely there was insufficient political gain for him.

¹⁰⁸ It appeared that in this instance the local politician (person SEM5) hoped to take full credit at the expense of the local council executive (person SEM4). See document F1M (p. 30, l.10 - p. 33, l. 3).

¹⁰⁹ Person SYF1, a representative of a national health professionals association. See document F1M.

¹¹⁰ This is seen with the involvement of persons SEM4, SEM5 and SYF1 in document F1M (p. 30, l.10 - p. 33, l. 3).

As districts are financially responsible for their health personnel and facilities, with stretched budgets major problems are commonplace. Facilities often have a lack of equipment which is poorly maintained, have unreliable supply chains with basic supplies that simply cannot be sourced or are beyond expiry dates. Sometimes supplies are inadequately stored in hot conditions, combined with poor maintenance of health facility infrastructure which is often dilapidated and/or dirty (Azevedo, 2017). Even at regional and national hospital level of the pyramid it is noted that important diagnostic and therapeutic equipment can be unavailable due to cost, with operations cancelled for lack of simple supplies like sutures (Wendland, 2010).

In my study I observed in all levels of the pyramid and found widespread deficiencies in every level such as lack of local anaesthetic and basic medicines and inadequate or no electrical or running water supplies in health centres and dispensaries, and sometimes in district hospitals. In district and regional hospitals, I found that it was commonplace to find that there was a lack of basic equipment together with broken-down items such as X-ray machines. I found that there was sometimes donated equipment from the Global North installed that could not be used as there were inadequate services available for function meaning unusable equipment simply filled a space that could not be repurposed (see Figure 2).

Additionally in regional hospitals there was much receipt of often NGO donated supplies that were disorganised, not unpacked, contained supplies that would deteriorate with time and were sometimes unwanted (see Figure 3). All these things contributed to, at times, a dysfunctional structure and poorly functioning health services.

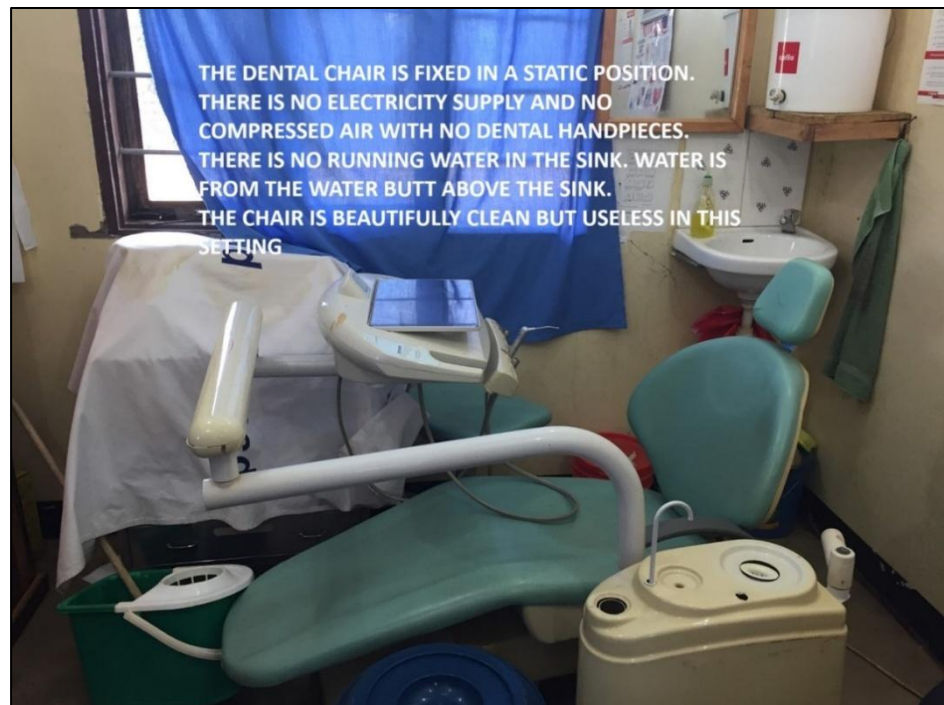


Figure 2: A dental chair donated by a Global North NGO in the dental room in a district hospital (Commentary added by AP to the photograph).



Figure 3: An office in a regional hospital with deteriorating, disorganised and unpacked donated supplies and equipment.

In most SSA health systems, healthcare is not free to users but with some degree of basic free care which varies from country to country. Most countries offer some form of health insurance. Tanzania offers an example typical of the region where government workers have a mandatory salary deduction and join the

National Health Insurance Fund (Afriyie *et al.*, 2024). For others a voluntary Community Health Fund can provide some insurance, but many are uninsured as poverty means there is no ability to contribute. A combination of the necessity to contribute user fees, health workers spending time in private practice to supplement their income, and the exclusivity of insurance schemes means some individuals are simply not seen. Inevitably the most disadvantaged, uneducated and those living in rural areas sometimes do not engage with health services and instead prefer the services of traditional healers (Azevedo, 2017). Even in circumstances such as pregnancy, where healthcare is usually free, often the additional need to demonstrate poverty brings stigma within uneducated local communities leading to the neediest disengaging from health services (Azevedo, 2017).

In the fieldtrips that I undertook with NGOs and UEHVs health services were offered free to patients, and it was commonplace to be inundated with large patient numbers at dispensaries and health centres. In some cases, serious clinical issues were discovered that required immediate management further up the pyramid at district hospital level, but this necessitated funding by the NGO as the patient inevitably would not be able to pay. On one occasion a patient attended with an acute life-threatening condition requiring a simple but urgent procedure under general anaesthetic at the district hospital in the district that the programme was taking place. The patient was informed of the cost being around £64¹¹¹ (see Figure 4) and indicated that they must instead *go home and die*.¹¹² The NGO funded the patient but both I and the middle grade health worker involved reflected on the fortune the patient had in attending during the NGO visit. A week earlier or a week later, and they would be likely dead. The health worker informed that this was a common issue rurally and I was left certain of the knowledge that on any other week the patient would not have been so fortunate.¹¹³ It seems from my observations that some health services in SSA lack a safety net with the rural poor being disproportionately disadvantaged.

¹¹¹ This is an estimate from currency conversion rates at the time into British pounds.

¹¹² A patient (SCM3) reported this to AP, translated from local dialect at the time by person SHM3A. See document F2M (p. 92, l. 13).

¹¹³ Person SHM3A was the middle grade health worker involved. This incident is detailed in document F2M (p. 90, l. 37 - p. 93, l. 16).

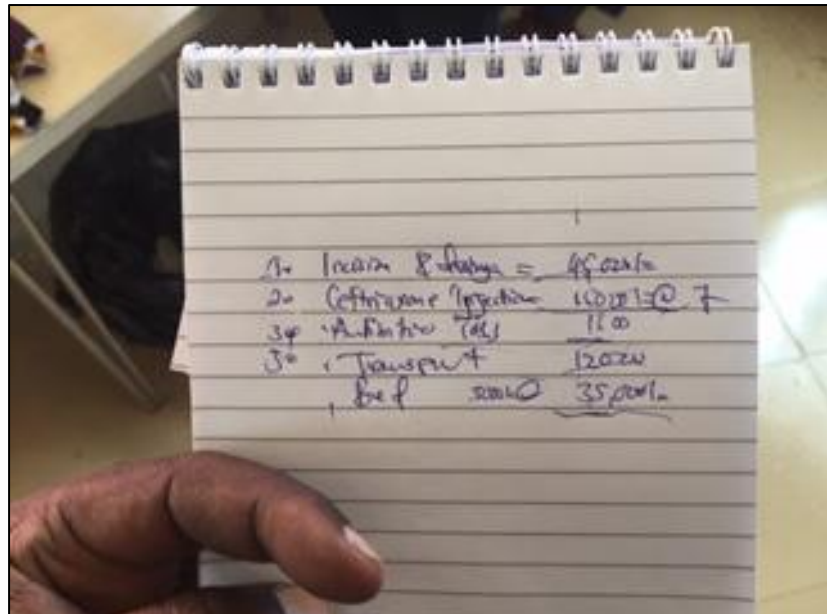


Figure 4: This user fee at a district hospital in local currency is £64 but equates to life or death for a patient

Recruitment and retention of health professionals in health services is problematic, particularly in remote and rural areas in Africa. This seems to be worst for mid-level cadres with 31% of posts unfilled in SSA (Dambisya *et al.* 2014). Of particular concern is the movement of health workers from rural to urban settings, public to private sector, and primary to tertiary care (Dambisya *et al.* 2014). Drivers for this remain unclear as literature abounds with articles that relate to rural recruitment and retention in higher income countries such as Canada and Australia, and most studies are not focussed on SSA. A study conducted in South Africa found that health professionals leave their posts due to corruption, safety of themselves and their families, poor infrastructure, and to give their children a better future (Labonté *et al.* 2015). South Africa is atypical of the region as it is one of the more economically developed areas of SSA and these findings may not be fully applicable to other SSA nations. In some instances, in SSA, in the public sector health workers are posted to areas with little regard to personal circumstances. Failure to report to postings is commonplace and some leave very soon after reporting. This is seen in Tanzania where only 63% of posted workers were still in post after a few days (Ministry of Health and Social Welfare, Tanzania, 2014). I saw instances of this in my research with a lower grade health worker being posted to a rural district whose population spoke a regional language of which they had no

knowledge.¹¹⁴ They were actively attempting to leave as they were unable to communicate with patients. In another example, a middle-grade health worker was posted three days overland travel away from his family and was disillusioned and depressed.¹¹⁵

Other factors affecting retention in African health services are staff shortages and unreasonably high workloads (Bradley *et al.*, 2015), poor infrastructure and poor management (Mbaruku *et al.*, 2014) and personal and patient safety (Shemdoe *et al.*, 2016). Whilst there are recruitment and retention issues amongst all health professionals, this was most pronounced within cadres such as clinical officers whose loss caused significant care disruption (Shemdoe *et al.*, 2016). Perhaps this is due to these cadres acquiring many additional duties from being *task-shifted* than those which they were originally trained to undertake. In my fieldtrips I had much interaction with these cadres of staff some of whom were trying to move on and who expressed feelings of overwork, exhaustion and demotivation. However, this was true of senior health workers also with many covering additional roles for years. For example, one person had been an acting regional health official for a region of 2.2 million people for over three years. This person was not a qualified physician and with no hope for recruitment they expressed sadness at their inability to undertake their own profession.¹¹⁶ They eventually left to a private practice setting. Situations like this are not uncommon.¹¹⁷ Some African governments are trying to address some of these issues by putting training schools near rural areas, actively recruiting health workers with rural backgrounds, and promoting rural experiences within health professional education. However, these changes will take time and health worker shortage is likely to persist for some time to come (WHO, 2021).

A basic understanding of SSA health services is essential for volunteering organisations and GNHVs, particularly those in a leadership role. Within this, collaboration is essential with local VPOs so that a better appraisal can be had of

¹¹⁴ For example, this applied to person SHM9. See document F1M (p. 43, l. 5-7).

¹¹⁵ For example, person SHM3A. See document F2M (p. 67, l. 32-33 and APs reflective comment on p. 68, Fn. 263).

¹¹⁶ For example, person SHM1A. See documents F1M (p. 9, l. 39 – p. 10, l. 2) and F4M (p. 75, l. 1 - 28).

¹¹⁷ For example, person SHM6A left their position in the region later filled by person SHM1A to go to a more urban region where there were more health professionals to share the load. See document F1M (p. 10, l. 15-16).

current conditions for specific programmes. The simple logistics of running programmes, particularly in rural areas, depend not only on understanding matters of hierarchy, referral, logistics and structure but require a pragmatic approach to the likely problems encountered. On my fieldtrips a source of frustration was that interactions with VPOs nearly always resulted in being informed that *there are no problems* to find on arrival in the field there were profound and deep-rooted problems.¹¹⁸ For some reason the VPOs find it hard to tell of the true situation. Overtime I sensed that this was largely the VPOs attempt to *protect* the IHV NGO from the truth, perhaps in case they refused to report to the programme. I travelled several times with one VPO senior administrator¹¹⁹ who always informed me that there were no problems but said with a wry smile. I interpreted that what they really meant was that there were no problems that they thought could not be solved together. I found multiple situations within programmes related to African health services that required immediate problem solving and adaptability despite being told that *no problems* existed. Some examples include arriving to find the health facility had been used the previous day for a circumcision clinic with dirty sharp instruments throughout rendering it unsafe.¹²⁰ On another occasion the *health facility* turned out to be a government outhouse used as a grain store infested by rodents.¹²¹ Other issues I observed include lack of basic supplies promised by the host district under MOU agreement,¹²² a senior health worker being absent from duty,¹²³ and failure of local staff to report on a timely basis.¹²⁴

Understanding the nature and likely problems around African health services allows IHV NGOs and VPOs together with their respective leaders to better set realistic expectations and goals. In addition, it allows them to contingency plan for the largely known problems that are likely to be encountered on IHV programmes. Without this understanding a volunteer organisation or an inexperienced programme leadership team or urban based SSA health workers may

¹¹⁸For example, person SPM2 (see document F2M, p. 63, l. 18) and person SPM6 (see documents F2M, p. 54, l. 41 and F4M p. 24, l. 1-3) adopted this approach.

¹¹⁹ Person SPM6 in fieldtrips 1, 2 and 4.

¹²⁰ See document F2M (p. 87, l. 17-24).

¹²¹ See document F1M (p. 48, l. 6).

¹²² See document F2M (p. 73, l. 22-31).

¹²³ Person SHM18 never reported for duty leaving the IHV programme short. See document F1M (p. 75, l. 34-35).

¹²⁴ Examples that occurred to some extent in all fieldtrips *inter alia* include persons SHM1A, SHM5A, SHM6A, SHM7A and SHM8A. See document F1M (p. 76, l. 25-26).

become overwhelmed with likely suboptimal programme results. In the following section I will detail my aims and objectives for this research.

1.12 Aims and objectives of this research

This section sets out my aims and objectives that helped guide me in answering my research question. As is evident from earlier in Chapter 1 research into IHV in the two SSA countries and wider SSA is characterised by a lack of empirical studies with much available literature having a focus on Global North perspectives. Furthermore, there is a considerable quantity of academic papers that are presented as case studies, commentaries, editorials and reflections rather than rigorous empirical research. Even systematic reviews regarding *medical missions* have wide inclusion criteria that include these types of papers for review (Caldron *et al.*, 2025; Roche, Ketheeswaran and Wirtz, 2017). In essence there is much to study in the IHV phenomenon in the two countries, so my aims and objectives are borne out of the focus of my research question which I restate being: *What are the main influences on short-term international healthcare volunteering in two sub-Saharan African countries? An ethnographic approach*. My specific aims are to provide a “thick description” (Geertz, 1973, p.6) and detailed interpretation of the IHV phenomenon in the two SSA countries. I hope to add to the wider discourse and literature on IHV by focussing on the under-researched region of SSA by situating my research in two SSA countries. I aspire also to draw out African voices in the IHV phenomenon, whilst not excluding other important facets of the IHV phenomenon, to bring a wide appreciation of IHV in the two SSA countries of study. This will be accomplished through the objectives outlined below:

- To develop a research paradigm¹²⁵ that is rigorous and able to answer my research question given the challenges, compromises and limitations¹²⁶ of study in the two SSA countries.
- To provide sufficient context, background and horizon¹²⁷ for the reader regarding IHV in SSA and the wider SSA region to permit reasonable understanding and critical appraisal of the research.

¹²⁵ My research paradigm is discussed in Section 2.1. The axiological component relating to ethical considerations is discussed in Section 2.3.1.

¹²⁶ Study limitations are discussed in Section 2.3.8.

- To collect¹²⁸ and analyse data¹²⁹ in such a manner that it can be convincingly interpreted to give *an* account of the IHV phenomenon in the two SSA countries.
- To find out what are the main influences¹³⁰ on IHV in the two SSA countries and interpret these for the reader.
- To highlight *an* African perspective¹³¹ within the research question whilst not prioritising this perspective to the detriment of other interest-holders in the IHV phenomenon in the two SSA countries.
- To produce a research report that adds to the empirical literature regarding IHV in the two SSA countries.
- To emphasize other areas of potential study regarding IHV in the two SSA countries and the wider SSA region which were beyond the scope of the research question¹³².

1.13 Chapter conclusion

This first chapter formed a background to IHV in the two SSA countries by both my commentary on my research and inclusion of sections of literature which I deemed important to the understanding of the research question. In consequence I have gone into less depth in some areas. For example, in Section 1.10 I have intentionally omitted to discuss regulation of NGOs and GNHVs in Global North nations choosing instead to focus on regulation relating to IHV in African nations to draw out an African perspective. Similarly, I have not discussed at all the ethical

¹²⁷ My horizon is detailed in Section 2.3.4; much context is provided throughout the thesis with Section 4.2 and its sub-sections providing significant context on African culture; research background is evident in Section 2.1.

¹²⁸ Data collection by largely participant observation is discussed in Sections 2.3.5 and 2.3.6.

¹²⁹ Data analysis is discussed in Section 2.3.7 together with detailed workings and reasoning. Coding can be found in Appendix 5.

¹³⁰ These are discussed in the entirety of Chapters 3, 4 and 5 and summarised in Chapter 6.

¹³¹ This permeates throughout the thesis with recommendations regarding an African perspective in Sections 6.3.1 and Sections 6.3.2.

¹³² This is detailed in Section 6.4

basis of volunteering, as whilst interesting and contentious, it does not relate directly to my research question. Finally, there are both low quality research and gaps in the literature surrounding the IHV phenomenon in SSA particularly around harms and benefits of volunteering so the literature presented should by its nature be treated with a degree of scepticism. Some gaps in literature are present largely because of the challenges of acquiring data on the IHV phenomenon in remote and rural areas of SSA. Whilst they represent an opportunity for further research, actually travelling to some areas of SSA is impractical and potentially unsafe due to poor infrastructure, a lack of basic facilities, political instability, conflict and disease which was the case in the two SSA countries primarily studied.

Within this chapter I included areas referred to in my own research minimally or not at all, for example in Section 1.3.¹³³ These areas were included as I felt they were important to aid understanding of IHV in the two SSA countries even though largely unaddressed by my fieldwork. Other sections were directly addressed by my fieldwork and so in these areas I refer more to my research findings. This engagement with literature should be seen as engagement with the limitations described. By its nature it is neither systematic nor systemised, but it is pertinent to providing sufficient context and addressing my research question. Finally, I set out the aims and objectives of this project that helped me focus on answering my research question. The next chapter will explore my research methodology which allowed me to collect data and interpret the IHV phenomenon in the two SSA countries.

¹³³ Titled *A brief history of international healthcare volunteering in SSA*.

CHAPTER TWO - Background and methodology

Chapter Introduction

This chapter details the background and methodology which drove my research on the IHV phenomenon in the two SSA countries. The chapter will start with two background sections. The first section discusses why I undertook this research and gives valuable information on my personal background as it relates to the IHV phenomenon in SSA. My background is important given the hermeneutic nature of my enquiry and should enable the reader to understand later in the thesis how my background may have impacted my interpretation of the IHV phenomenon. This section additionally addresses the formulation of my research paradigm and discusses the axiological, ontological and epistemological dimensions of my research. The second section discusses how and why I formulated my research question which is pivotal to this work.

Most of this chapter gives the reader context, background, reasoning and justification for how and why I undertook a qualitative ethnographic approach to answer my research question, and the specific methodology I used to come to valid and reasonable conclusions. It further gives the reader information on the difficulties I encountered during my research such as managing ethical concerns, triangulation, reflexivity, data prioritisation, role conflict, data analysis, limitations, and exclusions from the study of the IHV phenomenon. In addition, it discusses why and how I foregrounded an African perspective in interpretation of the IHV phenomenon in SSA. A significant amount of methodological literature will be referred to in this chapter so that the reader can appraise my methods against accepted qualitative methods.

My aim for this chapter is to give the reader clarity regarding the origin of my research question and its significance and relevance for study together with the methods undertaken to produce my interpretative account. I hope that I have provided a sufficient background story that engages readers with not simply a valid account, but a compelling account of my research. Furthermore, this chapter should

give the reader a road map to understand how I approached research of the IHV phenomenon in the two SSA countries.

2.1 Research background

My personal background is embedded in Africa. My childhood was largely spent in Uganda and Malawi but predominantly Uganda until conflict and regime change necessitated a move to Malawi. In both these nations, as a child, I witnessed the effects of diseases such as sleeping sickness, malaria, leprosy and river blindness. On later reflection, as an adult, I realised I had observed some of the gaps in health services in SSA, although I had no real appreciation of this at the time. I had positive role models in my parents who volunteered in a leper colony in Uganda and in a river blindness research centre in Malawi. I would frequently visit these sites, and I gained some appreciation of health and disease and how volunteering could help ease suffering.

Whilst I physically left Africa, in my mind, I never left. I entered a health profession and at the first available opportunity, my elective, I participated in a summer long elective as a UEHV in urban and rural Kenya in my chosen profession. Upon graduation I was involved with various NGOs related to a variety of IHV programmes in SSA. On later reflection some of these experiences whilst positive at the time were far from ideal in respects like producing meaningful impacts for SSA communities. I had a hiatus from IHV in SSA when my own children were young but during this time, I supported an IHV NGO who sent UEHVs to SSA.

Returning to being an UEHV I had by this time realised that there were differences in standards between IHV NGOs and therefore, I chose who to volunteer for, carefully selecting an NGO that I felt offered real benefits to SSA communities. I volunteered several times and still volunteer for this NGO. Later some of the fieldwork for this research would be undertaken during volunteer programmes with this NGO in the two SSA countries. During the time I started volunteering for this NGO, I enrolled in a Master of Laws degree and decided to write a dissertation looking at regulation, law and distributive justice in IHV. This

was my first foray into academic study regarding IHV which left many questions unanswered that I wanted to study further. During these studies I recognised that IHV is an under-researched area within the academic literature, with mostly personal accounts of volunteering experiences from individual volunteers and NGOs giving a Global North perspective. I decided to try to address that lacuna by examining IHV from a host community perspective rather than looking at IHV solely through the lens of the UEHV or Global North volunteering organisation.

I chose to study the IHV phenomenon predominantly by fieldtrips with IHV NGOs in two SSA countries in SSA. Selectivity of where I would study was a necessary function of my own context. Opportunities for access to the phenomenon to be studied required access to be negotiated through my existing roles within IHV in the two SSA countries. This was negotiated by discussion with the IHV NGOs and senior SSA actors. (see Section 2.3.1 for further details regarding access). For me though as I later would state in a bracketing interview at the start of this study with my primary supervisor:

“The connection I have with the region (SSA) means...it’s never been in my mind that I would go anywhere else.”¹³⁴

I will discuss aspects of selectivity in more detail later in this chapter in Sections 2.2, 2.3, 2.3.2, 2.3.7 and 2.3.8 and bracketing will be further addressed in Section 2.3.2.

To conduct my research, it was necessary for me to have an appropriate research paradigm to guide my approach to study. Axiology is considered to be the first building block of a research paradigm and considers the value of the research and ethical considerations (Brown and Dueñas, 2019). My first chapter presents sufficient background to IHV in the two SSA countries to demonstrate the gaps in understanding of the IHV phenomenon, giving adequate value to my research. In addition, I bring my own values, in relation to my personal background and association with Africa, to this research as this relates to the values behind my motivation for the thesis topic. In Section 2.3.1 I address ethical considerations to show that these were built into my research paradigm.

¹³⁴ See transcript of my bracketing interview in document B1 (p. 5, l. 19-23).

The epistemological approach I undertook to explore IHV in the two SSA countries relates to interpretivism as I was attempting to study a multi-faceted phenomenon that involved “humans as actors in the social world” (O’Reilly, 2012, p.53). Furthermore, interpretivism seeks to understand behaviour in the context of a particular culture/society (O’Reilly, 2012). In my research, the particular cultures I was trying to interpret were located within IHV in the two SSA countries. I brought to this research my own horizon of understanding and biases which I will later discuss in Section 2.3.4. I sought to try to create an epistemological basis that allowed me to adequately study the types of evidence that I was likely to encounter in the phenomenon of IHV in the two SSA countries. These included the need to investigate during IHV programmes activities like training, observing, assessing, socialising, de-briefing and problem-solving, etc. Investigating these required me to participate and observe in meetings, conversations, speech-in-action, decision-making, correspondence, and social media posts etc., related to IHV.

From an ontological viewpoint there were many things about the IHV phenomenon in the two SSA countries that I knew already from my own background (see earlier in this section) that interacted with my research. Additionally, there were things regarding the phenomenon “that we can know” (O’Reilly, 2012, p. 52). For example, I knew something about or could find out about the practices, behavioural tendencies, particular actions, motivations, attitudes, values, perceptions, feelings, discourses, choices, policies, organisational cultures and collaborations etc., related to IHV. In addition, given my participant roles I had strong knowledge of systems and existing relationships meaning that I could find out about the IHV phenomenon at both programme level and strategic level. Considering axiological, epistemological and ontological aspects it was obvious that the kind of evidence that I needed to study the phenomenon was subject to interpretation and not proof. I thus felt that it could only be reasonably investigated by a rigorously conducted hermeneutical approach (see Section 2.3). This lent itself to qualitative enquiry and my methodology (which forms the remainder of this chapter) is thus guided by my axiological, epistemological and ontological approach to my research question.

This Section represents why I undertook this research together with my axiological, epistemological and ontological approach within this study. I will now go onto discuss how I formulated my research question.

2.2 Formulating a research question

My original intention with this study was to attempt to interpret IHV in its widest Global sense. It became clear early during my study that with all field sites being in the two SSA countries, for practical reasons, which I will discuss later in this chapter, that extrapolating potential interpretations to other cultures was inapplicable beyond SSA. Additionally, early into my research ongoing interpretation from my fieldwork in SSA meant that African culture was a theme that was going to be important in this study. As Idang (2015) highlights there are core similarities shared throughout African societal life which differ markedly from other cultures. For example, trying to interpret the IHV phenomenon in a South-East Asian¹³⁵ situation would be fruitless given materially significant differences between cultures¹³⁶ because as Wolcott states when discussing the nature of ethnography:

Cultural interpretation...is the essence of the ethnographic endeavor.
(Wolcott, 1985; p.190).

Finally, as I have already discussed in Section 2.1, I have a lesser understanding of culture out with Africa given my own background and life choices, so the locus of the research question became the two SSA countries. However, given commonalities within African culture the results of my study may have considerable relevance to the IHV phenomenon throughout SSA.

Despite this locus, I felt that it was necessary to collect data from all aspects of the multi-faceted IHV phenomenon to fully appreciate the influences on IHV in the two SSA countries. The Global North perspective on IHV is an important part of this study and given my roles within one of the IHV NGOs this presented an

¹³⁵ South-East Asia comprises 11 countries divided into mainland (for example, Thailand and Vietnam) and maritime (for example, Philippines and Timor-Leste) zones.

¹³⁶ To some extent African societal life exhibits core similarities across territories (see Sections 4.2, 4.2.1, 4.2.2 and 4.2.3). This is not the case in South-East Asia, see (Ullah and Ming Yit Ho, 2020).

opportunity that I used to collect and analyse data that interpreted the organisation, priorities, workings, networks, and management of an IHV NGO as it related to SSA. Additionally, it allowed exploration of the various collaborations between NGOs and other IHV interest-holders in the UK and SSA. The opportunities that I had for study on fieldtrips were limited to short-term volunteering, I thus could not reasonably extrapolate influences to include long term volunteering, so my research question is thus directed towards short-term volunteering. I felt it important to clarify the main methodology that I chose to study the IHV phenomenon for the reader within the title of my research this being an ethnographic approach to enquiry. Whilst not contained in my research question it is important that the reader is aware that from the outset I sought to highlight within the study African perspectives related to IHV from indigenous individuals, local NGOs, VPOs, governments, and communities in the two SSA countries. This was to try and give voice to their views which had largely been unheard in previous study. I will discuss this in more detail later in this chapter.

Ultimately my research question of *What are the main influences on short-term international healthcare volunteering in two sub-Saharan African countries?* An ethnographic approach allows me to both discuss influences that affect the IHV phenomenon that are of overarching importance to those in the Global North and SSA as well as foregrounding, but not privileging African perspectives on SSA. I will now go on to detail my methodological reasoning as to how I developed this study to attempt to answer my research question.

2.3 Methodological reasoning

Answering my research question lent itself to an interpretive approach as enquiry of the IHV phenomenon required a “thick description”¹³⁷ to understand its many facets (Geertz, 1973, p.6). This meant that my description was analytical rather than superficial as:

Culture is not a power, something to which social events, behaviors, institutions, or processes can be causally attributed; it is a context,

¹³⁷ Geertz (1973, p.6) indicates that he “borrowed the notion” of “thick description” from Ryle (1949).

something within which they can be intelligibly - that is, thickly - described (Geertz, 1973, p.14).

Such a thick description is inappropriate for quantitative methods. The empirical component of this research studied the IHV phenomenon in two SSA countries by a multi-sited study using an ethnographic approach, as described by Marcus (1995) and Candea (2009). The primary focus was on two case study IHV NGOs who applied different methods to addressing similar goals (primary healthcare, training of health workers and health education, promotion, and coaching) in two SSA countries. Participant observation was my principal method of study as it allows exploration of the IHV phenomenon by offering a logical framework and process of scrutiny that supports flexibility, has no pre-determined boundaries, is opportunistic and needs problems to be reshaped dynamically (Jorgensen, 1989). I had a reasonable understanding of where the loci of my study should be situated before embarking on this research. For example, I knew they were likely to be situated in challenging resource-limited environments in the two SSA countries where health illiteracy and lack of community health workers were prominent. Additionally, I knew some communities would have experienced IHV before, some with negative and others with positive perceptions and some would never have encountered GNHVs before. Participant observation was my main data collection tool as I firstly had increasing roles and opportunity as an UEHV to volunteer with and/or collaborate with these NGOs, and thereby to undertake fieldwork in an appropriate SSA setting. Secondly, the likely role of participant observation in ethnographic study meant that I had opportunity to gain an insiders' view as I was a member of the IHV community of practice. This was important as deeper meaning is mostly not revealed to outsiders according to Jorgensen (1989). I will discuss participant observation further in Section 2.3.5.

I felt that recording of some demographic data would be needed as Marshall (1996) argues that some demographic data recording is required in an ethnographic approach to indicate suitability for study inclusion. However, the caveat here was the need to adhere to good practice in demographics which involves only recording data relevant to or which may affect the study (Polit and Beck, 2012). In my research, data that I included was sex, and role(s) in relation to the IHV phenomenon in the two SSA countries. I felt sex to be useful data to collect as

women are underrepresented within healthcare professions in Africa (Monnet, 2015). I will discuss data collection later in Section 2.3.3 regarding triangulation and Section 2.3.6 regarding the different types of data I collected.

With the support of my primary supervisor, I planned a methodology of using thematic analysis to analyse the *data corpus*, as described by Boyatzis (1998). I chose this method because it was a good fit with my research paradigm as I required an interpretive and hermeneutic approach to analysis. Hermeneutics is an interpretation theory (Rodham, Fox and Doran, 2015). It is a philosophical process that can disclose meanings by interpretation through written word and beyond text to look at images and actions as forms of discourse. Clarity in disclosing “paradigmatic orientations and assumptions” (Kiger and Varpio, 2021, p. 846) is essential to ensuring that research suppositions and interpretations are considered trustworthy with this analytical methodology. I have already detailed this information regarding my research paradigm in Section 2.1. In addition, thematic analysis is a flexible tool which organises structures within data and can give a rich and detailed description of a dataset, whilst additionally coping with complex data (Braun and Clarke, 2006). Additionally, it is one of the few analytical tools in qualitative research where there is consensus that it is a core skill in thematizing meanings (Holloway and Todres, 2003). Thematic analysis has the added advantage that:

It allows a researcher...to more easily *communicate* his or her observations, findings, and interpretation of meaning to others who are using different methods (Boyatzis, 1998, p.6).

However, it is a method that is criticised for having inadequate guidance around how it is undertaken (Antaki *et al.*, 2003). This has enhanced the critical notion that in qualitative research “anything goes” (Antaki *et al.*, 2003, p.16). Braun and Clarke (2006) detail a flexible but sound road map for thematic analysis using a six-stage process which answers much of the method’s critics. It was this process that I aimed to follow.

Data analysis is an iterative process with no predefined themes or categories. The talk of qualitative data analysis is often of themes that emerge from

the data (Rubin and Rubin, 1995; Singer and Hunter, 1999). This might imply a passive process which derives passivity in the emergence of themes from data. I prefer the notion of an active process where themes exist in the brain derived from thinking about the data then linking data as understanding develops (Ely *et al.*, 1997). I understood that data collected was likely to be *messy* data, as described by Lee (2004), due to its heterogeneity. However, due to the unanticipated volume of data collected I needed to make decisions regarding data prioritisation during this study. I will discuss the thematic analysis I undertook in detail in Section 2.3.7 and will return to data prioritisation in Sections 2.3.8 and 2.3.9. The following sections from 2.3.1 to 2.3.9 will give a detailed account of my methodology which I will commence with ethical considerations.

2.3.1 Ethical considerations

Ethical approval was sought and granted by the University of Glasgow MVLS College Ethics Committee for this study (Project number 200160134).¹³⁸ In particular, approved methods allowed were the use of semi-structured interviews and participant observation for data collection. I noted in my research ethics submission that risk to informants was minimal, however in common with ethical principles of an ethnographic approach I reflected that I must be continually aware of potential risks such as causing offence by use of culturally inappropriate language and gestures (Karpf, 2006). Additionally, as my research progressed, I tried to follow the robust guidelines of the UK Statistics Authority (2022) who produce a useful checklist and additional resources for qualitative research methods.

Relevant access permission was sought and granted from the study NGOs whose programmes were to be the loci of the fieldtrips. This was done in the case of NGO 1 by written application and verbal explanation and was decided by the NGO programmes manager and chairperson of their clinical advisory group. I was asked to respect sensitive confidential information as the only caveat, as discussed in the previous section. In terms of NGO 2 access permission was sought later in the study prior to me visiting their programme and granted by two decision makers

¹³⁸ The MVLS College Ethics Committee approval letter together with explanatory notes forms the entirety of Appendix 6.

in the NGO. No caveats were asked of me, but I chose to respect the same standard of confidentiality as with NGO 1.

As the four fieldtrips were occurring in two SSA countries I needed permission to conduct semi-structured interviews in these locations. Attempts were made by me to obtain ethical approval with relevant National bodies within the countries of potential study in SSA. This proved problematic as there appeared to be no known body who could be identified to submit any application in that the nature of the study was not viewed by the National bodies as *research* in that it was neither clinical trial nor research involving a procedure on a human subject. Therefore, the project seemed to not fall under the remit of anybody. This was an unsatisfactory situation that left me with a degree of uncertainty as to the ethical appropriateness of conducting semi-structured interviews in the two SSA countries. I thus decided to omit semi-structured interviews entirely from my methodology to ensure no ethical compromises were made although another reason why I did not use this well accepted ethnographic method was due to conflicts of interest which I will discuss in Section 2.3.4.

The promise of confidentiality in research has been discussed for decades as essential to protect individuals from harm (Demi and Warren, 1995), to uphold good ethical practice and research ethics (Bogdan and Biklen, 1998), to maintain privacy (Fontana and Frey, 1994) and to ensure accuracy and integrity of data (Bogdan and Biklen, 1998). In addition, institutions wherein researchers work are bound by regulations, principles, guidelines, and laws to uphold standards of confidentiality and data protection.¹³⁹ Confidentiality though causes the qualitative researcher a predicament. Effectively a qualitative researcher may either discuss accurately the results which may expose individuals to potential harm and/or loss of privacy or choose to withhold discussion of some matters which potentially questions the validity of the research (Baez, 2002). I will return to this last point when I discuss exclusions in Section 2.3.9.

¹³⁹ See for example, the *code of good practice in research* of the University of Glasgow (2023) which I adhered to during this study.

At the outset of the research, I was aware from recent past experiences¹⁴⁰ of being a participant in IHV programmes in SSA, that there was likelihood of potentially inflammatory data being collected and interpreted which would necessitate careful reflection to determine inclusion or exclusion. Furthermore, with a paucity of senior health workers in both SSA countries that were the loci of study and with only two NGOs being studied there was a real risk that some individuals observed would be relatively easily identifiable, so protections would be needed. Thus, I considered that close adherence to confidentiality and data protection protocols was necessary as I felt that the risk of loss of privacy in this study outweighed any questions of validity were some matters to be excluded. I reflected on this carefully at the time to gain an appropriate balance and to mitigate any validity concerns. As I became more deeply embedded into particularly NGO 1 there were opportunities to observe more closely small numbers of individuals in senior and strategic roles related to the IHV phenomenon in the two SSA countries. To collect and interpret the resultant data, crucial to better understanding of the IHV phenomenon, there would be an inevitable risk given the small numbers of individuals involved, that privacy of individuals may be compromised.

Similarly, there was a risk to me, such as being deemed *persona non grata* in the host countries (thus excluding me from going on further IHV trips), damage to my standing with the NGOs, damage to my professional reputation, and damage to personal friendships in the two SSA countries and the UK, etc. The dilemma I had was then to either exclude this data or to minimize the risk by enhancing confidentiality within the methodology. I minimized the risk by removing from this thesis and redacting from any associated appendices any identifiable information about my profession or others whom I observed, the countries or places where the study took place, the area of operation of the NGOs, the names of the NGOs and specific details of programmes that would identify the NGOs. Furthermore, rather than referring to Country 1 or Country 2 I sometimes referred to *one of the SSA study countries* to enhance the confidentiality of individuals. These were the reasons for not identifying details that most would expect me to identify. That said my biggest concern was removing the details of my profession and thus the clinical area of operation of the NGOs. Following reflection, I do not think that knowing

¹⁴⁰ I participated in IHV programmes in the two SSA countries in 2013, 2015 and 2016 prior to commencing this research.

these details is absolutely material to my account as the nature of the IHV NGO programmes in this study have a shared commonality with many IHV programmes in the two SSA countries irrespective of profession or specialty being primary care focused involving a combination of health promotion, training and clinical treatment.

One other ethical issue that I wrestled with was the issue of covert observation of the IHV phenomenon. Whilst observation was primarily overt, I noticed that over time some of the actors I was observing became very familiar with me such that I felt they had forgotten they were being observed. This was heightened to me as during fieldtrips nobody else was aware that late at night and into the early hours of the morning, I would write up my daily observations in the privacy of my room. I did this covertly and kept this task secret from other IHV actors on fieldtrips. Essentially, for me, at times I felt I had morphed into being a covert observer. This occurred, for example, over time during fieldtrips and during meetings. This is a well-known issue in qualitative research as:

It may be impossible to maintain a neat distinction between covert and overt research. Settings are often more complex and changeable than can be anticipated (Iphofen, 2015, p.2).

Sometimes though my online exploration of, for example, things like IHV NGOs websites involved overtly covert observation. Covert research inevitably brings with it suspicion of being unethical (Spicker, 2011). Its justification particularly around the appropriateness of observing human behaviour without the person's knowledge has been debated for decades (Homan and Bulmer, 1980; Calvey, 2017). Covert research is advantageous as actors are unlikely to change behaviours (Iphofen, 2015). Essentially, where there is covert research, the researcher must weigh up the likely benefits of the research against possible harms to those covertly observed and the observer (Podschuweit, 2021). Whilst Feldman (2010) considers that there is nothing wrong with covert research as modern society is full of deception, I struggled with this notion throughout my study. On reflection, the lengths to which I have gone to protect *inter alia* confidentiality, as described earlier in this section, may be considered excessive by some. For me, this was

necessary to mitigate both my uncomfortableness with covert research and to assure risks of harms were minimized.

The highest standards of confidentiality and data protection practices were adhered to by me in this study to satisfy the University of Glasgow Research Ethics Committee and the professional standards that the UK regulator of my profession would expect. I adhered also to the UK *Data Protection Act 2018*,¹⁴¹ the code of good practice in research of the University of Glasgow¹⁴² and other legislation¹⁴³ pertinent to these issues, in all respects, so that risks were minimized in terms of data loss, transfer, and storage. Only I have access to the code, and personal information about individual actors. I ensured that data was appropriately organised in files within a folder system. Any identifiable data is stored within password protected files on my University of Glasgow One Drive. No confidential data is held on local disk storage. All other data and associated files related to this research project are stored on my University of Glasgow One Drive. A copy of the data is kept on an encrypted¹⁴⁴ password protected disk in a locked cabinet (separate from a cabinet that contains another encrypted¹⁴⁵ password protected disk which holds the code and minimum information about the actors). Data is backed up automatically onto my University of Glasgow One Drive. The encrypted drives are backed up weekly. Some data is shared with supervisors¹⁴⁶ and reviewers.¹⁴⁷

Data will be archived for potential future use and/or appropriate dissemination and publication. The data will be kept for a minimum period of 10 years. Thereafter this will be reviewed annually and if deemed appropriate it may, in time, be destroyed appropriate to the sensitivity of the material to protect confidentiality based on data protection requirements and regulations at that time. Please note a data management plan has been put in place, reviewed annually and

¹⁴¹ The UK *Data Protection Act 1998* preceded the *Data Protection Act 2018*. I adhered to the 1998 Act at the start of this study.

¹⁴² See University of Glasgow (2023).

¹⁴³ See the *Freedom of Information (Scotland) Act 2002*.

¹⁴⁴ Encryption is with Windows Bit Locker USB Encryption as recommended by the University of Glasgow.

¹⁴⁵ Encryption is also with Windows Bit Locker USB Encryption.

¹⁴⁶ Using my University of Glasgow One drive.

¹⁴⁷ Using the University of Glasgow's postgraduate research student review system.

approved by reviewers to ensure compliance throughout the course of this research.¹⁴⁸

In addition, I sought to find out about the law and ethical codes of practice related to confidentiality and data protection of the governments and health professions regulators in both SSA countries where my study was located and adhered to these. The reader will note that the thesis does not specifically reference some things that ordinarily would be referenced, for example the names of the health professions regulators in this paragraph, as this would identify these countries and my profession. In the next section I will address the efforts made to ensure rigour and reflexivity in my research.

2.3.2 Rigour and reflexivity

Rigour and reflexivity are considered essential to maintain standards in qualitative study. In essence rigour is the degree of trustworthiness of a study. Koch (2006) argues that rigour is present in research if a reader can reconcile the events that took place together with the influences and the actions of the researcher. Rather than looking at rigour from scientific paradigms alone Guba and Lincoln (1989) using a constructivist or qualitative paradigm espouse rigour within facets of credibility, transferability and dependability.

The facet of credibility requires self-awareness of the researcher and is enhanced by descriptions and interpretation by the researcher of the research experience (Koch, 2006). As I describe in a forthcoming paragraph in this section self-awareness by reflexivity was prominent in this study, and I hope the reader will find sufficient evidence throughout this thesis of my detailed account of the research experience to assure sufficient credibility. Credibility can be further enhanced by informant validation, member checking and triangulation. I will discuss triangulation in the following section. Lincoln and Guba (1985) consider informant validation as the most robust way of checking data. Mays and Pope (2000) though argue that such validation is limited as data designed for dissemination will inevitably give a different account to an informant. Barbour

¹⁴⁸ In line with the code of good practice from the University of Glasgow and legislation from UK Government and Scottish Government as already indicated in the preceding paragraph.

(2001) warns that there is sometimes a risk of collusion with informant validation as a researcher may accept an informant's views at the expense of their own views. Additionally, informant validation is more applicable to research where informants and researchers interact frequently over time rather than in one-off fieldwork situations as is common in health research (Barbour, 2001). In my study informant validation was impractical in my field settings and this was identified early in methodological design by me due to the limitation of communication in remote and rural areas of the two SSA countries which include digital poverty, data cost and infrastructure issues. Whilst informant validation requires participant feedback about raw data or analysis, member checking involves soliciting feedback concerning raw data or later interpretations. Whilst Cho and Trent (2006) support the use of member checking for validity, others such as Motulsky (2021) argue that it can impede the researchers thought process and reflexivity going on to report that exclusion of member checking does not threaten study validity. Lloyd, Hyett and Kenny (2024) suggest if member checking is used its purpose and how it aligns with the epistemological viewpoint of the research should be made clear. For similar reasons to informant validation, I did not use member checking. It may have been practical to use these methods with UEHVs and other Global North actors but not with those from SSA. To do this for one group and not the other risked me prioritising one group over another. This was unacceptable as I was hoping to foreground an African perspective.

Some authors describe transferability within a constructivist paradigm as meaning that context must be described sufficiently by the researcher for the reader to be able to make similar decisions possible (Guba and Lincoln, 1989). Others though recognise that what may be important for transferability or fittingness is that the reader views study findings as having meaning and application based on their individual experiences (Sandelowski, 1986). Throughout this thesis I have attempted to describe an adequate context, which is important, as in research based on hermeneutic experiences it is predominantly the “central interpretive relationship of the researcher” (Regan, 2012, p. 286)¹⁴⁹ that is the primary method of interpretation. This was my situation in this study and whilst a reader may disagree with my interpretation, I hope the reader understands the methods by

¹⁴⁹ Regan (2012) draws inspiration from the work of Gadamer, cited and referenced as Gadamer (2004) but originally published in German in 1960 titled *Wahrheit und Methode*.

which I came to my interpretations. If I achieve that in this thesis, I will have a degree of transferability.

My understanding of dependability as a facet of rigour is that regarding consistency of data, a dataset should be able to be audited to be dependable (Lincoln and Guba, 1985). In practical terms Sandelowski (1986) indicates that a decision trail is necessary so that another researcher is able to follow the trail of the original researcher and could come to the same or comparable conclusions as the original researcher given the available data, experiences and perspectives of that person with no contradictory conclusions. In my thesis I give an audit¹⁵⁰ and decision trail¹⁵¹ regarding all aspects of my methodology. I believe this gives some dependability notwithstanding that with my own lived hermeneutic experiences of the IHV phenomenon, another researcher is unlikely to come to the same conclusions as our perspectives will differ. Guba and Lincoln (1989) equate dependability in the constructive paradigm to reliability in the scientific paradigm, reliability being defined as the extent to which results can be reproduced using the same conditions. In my study the same conditions in which fieldwork took place are *not* reproducible, so reliability is neither appropriate nor relevant in this study. My study has elements of dependability but *not* scientific reliability. By the nature of my research, I have thus not aspired to statistical generalisability but rather to reflect the important influences on my research question through my lived experiences.

One aspect of rigour is that a researcher should manage any prior assumptions of phenomena studied by the self-reflective process of bracketing (Starks and Trinidad, 2007). Whilst bracketing is considered good practice there is neither consensus on what constitutes bracketing (Gearing, 2004; Tufford and Newman, 2010) nor consensus on when to bracket (Glaser, 1992; Rolls and Relf, 2006). In this study, I chose to undertake a bracketing interview¹⁵² at the start of the study with my primary supervisor to enable reflective phenomenological analysis of prior assumptions. The bracketing interview allowed me to reflect on *inter alia*

¹⁵⁰ Appendices 1 and 2 give an *audit trail* for the reader.

¹⁵¹ Appendices 3, 4, 5, 6 and 7 give a *decision trail* regarding my progression from data to codes to categories to themes to interlinked themes.

¹⁵² The full transcript of my bracketing interview can be seen in the entirety of document B1.

my assumptions on viewpoints regarding different volunteering programmes¹⁵³ and health inequality¹⁵⁴ between the Global North and Africa, which I felt were likely to be important to this study. For example, it confirmed to me that going into the study I held views from my past experiences that some IHV programmes were more for the benefit of the volunteer than the benefit of the host community,¹⁵⁵ yet some offered more benefits to host communities particularly those that involved capacity building.¹⁵⁶

Additionally, I understood that there were big differences in health services between the Global North and SSA.¹⁵⁷ I expressed in my interview that there was no doubt that a good percentage of people in the UK, do not fully understand how lucky they are to have a well-developed health service.¹⁵⁸ Equally well I believed that large numbers of people in Africa were largely ignorant of the inadequacies of their health services, indicating that people had no opportunity to experience anything different.¹⁵⁹ Undoubtedly the bracketing interview allowed me to reflect that matters like these were on my horizon as worthy of further exploration in this study.

Bracketing alone is inadequate to give sufficient rigour to a study. Reflexivity is an important component of qualitative enquiry for a researcher to improve rigour of which there is no consensus on definition. I have adapted the definition of Langer (2016) so for me reflexivity in research can be thought of as:

The experiences of the researcher in the research process being expressed in such a manner that they can reveal the nuances of relationships and interactions between the researcher and others related to the phenomena of study. In so doing the researcher may gain meaning of and for interpretation of the phenomena (adapted by me from Langer, 2016, p. 736).

¹⁵³ See document B1 (p. 2, l. 10 - p. 3, l. 13).

¹⁵⁴ See document B1 (p. 1, l. 24 - p. 2, l. 4).

¹⁵⁵ See document B1 (p. 2, l. 32-34).

¹⁵⁶ See document B1 (p. 2, l. 34-38).

¹⁵⁷ See document B1 (p. 12, l. 8-11).

¹⁵⁸ See document B1 (p. 11, l. 31-35).

¹⁵⁹ See document B1 (p. 11, l. 35-37).

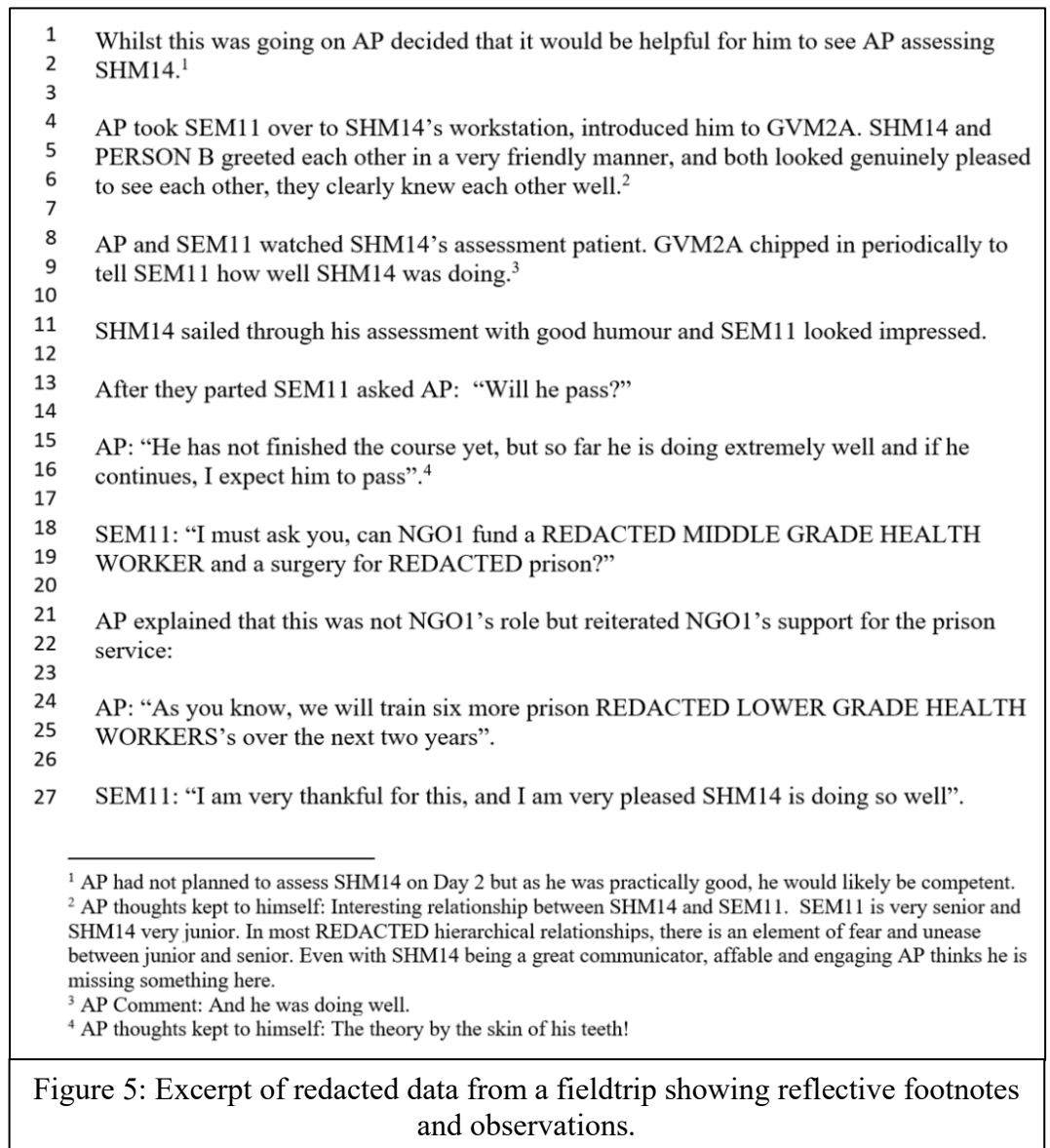
The benefits of reflexivity in all aspects of qualitative research are well-documented (Finlay, 2002). Reflexivity is considered one process that a researcher can use to help study role conflict and its impact throughout a study (Jack, 2008). Reflexivity allows a researcher to reflect on oneself throughout the qualitative research journey and to reflect on how personal and professional factors and the experiences encountered within the research may influence the research (Demi and Warren, 1995). For example, my professional roles and consequent role conflict were a feature of this study. My NGO role during fieldwork was largely a leadership role so I reflected that it was inevitable that I was observing others whose response towards me would differ based on my perceived position in an African and IHV NGO hierarchy. Equally my response to them may differ based on my perceived notions of them.

Additional rigour is imperative by means of further reflexive methods such as writing memos during fieldwork and analysis as a means of examining and reflecting upon the researcher's engagement with the data (Cutcliffe, 2003). In addition, maintenance of a reflexive journal is considered helpful to identify preconceptions (Ahern, 1999). For practical reasons, being mainly the demands of leading an IHV programme, a formal reflexive journal was impractical. However, in this study I situated reflexivity at the heart of the data by writing explanatory notes taken by me during fieldwork as footnotes, thoughts, and reflections which, when transcribed, appeared as formal footnotes in the text of the data collected.¹⁶⁰ I wrote these up every day upon return to local accommodation, staying up late every night during fieldwork to maintain a contemporaneous record of reflections to ensure appropriate reflexivity throughout the study.¹⁶¹ Further reflections and explanations, to enhance context, were added as understanding increased and the footnotes analysed and interpreted as an integral part of the data. In some cases, the reflective analytical notes were as or more important to interpretation than the actual data observed.

¹⁶⁰ These are evident in Figure 5, Figure 7 and Appendix 4.

¹⁶¹ For examples of when I remarked on this see document F2M (p. 71, l. 32), document F3M (p. 15, l. 23-24) and document F4M (p. 105, l. 11).

For an example see Figure 5:¹⁶²



¹⁶² Here in document F2M (p. 100), my reflective fieldnote (Fn. 2) indicated some potentially disconfirming evidence of an interesting hierarchical relationship between person SHM14 and person SEM11 (as observed in l. 4-6). At the time I did not understand its nature, so I indicate this. Further evidence later in fieldtrip 2 (document F2M, p. 102, l. 25-31) clarified this: In this case the over friendly relationship between people far apart in a rigid hierarchy was ultimately due to the senior being good friends with the junior's father. Perhaps person SHM14 being selected for training by person SEM11 could be construed as partiality or even nepotism.

2.3.3 Triangulation

Triangulation is another method of potentially enhancing validity. This compares results from two or more different methods of data collection (for example, observation and interviews) or two or more data sources (Bloor, 1997). Triangulation maximises comprehensiveness even though it may not be a true validity test (Johnson, 1997). I planned from the outset to use different methods of data collection and two or more data sources into the methodology of this study. I initially planned to use participant observation and semi-structured interviews as my main different methods of data collection but for reasons which I have already detailed in Section 2.3.1 and will discuss further in relation to conflicts of interest in Section 2.3.4, participant observation became my main method of data collection. I will discuss this participant observation later in Section 2.3.5.

Other methods included talking to people I encountered and investigating publicly available documents from NGOs, VPOs, training organisations and national and local bodies in SSA and the WHO African region. In determining who to talk to and observe in more detail I used the accepted ethnographic approach of purposive sampling which aims to bring out diversity within a phenomenon (Kuzel, 1992). This allowed me to sample several individuals to be observed from the two SSA countries who potentially could provide particularly rich data related to the IHV phenomenon and whose observation likely would add much to gaining better understanding of an African perspective.¹⁶³ In addition, Barbour (1999) notes that interrogating the data purposively was as important as selecting purposively. This was a methodological aim of the study which I will discuss further in Section 2.3.7.

I used different data sources by utilising a variety of different field settings in two SSA countries with more than one NGO being involved.¹⁶⁴ Whilst most observation was done in remote and rural areas these were in different regions with different local ethnic groups who spoke different languages. The fieldtrips started

¹⁶³ These individuals are listed in Appendix 1 together with the reasons why I chose to observe them more closely. For some my decision allowed me access to data that was rich in quality and quantity (for example persons SHM1A and SEF1A). For others my decision provided less data than I anticipated when first sampled (for example person SHF2).

¹⁶⁴ Redacted contextual data regarding the field settings are detailed in Table 2 (NGOs), Table 3 (Countries) and Table 4 (Fieldtrips).

and finished in urban areas¹⁶⁵ of the two SSA countries, so observation took place in these areas also. I attended meetings in the two SSA countries related to IHV with district, regional and national government officials and employees, village chiefs and elders. In addition, I met with local health workers of different professional groups from very junior cadres to national leaders and representatives from national health professional associations all of which gave additional documentary source triangulation. I will discuss this in more detail in Section 2.3.6.

For further triangulation I looked at social media as a documentary source. This was effectively opportunistic research as described by Iphofen (2015). I focused on *WhatsApp* as this is the most widespread and popular communication application used in SSA (Vogt, 2020). In addition, I became part of many *WhatsApp* groups relating to IHV in the two SSA countries which provided much opportunity. The use of *WhatsApp* to collect observational data was useful because in parts of Africa the digital networks are often unreliable.¹⁶⁶ Furthermore, as many smart phones are obsolete and data cost is expensive,¹⁶⁷ *WhatsApp* is considered by most I observed in the two SSA countries as the least unreliable and most cost-effective method of modern communication. This use of *WhatsApp* groups allowed triangulation, on occasions, of multiple perspectives and in some instances perspectives from UEHVs, IHV NGOs and other Global North and African interest-holders within the same communication thread. This enabled data collection to continue to draw out an African perspective whilst often hearing other perspectives on the same subject.

Further triangulation by using different researchers was identified early as impractical in this project due to the need for participant observation by me as an *insider* to one of the NGOs of study. In addition, it would have been cost prohibitive as the main fieldwork sites were in remote and rural settings in the two SSA countries and use of another researcher would involve double the transport and subsistence costs. Barbour (1998) further observed that whilst triangulation is

¹⁶⁵ In both countries.

¹⁶⁶ Evidence of unreliability of digital networks is seen, for example, in document F1M (p. 26, l. 42-43) as reported by persons GVF6 and persons GVF9.

¹⁶⁷ Data cost is variable throughout the two SSA countries and wider SSA, but economic disparities in the region can limit affordability, so in relative terms it remains expensive. This disparity is worse in rural areas as higher digital infrastructure cost can mean higher prices being borne by those with low incomes (see Tremhost Africa, 2025).

important it is dependent on the context. The context for this study was primarily remote and rural SSA,¹⁶⁸ a challenging environment, where compromises needed to be made to collect meaningful data. For example, most of the fieldwork sites were one to two hours from small urban towns on unpaved roads with main centres being four to six hours distant. It was the norm for rural health posts in this study to have no electricity or clean running water with health centres having similar or very limited and largely unreliable facilities.¹⁶⁹ It was the norm to be without access to modern communication methods for sometimes days at a time.¹⁷⁰ Additionally, it was the norm for the NGO programme being observed to involve very full and intense participant work¹⁷¹ in a hot, humid and noisy environment.¹⁷² In reality during my fieldwork on some days opportunity for participant observation was less than others.¹⁷³

Searching for disconfirming evidence is important in qualitative research and can enhance trustworthiness and validity of a study (Booth *et al.*, 2012). This involves searching the data, sometimes refining codes and recursive reflections regarding developing theories, themes, and interlinked themes. This was something I undertook in my research to refine my account to make better sense of it. An example of disconfirming evidence in my research is the interlinked theme of *respect* which is discussed at length in Section 5.5. In African culture respect is intimately associated with the *ubuntu*¹⁷⁴ philosophy, with nearly all Africans showing respect as an almost inviolable cultural value. Yet I found disconfirming evidence that showed exceptional actors who did not appear to have *ubuntu*. Following recursive reflection, I was able to link those who did not show *ubuntu* with disrespect. This was a counterpoint to the influence of respect within IHV in the two SSA countries (see Section 5.5). Incorporating disconfirming evidence into a final report can be challenging as a best fit approach may not fully account for

¹⁶⁸ Fieldtrip sites and further context regarding them are detailed in Table 4.

¹⁶⁹ See for example my comments regarding a health centre being used for fieldtrip 1. This was 75 minutes travel on an unpaved road from a small town with electrical sockets but no electricity and no running water, see document F1M (p. 27, l. 21-24).

¹⁷⁰ See for example document F1M (p. 52, l. 13).

¹⁷¹ I detail contextual information regarding my participant (non-researcher) roles in Table 1.

¹⁷² For example, I reflected in document F4M (p. 47, Fn. 272) of *the testing heat and humidity* and need for UEHVs to look after themselves to avoid dehydration.

¹⁷³ For example, in document F2M (p. 41, l. 14) I remarked that there *was little time for observation during the day*.

¹⁷⁴ The *ubuntu* philosophy and the influence of *ubuntu* on IHV is the subject of Section 4.2.2. *Ubuntu* is a guiding principle/behavioural code firmly rooted in African consciousness and culture.

this evidence, although it can allow acknowledgement that an interpretation presented may be unable to fully accommodate specific things observed. However, disconfirming evidence can be pragmatically incorporated into thematic analysis, which being flexible is inclusive of such evidence and exceptions (Lincoln and Guba, 1985). This flexibility is one of the reasons I chose thematic analysis as my method of data analysis (see Section 2.3.7).

My study promoted validity by gathering a wide variety of data from multiple different sources,¹⁷⁵ in different nations¹⁷⁶ and from four fieldtrips.¹⁷⁷ Nevertheless, I as the researcher am presenting *an* account based on my interpretation of the data. I am acutely aware that different people will interpret the IHV phenomenon from their own unique perspective and offer different opinions. Additionally, I am aware that there were sources that I did not have access to that may well have aided richer data collection or enhanced my analysis. For example, my access in Country 2 to higher-level strategic meetings regarding IHV led me to realise that whilst I had some access in Country 1 it was not at the same level as Country 2.¹⁷⁸ Another example is an unforeseen event like the Covid-19 pandemic which brought facets to the IHV phenomenon that I had no previous awareness of.¹⁷⁹ This required a different approach to study than fieldtrips which has meant I likely have merely scratched the surface of this part of the IHV phenomenon. Undoubtedly there will be gaps within my data and potential shortcomings in interpretation as a result.

2.3.4 Researcher bias and conflicts of interest

In qualitative research it is the researcher who is the data collection instrument, data analyser and interpreter and thus the person who determines by their own values and assumptions which themes merit further exploration (Jack, 2008). It is these values and assumptions that may become clouded by personal bias and potentially conflicting roles.

¹⁷⁵ See my list of participants observed in Appendix 1 and details regarding NGOs observed in Table 2.

¹⁷⁶ See Table 3 for country details.

¹⁷⁷ See Table 4 for fieldtrip details.

¹⁷⁸ For example, in Country 2 I had access within the Ministry of Health. See document F3M (p. 99. l. 4 – p.101. l. 16).

¹⁷⁹ See documents C1, C2 and C3.

I have already partially discussed bias and reflexivity in previous sections however worthy of note is my cultural background in trying to draw out an African perspective in this study. I am not African but have had prior lived experiences for a significant time period in Africa and believe that I have sufficient understanding of African culture and society around which a reasonable interpretation of IHV in the two SSA countries could be framed. Nevertheless, I have lived in and visit SSA with all the privileges of race and socio-economic status and realistically could only ever partially understand the real-world existence and its challenges for an indigenous person living in the two SSA countries. Therefore, I partly agree with the views of Owusu (1978) that a more appropriate research instrument would be an indigenous researcher who would likely understand African realities better. This was impractical in this study for reasons of both insider access and expense. However, I believe that being a non-African may have been advantageous in interpreting the IHV phenomenon in the two SSA countries as:

The less familiar you are with a social situation, the more you are able to see the tacit cultural rules at work (Spradley 1980, p.62).

Despite my biases I have nevertheless tried to present a reasonable interpretation, that stands up to criteria of validity and rigour sufficiently well in so far as can be achieved from a non-African. I considered my biases, at the start of the study, to be as a result of my particular horizon. For example, I was privileged in terms of race, being a member of a health profession that brought with it a degree of socio-economic status and was in a position of power given my roles in IHV.¹⁸⁰ To mitigate my biases I had to, at times, consider my observations by trying to set aside my assumptions (Young, 2017).¹⁸¹ In addition, I needed sometimes to approach my research as if I were in the shoes of the person being observed to achieve a degree of empathetic and deep understanding (Nickerson,

¹⁸⁰ See Table 1 for my participant (non-researcher) roles in IHV during this study.

¹⁸¹ Setting aside of assumptions could be considered as *epoché*, which was originally discussed by Husserl in 1913. See the translated version referenced as Husserl (1982).

2025).¹⁸² These necessities required me to be highly reflexive throughout the study.¹⁸³

Throughout this study I wrestled with increasing role conflict as my roles within IHV in the two SSA countries increased during the study. For clarity I will sometimes refer to the two main study NGOs as NGO 1 and NGO 2 and the two SSA countries that were the loci of the fieldwork as Country 1 and Country 2. For example, my role with NGO 1 increased to the point that I became a trustee of the NGO, a member of their clinical advisory group and a clinical lead on their programmes with ultimate responsibility for many decisions affecting the running of a programme. These roles meant that I became a person who had influence on the direction of travel of programmes and other aspects of the NGO.¹⁸⁴

This role conflict was at the same time advantageous and disadvantageous. From a positive viewpoint I had unique and unprecedented access to how NGOs operate in the two SSA countries from a very broad perspective. This allowed triangulation of data from funders, employees, and persons of influence within host communities and governments in the two SSA countries. This facilitated a more complete analysis and interpretation of the IHV phenomenon in the two SSA countries than first envisaged. However, from a negative viewpoint the study could be criticised as inevitably there was an increased risk of further unintentional bias for me. An unexpected negative was the degree of tension this created for me, a phenomenon which Hamberg and Johansen (1999) similarly describe. This tension was largely self-induced in that I felt anxiety believing that observing the phenomenon as a volunteer was at times morally wrong with senses of guilt about writing reflective footnotes that gave negative opinions regarding other actors whom I knew.¹⁸⁵ To give further context regarding my participant (non-researcher)

¹⁸² Achieving a degree of empathetic and deep understanding could be considered as *verstehen*, which was originally described by Dilthey in 1907. See the translated version referenced as Dilthey (1977).

¹⁸³ For example, this is demonstrated in my reflective field notes in documents F1M, F2M, F3M and F4M.

¹⁸⁴ See for example, *strategy planning* in my trustee role in Table 1.

¹⁸⁵ For example, in document F4M (p. 58, Fn. 360) I gave a negative opinion on the behaviour of person SPM2.

roles and responsibilities during the course of my research see Table 1,¹⁸⁶ where these are explained in some detail:

GNHV role	NGO	Country	Description of participant roles
Clinical Lead	1	1	Pre programme: Planning; problem solving; mentoring of GNHVs; planning with NGO 1 leadership. On site: On-site orientation; twice daily meetings with VPO, assistant clinical lead and senior SSA health worker; meet and greet (multiple especially Day 1); set-up and pack down of clinics (different for week 1 and 2); problem solving multiple issues; directing clinical and didactic teaching/training feedback and assessment; management of GNHVs; managing with senior SSA health worker referrals and doing clinical work for more complex clinical issues; some 1:1 training (for underperforming trainees); directing health promotion initiatives; directing instrument sterilisation; leading debrief; planning changes needed on a daily basis; incident management and reporting. Post programme: Welfare calls with returning GNHVs; report on programme for NGO 1; debrief of programme with NGO 1, VPO and SSA collaborators, agreeing actions needed.
Teaching Lead	1	1	This was similar to “clinical lead” <i>above</i> although I was not responsible for directing sterilisation and directing health promotion. I was additionally the assistant clinical lead on this programme so was involved, to a lesser extent than the clinical lead, with everything else detailed for “clinical lead” <i>above</i> . This programme (Fieldtrip 1) trained senior SSA health workers to be trainers as well as task-shifting lower grade SSA health workers, so the teaching load was higher.
Clinical advisory group	1	1, 2, online	Development of clinical procedures and protocols for IHV programmes; development of clinical and didactic teaching for IHV programmes; development of monitoring and evaluation, learning and assessment materials for IHV programmes; development of health and safety and emergency protocols for IHV programmes; development with VPOs and SSA stakeholders and other collaborators various responsibilities, procedures and protocols for IHV programmes related to joint working; development and mentoring of GNHVs to be clinical leads; development of GNHV orientation materials; review of IHV programmes and modifications to clinical protocols and procedures in light of issues encountered
Trustee	1	1,2, UK, online	Strategy planning; crisis management (Covid-19 etc.); risk management; financial planning; clinical and training input to trustee board; governance; advising.
Observer and trustee representative	1 and 2	2	Observing and reporting for NGO 1 to the NGO 1 CEO and trustee board on NGO 2 IHV programme activities to determine appropriateness of collaboration between NGO 1 and NGO 2 in joint IHV programmes.
Presenter/trainer	2	2	Presenting on NGO 1 activities and health promotion to NGO 2 and training middle grade SSA health workers.
Teaching coordinator	1 and 2	2, online	Led and developed teaching materials for two phase IHV training course: Phase 1: Online training to upskill and teach how to teach middle grade health workers b) Coordinated UK aspects of a SSA middle grade health worker led (with senior and government support) health promotion course to train SSA community volunteers to cascade key health promotion messages to remote and rural communities in Country 2.
Expert advisor	Other	SSA, online	Part of working group (all SSA) of WHO African region to set up a health promotion course in a specific health area for use SSA wide. Giving expert advice based on experiences of health promotion courses delivered in Countries 1 and 2.

Table 1: Participant (non-researcher) roles of principal researcher

¹⁸⁶ Please note that my roles as a trustee and in a clinical advisory group continued year round during this study. My teaching coordinator role commenced in 2020 and was an ongoing year round role for the remainder of this project.

Furthermore, as discussed by Sword (1999) I found that at times role conflict caused dilemmas between the role of researcher and clinician/educator in the field setting. For example, one of the reasons I chose not to use semi-structured interviews as a data collection method was that I was in a position of authority and power whilst on NGO programmes meaning that daily and strategic management decisions about the programme and summative decisions on trainee success or failure were the joint responsibilities of me and the most senior host government health worker participating in the programme. This meant that use of semi-structured interviews was likely to result in tension and a power asymmetry as asserted by Hamberg and Johanssen (1999). Through my knowledge of African culture and the assertions of Wilcox (1975) I realised that in SSA there is much respect for authority, and any challenges are considered disrespectful.¹⁸⁷ The predominant view as expressed by Rooney (2007) is that respect for authority is so deeply ingrained in African society that this respect and deference may not encourage a questioning attitude in people. In consequence, I felt as the research instrument that I was more likely to gain responses in a semi-structured interview that participants hoped I wanted to hear rather than being assured that this was their actual viewpoint. I have already touched on other ethical reasons I did not use this method of data collection in Section 2.3.1.

As the study progressed, a further complication arose when the secondary supervisor¹⁸⁸ became involved in a primary decision-making role in Country 2 and became increasingly involved with the operations of NGOs 1 and 2 during the study.¹⁸⁹ This even resulted in the secondary supervisor visiting an NGO 1 programme led by me in Country 1.¹⁹⁰ My secondary supervisor was observing the programme at the invitation of the chief executive of NGO 1. Again, this brought complex issues in that the secondary supervisor now had a unique insight into some of the NGO programmes being studied and was able to gain access for me to further study opportunities related to the IHV phenomenon in the two SSA countries. This could only benefit understanding of the phenomenon. For example, NGOs 1 and 2 started collaborating in Country 2 and this allowed me to undertake

¹⁸⁷ See sections 4.2, 4.2.1, 4.2.2 and 4.2.3 regarding African culture and Section 5.5 regarding respect and disrespect.

¹⁸⁸ The secondary supervisor thus became a participant and forms part of the data as person GOM1A and GOM1B given their differing roles.

¹⁸⁹ As the *alter ego* role of person GOM1B.

¹⁹⁰ As the *alter ego* role of person GOM1A.

fieldwork visiting an NGO 2 programme there. This collaborative relationship developed further such that I led a collaborative programme for NGOs 1 and 2 by developing online educational materials for health workers in Country 2 during the Covid-19 pandemic. Thereafter I found myself representing and volunteering for these NGOs on a working group of the WHO African region to be involved in a project with them giving me further unique insights into IHV in wider SSA.¹⁹¹ Without the networking opportunities provided by the secondary supervisor this would unlikely have occurred.

Ultimately, the secondary supervisor has become part of the data and would inevitably have personal bias and assumptions regarding IHV in the two SSA countries which may have had the potential to influence my understanding of the phenomenon. My concerns about my potential bias and role conflict have been an ever present in this study and continual reflexivity has been necessary for me to ensure study validity and rigour throughout all methodological processes. Fortunately, as the majority of the data collection took place during two-week periods of a short-term IHV programme I was able to manage the conflicting roles and my concept of self effectively which according to Jorgensen (1989) is difficult to do over extended time periods.

2.3.5 Participant observation

I chose participant observation as my main method of data collection in this study as I felt it was the most practical, ethical and a widely accepted method available:

To discover the hidden principles of another way of life (Spradley 1980, p.4).

Participant observation has been the benchmark of ethnographic approaches to study for more than a century (Hendry, 1999). In addition, DeWalt and DeWalt (2002) argue that such observation gives a holistic understanding of phenomena to be studied. Additionally, it helps increase study validity as the participant observer is likely to have a better understanding of the context and phenomena studied

¹⁹¹ See Table 1 regarding my *expert advisor* role for WHO African region.

(DeWalt and DeWalt, 2002). However, the method does have limitations. Examples of limitations described were that most participant observers at some point may be excluded from some aspects of cultures or settings by exclusion, which can take the form of exclusion from events, intentional talking in another language in the researcher's presence and moving away to talk out with a researcher's earshot (Schensul, Schensul and LeCompte, 1999). In my study I experienced these behaviours, but infrequently, and sensed this was more due to my leadership responsibilities in my participant rather than observer role in my circumstances.¹⁹² Essentially then participant observation can only give an incomplete account of the phenomena that are to be studied.

Participant observation requires, as its name suggests, participation and observation. This is essentially a continuum described by Spradley (1980) who categorises participant observation by the degree of participation of the researcher proposing five categories, non-participation, passive participation, moderate participation, active participation, and complete participation. Others prefer to term either ends of the continuum as being a “fly on the wall” at the least participant end to the “fly in the soup” at the most participant end (Thomas, 2019, p.4). In this study at times, I observed in all of these participant roles, but undoubtedly my fieldwork, where I collected most data, involved being in a *hyperactive* participant observer role who was a *fly in thick soup*¹⁹³ given my NGO responsibilities.¹⁹⁴ Examples of non-participation were when I observed IHV NGO social media sites. Passive participation occurred where I sat in on meetings of IHV interest-holders without giving contribution and moderate participation where I had peripheral or cameo roles in IHV NGO activities. At times I would be close to being a complete participant, for example in some aspects of my trustee role with NGO 1 but even in these circumstances observation is possible (DeWalt and DeWalt, 2002).

What I felt was important was that I was aware where I was along the continuum at all times whilst observing in this study as there is less access to data when less participation so the relative degree of objectivity and subjectivity can change depending on where on the continuum the researcher is observing (DeWalt

¹⁹² For example, see document F1M (p. 28, l. 14-15). Here the NGO leadership team (AP and persons GNF1A and GVF4B) is intentionally excluded from a whispered conversation by person SHM6B and person SYF1.

¹⁹³ Adapted from Thomas (2019, p.4).

¹⁹⁴ See Table 1.

and DeWalt, 2002). For example, when observing as a *hyperactive* participant observer in this study reflexivity (as prior discussed in Section 2.3.2) was very important to maintain subjectivity and I used footnotes extensively. When in a passive participation role such as sitting in on meetings with IHV interest-holders' subjectivity was easier but undoubtedly, I was less of an insider, and I had less access to data that may have been important.

Participant observation requires that both the participant role and observer role are managed effectively by the researcher. Access as participant observer for me was relatively straightforward as I had permission from NGOs granted easily as I was a trusted UEHV and equally trusted by VPOs and other actors in the two SSA countries. (I have already discussed this in Section 2.3.1) Equally, access was facilitated during fieldtrips as I understood both the formal and informal hierarchies involved in healthcare settings in Africa, VPOs and in NGOs from being an experienced UEHV and from having lived in and visited SSA over the years.¹⁹⁵ It was thus relatively easy for me to establish rapport with most IHV interest-holders as good rapport is considered important in the participant part of the role to gain acceptance in the field (Kottak, 2008).

The observation part of the role required more practice. Undoubtedly to get to the start of this study I must have been observing previous IHV programmes in SSA,¹⁹⁶ partially unwittingly, as I formed views and questions based on those observations that were influencing factors in why I started this research project in the first place. Nevertheless, once I started the study, I found the work of DeWalt and DeWalt (2002) helpful in how to effectively observe by “*seeing* detail as fully as practical in situations” (De Walt and De Walt, 2002, p.69). *Seeing* meant using all senses, counting, looking at space, movement, body language, being reflexive etc., and taking notes where possible and writing them up as close as possible to the observed events, a protocol which I followed religiously. I aimed to observe the stories and everyday contexts of an IHV programme in the two SSA countries during my fieldtrips whilst at the same time looking for exceptions and differences. I had to bear in mind my research question throughout my observations to draw out an African perspective. This type of good practice in observation is once again

¹⁹⁵ Hierarchies in IHV in the two SSA countries are discussed in Sections 5.4, 5.4.1 and 5.4.2.

¹⁹⁶ It was during IHV programmes in the two SSA countries in 2013, 2015 and 2016 that I started to form views that initiated me thinking seriously about researching the IHV phenomenon.

based on the methods described by DeWalt and DeWalt (2002). I was however conscious that in foregrounding an African perspective I did not observe everything. For example, some of the activities of UEHVs took a backseat when faced with a choice of observation of an African actor.¹⁹⁷ Finally, I reflected on the quality of my observations, and the trueness of the adage *practice makes perfect*. There are many imperfections in the quality of my observations but overall, each fieldtrip is better in terms of observer detail and reflexivity than the preceding one and I became better at participant observation through the course of the study.¹⁹⁸

In much of my participant observation following writing up my field notes I was recalling reported speech rather than actual speech. Rarely, I would have available recorded videos taken on behalf of the IHV NGO¹⁹⁹ where I could hear actual speech but for the most part my observations relied on accurate recall of speech as close as practical to the time of actual speech. This occurred on the same day in my research. Essentially as the researcher at best, I was trying to transcribe what I think someone has said, in effect, “indirect speech”²⁰⁰ (Jespersen, 1924, p.290). Indirect speech brings with it problems as verbatim recall is unusual (Lehrer, 1989). Whilst I think my recall is good, reported speech has a risk of misquotes and a degree of inaccuracy (Mayes, 1990). Changes in tense or pronouns are commonplace in reported speech. According to Clift and Holt (2006), reported speech is a misnomer. Nevertheless, in participant observation reported speech is an accepted method of recording data having the ability to convey valuable insights, although it has limitations and the reader should take this into account.

I did consider using other well accepted methods other than participant observation in my study such as the use of semi-structured interviews and focus groups. Indeed, in the case of interviews I went as far as gaining ethical approval for these from the University of Glasgow Research Ethics Committee before discounting these methods for reasons prior discussed in Sections 2.3.1 and 2.3.4.

¹⁹⁷ For example, in fieldtrip 2 I undoubtedly focused observations more on the African members of the IHV programme leadership team (persons SHM3B and SPM6) rather than another UK member of that team (person GVF1B). This is seen throughout document F2M as evidenced by a relative lack of observations of person GVF1B considering their leadership role.

¹⁹⁸ This is seen by my own self-reflection. For example, document F2M (relating to fieldtrip 4) is more nuanced and has more detail than document F1M (relating to fieldtrip 1). It could be that not just was I better at participant observation but that my understanding of the subject matter was better latterly.

¹⁹⁹ Usually, a member of the VPO team did the filming.

²⁰⁰ This was referred to by Jespersen (1924) in *Latin* as *oratio obliqua*.

Interviews are one of the most used forms of data collection in qualitative research (DiCicco-Bloom and Crabtree, 2006). Whiting (2008) argues that structured interviews often involve questionnaires and closed questioning and are a more useful tool in quantitative research. However, semi-structured in-depth interviews are often used in qualitative health research and should be personal, intimate, and in-depth where the researcher asks open direct questions which aim to produce detailed narrative accounts and stories (DiCicco-Bloom and Crabtree, 2006). Focus groups are a popular sociological method of obtaining data which can provide rich understanding of data (Agar and MacDonald, 1995). However, in my study the demands of leading an NGO volunteer programme made these forms of study impractical.

Given the need to address the many controversies in qualitative methods a pilot study allows *inter alia* estimation of study parameters (Arain *et al.*, 2010) and tests research methods (Kim, 2011). I considered a pilot fieldwork study to look at issues such as how to purposively sample actors for observation, how best to transcribe data and reflections during fieldwork, how best to balance my participant and observation roles and how to best foreground an African perspective in the field. However, I was mindful of the words of Perry (2001) who implies that the nature of qualitative research means that a separate pilot study does not exist. The reasoning for this is that common qualitative research methodology relies on emergent methodology throughout the research process, so methodology inevitably changes throughout a study (Maxwell, 1996).

With no consensus on pilot studies in qualitative research, I initially felt that undertaking a pilot study would on balance be considered good practice and would be likely to give the main study more rigour and validity. Ultimately, I did not undertake a pilot study for two reasons. Firstly, the expense and time in travelling to the two SSA countries would mean that I may not have sufficient further opportunities to collect enough data. Secondly the nature of my first fieldwork opportunity involved NGO 1 deciding to invite a cohort of senior health workers into the programme as participants meaning that I would have a one-off invaluable opportunity to observe these individuals who would likely provide data that furthered study of an African perspective in IHV in one of the two SSA

countries.²⁰¹ Participant observation on four fieldtrips to the two SSA countries was thus my main method of data collection, but I observed much more which I will detail together with reasons why I did this in the following section.

2.3.6 Data collected

The data I collected for the empirical component of my research came primarily from participant observation of four IHV fieldtrips involving two IHV NGOs.²⁰² These IHV NGOs operate in providing healthcare, training and health promotion to rural communities and health workers in SSA. I hoped to study three IHV NGOs, but I was unable to gain sufficient insider access to a third NGO although this NGO did on occasion communicate and collaborate with NGOs 1 and 2 and some very limited passive participant observation was possible, but it was never sufficient to be studied in depth.²⁰³ The two study IHV NGOs in this research were all based in the UK. However, the NGOs differed in their age, size, countries of operation and approach to provision of care, training, and education.

At the start of the study NGO 1 primarily operated in Country 1 and NGO 2 operated in Country 2 although later they would collaborate in Country 2. This selectivity was a necessary function of my own context and opportunities for access to the IHV phenomenon to be studied in the two SSA countries which I negotiated through my existing roles within IHV in the two SSA countries. I discussed this in Section 2.3.1. Further details of the two study IHV NGOs are detailed in Table 2 and some basic details of the two countries in Africa are detailed in Table 3 to give the reader context:

²⁰¹ See the first row of Table 4 that gives more information regarding fieldtrip 1.

²⁰² See documents F1M, F2M, F3M, F4M and *their* respective associated appendices listed in Appendix 2.

²⁰³ For example, *inter alia* this third NGO is discussed in document F1M (p. 83, l. 36 – p. 84, l. 3) by person GNF2, in document F2M (p. 107, l. 30 – p. 108, l. 14) by person GNF2, and in document F2M (p. 42, l. 8-10) by person GNF3A.

NGO	Area of Operation	NGO purpose	Nature of NGO	Number of programmes in SSA
1	Country 1. Country 2 (collaborating with NGO 2).	Training and task shifting lower grade health workers Postgraduate training and mentoring of profession specific health professionals (middle grades) Online training Emergency primary healthcare Health promotion in specific areas.	Initially small staff based in UK and GNHVs. Later mixture of self-employed contractors and GNHVs.	4-6 per annum in SSA with GNHVs. 10 led in SSA by health workers from SSA. With NGO 2: Variable in country 2 mostly led by health workers from SSA.
2	Country 2 (1 region). Country 2 (collaborating with NGO 2). All regions.	Provision of CPD and funding undergraduate education for profession specific health professionals (mainly middle grades) Postgraduate training and mentoring of middle grades Online training Provision and maintenance of health equipment Emergency primary healthcare. Health promotion in specific areas.	2 lead GNHVs (NGO founders) and GNHVs,	2 per annum in SSA with GNHVs. With NGO 1: Variable in country 2 mostly led by health workers from SSA.

Table 2: Further details regarding the study IHV NGOs

Country	Population	Urban/rural population split (%)	Number of trained health workers in health profession of study
1	Over 60 million	Approximately 70% rural	600 - 800
2	Over 20 million	Approximately 80% rural	200 - 300

Table 3: Basic details of the two SSA countries²⁰⁴ where fieldtrips were located²⁰⁵

²⁰⁴ Country data regarding population and health spending has been provided from the WHO (2025a). Much is out of date as the countries do not provide up to date data to WHO. The health data is provided by estimates of unreliable information provided by various government departments in the respective countries. At best this table represents for the reader some context on the lack of health professionals in the two SSA countries that were the loci of this study.

²⁰⁵ My thesis briefly refers to a minimal quantity of data related to IHV in SSA regarding three other countries that were *not* the loci of my fieldtrips. For completeness *Country 3* is a country of over 50 million people. It is approximately 70% rural. It has 1000-1500 trained health workers in the health profession of study. *Country 4* is a country of over 15 million people. It is approximately 70% rural. It has 100-200 trained health workers in the health profession of study. *Country 5* is a country of over 60 million people. It is approximately 70% rural. It has 1500-2000 trained health workers in the health profession of study.

Apart from the opportune access to these IHV NGOs and the territories in which they worked, the substantive justification for this approach and selectivity was that they are representative of typical primary healthcare IHV NGOs that operate in remote and rural communities in SSA. Thus, these two NGOs presented highly suitable loci for studying the empirical phenomenon that this project sought to examine, being the influences on IHV in the two SSA countries foregrounding an African perspective. I will discuss some of the limitations of this selectivity in Section 2.3.8.

Fieldtrip data was collected from four fieldtrips, each of a short-term duration (11-16 days).²⁰⁶ Whilst the fieldtrip only lasted for this short period, data was collected from the first planning stages of the trips to the last debriefing of the trip. Thus, participant observational data was collected for around a 7-8-month period for each trip. Fieldtrip participant observation as well as looking at the everyday experiences of the actual IHV programme included observing things like meetings and telephone calls with IHV NGO leadership, meetings that pertained to the trip, communications with interest-holders in the UK and Africa and informal and formal briefing and debriefing meetings about the trip. This is not an exhaustive list. All the participant observational data included reflective field notes and notes that would enhance later understanding of the observations, for example, demographic factual data on the numbers of health workers in the specific area where the trip was located.²⁰⁷

Inclusion of wide-ranging fieldtrip data was important as solely studying an African viewpoint of IHV would have failed to interpret the complex patchwork quilt that is the volunteering phenomenon, so the *data corpus* included study of the selected IHV NGOs from a very wide perspective together with individuals and organisations that potentially influenced those NGOs. If I had not done this, I would have likely been unable to interpret the complex interplay of African and

²⁰⁶ The specific details of each fieldtrip are detailed in Table 4.

²⁰⁷ For example, demographic data collected in fieldtrip 4 is evident from secondary sources (a redacted regional profile) in the entirety of document F4A1. For this trip NGO 1 provided demographic data in a briefing evident in document F4M (p. 2, l. 28-33). In addition, a regional government official (person SHM1B) also provided the same data. See document F4M (p. 75, l. 10-14). Whilst there were some broad similarities in the demographic data, they were all different. This leaves me with a degree of scepticism regarding the validity of demographic data regarding fieldtrip sites in rural areas in the two SSA countries.

Global North viewpoints, and the conceptual, political and cultural issues between these which I will address in later chapters.

All fieldtrip data was meticulously documented into a single document of written participant observations identified by page and line number. To give an idea of the amount of data, each fieldtrip contained an average of 112 pages of single spaced A4 paper. Within the document were reflective footnotes which were also later analysed. On average on each fieldtrip, I wrote 493 reflective field notes. Appendices were used which included other data related to the fieldtrip such as transcripts of videos (transcribed by me) that the IHV NGO or VPO had recorded of various individuals and/or groups during the trip and placed on social media or NGO websites. Additionally, they included a variety of documents related to the IHV programme received before, during and after the trip. Where appropriate, I placed reflective field notes on the appendices. The appendices in addition to the main document were thus part of the dataset for each fieldtrip. There was an average of 14 appendices per fieldtrip (see Appendix 2).²⁰⁸

Some limited informal analysis occurred at the time of data collection and documentation, and my reflective analytic thoughts appear throughout the data in some of the reflective footnotes.²⁰⁹ It is worthy of note that data analysis is inseparable from the act of collecting data and is not something that resides solely in a subsequent stage of the research. I will discuss data analysis in detail in Section 2.3.7. This format of meticulous documentation, use of appendices where appropriate, and reflective footnotes was used for all subsequent categories of data analysed, in addition to the fieldtrip data, to ensure consistency of method, validity, and to catalogue the data methodically for formal analysis and interpretation. The fieldtrips were situated as seen in Table 4:²¹⁰

²⁰⁸ Appendix 2 details a document indexing system and inventory for data.

²⁰⁹ See, for example, in document F2M (p. 48, l. 25-26) that the first footnote (Fn. 205) derived from this observation has had some informal analysis as I state *clearly there is some health politics going on here*. This can be seen in Appendix 3 as this excerpt of data is in the pages of data that I have provided as an example of my coding.

²¹⁰ They are listed in Table 4 in chronological order.

NGO	Country	Time	Purpose/Personnel	AP participant role	Commentary
1	1	November 2017; 16 days	Training rural health workers and training trainers; health promotion 6 GNHVs; 7 Senior SSA health workers; 1 Middle grade SSA health worker; 6 Lower grade SSA health workers; 4 VPO staff; 5-10 SSA visitors	Training lead	The trainers being trained were five senior regional health workers in Country 1; representative of a SSA National health professional association observed the trip to report to the Ministry of Health of Country 1
1	1	September 2018; 15 days	Training rural health workers; health promotion 13 GNHVs; 1 Senior SSA health worker; 1 Middle grade SSA health worker; 6 Lower grade SSA health workers; 4 VPO staff; 5-10 SSA visitors; 4 UK VIPs	Clinical and training lead	Programme visited by CEO of NGO 1 and others including the secondary supervisor
2	2	September 2019; 11 days	Observing NGO 2 programme for feasibility of NGO 1 and NGO 2 joint programmes; meetings with others including Ministry of Health of Country 2 15 GNHVs; 1 Senior SSA health worker; 10 Middle grade SSA health workers; 10 VPO staff; 5-10 SSA visitors; CEO NGO 1; 2 leaders of NGO 2	Trustee representative of NGO 1; observer of NGO 2; trainer and presenter at SSA middle grade health worker conference	Additional observers were Government and National Association officials of Country 2 and a representative from an NGO in Country 1
1	1	November 2019; 15 days	Training rural health workers; health promotion 13 GNHVs; 1 Senior SSA health worker; 1 Middle grade SSA health worker; 6 Lower grade SSA health workers; 4 VPO staff; 5-10 SSA visitors; 2 SSA VIPs (Country 2)	Clinical and training lead	One of the trainers trained in the November 2017 fieldtrip trained on this programme; the same officials and representatives from Countries 1 and 2 that observed the September 2019 programme were in attendance in various capacities
<i>Table 4: Contextual information regarding the four main fieldtrips²¹¹</i>					

²¹¹ Fieldtrip 3, in September 2019 observed NGO 2 IHV programme activities. This involved emergency primary healthcare, mentoring of middle grade health workers, health promotion and repair of health equipment.

As the study progressed so did my ability to collect data and improve my documentation, reflexivity and informal analysis of the IHV phenomenon in the two SSA countries. At the same time my IHV NGO roles increased by, for example, becoming a trustee of NGO 1²¹² between the first two fieldtrips. Both factors presented further networks of opportunities for participant observation. Whilst my formal fieldtrips are detailed in Table 4, other fieldwork took place by participant observation in the UK and data was collected in the UK which specifically related to the operations, management, aspirations, funding, and issues that faced NGOs 1 and 2 throughout the study.²¹³ This data for practical reasons was weighted towards NGO 1, particularly in the earlier years of study, as I was an *insider* with NGO 1 being a trustee, clinical lead, UEHV, programme advisory group member and later led development of some of their programmes in Country 2. As NGOs 1 and 2 collaborated more, UK based fieldwork data relating to NGO 2 was able to be collected as I became more of an *insider* with NGO 2.²¹⁴ Furthermore, some limited data was collected regarding a VPO in Country 1 that NGO 1 used as a VPO for programmes in Country 1.²¹⁵

The secondary supervisor was involved in a project in Country 2 that required multiple collaborators and so some observational data was collected regarding this project and their respective roles²¹⁶ within the project of NGOs 1 and 2 as it related to the IHV phenomenon in the two SSA countries. The data that I acquired from these other sources of fieldwork was small in volume compared to my fieldtrips in SSA and in some cases I would be a participant observer within a meeting where I might find no relevant data or a single sentence that aided in answering my research question. On other occasions data collection was more fruitful in these settings. This additional fieldwork observational data was collected from predominantly various meetings, telephone, and email communications with IHV interest-holders and from documents produced by the various IHV NGO and SSA interest-holders. On many occasions my extensive participation was such that I documented my actions in decision making processes as I was in a sense self-

²¹² I became a trustee around April 2018.

²¹³ This can be seen in the data inventory in Appendix 2.

²¹⁴ My roles in both NGOs were detailed in Table 1.

²¹⁵ For example, see document F2M (p. 116, Fn. 678 and 679) where person SPM6 speaks for this NGO.

²¹⁶ NGO 1 and NGO 2 developed IHV training programmes for health workers and non-health volunteers related to health promotion as part of this collaborative project.

observing myself so reflective footnotes to this effect were also included in the data.²¹⁷

Secondary data sources were explored from relevant analyses related to the IHV phenomenon published in the academic literature. Other secondary sources thought useful for scrutiny were publicly accessible Global North and Global South guidance, policies, regulations, laws, and advice related to the IHV phenomenon in SSA. Relevant published documents from transnational bodies such as the UN and WHO which may inform the phenomenon were explored.²¹⁸

Social media is seen by many as a platform upon which can be staged a perfect or ideal presentation of self (Birnbaum, 2013). This is high stakes as in the era of social media mass communication there is a need to be perceived as giving off the correct impression (Castells, 2009). This is particularly true for IHV NGOs, who increasingly use social media to connect with UEHVs, a wide variety of potential interest-holders, supporters, and funders.²¹⁹ Appropriate communication has been shown to have potential to increase social capital and influence (Kittilson and Dalton, 2008). However, there is a digital divide in that only a small number of Global South interest-holders and VPOs use social media,²²⁰ but those that do are more interactive (Armstrong and Butcher, 2018).

My initial plan was to research the social media communications of the study NGOs for a short-defined period, but on reflection social media outputs are often sporadic and more frequent during and around programmes. I thus felt it was more appropriate to study communications throughout the full period of study. I did this by purposively sampling the data and selecting only data relevant to better interpreting parts of the IHV phenomenon in the two SSA countries that helped to answer my research question, following collection of other data. For example, nearly all social media outputs from IHV NGOs were entirely positive, whereas I would know from my *insider* role that other data may suggest that something

²¹⁷ For example, in document T3 (p. 6, l. 29-3) I reflect in Fn. 15 around discussions I had in a clinical lead meeting.

²¹⁸ Many of these secondary sources are referred to throughout this thesis. They are appropriately cited and referenced.

²¹⁹ For example, NGO 1 and NGO 2 had *Facebook*, *Instagram* and *X* (formerly *Twitter*) social media accounts.

²²⁰ During the time of this study the VPOs observed did not use social media accounts.

negative had occurred, yet this would either be ignored or modified to give the right public impression.²²¹ To do this involved using a variety of outputs such as official websites, *Facebook*, *Instagram* and *X* based on NGO preferred methods of communication or social media activity. I tried to observe similar data from VPOs, and any local interest-holders related to the NGOs of study in SSA to foreground an African perspective, but this was impossible as most did not have a website, so this remains a lacuna in the data set. I obtained less useful data than I expected from social media with the exception of some participant observation of *WhatsApp* communications with UK and SSA interest-holders which I observed as previously discussed in Section 2.3.3.²²² This is unsurprising as Shumate and Dewitt (2008) observe that there is a North-South divide in the virtual world as well as the physical world. This lack of a website or social media outlet for VPOs and other African IHV interest-holders may potentially reduce their opportunity for networking, funding, and influence. In practical terms this may represent an example of digital poverty in the region.

After my third fieldtrip to the two SSA countries I felt data saturation had almost been reached but with a fourth fieldtrip already planned two months thereafter, this trip came with unique opportunity. NGO 1 and NGO 2 had decided to work closely together to develop the NGO 1 training model in Country 2 and indeed this was partially the purpose of the third fieldtrip. NGO 2 had obtained a grant for a pilot programme which was planned to be run jointly by both NGOs with me leading the IHV programme. Therefore, a representative of a national association²²³ and another from government²²⁴ from Country 2 were to participate in the fourth fieldtrip in Country 1 as observers so they could report back to interest-holders in Country 2. In addition, there would be a senior African health worker²²⁵ from Country 1 and representatives²²⁶ from the VPO in Country 1, all together, and all of whom had been observed at different prior fieldtrips by me in one location. This was another unique opportunity to undertake participant

²²¹ For example, in document F1M (p. 83, l. 40-41), person GVF4B reported a negative issue, which an IHV NGO has reported more positively.

²²² Whilst some *WhatsApp* correspondence is reported in main fieldtrip documents it additionally occurs in documents F2A7, F3A14, F4A10 and S3. See Appendix 2.

²²³ Person SEM1D whom I had previously observed in fieldtrip 3.

²²⁴ Person SEF1A whom I had previously observed in fieldtrip 3.

²²⁵ Person SHM1A whom I had previously observed in fieldtrip 1.

²²⁶ Person SPM2 (previously observed in fieldtrips 1 and 2), person SPM3 (previously observed in fieldtrip 3) and person SPM6 (previously observed in fieldtrips 1 and 2).

observation to further foreground an African perspective and potentially gain new rich quality data. This proved to be a sound decision which added much to interpretation.²²⁷

In traditional ethnographic study data saturation is often unproblematic given the length of time of study, meaning that much data is gathered (Fusch and Ness, 2015). It is widely accepted that not reaching data saturation in qualitative research will have negative effects on research quality and content validity (Bowen, 2008). What lacks consensus is the definition of data saturation in qualitative research. Despite this lack of consensus, principles exist that most researchers agree as a starting point for data saturation. Essentially data saturation is reached when sufficient data is available to reproduce the project (O'Reilly and Parker, 2012), when no further new information related to the phenomena are being found in the data (Guest, Bunce and Johnson, 2006), and when further coding has become unreasonable (Guest, Bunce and Johnson, 2006). I aimed to adhere to these principles in my methodology, but in reality, my project was not reproducible as access and opportunity would be different for a different researcher. Data saturation was thus reached and despite a fifth fieldtrip being planned for June 2020 to study NGOs 1 and 2 in Country 2, data collection effectively ceased in the SSA field setting. However, the onset of the Covid-19 pandemic, which resulted in cancellation of the fifth trip, presented the opportunity for new virtual participant observation, as the Covid-19 pandemic threatened unprecedented change to all sectors of society including IHV in the two SSA countries. This further enhanced the *data corpus*²²⁸ in meeting data saturation by giving additional data that was rich in quality as described by Dibley (2011) to allow further interpretation of the research question.

With cancellation of a fifth fieldtrip due to Covid-19 NGOs 1 and 2 worked together to seek permission to successfully re-purpose the grant to provide a virtual training programme delivered to health workers in Country 2. I was asked to coordinate this programme and did so with the further collaboration of a digital education provider in the UK and senior health workers in Country 2. The

²²⁷ Effectively I had a combination of persons from the two SSA countries attending fieldtrip 4, most of whom I had already purposively sampled to observe more closely (persons SEF1A, SEM1D, SHM1A and SPM6) during fieldtrips when I first encountered them. See Appendix 1.

²²⁸ Post Covid-19 data is seen in documents C1, C2, C3 and C4.

programme was successfully delivered in early 2021 giving me further participant observation opportunities. NGO 1 and 2 hoped to provide a second phase of the programme where training would be provided by the now already trained health workers to community volunteers who would then deliver key health messages to their local community. A further grant was successfully obtained by NGOs 1 and 2. I coordinated the didactic educational part of the programme in collaboration with volunteers from NGO 2 and a senior health worker in Country 2 and gained opportunistic virtual participant observation opportunities. The programme was and continues to be delivered in remote and rural areas of Country 2 via a VPO in Country 2.

The changes to NGO operations prompted by the Covid-19 pandemic and the effect on actors and VPOs in Africa from both the pandemic and the consequent relationship changes with IHV NGOs in the two SSA countries were unprecedented. Health systems in the Global South were already underfunded, inadequately staffed and economically precarious prior to the pandemic (Shamasunder *et al.*, 2020). The pandemic brought this inequity into focus whilst leaving health systems in the two SSA countries in an even more precarious state. The inability to travel left IHV NGOs unable to deliver programmes in SSA exposing collaborators in the two SSA countries to sudden loss of revenue whilst being unprotected from the full economic impact of this as there was minimal or no governmental support available in the two SSA countries.²²⁹ NGO 1 and NGO 2 had as their prime focus volunteering programmes in remote and rural SSA, and each had local interest-holders with whom they had collaborated for many years and to whom there was moral rather than financial obligation. Additionally, both IHV NGOs had collaborative relationships with health workers in SSA to whom there was also moral obligation.²³⁰ NGO 1 had several employees in the UK, some of whom were employed solely to manage volunteer programmes, whose jobs were immediately threatened by the suspension of programmes and need to meet financial obligations.²³¹ There were many unknowns for both IHV NGOs and those in the two SSA countries, not least their financial viability, patency of funding streams and their economic survival. As I was a trustee of NGO 1, the NGO role

²²⁹ See document C1 (p. 116, l. 23). Here person GNM2 informs SSA collaborators of IHV programme cancellation.

²³⁰ See document C2 (p. 39, l. 23-30). Some UEHVs in a limited way used personal funds to support some SSA colleagues in the two SSA countries during this time.

²³¹ See document C2 (p. 8, l. 18-20). Here person GNF2 expresses this sentiment.

placed me in a central role to observe management decisions pivotal to NGO survival and recovery from the effects of the Covid-19 pandemic which would affect their collaborators in the two SSA countries.²³² This involved setting a post-pandemic plan and strategy for the NGO and communicating changes to interest-holders. Some data was collected from participant observation of mainly *Zoom* meetings.

The Covid-19 pandemic and resultant need for IHV NGOs and SSA interest-holders to change brought opportunity to study the IHV volunteering phenomenon further. During the Covid-19 pandemic I collected active participant observational data, in a similar manner as all other data had been collected from collaborative *Zoom* meetings and *WhatsApp* groups related to the joint project in Country 2. This included further passive participant observation of social media responses from NGOs 1 and 2 and a television appearance by three health workers from Country 2 on a local news channel in Country 2. This was repeated for the second phase of the programme where, in addition to similar interest-holders as the first phase, active participant observation of a different local VPO took place.²³³ This implementation partner was a SSA based NGO who was unknown to NGOs 1 and 2 but known to and chosen by the senior health worker²³⁴ coordinating operations on the ground in Country 2. These virtual IHV programmes coordinated by me drew the attention of WHO African region who aspired to encourage similar programmes in other parts of the region. I²³⁵ and other interest-holders including the national government coordinator in Country 2²³⁶ were invited to join a *Zoom* short life working group to try take this forward as expert advisors. This gave an opportunity to observe senior health workers, health administrators and educators from across SSA giving me new perspectives at a strategic level which by its nature was already highlighting an African perspective.

²³² Not only was I observing but I was in a decision making role. In document C2 (p. 1. 22-40) I articulate to fellow decision makers that IHV NGOs *are between a rock and a hard place...with absolutely no right answer*.

²³³ Whilst active participation this was not fieldtrip participation; it was online support. Figure 14 shows a member of a VPO (a community volunteer) cascading health promotion messages in a church in Country 2.

²³⁴ Person SEF1A.

²³⁵ My role in this is described in Table 1 for context.

²³⁶ Person SEF1A.

This Covid-19 participant observation yielded important additional new data but of lesser quantity than the fieldtrip data previously discussed. This data was important to foregrounding an African perspective given the mutual need for all those involved in IHV in the two SSA countries to ensure collaborative relationships were maintained in so far as was possible post pandemic.²³⁷ In the next section I will discuss data analysis, which I undertook using thematic analysis.

2.3.7 Thematic analysis

Qualitative data analysis has been variously described as taking apart puzzles and then reconstructing them (LeCompte and Preissle, with Tesch, 1993) and as akin to assembling a jigsaw puzzle (LeCompte, 2000). Given the sheer quantity²³⁸ of diverse *messy* data obtained about the IHV phenomenon in SSA the puzzles and jigsaws in this study were both large and had a degree of complexity. Most of my methodological reasoning in choosing thematic analysis as my preferred method of data analysis has already been discussed in Section 2.3. However, it is important to add that it has sufficient flexibility for the researcher to learn its use easily, to generate unexpected insight, and to focus the researcher's mind on similarities and differences in the data (Braun and Clarke, 2006). For example, this flexibility enabled me to draw out a theme of cultural competence and cultural tension to help answer part of my research question which I will discuss in Chapter 4.

I used the six-stage process of thematic analysis described by Braun and Clarke (2006). I firstly had to familiarize myself with the data which I did initially during participant observation but then by transcription, reflexivity, reading and re-reading so that prior to formal analysis I informally had an idea that for example cultural competence was something that occurred often in the data and involved UEHVs and SSA actors. Thereafter I generated initial codes by systematic interrogation of the data. The third stage involved organizing my data into initial categories, which were reviewed and re-categorized following recursive reflection.

²³⁷ For example, in document C2 (p. 33, l. 41) person SPM2 articulates the SSA VPO expectation that relationships with IHV NGOs will carry on after the covid-19 pandemic. From an IHV NGO viewpoint it is evident that relationships with collaborators are valued too. See document C2 (p. 34, l. 50).

²³⁸ My data inventory system (Appendix 2) gives the reader an idea of the large quantity and diverse nature of the data.

Thereafter I reviewed the categories from which after further recursive reflection potential themes were constructed. This can involve a literal thematic map, but in my case, I found it easier to interlink themes that aided me in how best to answer my research question. I then defined and constructed my interlinked themes eventually moving from four to three interlinked themes for my final selection (see appendices 5, 6 and 7). In effect, I took a deductive approach where:

Themes are actively constructed...derived from a data set that answer a research question as opposed to mere summaries or categorizations of codes (Kiger and Varpio, 2020, p. 846).

Braun and Clarke (2006) describe defining and naming themes as the fifth stage, but my themes are more defined and less well named, as the final themes used interlinked themes important to the research question instead of being a memorable theme name.

The final stage of analysis is the research report which is this thesis, and it will be for the reader to judge whether my thematic analysis has been well interpreted and does the research question justice. This whole process was not linear; it was recursive with me going forward and back to parts of the data to aid interpretation. The analysis also took time to gain deep understanding and, in my case, literally years for some aspects of the data to get to the stage that I could meaningfully present the research report. Ely *et al* (1997), indicate that the analytical process develops over time and should not be rushed, and I would agree with this assertion given my experiences. I will return to the finer detail of my analysis later in this section.

Decisions like the selection of units of analysis, codes and other factors like sample size represent areas with little consensus. For example, an appropriate unit of analysis is considered by Downe-Wamboldt (1992) as a large entity such as a complete interview. Yet Weber (1990, p.49) considers it as a smaller unit for example “a code” whereas Feeley and Gottlieb (1998) argue for a minute scale like every word written in a transcript. In data analysis agreement is rare but the notion that codes “are tools to think with” is a useful starting point (Coffey and Atkinson, 1992, p.32). I found deciding on a unit of analysis for this study was problematic as

none of the previously described units were suitable for the project given the diverse nature of the data. I thus defined a suitable unit of analysis for this study which I used throughout analysis as:

Text of variable length, image(s) or sound(s) or other sensory input(s) that present a code or codes drawn from the dataset related to the phenomenon.

This definition covers all available textual scenarios from a single word to whole paragraphs and allows multiple themes to be coded from the same piece of text. It was also inclusive of non-textual data like smell and sounds. This was important as my horizon and subjectivity as the researcher is material to the analytical account. For example, I used my sense of smell to code *harms* regarding an outhouse next to the village dump, that an IHV programme had been moved to for health training by a district official, remarking:

*All rooms were very odorous, and it was in every respect unsuitable as a health facility.*²³⁹

Thematic analysis in this study was undertaken manually using a systematic approach to the *data corpus* to identify codes, themes, interlinking themes and ultimately to make decisions on the most appropriate content to answer the research question. I did consider using computer assisted qualitative data analysis software (CAQDAS) to aid analysis. There are advantages and disadvantages of using CAQDAS. Undoubtedly, the analytical task of data organisation and processing is facilitated by CAQDAS (Sinkovics, Penz and Ghauri, 2008). CAQDAS does not eliminate the sometimes *messy* nature of qualitative research, nor can it bring interpretation to data, it rather makes analysis of large amounts of data more reasonable and transparent, by systematized comparison and enhanced documentation (Sinkovics and Alfoldi, 2012). It further allows researchers to spend less time on clerical and manual tasks and gives a better audit trail (St John and Johnson, 2000).

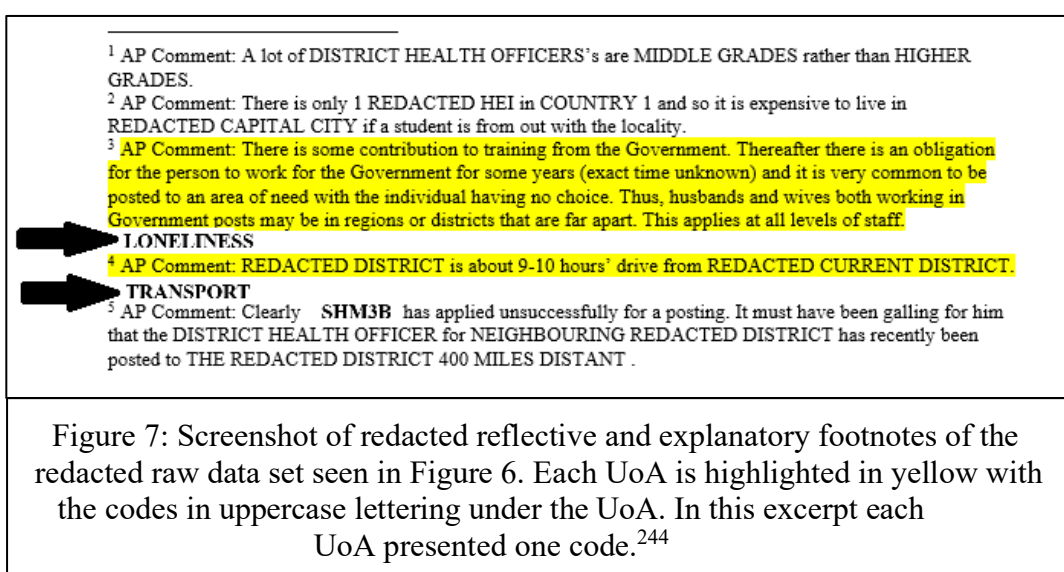
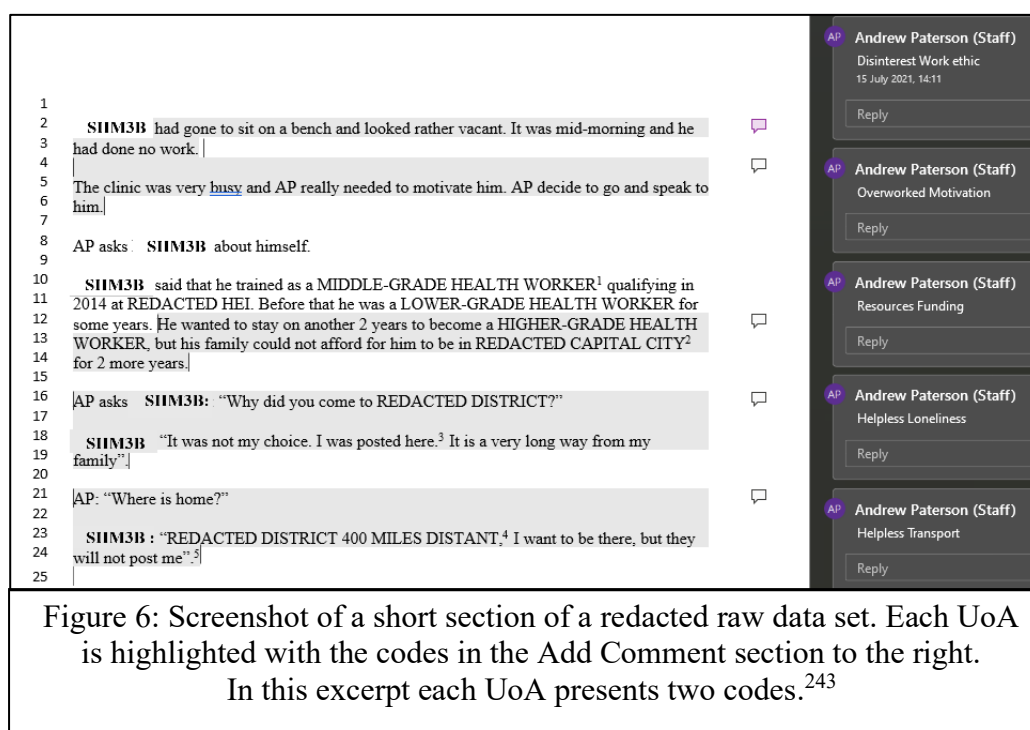
²³⁹ Person SCM2 moved the IHV programme from the village health centre, without consultation with others and at short notice to an unsuitable outhouse. See document F1M (p. 47, l. 15-16).

However, criticisms and disadvantages to CAQDAS are that a researcher can be too close to the data so that there is inadequate space to deeply reflect and consider the larger perspective, the so called “coding trap” (King, 2008, p.139). This perspective was crucial to interpretation in this study. King (2008) raises further concern that CAQDAS risks a loss of perspective whereby there is risk that extracts, or quotes may be used out with context. A further danger with CAQDAS is that over dependency risks the researcher focusing on procedure, to provide a suitable audit that can be defended, rather than the wider focus on method and philosophical concerns (Salmona and Kaczynski, 2016). St John and Johnson (2000) raise further concerns that CAQDAS pressures researchers to look at data as breadth and volume rather than meaning and depth. In effect CAQDAS may mislead a researcher to look at data from a more quantitative rather than a qualitative lens. If this happens the risk is that CAQDAS may mean data analysis is software driven rather than researcher driven (Mueller, 2019).

I used a checklist adapted from the University of Northampton (2017) to try to balance the advantages and disadvantages of using CAQDAS to aid decision-making between manual analysis or CAQDAS. In this study the results were largely equivocal being perhaps very slightly in favour of CAQDAS due to the high volume of data being analysed. I ultimately decided on manual analysis as the importance of reflection in the analytical process was too important in this study to risk loss of larger perspective and loss of context in the interpretative process. I felt that whilst manual data handling was laborious, that reliance on CAQDAS in my case risked being at the expense of detailed familiarity with the *data corpus* which is only gained by handling it manually.

I identified codes in the data and reflective footnotes coding from units of analysis (UoA) based on my definition of a UoA, as described previously. I had no predefined themes and adopted an open coding approach, perhaps over coding at first. For ease of handling multiple codes from a single UoA I used up to three codes from the UoA on the datasheet. If, on rare occasions, a UoA required more than three codes this was identified in the data, as if the text has been split, to provide a repeat UoA with the additional codes for ease of reading and analysis. Coding from the four main fieldtrips was a laborious task given the volume and number of codes but less so in other data as with my research question

foregrounding an African perspective there was much less data relevant to my research question. Indeed, some data I collected at the outset of this study, for example reasons why UEHVs volunteer, added little to my research question but was collected as at the time as I did not know it would be less important.²⁴⁰ For examples of my data coding see Figures 6²⁴¹ and 7²⁴² which show coding from a sheet of fieldtrip data and coding from the reflective notes of that sheet of fieldtrip data.



²⁴⁰ The reader will note that the reasons for volunteering was briefly discussed in Section 1.9 largely to provide contextual information about GNHVs.

²⁴¹ Example taken from document F2M, p. 67.

²⁴² Example taken from document F2M, p. 67.

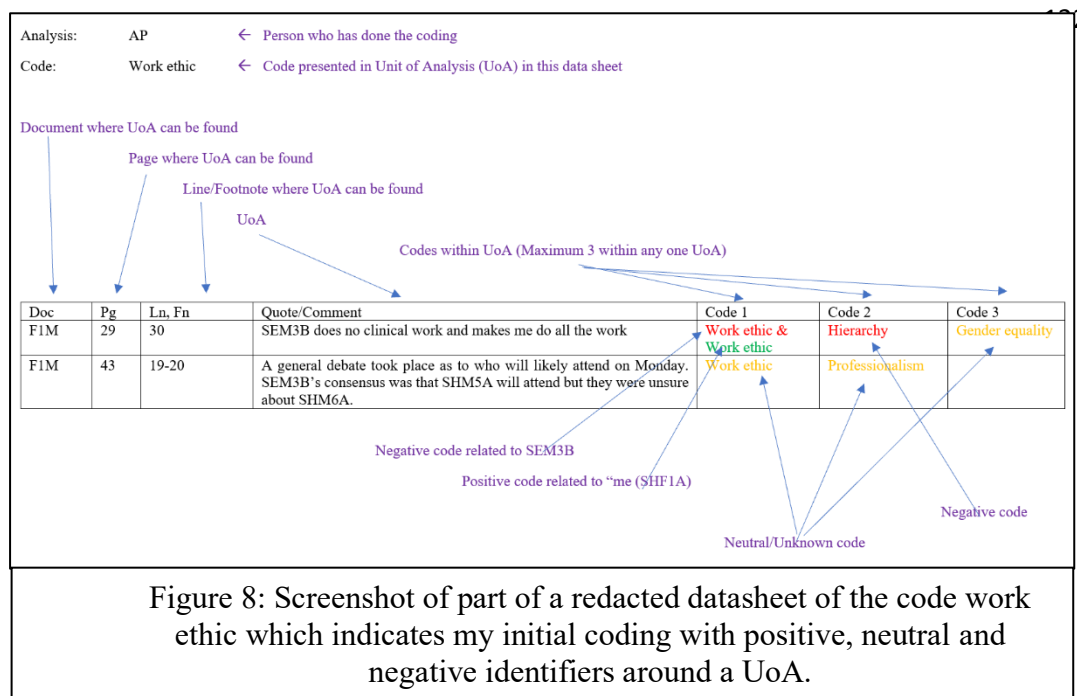
²⁴³ Appendix 3 gives a more comprehensive example of coded fieldtrip data (13 pages).

²⁴⁴ Appendix 3 gives a more comprehensive of reflective coded fieldtrip notes (13 pages).

As a first approach to the data and to help me think I found it useful to loosely classify the codes as positive, negative, and neutral. I did this by colour coding the codes on data sheets as red, amber and green. Red indicated to me a negative code for the phenomenon, amber a neutral or unknown code for the phenomenon and green a positive code for the phenomenon. However, within a UoA there may be a code that I would classify as both negative and positive or negative and neutral or neutral and positive dependent on the viewpoint of the actors or context mentioned. In effect I was attempting to code both my analysis of a situation and that of others. This approach exposed my early methodological naivety as I had misinterpreted the approach of Braun and Wilkinson (2003) who used a questionnaire involving positive and negative values. Whilst as a starting point it was a reasonable approach, as it allowed me to realise that data may have different value, ultimately as it had no primary validity it required modification. Undoubtedly this was erroneous on my part, but I learnt much from it (Schwartz, 2008).

I thus evolved my approach and open coded data without these potential value judgements. I have put into Appendix 3 of this thesis several pages of redacted coded fieldtrip data and reflective coded fieldtrip notes. Once coding was finished, I put each code into an individual dataset related to that code which also included the other associated codes, so I had an idea of the individual UoA that presented the code and where it was within the *data corpus*. Appendix 4 gives the reader an example of organisation of several pages of coded fieldtrip data relating to a specific code.²⁴⁵ A full list of codes derived from the data can be seen in Appendix 5. These appendices should enable the reader to better interrogate my coding. In Figure 8 I detail an example of my first attempt at coding which exposed my initial naivety by use of positive, neutral and negative classifications:

²⁴⁵ The exemplar code is *respect*.



As I went through the process, I categorised codes together for what I felt at the time there was sufficient evidence of relation or similar meaning. Codes were grouped within areas of similar meaning. To give the reader an example I categorised the following codes together which I felt were important for interpretation:

Confidentiality; Cultural competence; Professionalism; Trust; Work ethic.

The categories²⁴⁶ were revised by constant comparison with some codes being recategorized which made more sense for interpretation as analysis of more of the *data corpus* proceeded. Some codes were discounted as there was insufficient data to provide adequate evidence for them to be considered reasonable to inform interpretation. In effect I would only use codes for which I felt there was strong evidence to use, and to do this required constant comparison throughout the process. This inevitably led to gaps in the answer to the research question, but this is the essence of an account using an ethnographic approach which leaves the remaining answers all the more robust. Sometimes identification and categorisation of codes can be problematic and time consuming and this was indeed the case in this study. However, time spent on reflection and frequent data review is likely to achieve good quality results. (DeSantis and Noel Ugarriza, 2000).

²⁴⁶ The reader will find later in this section details my list of initial categories and final categories and reasons for recategorization and discarding of codes.

In the forthcoming pages I detail my lists of initial categories and final categories and my full reasons for recategorization and discarding of codes. The categories are listed in alphabetical order of the first code in the respective category. At this initial categorization stage, I changed the name of the code *tribalism* to *ethnicity* for reasons explained in a footnote in Appendix 5 and in Section 4.5 of this thesis. My initial categories are seen in Table 5:

Initial categories:
Accommodation, Telecommunications; Transport; Utilities; Weather
Accusation; Anger; Criticism; Insult; Threat; Untruth
Addiction; Burnout; Disability; Health; Harms; Emotional; Exhaustion; Overwhelmed; Overworked
Altruism; Commitment; Compassion; Courage; Humour; Positivity; Reassurance
Ambition; Materialism; Mindset-Closed; Self-interest; Image
Appreciation; Friendship; Gratitude; Greetings
Authoritarian; Hierarchy; Politicisation; Power
Brutality; Crime; Corruption; Harassment
Bureaucracy; Governance; Monitoring; Oversight; Regulation
Collaboration; Communication; Cooperation; Partnership
Competence; Effectiveness; Enthusiasm; Entrepreneurism; Feedback; Inclusivity; Initiative; Innovation; Insight; Leadership; Learning; Mindset-Open; Motivation; Organisation; Orientation; Planning; Prioritisation; Problem solving; Responsibility; Restructuring; Success; Teaching; Teamwork; Vision
Conciliation; Confrontation; Influencing; Misunderstanding; Negotiation
Confidentiality; Cultural competence; Professionalism; Trust; Work ethic
Corporate social responsibility; Mentoring; Respect; Role model
Cultural tension; Decolonization; Ethnicity; Gender equality; Myth; Neo-colonialism; Paternalism; Racism; Submissive
Dependency; Helpless
Disinterest; Realism; Scepticism; Suspicion
Funding; Maintenance; Poverty; Recruitment & retention; Resources
Guilt; Moral luck; Partiality; Regret; Unpredictability; Worry
Religious motivation; Volunteerism; Voluntourism
Safety; Supplies; Support; Sustainability

Table 5: Initial categories

At this stage I discarded the following codes as I had insufficient data for them to be of utility in addressing my research question (see Table 6):

Accessibility	Protective
Good intention	Quiet
Nutrition	Readjustment

Table 6: Codes discarded after initial categorization

The code *digital learning* was subsumed into the code *learning* as it still had potential validity here. As a standalone code it had insufficient data to be of utility in addressing my research question.

It was clear to me at this point I had too many categories and this initial categorisation was a mere starting point. I then spent much time reviewing data and categories as the third stage of my six-stage analysis (Braun and Clarke, 2006). My goal involved searching for potential themes and organizing my data around those themes in categories. Review and re-categorization following recursive reflection was an imperative for me, as I was some way off finding robust themes that would answer my research question. This was not a linear process and there was much back and forth reflection.

My final categorisation prior to selecting themes and thereafter interlinked themes is detailed in Table 7. The categories are listed in alphabetical order of the first code in the respective category.

Final categories following re-categorization:
Accusation; Addiction; Anger; Authoritarian; Brutality; Confrontation; Corruption; Criticism; Crime; Disinterest; Harms; Harassment; Insult; Mindset-Closed; Self-interest; Threat; Untruth
Burnout; Disability; Emotional; Exhaustion; Guilt; Health; Helpless; Materialism; Misunderstanding; Overwhelmed; Overworked; Regret; Submissive; Unpredictability; Worry
Appreciation; Altruism; Commitment; Compassion; Conciliation; Courage; Friendship; Gratitude; Greetings; Humour; Mentoring; Mindset-Open; Positivity; Reassurance; Role model
Hierarchy; Politicisation; Power;
Bureaucracy; Governance; Monitoring; Oversight; Regulation
Collaboration; Cooperation; Partnership
Dependency; Sustainability
Cultural competence; Cultural tension; Professionalism; Trust; Realism; Respect; Scepticism; Suspicion
Decolonization; Ethnicity; Gender equality; Myth; Neo-colonialism; Paternalism; Racism
Funding; Poverty; Recruitment & retention; Resources

Table 7: Final categories following recategorization

Therefore, the following categories were discarded at this final recategorization stage as seen in Table 8:

Category discarded	Reason
Accommodation; Maintenance; Safety; Supplies; Telecommunications; Transport; Utilities; Weather	Did not answer the research question. Not unique to IHV in the two SSA countries, more of a generic problem in the countries. This has already been discussed in this section of my thesis.
Ambition; Competence; Communication; Confidentiality; Corporate social responsibility; Effectiveness; Enthusiasm; Entrepreneurism; Feedback; Inclusivity; Influencing; Initiative; Innovation; Insight; Leadership; Learning; Motivation; Negotiation; Organisation; Orientation; Planning; Prioritisation; Problem solving; Responsibility; Restructuring; Success; Support; Teaching; Teamwork; Vision; Work ethic	Did not answer the research question. Some of these codes are important in how IHV collaborations work but are not in themselves main influences. Many of these codes have been discussed throughout the thesis, in relation to the phenomenon as attributes that IHV actors/interest-holders may possess or undertake.
Religious motivation; Volunteerism; Voluntourism	Did not answer the research question. Relates more to why UEHVs volunteer. Important background contextual information, so included in Chapters 1 and 4. ²⁴⁷

Table 8: Categories discarded at final recategorization

²⁴⁷ Religious motivation is mentioned in Sections 1.3, 1.4, 1.9 and 4.2.3 (in relation to African cultural values); volunteerism is mentioned in Sections 1.3, 1.4, 1.5, 1.6, 1.9 and 1.9.1; voluntourism is mentioned in Section 1.9.3.

I also discarded further codes altogether during this final re-categorization process as seen in Table 9:

Code discarded	Reason
Image	Insufficient data to take forward. Brief passing mention in Section 2.3.9.
Moral luck	Insufficient data to take forward. Brief passing mention in Section 1.3 to give important contextual information.
Partiality	Insufficient data to take forward. Not discussed in the final write up as ultimately not relevant to my research question and does not add sufficient context.

Table 9: Codes discarded in the final recategorization process

When I started then looking at broader themes, I regularly restated my research question being *What are the main influences on short-term international healthcare volunteering in two sub-Saharan African countries? An ethnographic approach* so that I was answering this question rather than looking at the often very interesting but less relevant codes as they related to the question. In simple terms theme identification for me involved looking for:

Something important about the data in relation to the research question
(Braun and Clarke, 2006, p.82).

I had options of using either a broader *inductive* approach to identifying themes or a narrower *deductive* approach (Braun and Clarke, 2006). Deductive approaches are often characterised by researcher driven ideas (Varpio *et al*, 2020). As I inevitably came to the research with my own horizon, biases and pre-existing knowledge a deductive approach fitted my research paradigm better. Whilst both approaches are acceptable (Kiger and Varpio, 2020) it is important that the reader is aware of my approach to put my findings in context.

Thematic analysis allowed me to look not just for patterns, but relationships within the data, including tensions, paradoxes, and contradictions, and as long as I analysed the data using the methodology previously described in this section, I

would ensure that the analysis was structured, consistent and rigorous. I spent much time using a recursive approach by going back a stage and then forward to identify, review, and keep or discard codes, categories or themes related to the research question.

For example, I initially had a category of codes namely *accommodation, telecommunications, transport, utilities and weather* which represented for me a barrier around IHV in the two SSA countries and I was thinking of a theme of *accessibility*. This related to lack of access to rural sites in Africa where IHV took place due to things like poor roads, no access in the rainy season, inadequate transport links, no electricity or clean water or modern communication methods. There was a significant volume of this in the data, and it was a point of issue and discussion for African, IHV NGOs, UEHVs and other Global North actors. In essence *prima facie* it looked like a theme worthy of significant discussion in the final analysis. But then I realised *accessibility* was not something that was unique to IHV in the two SSA countries; it did influence the phenomenon, but this was an omnipresent theme for any activity that may take place in rural SSA not just IHV, so it did not really add to answering my research question so ultimately, I discarded it, and its only role in this thesis is this passing mention.

I struggled with naming of themes, finding that a snappy name often eluded me when looking for themes. For example, cultural competence became a theme not just a code as I realised it was pivotal to my research question and moreover it had other facets like cultural incompetence which were a big part of this theme.

To address my research question, interlinking of themes represented the most important part of the interpretation as I was selecting themes that would directly answer my research question foregrounding an African perspective. This involved more recursive construction by interpretation of some very demanding puzzles which took considerable time. Interlinking of themes is suited to thematic analysis and builds the themes as a set of concepts (Olaogun and Fatoki, 2009). Concepts are abstract constructions and not the data so are dependent on the interpretation of the data by the researcher. The interlinked themes are ultimately my construction even though they are grounded on realities derived from the field setting. The initial step in interlinking themes is to determine the central or core

category concept around which other themes can be arranged to explain the nature of the research (Olaogun and Fatoki, 2009). Thereafter, recursive revision of concepts was essential to refine them. It was this deductive approach that I used to seek to answer my research question which sought to highlight an African perspective whilst doing justice to wider perspectives. I will present my interlinked themes as the influences that answer my research question in Chapters 3, 4 and 5. Inevitably there were difficult decisions required in terms of prioritization of themes as the researcher cannot tell all as space, time and evidence will not permit this and some more minor influences have only a passing mention and some none in this analysis. The final selection of interlinked themes is detailed in the forthcoming pages. This includes information on my progression from potential theme selection to final interlinked themes for inclusion in this thesis and the reasoning for my decisions.

From my final categories I chose potential themes and following re-reading and further analysis as per the methodology described by Braun and Clarke (2006) and reaffirmed by Kiger and Varpio (2020) I eventually chose three interlinked themes. These themes were the subjects of Chapters 3, 4 and 5 in this thesis. Initial theme selection drew out the following categories as potential themes that I initially felt were interlinked together as an important influence on IHV in the two SSA countries are seen in Table 10. The interlinked themes are listed in alphabetical order of the first word in the respective theme.

Potential interlinked themes	Comments
Bureaucracy; Governance; Monitoring; Oversight; Regulation	At the time this grouping seemed worthy of exploration primarily as this grouping was a <i>double-edged sword</i> in acting as both a barrier and a driver for IHV.
Cultural competence; Cultural tension; Professionalism; Respect	I was not discarding <i>ethnicity</i> and <i>racism</i> which I subsumed into <i>cultural competence</i> and <i>cultural tension</i> . <i>Trust</i> was subsumed into <i>professionalism</i> . <i>Suspicion</i> was subsumed into <i>cultural tension</i> . <i>Gender equality</i> was subsumed into <i>hierarchy</i> . ²⁴⁸ At this stage I was fairly confident this was a <i>main</i> influence on IHV in the two SSA countries.
Collaboration; Cooperation; Partnership	At this stage I was fairly confident this was a <i>main</i> influence on IHV in the two SSA countries.
Dependency; Sustainability	At this stage I was fairly confident this was a <i>main</i> influence on IHV in the two SSA countries, but I was unsure of where it may fit in with other influences.
Hierarchy; Politicisation; Power; Neo-colonialism	Here I was not discarding <i>decolonization</i> ²⁴⁹ as it was subsumed into <i>neo-colonialism</i> .
Funding; Poverty; Recruitment & retention; Resources	At the time this grouping seemed worthy of exploration primarily as these issues are widespread in IHV in the two SSA countries.

Table 10: Initial selection of potential interlinked themes

At this stage I discarded *myth*, *paternalism*, *realism* and *scepticism*. *Myth* was nevertheless discussed in Section 4.2.3 and *paternalism* warranted a brief mention in Section 1.3 (primarily for context). The reader will note that some

²⁴⁸ Ultimately *Ethnicity* and *racism* were discussed in Section 4.5; *trust* and *suspicion* in Section 4.4 and *gender equality* in Section 5.4 of this thesis.

²⁴⁹ *Decolonization* was discussed in Section 5.6.2 of this thesis.

groups from my list of final categories were not in my initial list of potential interlinked themes. This is detailed in Table 11.

Categories discarded from initial list of potential interlinked themes	Reasoning
Accusation; Addiction; Anger; Authoritarian; Brutality; Confrontation; Corruption; Criticism; Crime; Disinterest; Harms; Harassment; Insult; Mindset-Closed; Self-interest; Threat; Untruth	Many of these are likely <i>an</i> influence on IHV in the two SSA countries however they are not a <i>main</i> influence. They involve potentially inflammatory subjects. They are not hidden but instead have been weaved throughout the thesis.
Burnout; Disability; Emotional; Exhaustion; Guilt; Health; Helpless; Materialism; Misunderstanding; Overwhelmed; Overworked; Regret; <i>Scepticism</i> , ²⁵⁰ Submissive; Unpredictability; Worry	Many of these are likely <i>an</i> influence on IHV in the two SSA countries however they are not a <i>main</i> influence. They involve potential barriers and issues that may reduce effectiveness of IHV programmes in the two SSA countries. They have been weaved throughout the thesis.
Appreciation; Altruism; Commitment; Compassion; Conciliation; Courage; Friendship; Gratitude; Greetings; Humour; Mentoring; Mindset-Open; Positivity; Reassurance; Role model	Many of these are likely <i>an</i> influence on IHV in the two SSA countries however they are not a <i>main</i> influence. They involve potentially beneficial attributes. They are not hidden but instead have been weaved throughout the thesis.

Table 11: Categories discarded from initial list of interlinked themes

The reader will note that *realism* is absent. My categorisation was at times imperfect. I should have discarded this at the previous stage and placed it in the discarded category *Ambition...Work ethic* where it undoubtedly fits better. It was thus discarded a stage later than it should have been.

²⁵⁰ I moved *scepticism* into a new category at this stage but then discarded the category.

Whilst I did not use a literal thematic map (Braun and Clarke, 2006) at this stage I felt I was nearing the end of my search for my main influences to answer my research question, and I was nearer to reading that map. This stage of potential interlinked theme selection drew out the following themes that I was reasonably confident were interlinked together as a main influence on IHV in the two SSA countries. Table 12 gives details of my intermediate selection of potential interlinked themes and a commentary on why I felt they were *main* influences in answering my research question. The interlinked themes are listed in alphabetical order of the first word in the respective theme.

Intermediate selection of potential interlinked themes	Comments
Collaboration, sustainability and dependency	I remained confident this was a <i>main</i> influence on IHV in the two SSA countries. I subsumed <i>cooperation</i> and <i>partnership</i> into <i>collaboration</i> .
Cultural competence and cultural tension	I remained confident this was a <i>main</i> influence on IHV in the two SSA countries. I felt though that these interlinked themes did not necessarily link well with <i>professionalism</i> and <i>respect</i> , so I moved these and created another grouping (see below) at this stage of my thematic analysis.
Power, hierarchy and neo-colonialism	I remained confident this was a <i>main</i> influence on IHV in the two SSA countries. I subsumed <i>politicisation</i> into <i>power</i> .
Professionalism, respect and volunteering discourse	I remained confident that <i>respect</i> was a <i>main</i> influence on IHV in the two SSA countries and particularly important for foregrounding an African perspective due to African cultural values. I felt <i>professionalism</i> underpinned much of IHV good practice and was an influence, but I remained a little uncertain about how much. Over the course of my study there was much volunteering talk some positive some negative that appeared in several codes. I convinced myself at this stage that this was influential on IHV in the two SSA countries. This was the grouping I was least confident in as a <i>main</i> influence on IHV in the two SSA countries.

Table 12: Intermediate selection of potential interlinked themes

During this process of intermediate theme selection, I discarded the following potential interlinked themes. These can be seen in Table 13 together with my reasoning as to why they did not warrant being a *main* influence to answer my research question.

Potential interlinked themes discarded during intermediate selection	Comments
Bureaucracy; Governance; Monitoring; Oversight; Regulation	These are <i>an</i> influence on IHV in the two SSA countries however they are not evident as a <i>main</i> influence. A section of this thesis (Section 1.10) discussed this influence.
Funding; Poverty; Recruitment & retention; Resources	These are <i>an</i> influence on IHV in the two SSA countries however they are not evident as a <i>main</i> influence. Sections of this thesis (Sections 1.2, 1.7 and 1.11) discussed this influence.

Table 13: Potential interlinked themes discarded during intermediate selection

After further reflection I selected the following interlinked themes as the main influences on short-term international healthcare volunteering in the two SSA countries. This final interlinked theme selection with reasoning is seen in Table 14.

Final interlinked themes	Comments
Collaboration, sustainability and dependency	This is a <i>main</i> influence on IHV in the two SSA countries. It is the subject of Chapter 3. I discuss why these themes were interlinked in my introduction to Chapter 3 which in turn discusses this interlinked theme in depth.
Cultural competence and cultural tension	This is a <i>main</i> influence on IHV in the two SSA countries. It is the subject of Chapter 4. I discuss why these themes were interlinked in my introduction to Chapter 4 which in turn discusses this interlinked theme in depth.
Power, hierarchy, respect and neo-colonialism	This is a <i>main</i> influence on IHV in the two SSA countries. It is the subject of Chapter 5. I moved <i>respect</i> into this grouping of themes as it underpins <i>hierarchies</i> and <i>power</i> in African culture. I devote Section 5.2 to discussion of the interlinkages around this theme.

Table 14: Final interlinked themes

I discarded the following potential interlinked theme at this final stage. See Table 15.

Potential interlinked theme discarded at the final stage	Comments
Professionalism, respect and volunteering discourse	<i>Respect</i> is a major influence on IHV in the two SSA countries and was moved into the interlinked theme of <i>power, hierarchy, respect and neo-colonialism in my final selection</i> . <i>Professionalism</i> is an influence on IHV good practice in the two SSA countries, but I remain unconvinced as to how much of an influence. <i>Professionalism</i> was weaved throughout the thesis but appears in relation to <i>trust</i> in Section 4.4. On reflection <i>volunteering discourse</i> is likely a facilitator rather than an influence on things like <i>neo-colonialism</i> and <i>white saviourism</i> . <i>Volunteering discourse</i> was briefly discussed in Section 5.6.1.

Table 15: Potential interlinked theme discarded at the final stage

As can be seen by my detailed workings thematic analysis in this study was time-consuming, methodical, rigorous and involved much recursive reflection. This allowed me to be confident of the decisions made over interlinked theme selection of the main influences selected to answer my research question. I will now go on to discuss limitations of this research in Section 2.3.8.

2.3.8 Limitations

In this section I will discuss some of the limitations of this study related to how I purposively sampled individuals of interest for more participant observation than others and how I had to be careful to foreground but not over prioritize an African perspective. I have discussed already some of the theory behind purposive sampling in Section 2.3.3. In addition, I will debate how my study may be limited by the activities of the IHV NGOs that I studied and my own profession as they were primarily chosen because I had opportunity of access to field settings these NGOs chose to work in. I will also discuss reconstruction bias, anecdotal bias and

the non-disclosure of the two SSA countries and the potential of these to bring limitations to my research.

During this study I observed many health workers from the two SSA countries, but I observed some more than others as informal analysis during fieldtrips indicated that these persons were likely to give more rich and detailed data in answering my research question or were from a group that was under-represented. As fieldtrips lasted from between 11-to-15-days, I would decide who warranted more detailed observation early into a trip to ensure sufficient time for observation. Women are underrepresented in the healthcare workforce in SSA despite gender equality being of paramount importance to global health in the 2030 agenda of the SDGs (Roca *et al.*, 2018). I thus chose to observe more of the female SSA health workers that I encountered on my fieldtrips as there were few of them and not to do so would potentially leave a lacuna in data and analysis. For example, on my first fieldtrip of nine senior and middle grade health workers only one was female and of six lower grade health workers there were two females. On that fieldtrip I observed two²⁵¹ of the three females more closely. The third I did not as they were from a religious group where observation from a male was less culturally acceptable.²⁵² I thus did not do more detailed observation on this person as I was mindful of the words of Iphofen (2015) that care is sometimes required to maintain the dignity and personhood of indigenous women health workers whilst recognising their cultural background.

Sex was not the only selection criterion that I used. It was clear to me early in the study that ethnicity may play a part in being an influence on IHV in the two SSA countries. I chose on occasion to observe the occasional SSA health worker or those from VPOs who I knew to be from a non-predominant ethnic group and indeed I will return to ethnicity in Section 4.5 of this thesis.²⁵³ On IHV fieldtrips I prioritized observation of those in influencing and leadership roles from the two SSA countries,²⁵⁴ VPOs,²⁵⁵ the local community²⁵⁶ and associated with the IHV

²⁵¹ Person SHF1A and person SHF3. Although ultimately person SHF3 did not reveal much rich data.

²⁵² Person SHF4.

²⁵³ I observed more closely persons SPM1 and SPM5 (both during fieldtrips 1 and 2).

²⁵⁴ For example, person SEF1A is a female in a leadership role observed in fieldtrips 3 and 4 and online.

NGO.²⁵⁷ I felt this was important as whilst I was foregrounding an African perspective to fully understand the influences on IHV in the two SSA countries I needed a much wider perspective of those who had influence and power in the IHV phenomenon.

To gain that wider perspective I sometimes had to make quick on the spot decisions as to who to prioritise for observation. This was because persons of interest related to the IHV phenomenon were sent by various IHV interest-holders to view or be a guest on a fieldtrip. They would visit the IHV programmes for varying time periods ranging from a few hours²⁵⁸ to a few days.²⁵⁹ Equally in my IHV participant leadership role on occasion I would leave the field site to visit local dignitaries and community leaders for courtesy visits to pay respects, as is the expectation in African culture of a visitor in my role. Many of these people had been instrumental in giving permission for the IHV NGO to operate in their locality and based on prior knowledge I was aware that some dignitaries were more important for me than others in interpreting the IHV phenomenon.²⁶⁰ Inevitably I sometimes missed opportunities. For example, my participant role prevented me meeting some people and on other occasions where I had to choose on the spot between two or three people to observe I sometimes chose the person who gave less or irrelevant data to better answer my research question. In this scenario observing the other was never going to be possible as they were a transient visitor to the NGO programme.²⁶¹ In Appendix 1, in addition to a list of participants, I detail a list of those I observed more closely and the reasons why I did this.

²⁵⁵ For example, person, SPM6 is a senior VPO administrator observed in fieldtrips 1,2 and 4.

²⁵⁶ For example, person SHM1A has multiple roles in IHV but was a pillar of the local SSA community observed in fieldtrips 1 and 4 and online.

²⁵⁷ Persons GNM3A and GNF3A are in NGO leadership roles. I observed them in fieldtrip 3 and online.

²⁵⁸ For example, person SCM4 visited fieldtrip 4 for 2-3 hours. See document F4M (p. 49, l. 17-18). This gave little time for observation of a respected community leader.

²⁵⁹ For example, person SYF1 visited fieldtrip 1 for 2 days. See document F1M (p.27, l. 32-33). This gave sufficient time for observation.

²⁶⁰ See for example, in fieldtrip 4 to prevent being seen as *disrespectful* three of the four programme leaders (persons SPM6, SHM1A and I) had to leave the programme to pay courtesy visits to the local politician (SEM13), local council executive (SEM12) and local medical administrator (SEF2), a fairly long return journey. All were met together and there was no opportunity for anything except photographs and pleasantries with no rich data collected. Had I had more time I have no doubt I would have gathered more valuable data, but here my participant leadership role meant that I had to get back promptly to the NGO programme. See document F4M (p. 89, l. 2 – p. 91, l. 3).

²⁶¹ For example, persons SCM4, SYM1 and SCF1 visited fieldtrip 4 together for a few hours introduced to me by person SHM1A. See document F4M (p.49, l. 8 – p. 53, l. 2). I had to on the spot choose between them. I chose person SCF1 as person SHM1A *bowed* to them (document F4M, p.49, l. 18). I knew enough of African culture that person SCF1 was considered more important than

The IHV NGOs whose fieldtrips were the loci of my participant observations were selected by me from my prior knowledge, my previous volunteering experience and my opportunity to be an insider in the research process. This limited the fieldtrips to the areas of operation of these NGOs, so observation took place in only two countries in SSA. However, fieldtrip locations were limited by the needs of ministries of health, local government and national health associations who would collaborate with other interest-holders to determine where IHV programmes were best situated. In effect the IHV NGOs would largely operate in a specific locus negotiated with SSA authorities in the two SSA countries.

The IHV NGOs did however have some say in the programme locus as they had a duty of care over volunteers. For example, the UEHVs would need to carry out a programme in an area where there was reasonable transport access, safe accommodation and in an area where both host and UK Government advice indicated travel to that area was safe. This sometimes meant access to areas of most need that were an African priority was impossible, and this was a limitation on observations. On occasion programmes were cancelled or areas changed due to conflict, political unrest or a public health emergency such as haemorrhagic fever outbreaks. In effect my observation was limited to areas where the host governments wanted the IHV NGOs to visit and further limited by IHV NGOs' safety concerns leaving a somewhat incomplete picture of the IHV phenomenon in more extreme circumstances. It is important to be mindful here that although I was a trustee of NGO 1, site selection was an operational matter, and trustees are generally uninvolved in operational matters.

Both the IHV NGOs I studied were based in the UK and this was a necessity of my opportunity of insider access. My study is limited by this as there are many other IHV NGOs that operate in SSA from the Global North. I believe from the encounters I have had and secondary research that European based IHV

the others (both local leaders who did not receive a *bow*) and this was a good choice as observing person SCF1's reaction to the NGO programme bore fruitful rich data. I then observed a little of person SCM4, who offered irrelevant data related to their own medical condition (document F4M, p. 50, l. 1-2). Briefly listening to person SYM1 (document F4M, p. 49, l. 11) I realised that person would have provided more data than person SCM4. Unfortunately, I realised I had chosen poorly. I was too late and as the visit drew to a close, I knew I had missed my chance for more rich data.

NGOs operate similar models and programmes in IHV in the two SSA countries and wider SSA as UK based organisations. In addition, there were several non-UK Europeans who were observed in their role as UEHVs in this study. However, there are a significant number of IHV NGOs who send GNHVs from the USA. Some IHV NGOs from the USA operate by sending larger numbers of GNHVs to one locale in SSA, often bringing large quantities of health equipment to largely treat large numbers of patients using Western healthcare methods rather than to provide training or capacity building for those in SSA, then leaving with the equipment. This is a model best thought of as a health brigade or medical mission.²⁶² During my research these particular models were criticised by people I observed in the two SSA countries.²⁶³ For an example, a senior health worker when discussing IHV in their country states:

*We have had so many problems with the Americans.*²⁶⁴

I am less confident therefore that my study can be extrapolated to be relevant to all IHV NGOs in all Global North settings and to the type described above that predominantly, but not exclusively, originates in the USA. I have no experience of participant observation within such IHV NGOs and there may be different influences exerted on the IHV phenomenon in the two SSA countries in these circumstances.

I observed IHV in only one field of healthcare and largely within primary care as this was a function of my participant role in my own profession and the nature of the IHV NGOs for whom I was a UEHV. However, I encountered and observed IHV actors whilst on fieldtrips drawn from a wide variety of healthcare professions with some actors being in district or regional hospitals in a secondary care setting. Inevitably there are likely some small differences in the relative importance of influences on IHV in the two SSA countries that may have a profession specific or setting component, but I believe that my observations and

²⁶² Person SCF2 pitched this to AP as an appropriate model for IHV in Country 1 hoping AP would get NGO 1 to return with a larger team and more Western type healthcare. See document F4M (p. 50, l. 20-22).

²⁶³ Following their visit to the programme person SCF2 indicated that they now realised this model was inappropriate for their community. See document F4M (p. 51, l. 8-11).

²⁶⁴ Person SEM1D reported this to AP regarding USA based IHV NGOs. See document F3M (p. 89, l. 5-6).

analysis within my healthcare profession reflects influences that are not profession or setting specific and can be useful for readers of all healthcare professions.

As discussed in Section 2.3.1 I chose not to identify the two SSA countries of study for ethical reasons. I do however give context on the two SSA countries in Table 3²⁶⁵. Not naming these countries is a potential limitation of this study as whilst fairly typical of many SSA countries with a paucity of indigenous health professionals the reader cannot be sure of the applicability of the study to any specific SSA country.

Reconstruction bias can arise from reliance upon memory when not making a contemporaneous record on the spot resulting in the potential for cognitive filling in of events. In my study a contemporaneous record at the time of observation was mostly impossible due to my hyperactive participant observational role on IHV NGO programmes. As discussed already in the Preface and in Section 2.3.5 I relied on reported speech for most of my participant observation. Guidance from the Forensic Science Regulator (2020) indicates that risk of cognitive bias is lower when there is a well-researched approach based on sound methodological principles. My research does not have zero risk of reconstruction bias and thus this may be a limitation of my study. However, I contend that the risk of reconstruction bias is low in this study. My research is based on sound ethnographic principles and reported speech was transcribed as close as possible to the time of speech²⁶⁶ so this may mitigate this potential bias. Other mitigations arise from various measures I took to optimise validity, including *inter alia* my bracketing interview, incorporating disconfirming evidence, reflexivity and use of triangulation in my methodology.

Anecdotal bias is a notion sometimes levelled at researchers who adopt interpretive approaches to research (Gupta, 2025). This is the type of approach used in my study. In this research it can appear to the casual reader that some of the narratives generated by me are mere anecdotal stories. It is important to realise that *narrativity* is not the same as *anecdote*. Furthermore, *anecdote* is not to be confused with *observation* that is to say *anecdote* brings spurious evidence whereas

²⁶⁵ Table 3 can be found in Section 2.3.6.

²⁶⁶ See Section 2.3.5.

observation brings programmatic evidence. In my case the narratives are “thick descriptions” (Geertz, 1973, p.6) generated by rigorous qualitative research processes and systematically collected data from participant observation. Participant observation *is* methodical in accessing sources of data, and even when opportunistic is not random. It brings a rigorous claim rather than scientific or statistical demonstration, and the method deployed in this research optimises its validity. For these reasons, rather than anecdotal bias, in my study mitigation of reconstruction bias is the more relevant measure for addressing validity.

Overall, my observations and analysis are thus limited by the opportunities I had of where and whom to observe, some of which were due to decisions made by others, the selections that I chose to make of who to observe, the nature of the IHV NGOs I studied and my profession and area of operation. Additionally, my research was limited by the demands of *hyperactive* participation observation, my leadership role in IHV in the two SSA countries and the daily appropriate and mistaken decisions that I made on prioritization of observation. My answer to my research question is thus limited as being only a partial account as by its nature it cannot be a complete account given the study limitations and the decisions I made. In the next section I will look at exclusions in this research.

2.3.9 Exclusions

Various aspects of the IHV phenomenon were excluded either from the initial study or from participant observation or from writing up in this final thesis. I have already discussed that in foregrounding an African perspective I have not discussed in detail some aspects of the phenomenon related to Global North IHV NGOs and GNHVs. That said I have discussed aspects of the IHV phenomenon related to those organisations and actors that are relevant to my research question, so I have been selective in my exclusion of some parts based on my understanding, interpretation and analysis on the IHV phenomenon in the two SSA countries.

I excluded from the study investigation of IHV in the context of humanitarian IHV to disaster areas irrespective of whether they were conflict or natural disaster induced and to those where volunteering has taken place within a wider multi-national effort coordinated by a transnational body to eradicate a

specific disease, for example, an Ebola virus outbreak coordinated by the WHO. I did this because the influences here are likely to be very different from the development type IHV that this project sought to study. The results of my study are inapplicable to this type of humanitarian volunteering and should not be extrapolated to these situations. Similarly, I excluded long-term volunteering from my study as my fieldtrips were related to short-term volunteering. I thus could not claim with reasonable certainty that influences were the same, despite this mostly being development volunteering. In addition, I excluded from my study IHV in the two SSA countries that emanated from North America as a donor, as their approaches to IHV sometimes differs markedly from the rest of the Global North as discussed already in Section 2.3.8. I excluded it to ensure the validity of my research.

I excluded some information from observation and analysis for confidentiality reasons. Some of my participant roles in IHV in the two SSA countries gave me insider access to highly sensitive and confidential information regarding the inner workings of IHV NGOs, health services in the two SSA countries and ministries of health in those countries. I knew from the outset that such information was confidential and/or privileged and as a member of a regulated health profession the standard of confidentiality expected of me in this respect was absolute confidentiality rather than relative confidentiality.

Whilst NGO and country selection in SSA was a function of my opportunity and access as an insider I did hope to study a third IHV NGO and to volunteer with them in a third SSA country. I excluded this for two reasons. Firstly, the country concerned was going through a period of political instability and civil unrest in border areas and I felt that it was inherently unsafe to visit. Secondly, I discovered that the IHV NGO concerned did not register health professionals with the relevant regulatory body for the clinical work that occurred on their IHV programmes.²⁶⁷ I was not prepared to volunteer with them as I would potentially be participating illegally, and this may put me at risk of regulatory investigation. In excluding this NGO and a third country in SSA undoubtedly my study has less triangulation than I intended but I still have sufficient for a valid account of the IHV phenomenon in the two SSA countries ultimately studied in detail. This third NGO collaborated to

²⁶⁷ See document F2M (p. 108, l. 21-22).

a limited extent with others encountered so I managed to observe some of their interactions in a very limited passive participant observation role.

I excluded from participant observation on my fieldtrips certain people. My participant role included management of patients in a clinical setting. Whilst I observed how IHV NGOs, UEHVs, SSA health workers and VPOs interacted with patients I felt it inappropriate to specifically observe or tell stories of patients except in a very broad sense to highlight a specific point related to my research question.²⁶⁸ That said some IHV actors from local SSA communities also sought clinical management. So, for some examples I sporadically observed village chiefs, village elders, community religious leaders and traditional healers in their community role as they interacted with the IHV phenomenon but not in their patient role as most attended for treatment. It was my normal practice on any fieldtrip to inform those present directly of my observational role and additionally for SSA actors to be informed by the most senior SSA health worker on the programme of this role. During my fieldtrips there were no dissenters, however if I sensed someone was uncomfortable, I simply chose not to observe as there were many people on any trip to observe. In practice this happened twice, and both involved a lower grade SSA health worker. On these trips my participant role was mostly one where a lower grade health worker was undertaking a training course for which I and the most senior SSA health worker had the final decision on success or failure for the individual. I felt that uncomfortableness of such individuals was rather due to my position in the IHV hierarchy (and possibly me being a foreigner) rather than any observational role as these individuals remained uncomfortable on any interaction with me and the most senior SSA health worker throughout.²⁶⁹

In terms of identifying data for my final analytical report I had to be selective as some codes and themes whilst worthy of discussion in other contexts were less relevant to my research question. I have already discussed an example of some potential interlinked themes that I excluded on this basis in Section 2.3.7. Data of this nature was still informally analysed and important points identified,

²⁶⁸ For example, the reader will note that I briefly reported speech from a patient to highlight a specific point in Section 1.11.

²⁶⁹ This occurred in fieldtrip 1. Person SHF1A informed it was because they were *scared* of me given my hierarchical position. See document F1M (p.43, l. 9).

formally analysed, and interpreted but much was excluded from further formal analysis as it did not offer rich data to add to interpretation of the research question. Some data once analysed and interpreted were of a highly controversial nature such as codes of *crime* and *corruption*, relating to economically related theft and bribery or accusations of bribery within the IHV phenomenon. The quantity of data relating to these codes was small so were I to discuss it fully I would firstly have over emphasized their importance in this thesis and secondly would mean I may detract from my main interpretation, potentially being seen as producing a polemic against various IHV interest-holders. Therefore, I excluded these codes, and similar others, from discussion although they exist in the *data corpus* and may warrant further interpretation later. This did not mean that this thesis avoided addressing controversial themes. For example, I will discuss ethnicity and racism in Chapter 4 and neo-colonialism in Chapter 5 as they relate to the IHV phenomenon since the data, subsequent interpretation and relevance to my research question required this be put in the final report.

There were some interlinked themes that I felt may be important influences on IHV in the two SSA countries. For example, my observations and analysis led me to feel volunteering discourse itself was an influence on IHV in the two SSA countries. When I recursively analysed and reflected further, whilst I had a reasonable quantity of data, much in terms of negative talk came from a small number of individuals and positive talk mostly came from the projection of a positive social media image for IHV NGOs. It may have some influence but ultimately, I excluded it from this thesis, other than a passing mention in Section 5.6.1, as I was neither convinced that it added to answering my research question nor that the triangulation of the data was sufficient for it to have adequate validity for full discussion.²⁷⁰ My aim in all of these exclusions was to try to ensure that the data that made my final analytical partial account was all the more robust and valid because of the exclusions rather than including data that would risk it being less robust and valid. I will now critically assess my methodology in Section 2.4.

²⁷⁰ See Appendix 7.

2.4 Critical assessment of my methodology

My methodology in this study is unique to my situation as a participant observer in different challenging field settings in the two SSA countries with each fieldtrip presenting opportunities and challenges that varied from the others. My roles dictated my opportunity for research, which in turn dictated my research choices, for example, which IHV NGOs to study. As the researcher, I inevitably bring my own horizon and cultural bias to the account to some extent, this being unavoidable. At the same time my participant observer role became more the *hyperactive* participant observer as time continued, so at times I had to adapt my methodology as new challenges presented. Whilst I used an accepted method of data collection in my ethnographic approach to research, namely participant observation, the study would have benefitted from some semi-structured interviews of a small number of key SSA actors to explore an African perspective more deeply in the IHV phenomenon. The reasons why I omitted this method have been prior discussed. I feel I had sufficient triangulation without semi-structured interviews for validity but even with close observation of some individuals it is only by asking specific open-ended questions that an even thicker description may be possible to enlighten interpretation.

To bring out the individual experience I aimed to provide sufficient understanding of research context, interest-holders, and researcher so that the reader can find meaning in the outcomes (Smith, Flowers and Larkin, 2009). I have tried to tell the story of my methodology and how it was developed together with the factors that influenced its development including problems encountered. I realise that non-disclosure of specifics like NGO names, country names and my profession may detract from some of the context but feel that my decisions were based on sound ethical judgements where I prioritised confidentiality in order to answer my research question whilst protecting others and myself better and more completely. I believe my context to be sufficient despite these intentional omissions although I do risk the disagreement of others.

The hermeneutic approach worked well for me as this allowed me the subjectivity to give an account in my own terms with my reflexive approach in writing up reflexive footnotes on the day of observations being of paramount

importance to maintaining this subjectivity. This allowed me later during analysis to recursively look back and see what I was thinking at the time of data collection which aided interpretation. Without this temporal currency my account would have been less valid as memories fade with time. Furthermore, I recursively used interpretative reflection throughout the entire process adding to my thoughts at the time of data collection by adding later reflexive thoughts which I felt was imperative to ensure that my interpretation resulted in a:

Detailed account of patterns of meaning and reflections on shared experience (Shinebourne, 2011, p.23).

As stated earlier I used thematic analysis as my method of data analysis following a rigorous approach to analysis as described by Braun and Clarke (2006). I have described the advantages of this methodology in this study already; however, I am aware of the limitations of this method. As a flexible method a disadvantage of the method is that for a researcher there is a large range of things that can be said about the data (Braun and Clarke, 2006). This can sometimes lead to difficulties in deciding what themes to select and focus their efforts on. This was true for me, and I found this frustrating and wasted considerable time before better focussing my research question. Furthermore, when compared to other methods, for example content analysis which uses frequency counts to focus on a micro level (Wilkinson, 2000), thematic analysis falls short of this fine detail. However, I was looking at broad themes as my topic was broad, which gave overarching influences to answer my research question, so thematic analysis suited me for this study. I felt therefore that I chose the best method to answer this research question rather than choosing it by “methodolatry” where a method is chosen because it appears to be a more important branded type of method but in reality, may not work well for a particular research question (Holloway and Todres, 2003, p.347).

It was necessary for me to both limit my data and analysis and exclude some aspects of the IHV phenomenon in the two SSA countries from observation or analysis or both for reasons described in preceding sections. My account is incomplete as it was methodologically impossible to be comprehensive. In simple terms there are certain findings that can neither ethically nor safely be committed to print such as sensitivities, promises of absolute confidentiality, and SSA

government and community considerations. In essence I “cannot know it all” (Davey, 2016, p.36). I am conscious therefore that my interpretative analytical accounts in the following chapters of my main themes are based on my interpretation with methodological rigour, so as to make claims of validity and dependability. My interpretation is not objective but is rather *a* true account of the IHV phenomenon in the two SSA countries rather than *the* true account. As such my interpretations:

Are systems, or economies, of truth... Ethnographic truths are thus inherently partial – committed and incomplete (Clifford and Marcus, 1986, p.7).

My analytical account is hopefully a “persuasive fiction” (Cohen, 1987, p.207) that has, with methodological rigour, been made and fashioned by me and gives a reasonable account that answers my research question. Perhaps the reader should additionally appraise my methodology at the end of this thesis as it is only then that they will know if my writing has sufficiently presented to the reader’s satisfaction:

Judgements about one group of people in a manner which will be persuasive to another (Cohen, 1987, p.207).

2.5 Timeline of research

The timeline of my research studies is detailed in Table 16 which has been adapted from Gantt (1919). My research commenced on a part-time basis in early 2017 with my thesis being submitted at the end of 2025. My research took a year longer than originally anticipated due to a partial hiatus in studies relating to increased responsibilities of my health professional role during the Covid-19 pandemic and caring responsibilities relating to a family member. Table 16 shows these time periods clearly. During these times progress on my research was slow.

In addition to the Covid-19 pandemic disrupting my studies as I have described above the Covid-19 pandemic necessitated cancellation of a fieldtrip in

June 2020.²⁷¹ However, the Covid-19 pandemic presented opportunities as IHV NGOs, and African interest-holders and actors collaborated to provide virtual programmes. Additionally, IHV NGOs and African VPOs had to adapt to survive during the Covid-19 pandemic and I was opportunistically placed for participant observation at a strategic level, at the time, due to my roles in IHV in the two SSA countries.²⁷² Thus, further data was collected and analysed which added to answering my research question meaning that this part of my study continued for longer than could have been anticipated at the outset of the study. This can be seen in my timeline in Table 16. I have already discussed the effect of the Covid-19 pandemic on data collection and data saturation in Section 2.3.6 in more detail.

²⁷¹ The reader will note that in Table 16 I devoted time in my studies in early 2020 to planning the fifth fieldtrip which was cancelled.

²⁷² My participant (non-researcher) roles are detailed in Table 1 which can be found in Section 2.3.4.

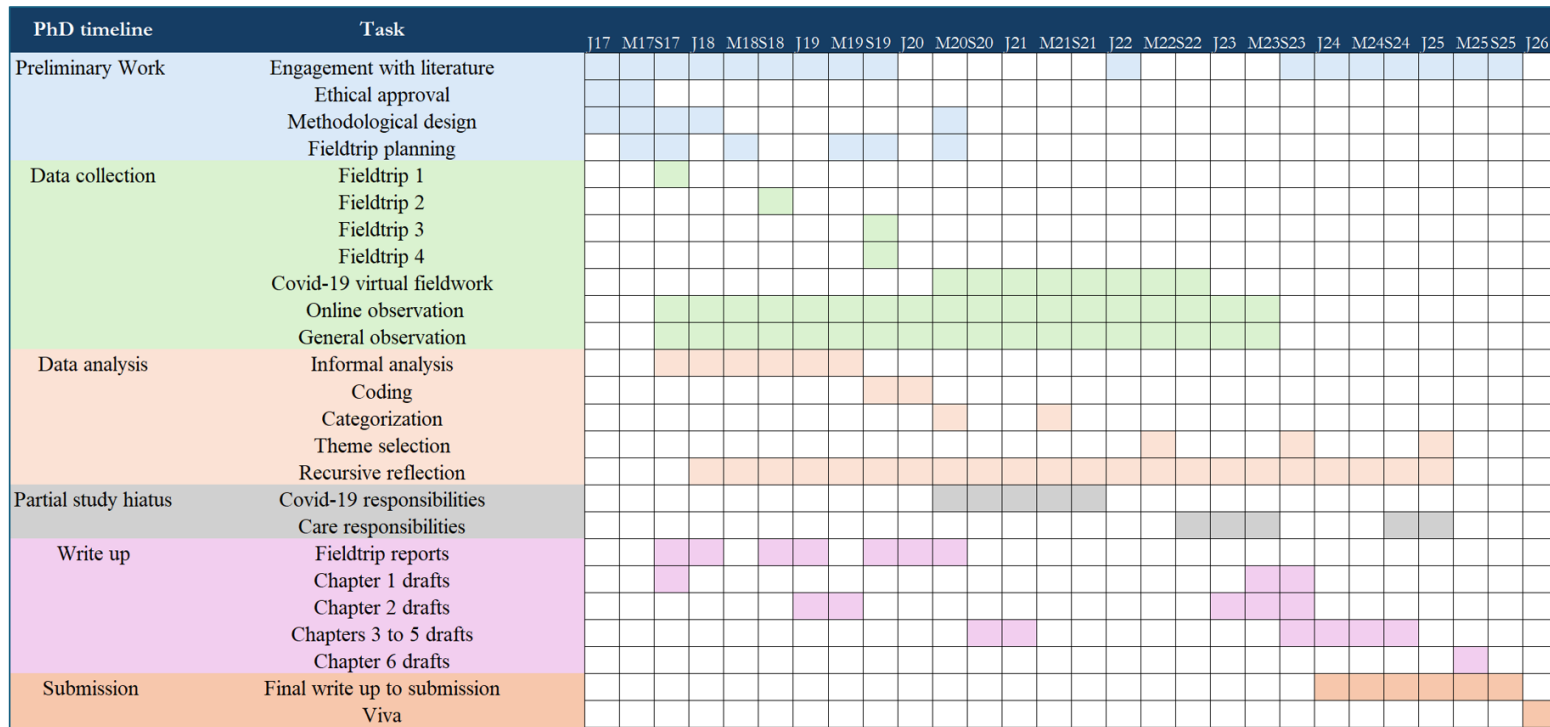


Table 16: Gantt chart showing PhD timeline. Adapted from Gantt (1919)

Key: Time cells are in blocks of 4 months: J = January-April; M = May-September; S = September – December.

The year is abbreviated without the century identifier in it. So, for example, 2021 is seen as 21.

2.6 Chapter Conclusion

My second chapter discussed both my own background within IHV in the two SSA countries and wider SSA and how this has been both the motivator for my study and one of the reasons I developed my research question to study the IHV phenomenon in the two SSA countries. The remainder of the chapter has given the reader context, detail and background to my research methodology so that my study can be framed within accepted qualitative ethnographic approaches of study. I have aimed to assure the reader of the efforts made to ensure that my research is ethically sound and my interpretations are valid.

I have discussed in detail with reference to appropriate literature my methodological reasoning and how I developed rigour and reflexivity into the study. I have debated how and why I used participant observation as my main data collection method and thematic analysis as my analytical approach to aid interpretation of the IHV phenomenon in the two SSA countries. I have given much consideration to telling the reader how I collected my data, and this has given quite specific detail and insight into the difficulties in collecting data on fieldtrips in remote and rural Africa and consequent compromises required. I have similarly discussed in depth how I approached various aspects of my research methods such as triangulation of data, researcher bias, conflicts of interests and ethical issues together with problems I encountered and how I mitigated or managed these problems. I discussed within my methods how I would highlight an African perspective within the IHV phenomenon in the two SSA countries.

In this chapter I considered the partial nature of my account and consequent answer to my research question given the limitations and exclusions in this study. Finally, I have critically assessed my methodology as part of my reflexive approach to qualitative enquiry. The next three chapters will inform the reader about the main influences I found in IHV in the two SSA countries. Chapter 3 will examine collaboration, sustainability, and dependency within the IHV phenomenon in the two SSA countries.

CHAPTER THREE - Collaboration, sustainability, and dependency

Chapter introduction

In this chapter I will present as influences on my research question the themes of collaboration, sustainability and dependency as they relate to IHV in the two SSA countries. Discussion of these themes will in part foreground an African perspective. I used a deductive approach to generate these themes from my final categories and link them together.²⁷³ Following categorisation, I had *sustainability* and *dependency* in one category and *collaboration*, *cooperation* and *partnership* in another. There were many similarities between *collaboration*, *partnership* and *cooperation* and the latter two I subsumed into *collaboration*. I linked these themes together as I found that sustainability permeates throughout the IHV phenomenon for both IHV NGOs and the need and desire of some SSA interest-holders to manage their own health services. Dependency though can be viewed as the antithesis of sustainability. Dependency coexists with sustainability and appears in part to be necessary, wanted and needed particularly by Africans in front line health service roles, the locus of many IHV activities. For sustainability to be enhanced and dependency to be better tolerated as a current necessary reality by IHV interest-holders, collaboration is the essential bond that links these themes. My research will propose that together these themes are a major influence on IHV in the two SSA countries worthy of significant discussion. In this chapter the first half primarily discusses collaboration whereas the second half treats sustainability and dependency together.

3.1 Definitions

Collaboration is a term with no consensus on definition and is often ill defined being sometimes mistaken for cooperation and the more formal term partnership. In my study a considerable amount of data in terms of quantity and importance was coded for all three of these terms. I have taken collaboration in this

²⁷³ See Section 2.3.7 for full details of my categories and themes.

study to mean the joint efforts of individuals or groups or organisations to work or volunteer together towards a common goal. I found that important collaborations in the IHV phenomenon in this research took the form of internal collaboration within IHV NGO teams, VPO teams and SSA health worker teams. It additionally involved external collaboration between various combinations of IHV actors in the UK, Europe, the wider Global North and Africa. Collaboration was sometimes vertical, involving many levels within interest-holder organisations and sometimes horizontal, involving collaboration with others of similar level either within or between organisations. I observed in this study informal and formal collaboration. In this study informal collaboration involved working and volunteering together without any formal agreement²⁷⁴ whereas formal collaboration was primarily based around written agreements such as an MOU²⁷⁵ although there is sometimes a continuum between informal and formal. Two other definitions are important when discussing collaboration. Collaborative inertia is where collaboration means progress is slowed or stopped altogether (Huxham and Vangen, 2000). Collaborative advantage is where collaboration brings mutually beneficial effectiveness (Huxham and Vangen, 2000). Both were observed in this research.

Sustainability is a term that in modern times is sometimes used incorrectly and inappropriately particularly in some commercial endeavours. In terms of this study, I prefer the definition of the United Nations Brundtland commission being that sustainability is:

Meeting the needs of the present without compromising the ability of future generations to meet their own needs (United Nations, 1987, p.16).

A useful explanation of sustainability is the three pillars model (Barbier, 1987). Essentially for something to be sustainable it needs economic sustainability, social sustainability and environmental sustainability. Trying to frame this for the IHV phenomenon in the two SSA countries means that for example for an IHV NGO to operate sustainably in these countries it needs to be viable economically without significant environmental detriment. By its nature, IHV often involves significant

²⁷⁴ For example, NGO 2 worked with a community organisation who provided help at clinics and pre-programme. See document F3M (p. 35, Fn. 165).

²⁷⁵ For example, see the entirety of document F1A2. Here an NGO are working on an MOU with multiple SSA collaborators.

air and overland travel. As teams of GNHVs are thus likely to have a high carbon footprint there needs to be sufficient purpose within IHV programmes for sending GNHVs to SSA to adequately justify any potential environmental impact. Inevitably, decarbonization strategies are likely to become increasingly important in the IHV phenomenon in forthcoming years (Dhawan *et al.*, 2023). It additionally needs to operate equitably and in harmony with the African communities it serves. Looking towards future generations in meeting their own needs the IHV NGO ultimately needs longer-term goals to try to set a framework with and for Africans so they can meet their own health needs without dependency on the IHV NGO anymore. Perhaps true sustainability for an IHV NGO is that it is no longer needed. Complicating matters in terms of definition is the considerable attention paid within volunteering²⁷⁶ to the United Nations SDGs, which give some legitimacy to IHV, as discussed already in Section 1.2. I will discuss these in terms of sustainability in IHV in Section 3.7.

Dependency is a contested, and can be a highly politicized, term that can sometimes give a sense of inadequacy or underdevelopment. Dependency is predominantly viewed as negative within IHV by IHV NGOs in contrast to the positivity of sustainability.²⁷⁷ In simplistic terms dependency is a state of reliance on something or someone else. For example, in three²⁷⁸ of the fieldtrips in my study it could be considered that a lower grade African health worker is dependent on those running the IHV programme to receive training in a particular task. However, whilst this definition of dependency is a reasonable notion it is a more complex construct and has been for decades. Some interpret dependency as a product of colonialism and neo-colonialism (Nkrumah, 1965). Others frame dependency in terms of foreign powers putting external pressures combined with internal factors in so called underdeveloped countries, leading to marginalisation of some groups (Namkoong, 1999). In health services, dependency is constructed as something that leads to loss of self-determination regarding health priorities as these are potentially ceded to others, with potential negative consequences like poorly integrated health services (Mutapi, 2025). Regardless of definition or construct it appears that

²⁷⁶ In my study, perhaps because of the nature of the NGOs, efforts around SDGs were focussed on NCDs. See for example, person SEM1A report a lack of engagement of decision makers in addressing NCDs. See document F3M (p. 48, l. 20-23).

²⁷⁷ For example, person GNF2 informs *that it was time to hand the management of the programmes to REDACTED AFRICANS*. See document T3 (p. 18, l. 30).

²⁷⁸ Fieldtrips 1, 2 and 4.

dependency in Africa is viewed by donor countries as an undesirable attribute, yet every human by necessity will have been dependent on someone or something else during their lives.

3.2 Advantages and disadvantages of collaboration in IHV

In the business world it is recognised that collaboration can be a highly resource intensive and painful process with conventional wisdom suggesting that collaboration is best avoided unless there is collaborative advantage (Huxham and Vangen, 2004). I found though that collaboration in IHV is more than the advantageous result of an IHV programme. It is more a way of developing and fostering advantageous relationships between UK, European and African partners. I observed a representative of an IHV NGO addressing African interest-holders and stating why such relationships are helpful for an IHV NGO:

*Because it's really important that we work with people that understand the country...and can help us build the model.*²⁷⁹

From an African perspective I found evidence of the advantage of having collaborative relationships with IHV NGOs. Take for example a health professional national association office bearer informing that:

*We have TWO REDACTED IHV NGOs going to places that we don't go because of our limitations.*²⁸⁰

Collaborations can be advantageous at a higher level in influencing health policy in Africa, perhaps because collaborators working together are seen as more trustworthy and may enhance project credibility. I observed this in both countries where this study was located. In Country 1, NGO 1 collaborated with many Africans to help promote health in relation to a specific harmful aspect of a traditional healing practice in one region. This built relationships and trust such that the Ministry of Health has now launched the programme nationally. Not only that,

²⁷⁹ Here person GNF2 discussed the importance of a potential collaboration in IHV with persons GNF3A, SEM1D and SPM3. See document F3M (p. 42, l. 30-31).

²⁸⁰ Here person SEM1D referred to a collaboration with NGO 2 and another IHV NGO about going to remote areas. See document F3M (p. 67, l. 7).

but this collaboration had financial advantages too, as according to one senior NGO leader:

*Changing community attitudes and behaviour is incredibly powerful for funders.*²⁸¹

In Country 2, I found that a collaborative project between NGOs 1 and 2 and many other African and UK collaborators led to the health project being an exemplar for the WHO, as they wanted to develop a model for use throughout SSA. This led to a senior African collaborator and some from the NGOs, me included, joining a WHO working group, with resultant input of collaborators into now published WHO open access resources.²⁸² Indeed, this raised the profile of the health matter in the nation such that the senior African collaborator and two middle grade health workers managed to promote it on national television.²⁸³ In the IHV phenomenon I found that collaborative advantage that helps with positive health behaviour change, national health policy implementation and building of collaborative relationships is well worth the effort, additional resources and difficulties in making the collaboration effective.

I found in my study that there were some disadvantages to collaboration. Collaborative inertia was one such problem where progress slowed or stopped altogether. I found a relatively common issue that led to collaborative inertia was the need for IHV NGOs to seek relevant permissions from African collaborators and other African bodies and organisations. This relied on accurate and sound advice from SSA collaborators as to who to ask permission of and for what precise purpose. I observed that this advice was sometimes misinterpreted as one IHV NGO found out:

*We thought that we had permission, but it turned out the REDACTED SENIOR SSA HEALTH WORKER wasn't in a position of authority.*²⁸⁴

²⁸¹ Person GNM2 informs about this. See document C3 (p. 4, l. 15).

²⁸² AP and persons SEF1A, GNM2 and GNM6 represented the collaboration on the WHO working group. See document V7 (p.12, slide 34 – p.16, slide 47).

²⁸³ Persons SEF1A, SHM19 and SHM20 appeared on national television. See document V8 (slide 9).

²⁸⁴ Person GVM4B made this mistake as person SHM21 exceeded their authority in Country 4. See document F3M (p. 9, l. 25-26).

In another instance an IHV NGO thought that permission had been granted to be at a specific government health facility, but incorrect permission had been sought due to miscommunication between the NGO and an African collaborator, resulting in frustration being expressed by the African collaborator to me as:

*Do they not realise they are working on government property without permission, they may think they are doing right but they are very wrong, they must realise there are rules, and they apply to REDACTED IHV NGO.*²⁸⁵

In the first example this stopped collaboration and the proposed programme turned out to be *unwanted*.²⁸⁶ In the second example significant delay occurred to planned programmes whilst further relevant permission was sought. Additionally, this caused a period where two key collaborators had strained relationships, that required rebuilding.

In my research I noticed that in some IHV collaborations inertia was evident, as a key player upon which there was dependency to deliver an essential part of the project failed to progress the project in a timely manner, leading to delay and frustration of other collaborators. This was difficult for NGOs to manage as in some cases key collaborators were companies doing *pro bono* work or volunteers who were difficult to replace. Take the example of an IHV NGO leader who states repeatedly, but with no response, to the tardy collaborator that:

*The team in REDACTED SSA COUNTRY are keen to get going.*²⁸⁷

In essence, a disadvantage of IHV collaboration is the time wasted and taken in trying to progress projects.

²⁸⁵ Person SEM1A reported this related to another NGO that we both witnessed working at a government run hospital. See document F3M (p. 29, l. 4-6).

²⁸⁶ See document F3M (p. 9, l. 31-32), reported by person GNF2. This relates to Country 4.

²⁸⁷ See document C3 (p. 7, l. 3). Here person GNF2 tries to manage the non-engagement of person GNM6 as person SEM14 and their team are becoming frustrated with delays (as were UK/European collaborators AP and persons GNF2, GNF3A and GNM3A).

Trust is essential to effective collaboration but is often framed as an individual-level phenomenon (Zaheer, McEvily and Perrone, 1998). This is sometimes drafted by SSA actors in formal collaboration in MOUs as the need for individuals to *observe utmost good faith*.²⁸⁸ In IHV, as individuals often represent organizations, it appears that success or failure of interpersonal relationships may affect trust. In simplistic terms, a disadvantage of collaboration in IHV is that if two individuals are less trusting and more suspicious of each other this may negatively affect the institutional collaboration that they represent. Take for example a SSA leader informing me of their thoughts about an individual representing a UK collaborator, stating:

*I find you full of enthusiasm and it makes me confident about the REDACTED IHV NGO programme, but I found REDACTED UK COLLABORATOR very difficult, I did not sense they believed in it.*²⁸⁹

This suspicion persisted for the SSA administrator until the UK collaborator was eventually replaced. Whilst I found that suspicion amongst collaborators at the start of collaborations was relatively common it usually did not persist. For example, on one fieldtrip I noted that one SSA senior health worker was initially:

*Suspicious of everyone.*²⁹⁰

And another was:

*Very reserved and suspicious of both me and NGO I.*²⁹¹

Indeed, I reflected about one SSA collaborator that initially I was:

*Instantly very uneasy in their presence almost as if you were being watched by a highly critical teacher.*²⁹²

²⁸⁸ As seen in document F1A2 (Section 14.1). Here the *utmost good faith* referred to is for individuals in two SSA government departments, a national professional association, an IHV NGO and a VPO to observe.

²⁸⁹ Here person SEM1A finds AP and person GNF2 *full of enthusiasm* but finds person GNM2 *very difficult*. See document F3M (p. 91, l. 29-30).

²⁹⁰ This was person SHM5A. See document F1M (p. 12, l. 1).

²⁹¹ This was person SHM8A. See document F1M (p. 15, l. 5-6).

I interpreted the initial suspicions as a route to building trust and not as a real disadvantage to collaboration but nevertheless collaboration on the first few days of any IHV programme may be negatively impacted by initial suspicion.

There is no perfect IHV collaboration, but advantages seem to outweigh disadvantages and interpersonal frustrations, although collaboration in the IHV phenomenon requires continual effort to continue to address the priorities of all collaborators. I will now address the collaborative relationships between national governments and NGOs.

3.3 Collaborative relationships between national governments and NGOs

An effective and transparent collaborative relationship between national governments and IHV NGOs is paramount to the avoidance of negative outcomes in IHV in the two SSA countries. Unfortunately, this often does not take place with one systematic review identifying a need for better collaboration reporting that IHV NGOs tend to work independently rather than collaboratively (Roche, Ketheeswaran and Wirtz, 2017). This is evident as without collaboration frustration can be seen from SSA governments. Take for example, a former minister of health of an African country who informs that on appointment as a minister they found that rather than being responsible for the health of their country they were instead the minister for foreign run health projects (Department of Health, 2010). Worse, without collaboration hostility may result. In my study in Country 1, effective collaboration required discussions and development by formal collaboration of a MOU between NGO 1, their VPO, two government departments and a national professional association, with the VPO conducting many day-to-day discussions. This largely worked well but following a change in personnel and an inter-personal issue with the new appointee the head of the VPO chose to partially exclude one of the three other African parties from collaborative discussions. Collaboration then stalled with hostility from the excluded party:

²⁹² This was person SYF1. See document F1M (p. 29, l. 35-36). I cannot explain why I felt this way. I just *sensed* this feeling.

*I have nothing good to say about NGO 1, only negative things.*²⁹³

The VPO head felt threatened indicating that the excluded party:

*Wants to shut NGO 1 down.*²⁹⁴

Resolution only occurred months later meaning collaborative progress in IHV programme development was delayed to the detriment of progress towards government health priorities. Resolution finally occurred with change to the structure of the VPO and a change in leadership of the excluded organisation and the later intervention of NGO 1 to improve relations with the excluded organisation.²⁹⁵ I asked the head of the VPO:

*How are things with the REDACTED EXCLUDED ORGANISATION?*²⁹⁶

The head replied:

*Much better, they are very positive about NGO 1...We helped the REDACTED EXCLUDED ORGANISATION with a REDACTED NATIONAL EVENT, and they see we are useful to them. Actually, they won a prize for the REDACTED NATIONAL EVENT, and they sent us a letter of appreciation.*²⁹⁷

In addition to aiding resolution, NGO 1 exercised more control over the VPO for a time, sadly but understandably meaning that from an African perspective the VPO appeared to be less trusted by the IHV NGO to collaborate directly at a high level. Their activities were more restricted to day-to-day project management.

²⁹³ Person SYF1 informed AP of this. See document F1M (p. 29, l. 42). Person SYF1 had been recently appointed as head of a national professional association. All parties had good inter-personal relations with their predecessor (person SYM5). Person SPM5 excluded person SYF1 from collaborative discussions. It was obvious to AP that the two did not have a good inter-personal relationship which spilled over into their professional relationship with each other.

²⁹⁴ See document F1M (p. 30, l. 8) as reported by person SPM5.

²⁹⁵ Person SPM2 reported the change in structure of the VPO in document F2M (p. 32, l. 34-35). Restructuring involved letting some people go which *was necessary* according to person SPM2. Person SPM2 reported the change in leadership of the excluded organisation in document F2M (p. 32, l. 43). Person GNF2 reports NGO 1's intervention in document T4 (p. 4, l. 25).

²⁹⁶ See document F2M (p. 32, l. 39).

²⁹⁷ Person SPM2 reports the improved relationships in document F2M (p. 32, l. 43 – p. 33, l. 2).

I found that collaboration with national governments required constant and dynamic relational discussions to ensure inclusivity, appropriate permissions and to ensure relevance to national health priorities. In both countries where fieldwork took place, NGOs and VPOs were faced with identifying the most appropriate individual civil servants and/or politicians within government departments to collaborate with. This was against a background in Africa where there were continual role changes, with lesser but significant role changes within NGOs and VPOs. Sometimes collaborative relations were excellent as indicated by a member of an IHV NGO leadership team:

*The REDACTED SENIOR GOVERNMENT HEALTH LEADER is a lovely person and very supportive. The regional health workers are here because he wanted them all to see the programme.*²⁹⁸

At other times relations meant less effective collaboration. I observed another senior government health leader being described by a different, and slightly lower ranked, but still senior government health leader as someone who:

*Delegates me to do this, then to do that and when I try report to them, I cannot find them.*²⁹⁹

I reflected, at the time, that it was evident that the more senior person was *not held in high esteem*.³⁰⁰ Indeed, I observed in Country 2 that constant changes of African senior government health leaders during programme delivery affected both NGO 1 and NGO 2 leading to delays in programme delivery.³⁰¹ Every change required re-establishment of relationships and sometimes much effort trying to find out who the new person to collaborate with was and how to contact them. Unfortunately, there was no evidence that I found of any handover from SSA governments to IHV NGOs regarding changes and *vice versa*. I found that capabilities varied between incumbents. For example, in my research, both study IHV NGOs³⁰² dealt with a

²⁹⁸ Person GNF1A states this regarding person SEM16. The regional health workers referred to are persons SHM1B, SHM5B, SHM6B, SHM7B and SHM8B. See document F1M (p. 46, l. 19-20).

²⁹⁹ Person SEM17 reports their frustrations about person SEM18.

³⁰⁰ AP reflects on person SEM18 in document F3M (p. 99, Fn. 457).

³⁰¹ This delayed the national rollout of an online training course (a government priority) for middle grade health workers for around 18 months.

³⁰² This relates to the incumbent of a senior government official position in Country 2 whose position necessitated significant collaboration with NGO 1 and NGO 2.

proactive, experienced and dynamic person.³⁰³ That person was replaced with an inexperienced and overworked person,³⁰⁴ who was later replaced with a hard to reach, less interested, but proactive person.³⁰⁵ This was not solely an African government issue as I found that personnel changes in one of the study NGOs meant a change of IHV priorities was not communicated to African government collaborators clearly.³⁰⁶ Collaboration gradually faded over time until further personnel change meant a rekindling of collaboration.

Interestingly even with good collaborative relationships I found IHV NGOs are sometimes entirely dependent on political priorities of SSA government health departments as to when action on a project may take place. This occurs despite having an MOU and verbal and written promises. For example, a senior African health official informed of an IHV NGO supplying much needed medical equipment to a hospital in Country 2. Rather than putting this equipment into use immediately, it was retained by their political masters to be put into the hospital two years later, timed for two weeks prior to an election.³⁰⁷ It appears that despite collaboration, on occasion IHV projects are stalled not just by SSA government health priorities but by political priorities.

Collaboration in IHV can be stalled by a lack of clarity when either an IHV NGO or SSA government fails to let collaborators know of a change in priorities in good time. In this study an existing MOU ran out and on trying to obtain renewal for a programme that the NGO had been led to believe was wanted, effective and dovetailed with government priorities, communication simply stopped. Even SSA senior health workers were unable to get any answer:

*Our difficulty is to get a response from the Ministry of Health.*³⁰⁸

When further senior African contacts tried to seek clarity from the SSA government the issue persisted:

³⁰³ Person SEF1A.

³⁰⁴ Person SEM15.

³⁰⁵ Person SEM14.

³⁰⁶ For example, person GNM2 had a different focus to their predecessor. See document C3 (p.4, l. 8-9).

³⁰⁷ Person SEM1A report this in document F3M (p. 84, l. 4-7).

³⁰⁸ Person SEF1B reports this to person GNF2 in document C3(p. 4, l. 19).

*The Ministry of Health position is not yet known. No one is willing to give a concrete answer.*³⁰⁹

Eventually, and by being informed by a chief health professional in a different African country, the NGO was informed that:

*They have stopped the programme because of remarkable complications.*³¹⁰

This whole episode took 18 months and when constructive dialogue was finally established with the SSA government the *remarkable complications* appeared to be an excuse. The government simply wanted a different and higher-grade cadre of health workers trained rather than the ones trained originally. It seemed that the higher-grade cadre had lobbied government as:

*There is fear of downgrading their profession and work, and there are a lot of stories going around.*³¹¹

In effect this put all IHV NGO programmes on hold for 18 months. Had timely collaboration via open and honest discussion taken place between the government and NGO, when the government changed priorities, the programme would have been altered to train the higher-grade cadre with minimal delay. Eventually but with much delay, the NGO altered the programme and now train this higher-grade cadre. I am uncertain and have no evidence as to why the SSA government was unable to have open and honest, albeit difficult, conversations with the IHV NGO, but good collaboration requires this to occur.

This is not just a problem of SSA governments collaborating towards NGOs, but issues occur in the other direction. I found that following a change of leadership one NGO for a time wanted to:

³⁰⁹ Person SEF1B used other contacts (persons SEF3A and SEM19). See document C3 (p. 4, l. 33-34).

³¹⁰ Person SEF1B (from one of the SSA countries) found out from person SEF4 (from the other SSA country) that the programme had *stopped* but government in that country (represented by person SEF4) had failed to inform the NGO.

³¹¹ See document C3 (p. 4, l. 29). Again, relayed to person GNF2 by person SEF1B (from one of the SSA countries) rather than directly from person SEF4 (from the other SSA country).

*Get rid of volunteers and focus on paid positions as there is a different relationship with employees rather than volunteers.*³¹²

As the NGO did not have sufficient paid personnel (and could not afford to employ more) some programmes were prioritised at the expense of others. This was done unilaterally and not in collaboration with SSA governments, leaving them in the dark as to why progress in some collaborative ventures had stalled.

It is worth noting at this stage that consistent with my understandings of African culture, any collaboration with SSA governments is best done face to face with individuals. I agree with Onwumehili (2024) who contends that African communication goes beyond verbal and non-verbal communication, but instead values silence and listening and is guided by hierarchical, and spiritual experiences. Communication and thus collaboration does not easily lend itself to virtual communication. Hence during the Covid-19 pandemic, particularly in Country 1, I found that some collaborative relationships faded completely, and post-pandemic required starting from scratch, which delayed IHV programmes restarting post-pandemic. Undoubtedly there were other factors involved in this reduction in collaboration such as more important SSA government priorities, digital poverty in parts of Africa and changing of personnel over time. Nevertheless, the lack of face-to-face relationships was problematic. In my study I found that in Country 2, due primarily to the stability in post of senior African collaborators,³¹³ collaboration continued during the pandemic. This allowed NGO 1 and NGO 2 to jointly deliver a health training programme with African collaborators which later was more sustainably delivered by African actors. My experiences in this study of the effect of collaboration on the IHV phenomenon of the Covid-19 pandemic were variable and I am unable to draw firm conclusions.

My study indicated that collaboration between SSA governments and IHV NGOs is a constant challenge for all concerned. For legitimacy and relevance, it is crucial that bi-directional collaboration occurs. However, this requires constant resourcing, building and re-building of relationships and adaptation to change from

³¹² See document C3 (p.2, l. 5-6) as expressed by person GNM2.

³¹³ Specifically, persons SEF1A, SEF3A and SEM1A.

both an African and NGO perspective. Not only is this type of active interest-holder engagement helpful for collaborations an additional spin-off is that it seems to be a good sustainability building strategy (Nwaozuru *et al.*, 2025). However, it does take a significant amount of resources and time to build solid collaborations that are capable of facilitating sustainability (Baumann and Cabassa, 2020). Collaboration between the two SSA countries governments and IHV NGOs is complex, and I found requires improvement. Perhaps better handovers from incoming and outgoing personnel and more open discussions on changing priorities between all collaborators would be simple but useful starting points to make collaboration more effective. I will now explore collaboration between NGOs, VPOs, local government and local communities.

3.4 Collaborations with VPOs, local government, and local communities

In my research, I found collaboration between IHV NGOs, VPOs, local government and local communities to be critical to volunteer programme success. In most cases IHV programme sites and timings were selected by close collaboration between senior government health officials, NGOs, VPOs and district governments and if people were to be trained as part of the programme this would be selected by districts. This was a complex process relying on government health officials indicating priority regions and districts. IHV NGOs would look at logistics like availability of transport from the UK and accessibility to a region together with health and safety issues like UK Government travel advice and suitability of safe accommodation. VPOs and district governments would identify whether or not there were sufficient district health workers to assist locally with a programme and adequate facilities. There was usually liaison with districts in a region to select the most appropriate district, which normally involved on-site visits to local communities.

Often this process would be done a year in advance of the programme and was done with great care and diligence, particularly by VPOs. A VPO site administrator informed me of the level of diligence undertaken,³¹⁴ in that they had

³¹⁴ For example, person SPM6 reported this in document F4M (p. 26, l. 6-7).

met months prior with the local politician, the local council executive and the local health administrator. They then came back to inspect health and accommodation facilities, met village elders and had been on site five days pre-programme problem solving.³¹⁵ All of this entailed travel of over six hours from the VPOs base into remote regions with minimal facilities. I found this type of collaborative commitment to be reproducible in all fieldwork sites. From an African perspective this level of collaboration demonstrated a work ethic crucial to logistic programme success. Unfortunately, I found this was sometimes neither seen nor acknowledged fully by UK and European collaborators as they could neither witness the pre-programme work of the VPO nor appreciate the lack of control they had over the very limited facilities in rural areas. Instead, IHV NGOs appeared more concerned about a positive volunteer experience leading to feelings of threat as an upset VPO lead informed:

*Last month's volunteer programme gave bad feedback at the end. They did not tell me during the programme just at the end... I'm sure they want to get rid of REDACTED VPO, they're looking at other VPO's.*³¹⁶

Collaboration in IHV would be much improved with better mutual understanding of the contributions of each collaborator and the lack of control they have locally over many factors³¹⁷ in the IHV phenomenon.

I found that collaboration with local government and local communities is essential for smooth running of an IHV programme. In most cases IHV programmes are plugging a gap in local health services and/or training or capacity building members of the local community and are therefore much wanted locally. However, NGOs must seek local permissions and culturally show appropriate respect to their hosts. From an African perspective, it is usually the VPOs who identify appropriate persons to meet and greet, and this is an important part of local collaborations. Without exception in all fieldwork trips, there was expectation that the whole volunteer team would pay a formal visit on the first morning of each trip to the local council executive, local politician and medical or health administrator.

³¹⁵ Person SPM3 described this role in detail. See document F3M (p. 90, l. 19-39).

³¹⁶ Person SPM2 informed AP of this in document F4M (p. 21, l. 2-27) about a recently completed IHV programme in a district in the same region as fieldtrip 4.

³¹⁷ For example, availability of food and basic supplies, power cuts, telecommunications, the weather, inadequate maintenance when things break, and sub-optimal infrastructure.

Each visit would involve speeches from host and the programme leadership team, which usually included me.³¹⁸ There were much formal thanks and welcome on both sides, formal signing of visitor books and formal photographs with assurances of safety and pleas to return from district officials. I took this to be the culmination of the collaborative process. This was the human side of the district genuinely giving permission to run the programme rather than any MOU or formal correspondence from national government. As a lead on an NGO programme, I relied totally on the VPO as to the nuances of who to meet in specific districts and who to invite to visit the programme sites and/or eat with the volunteer team in the evening. For example, in one district the regional health official happened to reside within the district where a programme was going ahead. I would have risked insult through ignorance, perhaps risking future collaborations, without the VPO site senior administrator telling me that I *must* invite them:

*Formally to the site and to dinner as this will show that there is regional approval.*³¹⁹

Again, this demonstrated to me the importance of effective collaboration in IHV in Africa with VPOs. Without this local knowledge and background groundwork the IHV NGO is vulnerable to jeopardising collaboration and reputation, and my research means that I simply cannot contemplate how an IHV NGO can be effective without a collaboration with a VPO or similar African group.

Sometimes I found that collaboration was less effective when local government officials wanted to promote their own agendas using the IHV programme for self or political gain. Take the local politician whom I observed effectively taking up an entire half day of an IHV programme by organising a launch event. This was done without collaboration, with the person appearing unexpectedly with a media crew rather than an expected informal site visit. This meant that the programme had to stop for a time as it would be considered rude not to attend the event. The local politician simply wanted to take full credit, which

³¹⁸ For example, see document F2M (p. 34, l. 43 – p. 35, l. 4) where person SPM6 instructs AP as to whom to meet.

³¹⁹ See document F2M (p.35, l. 4-5). I was told this by person SPM6.

created tension with other local collaborators, to tell *his people* what he was doing for health in the district.³²⁰

Or a village executive whom I witnessed moving unilaterally and without collaboration the site of an IHV programme from the planned health centre to the ward offices.³²¹ These were unsuitable as a health facility being dirty and next to the village dump. The likely reason for this move was that the village executive wanted local people to see their involvement and take credit, perhaps increasing their community standing. Again, both VPO and IHV NGO simply had to accede to this inadequate arrangement and make the best of the situation for fear of insult or being perceived as disrespectful to the village executive.

Usually, the first face-to-face engagement that UEHVs have with the local community in which they will carry out a programme is the day they arrive on site. In my research in all cases the local community had already collaborated with the VPO, and the programme will have been approved by local elders and village chiefs. That said, as part of community engagement and continued collaboration with an NGO programme, site visits by community members were an everyday occurrence at all field sites. As a site lead, collaboration between me, the most senior SSA health worker present and the senior VPO site administrator on the ground identified those to invite with a flexibility that anyone may decide to visit. All would need to be formally shown around by one of this leadership group whether at an inconvenient time or not. My research has examples of visits from village elders, village chiefs, religious leaders, traditional healers and other health workers. Some gave valuable African insights into local community views of IHV. Take for example a retired hospital director who informed:

*The only thing you can get money for here is HIV-AIDS nothing else, NGOs are not interested in going too far out of REDACTED LARGE CITY.*³²²

The same person went on to say:

³²⁰ See document F1M (p.30, l. 18 – p. 32, l. 4). Here the local politician (person SEM5) takes public credit at the expense of a regional government health official (person SEM3A) and the local council executive (person SEM4).

³²¹ See document F1M (p. 46, l. 39 – p. 47, l. 16). Person SCM2 engineered the move described.

³²² Person SCF1 reported this. See document F4M (p. 52, l. 9-10).

*There are so many false dawns you don't believe it until people are actually here, over the years many promise but don't come. So, when REDACTED told me you were here, I had to come to see for myself.*³²³

Sometimes as well as visiting, visitors would want to address the whole team. As a site lead, I always acceded to their request; from an African perspective it would be insulting not to. One village elder wanted to express gratitude to the entire NGO and VPO team stating with his hands clasped as if in prayer that they were:

*Very grateful for you leaving your families, travelling over the world and just coming to help my people. I bless you, and you should continue to have this type of spirit.*³²⁴

I found that these visits were the very essence of collaboration with a community and necessary for the community to express their views on a programme as well as being uplifting for weary UEHVs, SSA health workers and VPO personnel. Sometimes there would be no talk whatsoever about the programme but instead about what was important to the community. For example, I and a VPO leader spent time talking and empathising with a village elder and a village chief about the lack of rain for their crops and the problems with villagers going to work in South African gold mines rather than farming.³²⁵ The NGO programme was not discussed at all but collaboration here was more about human interaction. This culminated in them informing me as we parted that we would always be made welcome in their village.

Effective local collaboration between NGOs, VPOs, local government and at grassroots level is of paramount importance and influence from an African perspective. In itself it can foreground what is important about a programme to local communities for the NGO who may over time gain a better understanding of the value of better local engagement in IHV. Collaboration between these interest-holders is imperfect but I found that despite this it is mostly effective given the large numbers and diverse interests of collaborators.

³²³ Person SCF1 reported this. See document F4M (p. 52, l. 18-20).

³²⁴ Person SCM1 gave an impromptu speech in their local language (translated into English by person SHM1A). See document F4M (p. 125, l. 9 - p. 126, l. 6 including Figure 63 and Figure 64).

³²⁵ For example, AP and person SPM3 met with persons SCM7 and SCM8 (see document F3M (p. 44, l. 15 - p.45, l. 8 including Figure 19).

3.5 Informal collaboration

Informal collaboration in IHV in this study was primarily based on trust and mutual understanding and took the form *inter alia* of problem-solving, networking, mentoring, and information and resource sharing towards common goals. Sometimes this was between groups of people and sometimes individuals.

I found that a key influence for effective collaboration in IHV was the informal collaboration between programme leadership teams on site. In my study, IHV programmes took place in remote areas with minimal ability for influence from outside the immediate programme locus due to poor and unreliable transport and communication infrastructure. Effectively, a programme leadership team is isolated from wider NGO, VPO and national government input for most of the duration of the programme, therefore problem-solving collaboration is essential. In this research a programme leadership team largely consisted of a site lead and deputy from the IHV NGO, a site administrator(s) for the VPO and a senior SSA government health worker. Irrespective of rules, regulations and MOUs the informal collaboration between this small number of individuals was the core group whose collective problem-solving ability would influence effective programme delivery.

Mostly, informal collaborations worked well and were largely based on trust and mutual understanding. I found that informal collaborations required multiple informal *huddles*,³²⁶ between all members of a programme leadership team, to successfully deliver IHV programmes with trust and mutual understanding in IHV. They required active listening and empathy with the individuals involved, even though in most cases some problems could not be solved. Very early on in one IHV programme, by listening to the problems of an African health worker, whom I had not known before, and whose problems I could do nothing about, allowed us

³²⁶ See for example document F4M (p.47, l. 1 and Fn. 270). Although a healthcare huddle was much less commonplace in the two SSA countries than in the UK, person SHM1A remarked to AP that *he had seen huddles during football matches on television and he liked being involved in a huddle* (Reported by AP in Fn. 270).

both to gain mutual trust and understanding of their issues by this relatively simple method:

*You have seen my facilities here in REDACTED DISTRICT HOSPITAL. There are no facilities, and the REDACTED LOCAL COUNCIL EXECUTIVE will not fund more.*³²⁷

And then:

*You can see there is a big need for my services but in REDACTED DISTRICT the district say I must charge REDACTED SMALL NOMINAL MONETARY SUM for REDACTED MINOR HEALTH PROCEDURE and these people [points to the waiting patients] cannot afford that.*³²⁸

I contend that simply acting as a sounding board for each other in the testing circumstances of an IHV programme builds the trust and understanding necessary to later negotiate inevitable problems by informal collaborative working. Later, during the same IHV programme due to a combination of overwhelming patient numbers and inadequate medical supplies, everyone in the leadership team was required to collaborate effectively and decisively to merely keep the programme going.³²⁹ I have no doubt this would not have been possible without mutual trust and understanding.

Building trust and understanding allows informal collaborators to take decisions that could be construed as bending the rules, as to make things work this is sometimes essential. Take for example a situation where lower grade health workers were supposed to be being assessed by the senior SSA health worker who states they would rather treat than assess, despite an MOU insisting they are the assessor not I:

³²⁷ Reported by person SHM3A in document F2M (p. 68, l. 4-5)

³²⁸ Reported by person SHM3A in document F2M (p. 68, l. 13-16)

³²⁹ For example, in document F2M (p. 85, l. 24-25) *supplies* are problem solved. In the same document (p. 97, l. 2-3) overwhelming patient *numbers* are problem solved.

*It is my Christian duty to treat patients and heal them, you do the assessments, I trust your judgement.*³³⁰

As I trusted them my reaction here was to accede to their wishes without discussion but at the end of each day to discuss and seek approval from the health worker of decisions made.³³¹ This ensured smooth running of the programme whilst considering the SSA health worker's view even though it was against the rules.

Unfortunately, informal collaborations within leadership teams do not always engender mutual trust and understanding and this sometimes translates to less effective IHV programmes. Take the example of a senior VPO site administrator who informed of an NGO site lead on an IHV programme who:

*Wouldn't let us go over 70 patients a day... SPM1 kept saying we are leaving people untreated...but GVM8 wouldn't take any more.*³³²

This attitude broke the trust and understanding from an African perspective and African informal collaborators on the programme were distraught that the IHV programme was less effective than it should have been, particularly as leaving patients untreated was viewed as a dereliction of duty.³³³ I further found that sometimes when IHV NGO site leadership teams failed to dovetail, this could affect African collaborators and the wider volunteering team. Again, mutual trust and understanding was affected to the detriment of effective internal and informal collaboration when it became apparent that leaders:

*Cannot cope with the responsibility*³³⁴ or had a *bad attitude*.³³⁵

³³⁰ Person SHM1A reported this in document F4M (p. 54, l. 28-29). AP checked again with person SHM1A later in the IHV programme with the same result. See document F4M (p.97, l. 16-17).

³³¹ See for example, document F4M (p. 120, l. 23-24). Here AP reports person SHM1A's views on the lower grade health workers competencies at a daily debrief.

³³² Reported by person SPM6, who challenged person GVM8 with no success. See document F2M (p. 55, l. 21-23).

³³³ This is in keeping with the *ubuntu* philosophy (see section 4.2.2) and moral values (see Section 4.2.3) of African culture.

³³⁴ Here person GVM6 informs person GNF1A that they do not want to be in an IHV programme leadership role again. See document F1M (p. 44, l. 20-21).

³³⁵ Here some UEHV's report about a programme leader (person GVF5). See document F1M (p. 44, l. 13-14).

Ultimately for informal collaboration to be effective from an African perspective, I sensed that SSA VPO site administrators and SSA health workers had high expectations of IHV NGO site leads, which some were unfortunately unable to meet.

I witnessed in this research that outside of an IHV NGO programme informal collaboration related to IHV NGO strategy was commonplace, as NGOs tried to adapt programmes to meet specific needs in Africa, gain funding for programmes, explore new opportunities, build networks and share information. Informal collaboration was essential to the IHV NGO being able to respond to changing priorities in Africa, differing financial pressures and changes within other interest-holder organisations. For example, in this study NGOs 1 and 2 developed a very effective formal collaborative project in Country 2.³³⁶ This started out informally by meetings and discussions until mutual trust and understanding of shared objectives was established and formal discussions were had with other interest-holders. Indeed, as part of my third fieldtrip for this study I travelled as a representative of NGO 1 to visit an NGO 2 programme in Country 2. My role was to continue informal discussions with NGO 2 and many African interest-holders to aid determination of whether formal collaboration was appropriate.³³⁷ In effect at a strategy level, I found informal collaboration to be a precursor and prerequisite of formal collaboration in IHV.

My research also had examples at a strategic level of where informal collaborations did not result in more formal collaborations. In their collaborative project in Country 2, NGOs 1 and 2 ran a successful pilot project training local volunteers to promote an area of health. Feedback from these promoters was that they could access even more remote localities with a bicycle to promote health. I and others explored this with a non-health related international NGO that provided bicycles for community projects in Country 2. Whilst being supportive, unfortunately that NGO did not yet operate in the region of the pilot project and their funding model did not dovetail with the project model, so no formal

³³⁶ More information together with the results of this collaborative project can be seen in documents V7 and V8 in their entirety.

³³⁷ See document F3M and associated appendices.

collaboration resulted.³³⁸ This is one of several examples in my research of informal collaborations that have not progressed further.³³⁹ In the IHV NGO phenomenon this is extremely common and an almost inevitable necessity. To take the formal collaborative step all parties have to be comfortable that the collaboration meets their organisational goals and has a reasonable chance of success. I felt that trying to informally collaborate with others, even if unsuccessful, was not wasted effort. It allowed IHV NGOs and VPOs to have an appreciation of other health and non-health issues in their countries, regions and districts of operation and helped build a wider collaborative network that may later be useful. I will now go on to discuss collaborative networks.

3.6 Collaborative networks

I have already discussed in Section 1.4 aspects of the problems in identification of volunteering networks in SSA. However, in this section I will focus on the importance of collaborative networks in IHV in the two SSA countries. I observed one senior staff member of a study NGO state the importance of collaborative networks concisely during the Covid-19 pandemic as:

*No single organisation can do everything, but together perhaps we can do the things that are needed.*³⁴⁰

A senior volunteer of NGO 1 expressed concern regarding a potential collaborator, who were an NGO working in a similar field in a different SSA country, as:

*They don't appear to collaborate with anyone, nobody has heard of them, and I find that worrying.*³⁴¹

As I have already demonstrated in this chapter, effective collaboration is essential in IHV. The IHV field in SSA is complex and at the very least it is necessary to

³³⁸ See document C3 (Appendix, p.9, Figure 6). Here AP, person GOM1B and person SYM2 meet informally to discuss collaboration with NGO 1 and NGO 2.

³³⁹ For example, in document T3 (p. 5, l. 23-30). Person GNF2 indicates a collaboration with a different NGO will not be going further due to *different priorities*.

³⁴⁰ Person GNF2 reported this. See document C3 (p.2, l. 10-11).

³⁴¹ Person GNF1A reported this about an IHV NGO working in SSA Country 5. See document C4 (p. 35, l. 25-26).

collaborate with SSA national and local government, an appropriate professional health association, regulatory body and a VPO or similar organisation to operate ethically, safely and professionally.

In reality I found that for the programmes I observed in the two SSA countries, there was a need for more than this basic range of collaborators to run successful IHV programmes, and instead a more complex collaborative network of organisations and individuals was required to deliver the programmes. I present from my observations two examples in pictorial form. The first represents the collaborators in an IHV online health project in Country 2 delivered jointly by NGO 1 and NGO 2 (see Figure 9) and the second represents another IHV health project in Country 1 delivered by NGO 1 using on-site UEHVs (see Figure 10).

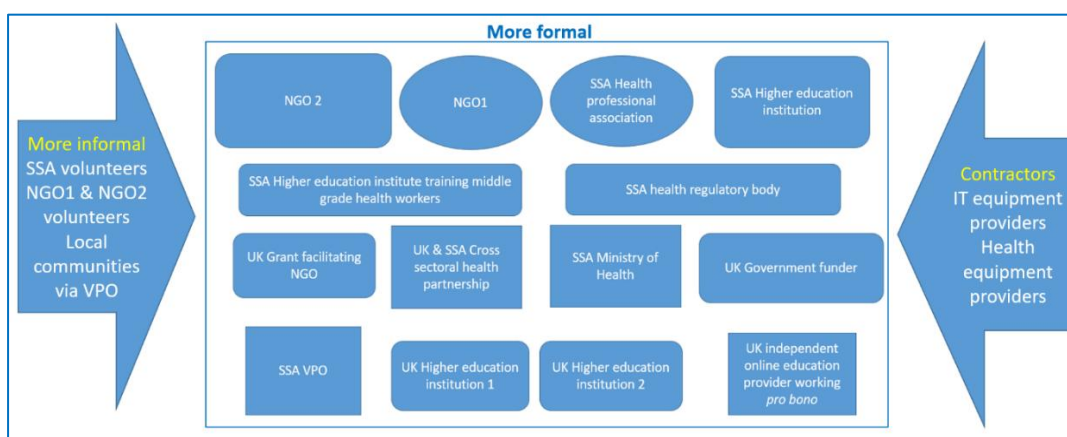
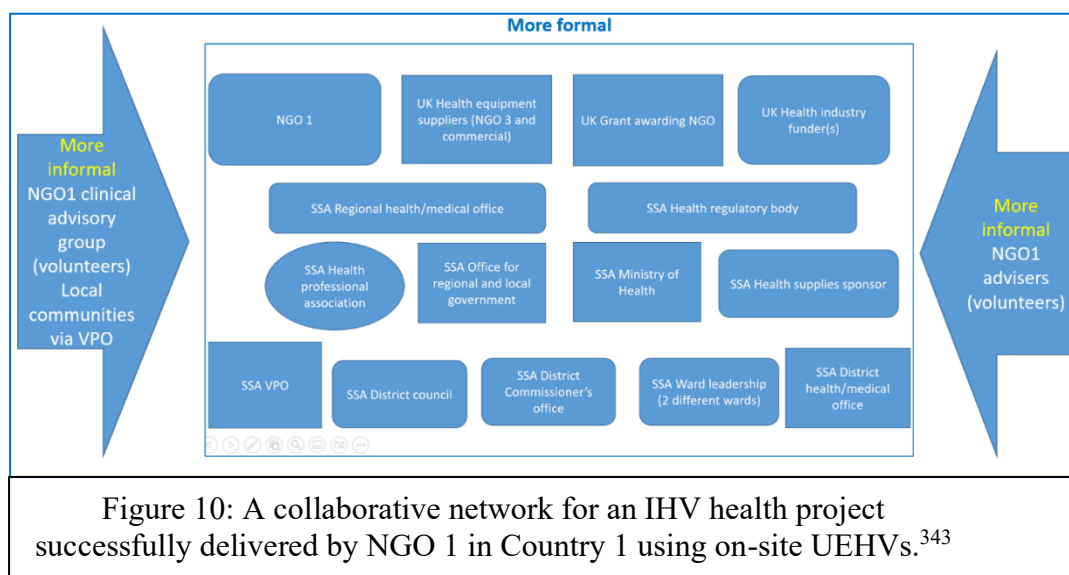


Figure 9: A collaborative network for an IHV online health project successfully delivered by NGO 1 and NGO 2 in Country 2.³⁴²

³⁴² This project is fully described in documents V7 and V8 in their entirety.



What these two Figures demonstrate is both the number and relevance to the two SSA countries of collaborators required to deliver IHV programmes using UEHVs, whether those volunteers are in Africa or outside Africa for the programme. I found that when programmes are delivered within a collaborative network, they are a credible influence and generally meet the health needs locally from an African perspective. Indeed, SSA governments and senior SSA health workers positively encourage and want the benefits of collaborative networks. Take my observation of a senior SSA Ministry of Health leader encouraging a study IHV NGO to:

*Collaborate with others in reaching the rural communities with unmet health services.*³⁴⁴

Furthermore, a senior SSA health worker stresses the importance of having:

*“Partners and collaborators... to help our nation.”*³⁴⁵

Having these networks is not problem free and there will always be disagreements and time-consuming issues that require compromise, negotiation, conciliation and mutual problem-solving. Instead of this being a hindrance I found

³⁴³ This IHV health project is the subject of three of my fieldtrips. Documents F1M, F2M, F4M and their respective appendices which give comprehensive further information on this collaborative network.

³⁴⁴ Person SEM17 asked NGO 1 to do this. See document F3M (p. 100, l. 5-6).

³⁴⁵ Person SEM1B reported this in an address to middle grade health workers. See document F3M (p. 24-25).

this helpful, as someone in the network tended to encourage others to settle their differences. Take some unresolved issues between a study NGO and a SSA national health professional association where a senior government leader at the SSA Ministry of Health intervened with encouragement that:

*You must reach an agreement.*³⁴⁶

Even on day-to-day issues collaboration within networks was improved by intervention of other collaborators, with being part of the network allowing individuals to have a heard voice. I found on my first fieldtrip that there was great disagreement on antibiotic overuse in rural areas on an IHV programme eventually settled by a group of largely senior SSA regional health workers and UEHVs coming to a general agreement that:

*Everyone has been prescribing too many antibiotics, and it requires to stop.*³⁴⁷

Sometimes IHV NGOs become involved in large-scale multi-sectoral collaborative networks or partnerships health issues in Africa with each of multiple NGOs providing a small piece in a much larger jigsaw. Multi-sectoral partnerships have been identified throughout the literature as suitable strategies to sustainably address a variety of health interventions (Dharmayat, 2019; Prasad *et al.*, 2022; Zakumumpa *et al.*, 2018). Different IHV NGOs contribute to different time periods and use very defined skills to deliver their part of the project. The IHV NGOs are usually *not* the major decision makers in such projects but *contributors* and may only interact with a small part of the network. I observed such a network evolve and develop in Country 2. The project from that network established a health plan in a specific area of health for a nation and starting from nothing introduced a capacity building project that trained a cadre of health professionals never before trained successfully in the nation.³⁴⁸ This project is ongoing and continues to evolve and develop and is a dynamic collaboration which aims to meet continually

³⁴⁶ Here person SEM16 made their views clear. See document F1M (p. 85, l. 17-18).

³⁴⁷ This agreement involved senior SSA health workers (persons SHM1A, SHM5A, SHM6A, SHM7A and SHM8A), a middle grade health worker (person SHF1A) and UEHVs (AP and persons GVF4A and GNF1B). See document F1M (p. 52, l. 24-26).

³⁴⁸ Details on this project can be found in document V9 in its entirety. Within this document are contributions from AP and persons GNF3A, GNM3A, GOM1B and GYM2.

changing health needs. I found it to be an effective use of IHV from an African perspective in SSA. This network is represented in pictorial form in Figure 11:

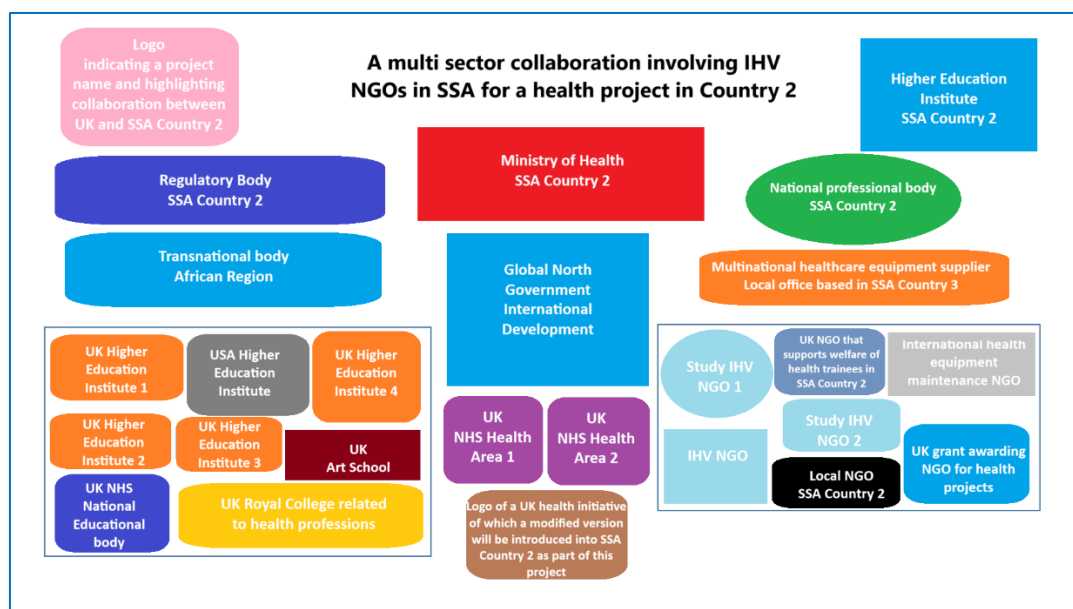


Figure 11: A multi sector collaboration involving IHV NGOs in SSA for a health project in Country 2: IHV NGOs are represented in the rectangle on the bottom right of the Figure (adapted, redacted and updated from Bagg (2022)).³⁴⁹

The importance of the collaborative IHV network is even more obvious in the absence of an appropriate collaborative network. Again, in pictorial form I present my observational findings of an IHV programme run by an individual in Country 2 without reference to other collaborators as previously discussed in Section 1.10 (see Figure 12).

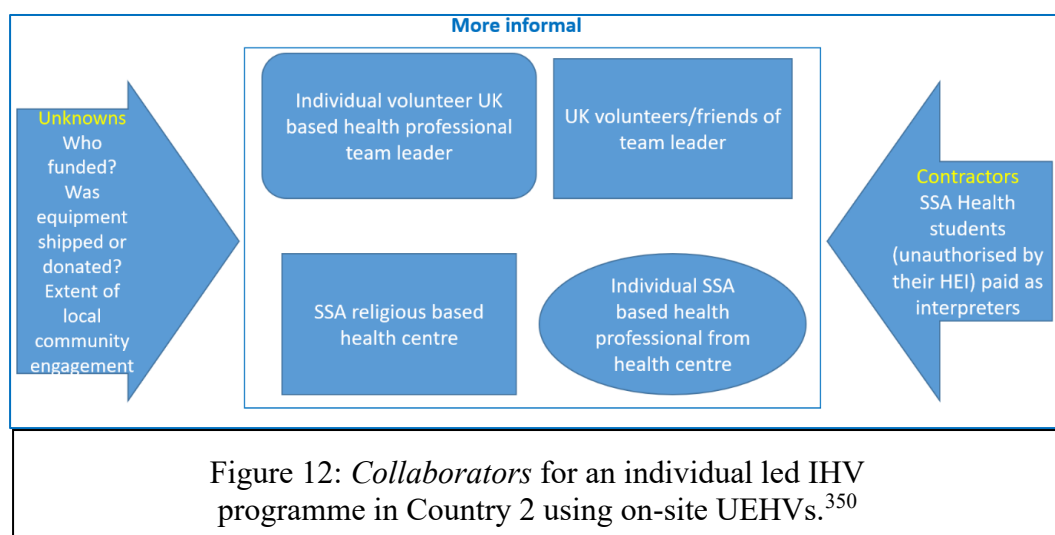


Figure 12: *Collaborators* for an individual led IHV programme in Country 2 using on-site UEHVs.³⁵⁰

³⁴⁹ See document V9 in its entirety.

³⁵⁰ See document C3 (p.5, l. 19-31).

Here it is evident that such an IHV programme is operating without credibility, unethically, illegally and with no legitimacy, mutuality or alignment with health policy from an African perspective. In effect, such an IHV programme does significant reputational damage to *bona fide* IHV NGOs, is unlikely to have significant impact and is potentially risky to patients and UEHVs alike.

Finally, the importance of collaborative networks is as important to African collaborators as it is to UK and European collaborators. I found that when I visited Country 2 to try to set up an IHV NGO programme for NGO 1 in collaboration with NGO 2 I was involved in trying to seek out an appropriate VPO. One potential VPO executive realised the importance of collaboration and was quick to point out that their VPO:

*Work with many partners and collaborative networks in Country 2 [listing four] and had worked recently with REDACTED INTERNATIONAL NGO... and were used to working with Western volunteers.*³⁵¹

The same person was pleased to hear that NGO 1 had an appropriate collaborative network in Country 2,³⁵² which I sensed meant that both organisations met each other's basic requirements to be potential collaborators, having a good collaborative network perhaps being akin to an unintended quality standard. I will now look at the influences of sustainability and dependency on my research question.

3.7 Sustainable development goals and volunteering

I have discussed already in Section 1.2 the SDGs in relation to giving volunteering and thus IHV NGOs a legitimate purpose in their activities. Here I will discuss the SDGs in relation to IHV in the two SSA countries. I found in my study that much effort in the IHV phenomenon centred around IHV being *sustainable* as this appeared important from an African perspective. For example, I

³⁵¹ Person SPM9 reported this in document F3M (p. 93, l. 24-30).

³⁵² Person GNF2 explained the nature of NGO 1's collaborators to person SPM9. See document F3M (p. 94, l. 1-3).

observed a senior SSA health worker addressing groups of African colleagues about the potential introduction of a new IHV NGO programme in Country 2 as:

*“It allows us to buy into a sustainable programme, and I would like to underline sustainable. Sustainable because one it’s a training programme and as a by-product you are providing a service for the community which is much needed.”*³⁵³

The opposite, being seen as *unsustainable* from an African perspective, I found was considered potentially problematic. Here the same senior SSA worker is imploring me (as a representative of NGO 1) to work with another IHV NGO as they view the other NGO to be *not sustainable*:

*They are needed now for treatment, but they are not sustainable.*³⁵⁴

And later:

*You must work with them, working together is the best thing that they can do, and they will see that training is sustainable.*³⁵⁵

Indeed, sustainability is important to IHV NGOs also. Simple examination of the public image of an IHV NGO nearly always indicates somewhere on their websites or social media that they are *sustainable*. I found in this study that it was difficult to fully understand what different actors meant by sustainability in relation to IHV. From an African perspective I did not observe a consensus on this issue. For some, sustainability appeared to mean that ultimately the IHV programme would be entirely run independently by SSA actors, for others it meant the IHV programme would be run more independently (with continued IHV NGO assistance) by SSA actors but funded by the IHV NGO, and for others it meant simply that the IHV NGO would commit to coming regularly. On this last notion of sustainability, I observed the views of a senior SSA government leader with responsibility for health saying of a proposed pilot IHV programme rather than a commitment to regular IHV programmes:

³⁵³ Spoken by person SEM1B. See document F3M (p. 68, l. 8-10).

³⁵⁴ Person SEM1B reported this to AP in document F3M (p. 18, l. 7).

³⁵⁵ Person SEM1B directly and personally told AP to do this in document F3M (p. 51, l. 34).

*I do not like it because it says pilot programme. A pilot programme means you might not come back; this will be the first programme, the first of many.*³⁵⁶

Similarly, I found that IHV NGOs reflected differences within understandings of sustainability with some decision makers wanting to minimize numbers of UEHVs and in doing so focussing efforts on programmes that:

*We should promote programmes that they [SSA health workers] can do themselves.*³⁵⁷

Others saw sustainability very much as a gradual move from a hands-on on-site approach to a hands-off facilitator and funder role with one decision maker in a study NGO being observed by me indicating that:

*The NGO will essentially become a UK funder and supplier of volunteers.*³⁵⁸

I found that in the IHV phenomenon, talk around sustainability was confusing, with several defining the concept quite differently which I feel makes trying to achieve progress towards common sustainable goals difficult. The only commonality I found was that most agreed that IHV should be aligned with the SDGs and that SDGs were important. But to me the SDGs are a set of high-level goals and targets upon which the performance or progress of a country or wider region, for example SSA, can be judged rather than an indicator of sustainability of specific health prevention or intervention initiatives. The SDGs do however represent areas of focus where IHV actors can potentially collaborate, and as SDGs may sometimes attract funding, they offer potential opportunities to realise funding from both an African and wider IHV perspective.

³⁵⁶ Reported by person SEM17. See document F3M (p. 99, l. 37-38).

³⁵⁷ See for example, person GNM2 reported this in document C3 (p. 4, l. 8-9). This is on the back of person SHM1A delivering an entirely SSA led successful HV programme (with some remote NGO assistance and financial backing) in Country 1. Person GNM2 reported that *they made it work, they did it themselves*. Again, see document C3 (p. 4, l. 8).

³⁵⁸ Reported by person GNF2. See document F2M (p. 22, l. 2).

In terms of IHV, whilst other SDGs may also impact on health, SDG 3 is the most important goal to consider regarding IHV. SDG 3 is a goal that aspires to:

Ensure healthy lives and promote well-being for all at all ages (United Nations General Assembly, 2015, p.14).

This overarching SDG however has been broken down into 13 *targets* (United Nations General Assembly, 2015) which the WHO alternatively label as *themes* (WHO, 2025b). These may enable IHV interest-holders to consider which priority area(s) their programmes may best be aligned to which may be helpful for programme evolution. I have listed the *targets/themes* as subsections in Table 17:

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SDG 3 subsection	Targets and/or themes
3.1	Maternal mortality
3.2	Newborn and child health
3.3	Communicable diseases
3.4	Noncommunicable diseases and mental health
3.5	Substance abuse
3.6	Road traffic injuries
3.7	Sexual and reproductive health
3.8	Universal health coverage
3.9	Mortality from environmental pollution
3.a	Tobacco control
3.b	Development assistance and vaccine coverage
3.c	Health workforce
3.d	National and global health risks
<i>Table 17: SDG3 health target and/or themes subsections (adapted from WHO, 2025b).</i>	

The importance of SDGs in this study relates to how progress is achieved towards targets in areas that could be positively contributed to by IHV. In my study both study NGOs were dealing with health programmes targeted at NCDs (Subsection 3.4) and were involved in aspects of universal health coverage (Subsection 3.8), areas of health workforce capacity building (Subsection 3.c) and a degree of

³⁵⁹ Subsections marked with a number indicate a date specific target and/or theme, for example in 2015 when drawn up the SDG subsection 3.6 indicated a target to halve the number of global road traffic deaths and injuries by 2020. Most health SDG subsections of this nature have some form of target to be achieved by 2030. Subsections 3.5 and 3.8 are not timebound. All subsections marked with a letter are not timebound. Instead, their targets and/or themes use words like substantially increase (3.c), strengthen (3.a and 3.d) and support (3.b).

development assistance (3.b). Progress against targets related to all SDGs including in these areas are published annually by the UN. So, for example observing the most recent report it is evident that:

Achieving global health goals faces significant challenges, with progress slowing since 2015 in areas like maternal mortality, premature deaths from major noncommunicable diseases, and access to essential healthcare. (United Nations General Assembly Economic and Social Council, 2024, p.7).

When looking at finer detail the SDG progress report can give IHV interest-holders specific important information that may be used as a basis for decision making by SSA government and health interest-holders and by IHV NGOs when setting health priorities, forming collaborative networks and targeting IHV programmes appropriately. For example, the most recent progress report indicates, when discussing SDG subsection 3.c, that whilst global health worker shortage has decreased from 18 million to 10 million since the SDGs were first published, population ageing means there are increased health needs, so the projected skill shortage gap is not reducing but widening (United Nations General Assembly Economic and Social Council, 2024). Such information is paramount for IHV interest-holders as it provides evidence that capacity building, task-shifting, staff training, recruitment and retention are even more of a priority for SSA governments and contributions that IHV can make towards these needs in SSA are likely to be beneficial from an African perspective. Furthermore, the systematic review from Bodkin and Hakimi (2020) stresses the crucial role that capacity building and training can play in facilitating sustainability in health programmes.

I found that the two SSA countries governments do appear to be influenced by SDGs, and they may priority set with SDGs in mind although the extent of that influence amongst many other factors is unknown. For example, during my research the area of health that I and the study NGOs operate in was rather unexpectedly prioritised into an essential government health package in Country 2. I observed a senior SSA health worker reporting this to mostly middle grade SSA health workers and IHV NGOs indicating that:

“Things are changing, as you know the Minister of Health puts down everything that’s a priority. This year for the first time in the history of REDACTED NATION, REDACTED SPECIFIC AREA OF HEALTH is part of the essential health package. Now, that means it’s a priority not a blank cheque, but it will be budgeted, there will be some costing for REDACTED SPECIFIC AREA OF HEALTH.”³⁶⁰

The same person continues:

“We need to take advantage of that...to make a plan that meets the expectations we and the people have and set priorities...we have to make the most of this opportunity...we need to discuss the IHV NGOs plan.”³⁶¹

In this context, many things had come together simultaneously being an effective collaborative network, a potentially sustainable project and appropriate priority setting influenced in part by SDGs. There was no money for this project from the SSA government but that aside just simply showing SSA health workers and the IHV NGOs that their area of health was prioritised motivated and inspired them to attempt to take this forward.

Within IHV, the health SDGs are sometimes viewed as unhelpful from an African perspective at programme rather than at a strategy level. Take for example the senior SSA health worker who informed me that they must take on implementation of health SDGs in an acting regional administrative role due to staff shortage. They reported to me that this will leave virtually no time to be involved in collaborative IHV programmes as they were having to attempt to deal with implementation of policies to meet SDG goals in IHV, maternal health and infant mortality none of which they were trained to deal with.³⁶² Furthermore, my research indicated that some African actors contend that some health SDGs are more prioritised and thus funded than others, the contention being that communicable diseases particularly HIV-AIDS receive more at the detriment of others. Take a VPO leader who told me:

³⁶⁰ Person SEM1B articulated this. See document F3M (p. 67, l. 17-20).

³⁶¹ Person SEM1B presented this. See document F3M (p. 67, l. 20 - p. 68, l. 1).

³⁶² Person SHM1B reported this. See document F4M (p. 103, l. 10-13).

*Health in REDACTED AREA had been neglected, or at least HIV-AIDS had been solely prioritised.*³⁶³

A retired district hospital director indicated though that it is not all communicable diseases that are prioritised just HIV-AIDS. When talking of their district I observed them reporting that there is:

*So much focus on HIV-AIDS that other things are spiralling out of control with a high rate of syphilis. Tuberculosis (TB) the worst it has been for decades.*³⁶⁴

So, my study is inconclusive regarding prioritisation of health SDGs although there is more evidence to suggest some prioritisation of HIV-AIDS. The issue is that for IHV programmes in health areas unrelated to HIV-AIDS funding opportunities and thus realisation of programmes may be more problematic.

It is not just from an African perspective that there is frustration of those operating in IHV in the two SSA countries with the perception of priority areas within the health SDGs. I observed an IHV NGO leader operating in the NCD area report on support for the IHV NGO from SSA Ministry of Health and other SSA interest-holders as:

*We have had nothing at all since we started.*³⁶⁵

This lack of support was despite being involved in delivery of collaborative government priority health programmes over a prolonged time.

Sometimes at programme level the health SDGs do appear to allow for appropriate collaborative and sustainable results when IHV NGOs and African collaborators work together. I was taken by a district hospital director to see a new ambulance acquired in collaboration with an international FBO as part of their IHV collaboration with the hospital. The ambulance was to access village dispensaries

³⁶³ Reported by person SPM9. See document F3M (p. 93, l. 21-22).

³⁶⁴ Described by person SCF1. See document F4M (p. 52, l. 12-13).

³⁶⁵ Detailed by person GVF4B in document F1M (p. 69, l. 32).

and bring birthing mothers in difficulty to hospital.³⁶⁶ I felt that this was an ideal relevant and sustainable improvement that would work in a rural setting. The ambulance was an easily maintained motorbike with an enclosed stretcher sidecar (see Figure 13). It would be able to negotiate the poor-quality roads to villages whereas a Western style one would not. This gave mothers in difficulty and newborn babies a chance of better outcomes, directly addressing health SDGs 3.1 and 3.2.



Figure 13: Motorbike ambulance with enclosed sidecar for use in rural SSA. An example of an IHV collaboration resulting in a sustainable solution that addresses health SDGs 3.1 and 3.2.

The health SDGs are an influence on IHV in the two SSA countries with more positive responses at a strategic level in the IHV phenomenon but with mixed responses at IHV programme level. The health SDGs are inherently a series of goals with targets and/or themes which appear to be sometimes confused with sustainability although the SDGs may well influence notions of sustainability. Differences in understanding of sustainability by actors within the two SSA countries makes it difficult for those collaborations striving for sustainability to aim for sustainable solutions or progress towards a health SDG. I will now look at the sustainability-dependency conundrum within IHV.

³⁶⁶ Person SYM1 showed me and others the ambulance and reported this as part of a group tour for UEHVs on the IHV programme's last day at the training site. See document F4M (p. 79, l. 24 – p.80, l. 4 which includes the figure seen in this thesis as Figure 13).

3.8 The Sustainability-dependency conundrum

In my research I observed on three fieldtrips NGO 1, in collaboration with multiple SSA interest-holders, implementing a model to *sustainably* task-shift lower grade health workers in a much-needed government priority health area. This would ensure that universal health coverage in specific health tasks was provided in rural and remote areas. This involved UEHVs acting as trainers but the next step in sustainability was by trying to introduce a train-the-trainers model. In this model, SSA senior and middle grade health workers would ultimately train their own lower grades with the IHV NGO withdrawing slowly over time, their job completed. This would leave an entirely SSA health worker run programme with potential for mentoring from afar if needed. This cascade training is something that most IHV NGOs would likely overwhelmingly agree represented their collective view of sustainable IHV.

Yet from an African perspective this was sometimes viewed differently, and I found that opinion varied as to taking the next step to sustainability. I was shown by a senior SSA health worker³⁶⁷ the differences in opinion between three senior SSA potential trainers by observing their messaging conversation:³⁶⁸

SSA senior health worker (person SHM8A):

*Let NGO 1 do it themselves they know what they are doing.*³⁶⁹

SSA senior health worker (person SHM1A):

*But we need to train trainers and then we can do it ourselves.*³⁷⁰

SSA senior health worker (person SHM6A):

³⁶⁷ Person SHM1A.

³⁶⁸ See document F4M (p. 72, l. 26 – p. 73, l. 14) for the whole conversation. Person SHM1A showed me a *WhatsApp* conversation in the local language. Person SHM1A then translated the pertinent messages for me into English. The conversation involved four people. Three persons (SHM1A, SHM6A and SHM8A) have specific reported speech attributed to them by me. The contribution of a fourth person (SHM5A) was not translated to me other than for person SHM1A to say to me that *not one single person supported me*. See document F4M (p. 73, l. 14).

³⁶⁹ Intimated by person SHM8A. See document F4M (p. 72, l. 10-11).

³⁷⁰ Reported by person SHM1A. See document F4M (p. 72, l. 28).

*It is not our job to train, let NGO 1 come and train, they are rich and can keep training our lower grades.*³⁷¹

SSA senior health worker (person SHM1A):

*No, it is our job to train, if we do not progress, they [NGO 1] will stop coming.*³⁷²

At the time of this conversation forty SSA senior health workers had been trained to run their own programmes by NGO 1, but cascade training had stalled and not commenced. NGO 1 had insufficient UEHVs and funds to train the entire country themselves. SSA senior health workers taking responsibility was the only solution to achieve the IHV NGOs view of sustainability. I observed one SSA representative of a national association suggesting that this model³⁷³ was entirely possible in their nation indicating that:

*We need you here for five years, by then, we will have enough trainers trained to cascade it everywhere....so I give you five years.*³⁷⁴

I reflected on this at the time indicating that I was:

*Unsure if this is optimistic, realistic or aspirational but it is a good target to have.*³⁷⁵

In hindsight this proved to be aspirational and unrealistic as most SSA senior health workers seemed entirely happy with the *status quo*, and I observed statements from various of them, all trained as trainers themselves, all expressing similar pleas to remain in a relative state of dependency:

*We don't want you going anywhere else.*³⁷⁶

³⁷¹ Reported by person SHM6A. See document F4M (p. 72, l. 32-33).

³⁷² Reported by person SHM1A. See document F4M (p. 73, l. 4).

³⁷³ The *train the trainers* sustainable model that had stalled in one of the SSA countries.

³⁷⁴ Person SEM1D indicated this in document F3M (p. 17, l. 8-9).

³⁷⁵ See AP's reflective comment in document F3M (p. 17, Fn. 83).

³⁷⁶ Person SHM6A reported this in document F1M (p. 69, l. 26).

“I’m very grateful for this collaboration...I give a request to you that next year we have at least four REDACTED SPECIFIC AREA OF HEALTH programmes to train lower grade health workers in the remaining districts with no REDACTED SPECIFIC HEALTH services in our region.”³⁷⁷

I have eighty lower grade staff that need to be trained by NGO 1.³⁷⁸

Yet in the other SSA country studied, when planning introduction of a similar model, I observed initial responses from a senior SSA health worker who indicated the need for sustainability that dovetailed more with the IHV NGOs view of sustainability:

I like the training model as it’s sustainable but to work here it must be cascaded, we must have the lower grade health workers and SSA trainers in from the start.³⁷⁹

However, for a different senior SSA health worker from the other SSA country the initial phase of the IHV NGO was sustainable *enough* for them without cascading. Hence the same relative state of dependency appeared to be acceptable to some:

Now I have seen it with my own eyes, these lower grade health workers are not just competent, they are amazing. What you people have done and what these young people have done is good and this is sustainable in our country also.³⁸⁰

³⁷⁷ Person SHM1B said this in a video recorded for NGO 1 and used on their website. The transcript of this is in document F4M (p.75, l. 25-27). The reader will note that this is an opposing view for this person than when they discussed sustainability with their peers following a *WhatsApp* conversation they translated for AP (see earlier in this section). As both these occurred on fieldtrip 4 it is unlikely the persons views had changed. Perhaps the explanation here is a good example of the *Local Hero effect* (*Local Hero*, 1983). As a senior health worker, person SHM1A hopes for sustainability but as a regional government leader the *alter ego* person SHM1B hopes for a degree of dependency. Given how upset person SHM1A was when recounting their *WhatsApp* conversation (see document F4M, p. 72, l. 10 and Fn. 450), I suspect their *personal* views are more for sustainability than dependency, but I remain unsure.

³⁷⁸ Person SHM5A reported this in document F1M (p. 16, l. 28).

³⁷⁹ Person SEM1B discusses this in document F3M (p. 16, l. 34-35).

³⁸⁰ Person SEF1D visited the IHV NGO programme in one of the SSA countries on behalf of the Ministry of Health in the other SSA country and reported this in document F4M (p. 121, l. 8-10). For them it appears sustainability is *enough* if it is the IHV NGO training health workers with some

I called this the *sustainability-dependency conundrum*, and this does appear to influence differing approaches to IHV in both the two SSA countries from Global North and African actors. Acceptance and indeed hoping for a degree of dependency from an African perspective appears relatively common and coexists with hopes for the varying notions of sustainability amongst SSA health workers. Yet from the IHV NGO perspective the goal appears to be sustainability, and dependency is seen as an unwanted trait. I am uncertain as to the precise reasons for this conundrum, but reasons seem to be multifactorial.

Perhaps from an IHV NGO perspective sustainability is a key influence as they do not want to be seen as imposing their ideas on SSA actors. Yet this may assume, sometimes incorrectly, that *all* SSA actors want ultimately to take charge of their own programmes. From an African perspective a degree of dependency in the IHV phenomenon may be at times partially necessary, wanted and needed by the nature and circumstances of health services in Africa. Perhaps necessary because the SSA health worker is often overstretched with many demands on their time of which the IHV programme may be a small part of what they do. A senior SSA health worker informed other health workers of a previous failed attempt to make a task-shifting programme sustainable when they were in a prior government leadership role:

*“We did this for some time, and it was obvious to us that it was not sustainable. We were taking these people out for training and there was a need for them to be at their stations.”*³⁸¹

A degree of dependency is perhaps wanted because with a lack of SSA health workers, particularly in rural areas, the SSA health worker can feel isolated and can find companionship, gain new knowledge, mentoring and problem-solving skills from continued collaborations with IHV NGOs and UEHVs.

A middle grade SSA health worker who had no colleagues in the same district in their profession reported their impending loss of companionship as:

help from senior SSA health workers. This is at odds with the Western notion of sustainability and their compatriot person SEM1B, who also visited the same IHV programme.

³⁸¹ For example, person SEM1A discussed this in document F3M (p. 64, l. 22-24).

*When you go, I will still have to work in that room in the district hospital.*³⁸²

The same middle grade SSA health worker suggests to AP that:

*We need to stay in touch...we need to learn and share knowledge.*³⁸³

Another middle grade SSA health worker hopes for post-programme mentoring:

*I learned lots from you people and I feel more responsible to my people...I want to keep on communicating with you for me to be able to access some treasures from you.*³⁸⁴

A senior SSA health worker discussed with me the importance of NGO 2 holding annual conferences that brought CPD and much wanted companionship by bringing together geographically isolated middle grade SSA health workers:

*I like what NGO 2 are doing as they hold the REDACTED MIDDLE GRADE SSA HEALTH WORKERS conference. This allows them to meet and talk and get additional training.*³⁸⁵

A degree of dependency is perhaps needed because there are simply insufficient funds available for Africans within collaborations to run their own programmes as many IHV NGOs are similar to the ones I observed,³⁸⁶ which in the case of NGO 1:

*Is a small NGO and does not have unlimited funds.*³⁸⁷

And according to some African interest-holders, SSA governments:

³⁸² Person SHM3A informed this in document F2M (p. 68, l. 21).

³⁸³ Reported by person SHM3A in document F2M (p. 68, l. 23).

³⁸⁴ See document F1M (p. 87, l. 16-20) as described by person SHF1A.

³⁸⁵ Reported by person SEM1B in document F3M (p. 12, l. 5-7).

³⁸⁶ NGO 1 is small, but NGO 2 is smaller.

³⁸⁷ Described to African interest-holders, in a meeting, in which I participated by person GNF1A. See document F1M (p. 67, l. 36-37). Interestingly, whilst not fully in the scope of my research, person SCF1 indicated to me that *you Brits never have enough money, American NGOs are rich and more likely to donate*. See document F4M (p. 52, l. 27-28). This potential disconfirming evidence gives some *additional* justification to me for excluding IHV NGOs that emanate from North America from my study as influences on IHV in the two SSA countries may differ (see Section 2.3.9).

*Do not fund some areas of health enough.*³⁸⁸

The SSA representative of a national health professional association told me:

*I see why the train the trainers didn't work, it was because their government wouldn't put any money in it... I must convince our government that now REDACTED SPECIFIC HEALTH AREA is in the essential health package NGO I can give us a whole cohort of trainers if we put some money into it.*³⁸⁹

Unfortunately, no money was forthcoming in the other country either and the IHV NGO notion of sustainability remains as yet unrealised in this instance.

I observed that confusing the sustainability-dependency conundrum were mixed messages relating to the role of IHV NGOs emanating from different senior SSA interest-holders to NGOs. Within collaborations that made it very difficult for the NGO to know if their programmes were still necessary, wanted or needed by SSA governments, health workers and communities. For example, in regard to simply running IHV programmes one senior SSA government health leader indicated that it was:

*Problematic with foreign NGOs doing programmes on site.*³⁹⁰

Whereas a SSA district government health official indicates:

*REDACTED REGIONAL GOVERNMENT HEALTH OFFICIAL and I need more lower grade health workers trained.*³⁹¹

In some cases, the views of some SSA individuals with opposing views to other SSA individuals in the same collaborative network can put an IHV NGO in an

³⁸⁸ See document F3M (p. 48, l. 22) as reported by person SEM1D.

³⁸⁹ Person SEM1D reported this in document F3M (p. 80, l. 18-19).

³⁹⁰ Reported by person SEF2 in document C3 (p. 3, l. 1).

³⁹¹ See document F1M (p. 60, l. 10-11). Reported by person SHF1B who indicates person SEM3A shares this view.

awkward position of not knowing whether to stay or go. Take for example these views from two SSA actors on the same IHV NGO programme:

Firstly, the SSA leader of a health professional representative body indicates that:

*This will be the last ever programme, I will shut you down.*³⁹²

Secondly, a SSA regional government official states:

*Please do not leave us we need you desperately.*³⁹³

I also found that at programme logistical level the sustainability-dependency conundrum exists in some instances. I observed NGOs bringing out from their donor country equipment to use on their programmes that was unavailable in the two SSA countries.³⁹⁴ Whilst this may make the role of UEHVs easier and safer in clinical treatment and clinical training, if the programme is dependent on this equipment there is little hope for SSA interest-holders to be able to run their own programme without significant modification. The more this happens the more dependency the programme has, yet SSA actors learn about and like using different equipment so do not necessarily see this as problematic.

IHV NGOs have different modes of operation and some on the surface appear to be more sustainable than others. In my study, NGO 1 operated a training and capacity building collaborative model which was widely accepted as *sustainable* by SSA interest-holders but in reality, aspects of their model gave degrees of dependency in the two SSA countries by the inability, for potential reasons already discussed, to enact their own cascade training driven by SSA actors. NGO 2 on the other hand had a treatment model which met the needs of underserved patients in hard-to-reach areas whilst using donations received to provide CPD for middle grade health workers and to fund student middle grade

³⁹² Person SYF1 said this. See document F1M (p. 33, l. 11).

³⁹³ Person SHM1B reported this. See document F1M (p. 35, l. 11). Person SHM1B waited until person SYF1 was out of the clinic before reporting this statement. AP noted this at the time. See document F1M (p. 35, l. 8)

³⁹⁴ See for example, in document F3M (p. 37, l. 21-23) AP observed an anaesthetic system unavailable in Country 2 at an IHV programme site. Person GNF3A indicates this is used throughout programme sites run by NGO 2. This is discussed in relation to *decolonization* in Section 5.6.2.

health workers through HEIs in their own country. This type of IHV model involving programmes that primarily involve patient care is sometimes criticized in literature as being unsustainable (Grant *et al.*, 2020; Walugembe *et al.*, 2019). My study found similar criticism, for example, a SSA senior health worker reports:

*Their work is amazing, but it is not sustainable.*³⁹⁵

Yet I would argue that this model has much in the way of sustainability to commend it. In terms of its treatment of the underserved it is after all “meeting the needs of the present...” (United Nations, 1987, p.16) being a key element of an accepted definition of sustainability. It is using that element to fund students in a health profession that is well needed, as I observed when told by another SSA senior health worker that they will:

*Embark on a programme of sponsoring to teach more middle grade health workers, who in the end will be bonded for some years to serve the hard-to-reach areas. If the programme succeeds, it will see REDACTED SSA COUNTRY reaching out to the rural communities with the scarce REDACTED SPECIFIC HEALTH services.*³⁹⁶

In my study I did not find IHV to be either entirely *sustainable* or entirely *dependent* in real-life situations. I found reasonably effective imperfect examples of IHV that were viewed by collaborators and interest-holders differently as to their degree of *sustainability* based on the views, biases and expectations of what IHV should look like and what *sustainability* means to different individuals and organisations. The sustainability-dependency conundrum in IHV does appear to be an important influence on IHV and particularly so from an African perspective. I must reflect that this study has merely highlighted this as an influence, but I have insufficient data to do more than postulate the reasons why it is an influence. This area of the IHV phenomenon warrants further research, being important as IHV NGOs need ethical and appropriate exit strategies for ending programmes themselves to try and ensure sustainable gains continue in the two SSA countries.

³⁹⁵ Person SEM1B told AP this. See document F3M (p. 102, l. 18-19).

³⁹⁶ Person SEF1B reported this. See document C3 (p. 5, l. 2-4).

3.9 Embedding sustainability in volunteering

Embedding a reasonable degree of sustainability in volunteering is necessary and desirable for Global North and African interest-holders. In a recent updated systematic review on the sustainability of health interventions across Africa, which included data from projects involving IHV NGOs, it is evident that there is a consensus on the importance of sustainability to maximize public health impact of health interventions (Nwaozuru *et al.*, 2025).

This need to embed sustainability is also evident in my study observations as for an IHV NGO the consequences of not embedding sustainability are articulated by an NGO clinical lead as:

*What legacy have we left? If we leave now, we have done nothing.*³⁹⁷

Another NGO clinical lead I observed reports frustration at the lack of sustainability:

*The REDACTED NGO needs to get the REDACTED SENIOR SSA HEALTH WORKERS to put some effort in, this isn't Live Aid it's not a humanitarian crisis, it's an attempt at sustainable development.*³⁹⁸

From an African perspective, when sustainability is in some way embedded in IHV it can empower African actors who can take ownership of and shape programmes in a much more locally relevant way than any IHV NGO can do. Take for example the SSA regional health administrator who attended an NGO 1 programme where six lower grade health workers were *task-shifted* in a specific health area. During the programme, I and another UEHV mentored this person and discussed health issues in their area together with potential solutions. Their response was to select two of the six, make some budgetary savings, fund their training, with the savings made, on a middle grade health worker training course in a neighbouring region in the same area of health as the *task-shifting* had addressed

³⁹⁷ Reported by person GNF1A in document C4 (p. 33, l. 15).

³⁹⁸ Reported by GNF4 in document C4 (p. 33, l. 28-30).

and plan to employ them two years later in the region. They later contacted me and the other UEHV involved stating:

*This is my dedication to you REDACTED UEHV and AP that you coming to Country 1 wasn't just to ordinarily train REDACTED LOWER GRADE HEALTH WORKERS but to make someone adopt, own and sustain a programme.*³⁹⁹

The actual course of sustainability here was never an intended consequence of the programme but was an unintended outcome. It was made locally relevant by UEHVs being on-site and interacting with a motivated individual who simply needed some positive mentoring, information sharing, motivation and to observe some positive role models.

Another example in my study of unintended consequence was my observation of similar on-site health promotion mentoring by a UEHV, who was a middle grade health worker, peer mentoring a SSA middle grade health worker who was inspired to implement in their district a *WhatsApp* based health promotion group chat which was locally relevant and sustainable as this is often the most realistically achievable digital means of communication in rural SSA. The middle grade health worker later informed the UEHV:

*The goal of my health project is to create a generation that will be free from REDACTED SPECIFIC diseases by raising awareness about the importance of REDACTED SPECIFIC health and its relationship to whole body health.*⁴⁰⁰

Whilst it could be argued for these examples that sustainability arose by chance the key features, I felt, were that the IHV NGO provided UEHVs on-site in the two SSA countries whose personal interactions affected positively SSA health actors. This seemed to act as a driver and influence for already highly motivated and driven individuals who were keen to effect sustainable change but simply needed a

³⁹⁹ See document T3 (p. 13, l. 41 – p. 14, l. 2). Reported by person SHM1B some months after fieldtrip 1. This concerns person GNF1A in addition to AP.

⁴⁰⁰ Person GVF10 mentored person SHF5 firstly during an on-site IHV programme and then later via *WhatsApp*. Person SHF5 set up a *WhatsApp* based health promotion for their local community. This is detailed in document C4 (p. 63, l. 2 – p. 64, l. 21).

catalyst to do so. The difficulty in embedding sustainability in this situation is the need for highly motivated UEHVs and highly motivated SSA actors to meet and some do not get the chance.

I have discussed already in this chapter the differing notions of sustainability in IHV programmes particularly from African health workers. Embedding sustainability into collaborative IHV programmes can be problematic because of this. Following considerable reflection to even attempt to embed sustainability into IHV requires in my view collaborators to discuss possible sustainable outcomes of programmes at the programme planning stage. This should involve all interest-holders so that there is mutuality regarding a common understanding of what *sustainability* means within a specific programme with recognition of what is the degree and nature of *dependency* that is acceptable to all collaborators. These will inevitably require difficult conversations which should include an exit strategy for the IHV NGO so that there is managed withdrawal in the collaboration whilst increasing African led responsibilities. Without these steps I would be concerned that sustainable gains made during programmes may be lost. Additionally I would agree with Melby *et al.* (2016) that IHV by its short-term nature has limitations regarding its contribution to sustainability. Perhaps an important principle for embedding sustainability is for IHV to be embedded within pre-existing community efforts focussed on sustainability (Melby *et al.*, 2016). This latter notion was mostly true of the IHV programmes in this study.

Furthermore, embedding sustainability within IHV collaborations not only is likely to require initial discussions on sustainability, but based on my study findings I suggest that collaborators regularly appraise how programmes are working in real-life settings. Changes can then be agreed that can better enhance sustainability throughout the lifecycle of specific IHV programmes. This will necessitate that communication of changes in policy or personnel is cascaded throughout the collaboration. Additionally, whilst most IHV programmes start with good intentions some will, despite best efforts, be later unwanted or no longer meet SSA or IHV NGO priorities or fail to provide reasonable sustainable gains. In these circumstances, open, honest, prompt and fair discussions within the collaboration are necessary to decide to cease the IHV collaboration in a controlled and managed manner to reduce risk of harm from sudden withdrawal as discussed in Section

1.8.1. If this can take place smoothly, collaborators should be able to take learning points from failure and move on to other programmes which may better embed sustainability in IHV.

Finally, over the last two decades much debate has taken place in regard to strengthening global health initiatives, culminating in the recent development of key shifts to improve universal health coverage arising from the Lusaka Agenda (Mwangangi and Røttingen, 2023). The WHO African region has produced a road map for SSA governments and collaborators to implement the outputs of the Lusaka Agenda (WHO, 2024). This road map *inter alia* suggests that stronger contributions are needed to strengthen primary healthcare in Africa and challenges national governments to move towards sustainable and domestic finance of health services and public health measures whilst charging collaborators with a catalytic role (WHO, 2024). With the launch of the Accra Reset (The Presidency of the Republic of Ghana, 2025), which suggests a transnational agreement to move from dependency on aid to self-determination in Africa, it is for Africa to lead and the Global North to be enablers rather than directors (Kaseya, 2025).

IHV is thus challenged to a role to contribute better to sustainability in SSA underpinned with a focus on providing encouragement, enablement and stimulus to African partners in primary healthcare. This is in a manner that has as underlying principles the imperative for Africans to lead and the need that ultimately there is a requirement for more domestic finance of health. Effectively, as discussed by some trying to bridge cardiac care gaps in SSA⁴⁰¹, volunteering needs a long-term and more structured approach to be sustainable in SSA (Kshetry *et al.*, 2026). Much of this is already being undertaken but this needs to be more focused. This may necessitate changes in the targeting and nature of collaborative IHV programmes, which may better embed sustainability in IHV in the two SSA countries.

3.10 Chapter conclusion

This chapter presented the three interlinked themes of collaboration, sustainability, and dependency which I have argued are key influences within the IHV phenomenon in the two SSA countries. I have defined these themes, indicating

⁴⁰¹ This study was focussed in Ethiopia and Tanzania.

where there is lack of consensus in definition and particularly in relation to sustainability, where there are different understandings of sustainability between and within different groups of IHV actors, particularly between SSA health workers.

I have presented and justified the importance of collaborative relationships between many IHV actors both formal and informal within the IHV phenomenon. I have provided evidence of the need for effective collaborative networks within IHV demonstrating not just the advantages, but I have additionally highlighted some of the problematic areas that can result in collaborative inertia rather than advantage. I have linked the need for collaborative networks to achieve a degree of sustainability with IHV programmes. I have debated the SDGs as a factor within sustainability and their importance to collaborative networks at strategic level. I have discussed mixed responses to SDGs at programme level and how they are viewed in considerations of IHV programme sustainability.

In this chapter I introduced the reader to the concept of the sustainability-dependency conundrum within IHV in the two SSA countries. I have tried to take account of views that allow differing notions of sustainability to coexist with dependency. Based on my data I have argued for the necessity to view dependency as sometimes necessary or wanted or needed in IHV in the two SSA countries, particularly from an African perspective.

Finally, I have presented possibilities for embedding sustainability better into volunteering by looking at the importance of individual interactions between UEHVs and SSA actors, empowering SSA actors to sometimes unexpected sustainable gains. I have discussed potential improvements to collaborative networks that may enhance sustainability, which can help with ethical exit strategies for IHV NGOs and better transitions to SSA actors taking their own sustainable health programmes forward. I have briefly discussed the outcomes of the Lusaka Agenda and Accra Reset which challenges IHV to be a catalyst to enhance sustainability in SSA. My next chapter will discuss and present two further important interlinked influences in the IHV phenomenon in the two SSA countries, being the themes of cultural competence and cultural tension.

CHAPTER FOUR - Cultural competence and cultural tension

Chapter Introduction

I have already briefly introduced cultural competence and cultural tension in IHV in the two SSA countries to the reader in Sections 1.8.1 and 2.3.7. I will discuss in this chapter the key influences of the interlinked themes of cultural competence and cultural tension on IHV in the two SSA countries. I will at times highlight an African perspective as the focus on cultural competence in IHV literature predominantly draws out the views of Global North interest-holders with under-representation of African views. Additionally, I will present some examples of cultural incompetence as this is distinct from cultural tension but can sometimes act as a precursor of cultural tension in IHV in the two SSA countries.

Both cultural competence and cultural tension were on my horizon early in my research, as from IHV experiences prior to this study, I knew that IHV NGOs espoused the importance of a UEHV being culturally competent. In addition, my first fieldtrip produced adequate rich data from which I generated codes related to these areas. Using a deductive approach these themes were generated following categorisation of codes. For a time, I felt they were linked with *respect*, which is indeed a large part of African culture⁴⁰² and an important influence on IHV and the two SSA countries. However, following much recursive reflection, *respect* was more intimately linked elsewhere.⁴⁰³ I linked these themes together as at IHV programme level the cultural interactions of involved actors from IHV NGOs and the two SSA countries appeared to influence programme objectives in its widest sense. At strategic level, particularly in relation to meetings and correspondence, I found cultural competence and cultural tension both influenced the interactions of IHV collaborators in different ways which may affect strategic decision making around some IHV programmes in the two SSA countries.⁴⁰⁴

⁴⁰² See Sections 4.2, 4.2.1, 4.2.2 and 4.2.3.

⁴⁰³ Whilst ultimately *respect* is part of an interlinked theme with *power*, hierarchy and *neo-colonialism* (see Chapter 5) it has much to do with *cultural competence and cultural tension* in the IHV phenomenon. In consequence, *respect* features prominently in this chapter in regard to African culture in Subsection 4.2.2.

⁴⁰⁴ See Section 2.3.7 for full details of my categories and themes.

In this chapter I will reinforce the widely accepted view that IHV NGOs and GNHVs should have a reasonable degree of cultural competence regarding SSA countries in which their programmes take place although I will argue that cultural variation within nations requires recognition. However, I will also present my findings that cultural competence can be lacking within IHV NGO teams, within groups of SSA health workers, and within SSA VPOs as many of these groups are themselves culturally diverse. Additionally, I will highlight the wide cultural diversity of rural and remote loci in the two SSA countries where IHV programmes take place and that sometimes nobody involved in IHV programme delivery, whether from SSA or the IHV NGO or the UEHVs themselves, has reasonable cultural competence in relation to the communities they hope to serve.

In order to explore these key influences fully I will provide the reader with significant context and background in relation to African culture, community values in SSA, and religious and moral values in the two SSA countries and wider region. It is important to note that in this chapter I am not aiming to unpack Edward Tylor's anthropological concept of culture (Livingston, no date).⁴⁰⁵ Instead in descriptive terms I will discuss some aspects of African culture that relate to my research question. Furthermore, I will consider aspects of suspicion, trust, ethnicity and racism in the IHV phenomenon in the two SSA countries and how they relate to cultural competence and cultural tension. In this chapter not only will I assert that these themes are a major influence on IHV in the two SSA countries, but I will give suggestions on how relationships can be improved to enhance cultural competence. Hopefully in doing so I will potentially reduce cultural tension by proposing seven basic principles (which I will present in my thesis conclusions in Section 6.1).

4.1 Definitions

Cultural competence is a poorly defined term which is often misunderstood. A reason for this is that culture itself is often seen as analogous to language,

⁴⁰⁵ Livingston (no date) cites Tylor (1871) who gives the classic anthropological definition of culture as "A complex whole, which includes knowledge, belief, arts, morals, law, customs and other capabilities and habits acquired by people" (p.1). This definition has since been expanded to include other things, for example, symbols.

nationality, and ethnicity (Kleinman and Benson, 2006). I observed this too in my research with a study IHV NGO telling UEHVs that:

*In REDACTED SSA COUNTRY it's rude to point at someone.*⁴⁰⁶

This agrees with the observations of Betancourt (2004) who observed that cultural competency sometimes assumes core beliefs based on perceived ethnic values. Furthermore, in healthcare cultural competency has sometimes been seen as a technical skill that can be trained for such that a clinician can become proficient (DelVecchio Good, 1995). IHV NGOs commonly claim to train UEHVs in *cultural competency*, but I found that cultural competency training is sometimes weighted to more of a list of *dos and don'ts* that are more akin to orientation rather than cultural competency, for example:

*Don't have valuables on display...carry passports and money with you at all times, no photos of government buildings.*⁴⁰⁷

In the absence of agreement and as definitions of cultural competency often focus more on the health professional and patient relationship I have therefore adapted and added to a combination of the work of Betancourt, Green and Carrillo (2002), and Stubbe (2020) to propose a definition suited to IHV in the two SSA countries and wider SSA. Whilst the health professional and patient relationship is important, so are the relationships between and within all IHV interest-holders from SSA and the Global North. I have thus defined my working definition of cultural competency as:

Cultural competency in IHV in SSA emphasizes the need for all involved to be aware of, and responsive to, each other's cultural perspectives and backgrounds, individual, family and community preferences. To ensure cultural competency the values, cultural traditions, language, notions of health and disease, and socioeconomic conditions of all should be respected

⁴⁰⁶ For example, Person SPM1 announced this at on-site orientation to UEHVs. See document F2M (p. 33, l. 23).

⁴⁰⁷ For example, Person GVF8 discussed their cultural training at an IHV NGO pre-programme training day with AP. See document F2M (p. 13, l. 6-7).

(adapted by me from Betancourt, Green and Carrillo, (2002, p.3), and Stubbe (2020, p.49)).

Cultural incompetency can be viewed as the opposite of the above definition or at least some part of it. From personal reflection and observation, most involved in IHV in the two SSA countries will be culturally incompetent in something, me included, as it is impossible for an *outsider* to fully understand the depth and breadth of other cultures within individuals, with *everyone* being an *outsider* to *someone*. I will discuss cultural competency and incompetency in Section 4.3 of this chapter.

Cultural tension is ill defined with no consensus on definition. I have taken it to mean:

The stress, disagreements and dissonance that can occur between and within individuals and groups when dissimilar values, attitudes, beliefs, or practices interact negatively.

In IHV in the two SSA countries, two other terms are worthy of definition. Firstly, culture shock⁴⁰⁸ is seen in my study in some UEHV's, but also in SSA interest-holders and may be a factor in some aspects of cultural tension which I will discuss later in this chapter. I have adapted the definition of culture shock from the American Psychological Association as:

The uneasiness, confusion, or distress experienced by people when they experience a new or unfamiliar or markedly changed cultural environment (American Psychological Association, 2007, culture shock).

Secondly, the term cultural humility is both useful in framing cultural competence in IHV and helping to defuse cultural tension in IHV. Cultural humility requires

⁴⁰⁸ For completeness, there is also the phenomenon of *reverse culture shock* first described by Oberg (1960). This can occur when individuals return home after a period in an unfamiliar culture and experience uneasiness, confusion or distress as described in the definition of *culture shock* (American Psychological Association, 2007). This may be due to the returning individual being changed whilst away and how the individual copes with this. Part of my clinical lead role (see Table 1) was to do welfare checks on returning UEHV's to try mitigating this experience. Whilst on my horizon this phenomenon perhaps lies outside the scope of my research question.

individuals within interpersonal relationships choosing to honour each other's values, beliefs and customs (Tervalon and Murray-García, 1998). Cultural humility thus requires individuals to be self-reflective, self-exploratory, and self-critical together with a desire to learn from others (Stubbe, 2020). Unlike cultural competence, where gaining knowledge of diverse cultures is helpful to aid a degree of understanding, cultural humility promotes openness and sensitivity and recognises intra-cultural variation (Stubbe, 2020). It adopts a person-centred position that reflects curiosity and can be considered other-oriented (Hook *et al.*, 2016).

4.2 African culture

I have alluded already in this thesis to the importance of African culture in the IHV phenomenon in the two SSA countries. Here I will explore this further to give the reader some important background as to why cultural competence and cultural tension are such an influence in IHV in the two SSA countries particularly from an African perspective. The term, African culture, can at first be considered a generalisation or an oversimplification as there is much cultural variation in Africa in terms of language, eating, religion, dress, greetings etc. Indeed Africa has much cultural diversity and many ethnolinguistic groups (van Pinxteren, 2020). However, it is generally accepted that African culture is markedly different from cultures in other regions or continents, but has commonalities across SSA (Idang, 2015). I observed this in my study with two SSA health workers from the two SSA countries discussing what they have in common:

In my country we eat ugali,⁴⁰⁹ you call this nsima, it is the same. Ugali unites Africa.⁴¹⁰

Prima facie this is just a corn meal maize, but it is so culturally important in Africa that in 2017 it became one of the few foods included in the United Nations Educational, Scientific and Cultural Organization's (UNESCO) list of the

⁴⁰⁹ *Ugali* and *nsima* are known by many different names. This is dependent on African language and region.

⁴¹⁰ Speaking to some middle grade health workers from one of the SSA study countries (persons SHM19, SHM20 and SHM22) and person SPM3 (from the other SSA study country) suggested this commonality to them. See document F3M (p. 62, l. 4).

intangible cultural heritage of humanity (UNESCO, 2006). Everything about this food including preparation, storage, cooking, and eating is bound to customs that involves traditional communal values and bonding built through generations (UNESCO, 2017).

African culture pertains primarily to the indigenous people of Africa. I am not being exclusive, but this represents my understanding of African culture as a way of life developed over centuries that guides the well-being of indigenous individuals and communities (Ramose, 2002). It is thus important that I reemphasize that regarding African culture I am clearly an *outsider*, albeit one with reasonable understanding of African culture, and so my narrative and findings may be limited by this. In my study I had the opportunity to observe some UEHVs who were African, but who had been educated and lived primarily in the UK or Europe. These persons were volunteering in Africa as they felt drawn back to the region, perhaps like my motivations to first start volunteering there. For them I found that African culture was familiar but also, they appeared to feel more of an outsider and experienced culture shock. See some examples below:

*I know I've become very Westernized...rural Africa is something I know little about and the culture shock is big for me too.*⁴¹¹

*I feel that I am a black muzungu⁴¹² here...I would love to work in REDACTED SSA COUNTRY, but I couldn't cope with the lifestyle as my lifestyle is now British...my parents would be annoyed and feel disrespected if I went back to REDACTED SSA COUNTRY as they had spent lots of money on my education to give me a better life in the UK.*⁴¹³

*I'm still a bit overwhelmed...it is very strange to be an ethnic majority rather than minority...I am on a real journey...I am so lucky to have had all the opportunities that I have in REDACTED GLOBAL NORTH COUNTRY compared to how little people have in REDACTED SSA COUNTRY.*⁴¹⁴

⁴¹¹ Person XVF1 reported this in document F4M (p. 28, l. 2-6).

⁴¹² *Mzungu* is a term for *foreigner* which commonly in the two SSA countries is a white person. It is not currently considered offensive. Variations are seen of the word within the two SSA countries and throughout the wider SSA region, for example, *azungu*, *mzungu*, *musungu*, *musongo*.

⁴¹³ Person XVF1 further articulated their thoughts. See document F4M (p.28, l. 12-20).

⁴¹⁴ Person XVF2 reported this in document F2M (p. 37, l. 6-11).

Perhaps African culture is modified in the wider African diaspora by influences of other cultures. As it is relatively common for members of the African diaspora to volunteer for IHV NGOs in SSA, this is worthy of further study as I have insufficient data in this study to do more than highlight it as an area of potential influence.

African culture in IHV is sometimes poorly understood by some UK and European interest-holders. This is unsurprising as research into African culture in the Global North regarding healthcare is sparse and the knowledge base amongst IHV NGOs is far from ideal. A typical example would be the excellent research of Chandratilake, McAleer and Gibson (2012) which looked at cultural differences in professionalism amongst health workers. This included most global cultural contexts but omitted Africans as there were insufficient in their study population. In my study cultural tension did result amongst UEHVs by failures to understand aspects of African culture. For example, I observed an UEHV becoming frustrated at the need to pay respects to community officials on a IHV NGO programme as they deemed this to be a *waste of time*.⁴¹⁵ Despite explanations by me of the importance of this in African culture this was insufficient to dampen the resultant cultural tension between the UEHV and some SSA VPO staff for a time. Another example was the perceived directness of imparting orders from a senior SSA health worker being found upsetting by an UEHV who indicated to the SSA senior health worker the inappropriateness of their:

*Commanding language to the VPO team and the NGO team...and their impolite manner.*⁴¹⁶

Essentially the SSA health worker was being perceived as rude by the UEHV whilst the SSA health worker failed to understand that the authoritarian directness largely seen as culturally appropriate in the two SSA countries was seen very differently by the UEHV. Both demonstrated a lack of cultural competence in this

⁴¹⁵ Person GVF13 expressed this opinion about courtesy visits aloud, which annoyed person SPM6. See document F4M (p. 33, l. 21).

⁴¹⁶ Here, person GVF9 took person SHM8A to task about their behaviour. See document F1M (p. 76, l. 17-19).

matter and tension resulted throughout the IHV programme between these individuals.

It is thus important to foreground African culture for the reader as an understanding of African culture is essential to better frame the interlinked themes of cultural competence and cultural tension in IHV in the two SSA countries. I will discuss next some of the core values of African culture illustrating, where appropriate, my findings and relationships of these values to my research question.

4.2.1 Community values

African culture places community values at its core such as a synergistic society that works in the fields and builds dwellings together and where a well-behaved child is seen as not just benefitting a family but society, so the wider village corrects and helps raise a child (Idang, 2015). These values contrast with individualistic values sometimes associated with Western culture seen by a parent who would find the intervention of others to correct a child inappropriate.

Some scholars criticise those from the Global North as being dismissive of African culture, feeling that they present Western cultural values as the sole solution to current challenges (Amin, 1989) with some believing that European culture is viewed as the standard to be adhered to (Asante, 2007). I did not see this in my research. Instead, I saw largely synergistic cultural values even though there were issues of cultural incompetence amongst those involved in IHV whether from the UK or Europe or the two SSA countries. For example, at programme level it was mutual support and good teamwork rather like a community of practice that were my predominant observations, for example, from a UEHV and a SSA health worker respectively:

*I loved the teamwork and the all in it together approach.*⁴¹⁷

*Thank you for your wonderful support to our poor people through
REDACTED SPECIFIC HEALTH services...I personally enjoyed working
in a great team.*⁴¹⁸

⁴¹⁷ Person GVF8 reported this in document F2M (p. 56, l. 33).

At a more strategic level observations were similar. Here for example are my observations on discussions between an IHV NGO and a VPO regarding programme planning:

*The details were thrashed out by all in a very open and honest discussion with agreement on minor changes.*⁴¹⁹

Perhaps the commonality of notions of service within healthcare partially transcend cultural differences in IHV in the two SSA countries. There were exceptions but my observations indicated that this was largely when Africans involved in IHV behaved more individualistically akin to perceived notions of Western culture which seemed to offend other Africans. For example, one VPO leader referred to a senior SSA national representative in a negative manner as they indicated that they only appeared interested in themselves, their position of authority, seeding discord, and financial gain.⁴²⁰ African culture approves and disapproves of certain things based on cultural values (Idang, 2015). I do wonder if the disapproval in the above example from one African about another is that this individualistic behaviour may be widely disapproved of.⁴²¹

There is sometimes a risk of cultural tension when those from the UK or Europe misunderstand African culture coupled with Africans misunderstanding Western culture. This can arise on an IHV programme out of simple errors of communication. For example, in African culture to call someone *fat* is to compliment them that they are healthy and well, whereas in the UK or Europe this may be viewed as an offensive bullying term (Ibrahim, Abdulai and Abubakari, 2020). For example, I observed an exchange between a SSA local community actor and a UEHV who were greeting each other after a two-year absence as they were

⁴¹⁸ Person SHF1A reported this in document F1M (p. 87, l. 14-15).

⁴¹⁹ AP observed and participated in discussions involving AP and persons GNF1A, GVF4A, GVF6, GVF9, SPM2, SPM5 and SPM6. See document F1M (p. 86, l. 23-24).

⁴²⁰ Person SPM5 reported this regarding person SYF1. See document F1M (p. 84, l. 39-42).

⁴²¹ For example, in the case of the issues between persons SPM5 and SYM1, widespread disapproval of person SYM1 was evident from other SSA actors, see document F1M (p. 60, l. 25 for person SPM6's views and p. 76, l. 12-13 for person SPM8's views). This disapproval was also evident from UEHVs, again in document F1M (p. 60, l. 23 for person GNF1A's views and p. 80, l. 33-34 for person GVF4B's views).

already acquainted from a previous IHV programme. The SSA actor greeted the UEHV as a long-lost friend and announced jovially:

*REDACTED UEHV you are looking so fat.*⁴²²

The UEHV looked affronted until someone from the VPO whispered to the UEHV that they were not being insulting but this meant that the UEHV was looking in good health.⁴²³ Here the quick thinking and cultural humility of the individual from the VPO undoubtedly averted cultural tension that could have made relations difficult as the two may have to spend considerable time together.⁴²⁴

4.2.2 *Ubuntu* philosophy

*Ubuntu*⁴²⁵ is a multi-faceted cultural concept across Africa, with no direct English translation, being an ethical code, a behavioural code, and an African consciousness, all firmly rooted in African culture (Kamwangamalu, 1999). Essentially it concerns what it means for a person to be *human* in an African cultural context (Sesanti, 2010). Some argue that *ubuntu* is difficult to define and that a traditional definition may diminish its essence (Broodryk, 2005).

For an individual a person has *ubuntu* if they are generous, respectful, dignified, caring, kind and compassionate to others (Ngubane and Makua, 2021). Looking at *ubuntu* from a communitarian view there are guiding principles of *ubuntu*. Collective solidarity is one such principle borne from the necessity of community survival in past times. In essence solidarity means community members willingly put the mutual welfare of the group above self (Mbigi, 1997). Collective action requires dependency on others and perhaps some of my results in the previous chapter mean the acceptance of dependency by some Africans may be partly related to *ubuntu*. Mutual interconnectedness is another principle of *ubuntu* expressed as respectfulness and cooperation (Tutu, 2000). For example, what an

⁴²² Person SCF2 announced this to person GVM5A. See document F2M (p. 81, l. 3-23, including Figure 32).

⁴²³ Person SPM1 defused the situation. See document F2M (p. 81, l. 10-11).

⁴²⁴ Person SCF2 worked in the hotel the UEHVs were staying in.

⁴²⁵ *Ubuntu* is derived from the word *umuntu* of the Nguni languages of Southern Africa but is known by many names throughout Africa dependent on cultural and linguistic heritage. For example, *hunu* (Shona), *botho* (SeSotho), *utu* (Swahili) etc.

individual does or has done to them affects the group. Compassion is arguably the most important guiding principle of *ubuntu* as it facilitates solidarity and interconnectedness by strengthening bonds and promoting positive relationships and sharing of limited resources (Mbigi, 1997). Finally, dignity and respect are a guiding principle of *ubuntu*. Poovan, Toit and Engelbrecht (2006) argue that respecting others and acting in a dignified manner engenders respect and trust from others. In African culture dignity and respect thus bring harmony to communities.

In my research *ubuntu* appeared as a consistent behavioural thread amongst Africans throughout my research. For example, compassion was exhibited by most Africans in IHV regardless of their position in the community. Take the person, themselves economically quite poor, who provided lunch for IHV teams. I observed them regularly giving *all the leftover food to the starving kids*.⁴²⁶

I observed a Senior SSA health worker commenting on a group of unemployed young Africans who had organised themselves to act as a voluntary VPO to help with many logistic arrangements, including aiding frightened patients through health procedures on an IHV programme:

*I'm very impressed with these young people (SENIOR SSA HEALTH WORKER POINTS TO A VOLUNTEER) they show respect to their community by volunteering for this.*⁴²⁷

So embedded was *ubuntu* in Africans in my study that when someone did not appear to have *ubuntu* it was so unusual that it seemed to act as a trigger for others. This often led to cultural tension between individuals.⁴²⁸ Take the lower grade SSA health worker describing to me the lack of compassion of a senior SSA health worker as:

*Causes me to make mistakes and is brutal.*⁴²⁹

⁴²⁶ See for example, person SCF3 did this in document F1M (p. 59, l. 15).

⁴²⁷ Reported by person SEM1B in document F3M (p. 39, l. 31-32).

⁴²⁸ After the incident in the following example, to reduce tension, AP moved person SHM10 to be trained in subsequent days by AP and person SHM1A. See document F1M (p. 57, l. 40-41).

⁴²⁹ The trainee complained to AP about the trainer. See document F1M (p. 52, l. 33). Identifiers were redacted due to the sensitivity of this data.

In some ways, I felt that from an African perspective SSA health workers and VPOs within IHV NGO teams who demonstrated *ubuntu* type behaviours (even though many UEHVs were unaware of the nuances of the *ubuntu* concept) were positive role models for UEHVs.⁴³⁰ These teams gelled well and were full of mutual trust and this seemed to influence smooth IHV programme running. Having *ubuntu*, it seems, is what UEHVs expect of Africans even though most UEHVs are largely ignorant of *ubuntu*. As a further example I observed an UEHV comment on how impressed they were with the compassionate behaviour of another senior SSA health worker as:

*How patient, encouraging and compassionate they were towards the child.*⁴³¹

Whilst *ubuntu* remains important in African culture, some African scholars believe that some African institutions operate in a manner that presents a Western view of culture and dismisses *ubuntu* as being a somewhat simple indigenous view (Ngubane and Makua, 2021). In my research I observed meetings in several African institutions at strategic level, and their processes and hierarchies seemed largely similar and familiar to Western institutions, an example being expectations of dress and titles of staff. However, culturally the individuals in these institutions themselves embodied African culture with greetings, language and respectful behaviour like my encounters with African interest-holders on IHV programmes.⁴³² I did however notice in Country 2, that whilst initial greetings between Africans in institutions were in their national language, the rest of the conversation took place in English even when no naturalised English speakers were involved. All involved spoke English even though their mother tongue, an indigenous language, was the national language. I asked a government official why this happened. Their reply

⁴³⁰ See for example, person SHM3A (a SSA middle grade health worker) was a positive role model for all UEHV's (AP included) in fieldtrip 2. See document F2M (p. 115, l. 28-29). Regarding VPOs person SPM10 (a SSA volunteer leader in a VPO) was a positive role model, in fieldtrip 3, for UEHVs and others from Uk/Europe including AP, persons GNF2, GNF3B and GNM3B. See document F3M (p. 49, l. 14-22).

⁴³¹ Person GVF9 reported this opinion regarding person SHM1A. See document F1M (p. 51, l. 17-19).

⁴³² See several examples: In district government offices (see document F1M, p. 19, l. 3 – p. 20, l. 3); in district health offices (see document F4M, p. 89, l. 23 – p. 91, l. 3); in district hospital meetings (see document F2M, p. 37, l. 35 – p. 39, l. 7); in ministry of health offices (see document F3M, p. 101, Figure 53).

indicated the importance of sometimes being aligned with Western views in African institutions:

*In our country we feel British, our REDACTED FIRST PRESIDENT always thought of Britain very highly, we have always been this way.*⁴³³

My research thus shows some evidence of these claims, but my experiences are limited to a small number of institutions, so I am unable to draw firm conclusions on the perspective of Ngubane and Makua (2021). Additionally, Muwanga-Zake (2009) argues that the adoption of colonial education systems and thoughts that Western philosophical views are superior has convinced some Africans, particularly the younger generation, to the extent that they value *ubuntu* less. My study showed no convincing evidence that *ubuntu* was less valued by Africans involved in the IHV phenomenon.⁴³⁴ There were exceptions in individuals as discussed above but these were uncommon.

Ubuntu in respect of human and communitarian values is not an exclusively African concept and is seen in other places where individualism and self-interest are less predominant values for example in parts of Asia, South America and some parts of Southern Europe (Ngubane and Makua, 2021). Whilst most of the UEHVs on IHV programmes in the two SSA countries that I observed were neither indigenous Africans nor from areas of the world normally associated with similar values, I observed that the motivations of many UEHVs who volunteer on IHV programmes in the two SSA countries expressed human and communitarian values. For example, a regular UEHV conveyed the sentiment of:

*I want to do good, better.*⁴³⁵

Another UEHV reported:

*I heartily believe in doing this and helping others.*⁴³⁶

⁴³³ Person SEM1B reports this in document F2M (p. 21, l. 7-17).

⁴³⁴ Given particularly the behaviour of people in NGO 2's volunteer VPO (all young persons), the young Africans I encountered had no shortage of *ubuntu*. See for example, AP's observation of several of them in document F3M (p. 39, l. 5-6).

⁴³⁵ Person GVF4A reported this in document F1M (p. 80, l. 7-9).

⁴³⁶ Person GVM2A informed this in document F2M (p. 10, l. 33)

And another says:

*It is important...to give to fellow humans.*⁴³⁷

However, on most IHV programmes there were UEHVs whose motivations were more individualistic. Take the UEHV who told me that IHV would *be great for their profile* and that they liked being *high profile*.⁴³⁸ For other UEHVs I observed motivations to volunteer such as to *fill a void after retirement*,⁴³⁹ and to break the perceived *treadmill*⁴⁴⁰ of working in primary care in the UK. UEHVs were therefore a mix of motivations some well aligned to *ubuntu* principles and some less well aligned. The potential for cultural incompetence and cultural tension was evident within all IHV volunteer teams I observed, and between all actors, with differing cultural values such as *ubuntu* influencing team harmony.

4.2.3 Religious and moral values

Religious values and spirituality, regardless of religious belief, are central to African culture. Some authors indicate that for the majority in SSA spirituality represents values and connectedness in African societal life (Adams and Trinitapoli, 2009; Mkandawire-Valhmu, Kako and Kibicho, 2012). It is important to appreciate that in African culture there is a widely held belief that life and death is a continuum from a corporeal state to a spiritual one where the essence of an individual does not change and where communication between living and dead is possible (Tosam, 2021). Religious values thus permeate all aspects of life in African culture (Mbiti, 1969). World religions such as Christianity and Islam therefore coexist with traditional belief systems and values, in most cases in reasonable harmony. The importance of religiosity in healthcare in Africa is reflected by the 35-43% of health facilities in Africa that are operated by religious institutions (Onongha, 2015).

⁴³⁷ Person XVM1 reported this in document F2M (p. 83, l. 26).

⁴³⁸ Person GVM1 discussed this in document F2M (p. 27, l. 1-2).

⁴³⁹ Person GVM5A informed of this reason in document F2M (p. 14, l. 24-27).

⁴⁴⁰ Person GVM3 informed this in document F4M (p. 11, l. 23-24).

In my study both religious values and traditional values were evident almost every day in IHV programmes in the two SSA countries. In both countries of study, I observed IHV programmes located in health facilities operated by religious groups. It was common for me to observe amongst SSA health workers involved in IHV those whose life purpose was religiously motivated, for example:

*My passion to reach those in need began after understanding how Jesus met people's needs in his lifetime in the world. This compassionate spirit grew more as I was involved in burden lessening events for people in need.*⁴⁴¹

And another who AP noted was:

*A devout Christian, whose purpose is their service.*⁴⁴²

Additionally, many SSA government offices and health facilities (whether religious or government operated) would usually start each day with prayers or blessings, with it being common to express thankfulness prior to communal eating.⁴⁴³ I observed an intuitive cultural competence amongst UEHVs that it was important to join in and show respect for these practices even though many had no religious motivation themselves. I saw no evidence that a lack of religious values amongst UEHVs was involved in cultural tension on IHV programmes. Where cultural tension occasionally occurred, it was between Africans whose religious values differed. Take the religious senior SSA health worker who negatively described other SSA health workers who were not religiously motivated as people who *are more interested in material things*.⁴⁴⁴

Furthermore, cultural tension occasionally happened when IHV FBOs took it upon themselves to push their specific religious values on SSA actors. Take the middle grade SSA health worker, who hosted an IHV FBO programme in their health facility, and reported both cultural tension and indeed anger towards the FBO:

⁴⁴¹ See document F1A1 (Figure 1) where person SHM1A described their motivation.

⁴⁴² This related to person SHM5A. See document F1M (p. 12, l. 4).

⁴⁴³ See for example, document F1M (p. 19, l. 5 and Fn. 51).

⁴⁴⁴ Person SHM1A reported this in document F1M (p. 55, l. 10).

*I was prayed for without asking me about my own faith or belief.*⁴⁴⁵

For IHV NGOs the importance of having a degree of cultural competence regarding religious values in African culture cannot be underestimated as religiosity is pivotal to local communities. In these situations, cultural competence enhances trust with valued and trusted community leaders. In my study I observed the mutual beneficial effects to the smooth running of IHV programmes and the agendas of local religious leaders by positive engagement with local community religious leaders. For example, churches in the two SSA countries are community hubs so I observed an IHV programme where IHV NGO trained SSA health promoters preached important health messages to their local communities from the church (see Figure 14).⁴⁴⁶



Figure 14: An IHV NGO trained health promoter delivers health messages from a local church.

I also observed a local chaplain preaching a religious sermon to large numbers of waiting patients at a health facility whilst the patients waited for health interventions during an IHV programme with the health facility director indicating that:

⁴⁴⁵ Person XHM1 described this in document V10 (Slide 5). This related to when they were based in one of the two SSA countries and were a middle grade health worker. They now are based in the UK.

⁴⁴⁶ Here person SCF4, a community health promoter, delivered key health messages in a religious building, trained to do so by SSA middle grade health workers in Country 2. The health workers were themselves upskilled as part of an IHV collaboration involving NGO 1 and NGO 2 and multiple African collaborators. See document V9 (slide 60). Place name identifiers (on the back of the chairs) have been redacted in this figure.

*It was the biggest congregation they had had for some time.*⁴⁴⁷

Neither activity would likely be permitted in a UK setting but in SSA this was culturally appropriate.

In discussing traditional values, I will focus on traditional healers as this is most relevant to my research question. The importance of traditional healing in Africa is evident as over 80% of Africans use traditional medicine (James *et al.*, 2018). Furthermore, traditional healing is more accessible than modern type healthcare with health worker to patient ratios of 1:200 for traditional healers and 1:20,000 to 1:100,000 for medical doctors to patients in SSA (Krah, de Kruijf and Ragno, 2018). Indeed, the WHO aims to integrate traditional medicine into national health systems to enhance person centred care (WHO, 2013).

Traditional healing is the locus where the Western worldview and the African traditional worldview of health and disease can sometimes clash culturally, and in IHV in the two SSA countries traditional healing is a constant presence that requires careful consideration by all IHV interest-holders. Before discussing my findings, it is important to explain the difference in worldviews. The African traditional worldview culturally accepts the existence and importance of ancestors and spirits, whereas the Western worldview predominantly does not (Hiebert 1982). Thus, in the African traditional worldview health, disease and healing are at the behest of the spirits who heal the faithful and bring negative consequences if they are displeased (Onongha, 2015). Being unhealthy for either individual or community indicates there is something wrong with their spiritual state (Onongha, 2015). IHV in the two SSA countries sits right in the middle of this cultural conflict.

Of importance in the IHV phenomenon is that just because a SSA health professional has been trained in Western healthcare methods this does not negate their traditional beliefs. In my study I found that these strongly held beliefs were in some instances simply beyond the cultural comprehension of the UEHVs. For

⁴⁴⁷ Person SYM1 remarked on this to me during the sermon delivered by person SCM5. See document F4M (p. 46, l. 15-16).

example, I observed midwives advising parents of babies with minor ailments to visit a traditional healer to have a body part removed, the practice being a form of infant mutilation.⁴⁴⁸ I further observed the most senior SSA health worker on an IHV programme referring a patient, who clearly had undiagnosed epilepsy, to a traditional healer to have *evil spirits* exorcised at the programme site, which I then witnessed, with the healer successfully managing the patient's *status epilepticus* with relative ease.⁴⁴⁹ This was difficult for UEHVs to process and resulted in some cultural tension towards the SSA actor involved perhaps because these treatment modalities were seen as *wrong* by the volunteers. For me, the latter example was beyond my comprehension too, so I discussed it with an African VPO administrator who reassured me that it was *normal in this setting*.⁴⁵⁰

My fieldtrips involved the training of African health workers to undertake simple surgical procedures and to deliver health promotion messages to local communities. Sometimes the message or a procedure would be rejected by the local community. A VPO administrator reported that a local ethnic group were resistant to a simple health prevention message that they hoped to promote as the local healer had informed the community that the use of a redacted simple prevention tool *made men infertile*.⁴⁵¹ Another issue reported to me by a lower grade health worker trainee and their UEHV trainer was that patients would not undergo a redacted surgical measure as:

*The healer tells them that if you lose a REDACTED SPECIFIC BODY PART evil spirits will go to your brain.*⁴⁵²

⁴⁴⁸ AP observed some midwives doing this in a district hospital setting and actively referring the patients to healers. See document F4M (p. 79, l. 13-14).

⁴⁴⁹ Person SHM24 referred the patient (who suffered this medical emergency during a simple surgical procedure) to a traditional healer (person SCM6) rather than the district hospital. Person SCM6 dealt with the matter easily. This was witnessed by AP and person GVF4B and other UEHVs. Some UEHVs lost trust with person SHM24 as they felt the referral was inappropriate. There was a bad atmosphere for a time. See document T1 (p. 53, l. 17 – p. 54, l. 18).

⁴⁵⁰ AP was reassured by person SPM6. See document T1 (p. 54, l. 16).

⁴⁵¹ Person SPM1 reported this to me. As person SPM1 was a member of a related ethnic group to the group with these beliefs they had good cultural competence in this matter. See document F1M (p. 46, l. 6-7 and Fn. 158). The ethnic group could not be dissuaded from using a traditional and less effective preventive tool.

⁴⁵² Neither person XVF1 nor person SHM23 were able to gain consent for the surgical measure, despite patients suffering pain and infection for which the measure would be curative. See document F4M (p.97, l. 8). In document F2M (p.70, l. 9-16) person GVF7 reports a similar issue with a simple preventive measure being thought to affect the brain by a healer in a different region of country 1.

In the latter case the traditional healer later attended the IHV programme as a patient and following a successful curative procedure apparently informed the local community that they had received spirits that informed that the surgical measure was now safe.⁴⁵³

My findings show a lack of cultural competence from UEHVs towards African traditional healthcare. It is perhaps easier for African health workers to manage, as many have been trained in Western healthcare and grown up with African traditional healthcare whereas the UEHV perhaps sees African traditional healthcare as an alien concept. To avoid cultural tension this is an area where cultural competence training may have a part to play for UEHVs. Indeed, NGO 1 introduced some training on what they described as *myth busting*⁴⁵⁴ to partially address this issue.

Moral values are deeply ingrained into African culture. There is a moral code that prohibits harming others except where that person themselves is deemed immoral (Idang, 2015). Moral values are in part broadcast through African society by the large repository of African proverbs and sayings that try to deter evil actions, with this largely verbal wisdom being a significant part of African cultural heritage (Mbiti, 1977). As part of this moral code, African culture does not tolerate theft, with transgressions such as theft bringing shame and disgrace, not just to the perpetrator but to wider family and kin (Idang, 2015). In my research I saw this moral code in action from several SSA health workers and VPO staff on IHV programmes. For example, here one senior SSA health worker was unimpressed with the actions of another African towards some UEHVs and states:

*I want to apologize to you that they are disrespectful to you.*⁴⁵⁵

Another example involved petty opportunistic theft from a UEHV at a previous IHV programme in a district where one of my fieldtrips took place. An UEHV had

⁴⁵³ AP reported this. See document F4M (p. 97, Fn. 595). In this note AP reflected that he borrowed the idea of engaging the healer from a previous clinical lead (person GVF16) who tried the same tactic long before AP started this research project during an IHV programme in 2013, for another traditional belief. It worked on that occasion too. AP was an UEHV on the 2013 programme.

⁴⁵⁴ *Myth busting* training was added to the lower grade health workers training programme as part of a UEHVs responsibilities on NGO 1 IHV programmes in Country 1 after fieldtrip 1. See document F1A7 (p. 3, l. 1-7).

⁴⁵⁵ Person SHM1A reported this. See document F1M (p. 35, l. 10-11).

apparently and unwisely left a small amount of money next to an open window. The disgrace felt by the local community was palpable two years later when the local politician apologized profusely to me about the theft, of which I was unaware:

*This will not happen again; I have discussed it with our police chief. You will be very safe here. REDACTED DISTRICT welcomes you.*⁴⁵⁶

However, I observed also that there was an expectation from African actors that African moral values would be adhered to by the IHV NGO and UEHVs. Occasionally this did not happen much to the embarrassment of IHV NGO programme leads, one of whom expressed to me about some UEHVs:

*No matter how much you tell them some people don't get Africa and shouldn't be here.*⁴⁵⁷

I found that for most actors in IHV whether from the UK, Europe or the two SSA countries, moral values appeared to be well aligned and adhered to, with most culturally competent regarding these values. Occasional lapses or unfortunate incidents do happen, and when they do, it was commonplace for others within the wider IHV team to try and defuse any incident with cultural humility which mostly avoided cultural tension.

4.3 Cultural competence and incompetence in volunteering

In donor countries the need for reasonable cultural competence for UEHVs and IHV NGOs volunteering in all parts of the world is well-recognized, for example the UK Department of Health (2010) states that:

The activity of organisations, employers and individuals should be...appropriate and sensitive to the needs and culture of the partner country (Department of Health, 2010, p. 24).

⁴⁵⁶ Person SEM6 apologized to me regarding this. See document F2M (p. 48, l. 18-19).

⁴⁵⁷ Person GVF4B reported this. See document F1M (p. 82, l. 3).

With most IHV NGOs taking cultural competence seriously and providing some form of pre-programme information or training about African culture, albeit some being more about orientation, I found that most UEHVs arrived on site for IHV programmes with reasonable cultural competence. There were exceptions as an experienced IHV NGO programme lead I observed stated:

*Some of the UEHVs think they're going to Ibiza.*⁴⁵⁸

And another UEHV reports a fellow UEHV on the IHV programme that they have:

*A television view of the world.*⁴⁵⁹

I found no evidence in my research of African health workers on IHV programmes or those from VPOs receiving any information or training on *modern* Western⁴⁶⁰ culture although most SSA actors demonstrated a reasonable degree of cultural competence. However, a significant minority were culturally incompetent at times. I observed one senior SSA health worker who struggled throughout an IHV programme with establishing positive relations with UEHVs remarking that:

*They had never been out of REDACTED COUNTRY, and any ideas of the UK were entirely formed from internet or television.*⁴⁶¹

A VPO administrator, who when I encountered them was participating in only their second IHV programme, expressed unease and inexperience to me in dealing with Western culture. I noted in my observations that they were:

*A little unsure of foreigners. They had only met one or two foreigners ever before and had never been out of REDACTED COUNTRY and hadn't even been to the REDACTED CAPITAL CITY.*⁴⁶²

⁴⁵⁸ Person GVF4B informed this. See document F1M (p. 82, l. 1).

⁴⁵⁹ Person XVM1 discussed fellow UEHV, person XVF2. See document F1M (p. 19, l. 28).

⁴⁶⁰ Most had some familiarity with British rules and structures from the colonial and post-colonial era as the fieldtrips in the two SSA countries were all located in anglophone countries.

⁴⁶¹ Person SHM8A reported this in document F1M (p. 36, l. 6-7).

⁴⁶² AP reported on a conversation with person SPF1. See document F4M (p. 29, l. 33-35).

Furthermore, their first IHV programme involved GNHVs predominantly from a different part of the Global North⁴⁶³ than the UK or Europe and they:

*Found those foreigners very demanding and that they complained a lot about things being not as they should be.*⁴⁶⁴

It seems just like some UEHVs regarding those from each of the two SSA countries as homogenous cultures, the same is evident from some SSA actors towards Western culture. In some cases, cultural competence in the IHV phenomenon does not fully appreciate cultural variations. Experiential learning though is evident for both UEHVs and African actors as an IHV programme progresses. For example, I found that I and most UEHVs were culturally incompetent on some IHV programmes where patient populations spoke local ethnic languages.⁴⁶⁵ Simply learning and using some basic greetings in the local ethnic language as opposed to the national language, made for better community engagement, enhancing trust and reducing cultural tension. I noted at the time:

*Everyone was very friendly especially if we used REDACTED LOCAL ETHNIC LANGUAGE greetings.*⁴⁶⁶

From an African perspective being mentored in basic Western cultural ways by an UEHV allowed some African actors to become more culturally competent through the course of a programme albeit remaining a little wary with the unfamiliarity of a foreign culture. Here I have been mentoring the same inexperienced VPO administrator as referred to earlier in this section, who later states of UEHVs:

*They seem to just want to enjoy REDACTED COUNTRY 1... and I feel more comfortable but still a little uncertain as I don't really know how to take foreigners.*⁴⁶⁷

⁴⁶³ An anglophone part of Australasia.

⁴⁶⁴ Person SPF1 reported this to AP in document F4M (p. 29, l. 35-37).

⁴⁶⁵ This was true in all fieldtrips but heightened in the 2nd site in fieldtrip 1 and in the 2nd site in fieldtrip 4. In fieldtrip 4, the 2nd site was 15 km from a national border. Some patients, from a different ethnic group, attended the programme by walking across the border. One patient collapsed from likely exhaustion. Management was much harder due to cultural and language barriers. See document F4A7 (p. 3, l. 5-8) reported by AP and person GVF3B to the NGO as a serious incident.

⁴⁶⁶ AP discussed this in document F1M (p. 58, l. 21-22). Here AP, person GVF6 and person GVF9 used this to good effect.

From an African perspective, I observed some SSA actors having sufficient insight into their cultural learning needs to try and learn other cultures. Senior and middle grade SSA health workers, even those based in predominantly rural regions and districts were usually based in the largest town in the region or district. With many IHV programmes being in very remote or rural areas most had a degree of cultural incompetence even in their own region when on IHV programmes. I observed one senior SSA worker who decided to stay each night in the remote village, which was an IHV programme site, express to me:

*I am glad I stayed in the village. It has let me experience what it is like living in a rural area and the problems these people have.*⁴⁶⁸

Some African actors though were evidently uncomfortable in village settings as I observed on an IHV programme in a remote area. In this situation, there was a bare minimum number of SSA health workers and VPO staff who were able to converse with the patients, who largely spoke a local ethnic language and did not understand the national language. I reflected at the time that:

*We had communication issues and would do so on every training day.*⁴⁶⁹

It was clear to me that on occasions the rural and remote loci of some IHV programmes were unfamiliar environments for all. Sometimes the customs and language of the village would mean nobody on the volunteer team, irrespective of their own level of broader cultural competence or background, had reasonable cultural competence. I felt this was where team harmony was important and that in collaboration most cultural issues could be negotiated by the collective. As an example, these could be to act on simple things during the programme that were important to the village but were previously unknown such as providing separate waiting areas for male and female patients as a particular village would want this (see Figure 15):⁴⁷⁰

⁴⁶⁷ Person SPF1 reported this in document F4M (p. 30, l. 1-3).

⁴⁶⁸ Person SHM1A discussed this with AP in document F1M (p. 41, l. 44-45).

⁴⁶⁹ AP reported this. See document F1M (p. 29, l. 7-8). Even the lower grade health worker (person SHM9), who was ordinarily responsible for health in the village was unable to converse with the patients. See document F1M (p. 43, l. 2).

⁴⁷⁰ See document F3M (p.36, Figure 14).



Figure 15: Waiting area for female patients outside a rural health post where an IHV programme is taking place. Male patients are on a different area of ground around 100 metres away.

At an IHV strategic level, I observed basic levels of cultural competence between actors from the two SSA countries and UK/European actors evident in most meetings and decision-making situations with again exceptions. Between IHV NGO decision makers, frustration occasionally arose at the lack of cultural competence of some decision makers by those who claimed to be more culturally competent. For example, an IHV NGO decision maker and experienced UEHV in SSA states of their fellow decision makers:

*They don't listen to me; you would think they would as I'm the only one with volunteer experience.*⁴⁷¹

Similarly, between SSA actors I observed cultural incompetence spill into cultural tension mostly over a perceived lack of cultural competence of their decision maker colleagues who work in urban areas by those decision makers working in rural areas. Here a rural decision maker told me of an urban colleague:

I have no equipment. Whatever they say they say this as they sit in their office in REDACTED CAPITAL CITY with their private patients and their

⁴⁷¹ Here person GVF4B expressed frustration with *they* (being other IHV NGO decision makers). See document F1M (p. 82, l. 7-8).

*working equipment. They have no idea whatsoever of the problems I have in REDACTED REMOTE REGION.*⁴⁷²

Or another example of a rural based SSA decision maker feeling that an urban based decision maker is culturally incompetent:

*If they had been involved, they wouldn't criticise it (an IHV NGO programme), as in rural areas there is no alternative, people are still dying of REDACTED SPECIFIC infections.*⁴⁷³

An alternative interpretation could be a simple lack of knowledge or lack of regard by the urban decision maker for the realities faced by the rural decision maker, but this still demonstrates a degree of cultural incompetence.

In my study, reasonable cultural competence was commonplace in IHV programmes in the two SSA countries both from an IHV NGO and an African perspective. I observed numerous examples of daily and mundane examples of cultural competence that contributed to smooth running of NGO programmes with increasing cultural competence occurring as the programme continued. This was largely due to the cultural humility of numerous individuals and programme leadership teams offering sound advice or problem-solving cultural issues before problems occurred or to lessen the effects of cultural incompetence. For example, I observed a senior SSA health worker very respectfully explaining cultural differences pertaining to a specific surgical technique that would not normally be used much in the UK and Europe for a particular condition to UEHVs as:

*I appreciate what you are doing, but the UK and REDACTED COUNTRY are two different settings, and we have more communicable diseases, and do more REDACTED SPECIFIC SURGICAL TECHNIQUES as there is no access to other options.*⁴⁷⁴

⁴⁷² Here rural based person SHM1B gave their views on the expressed thoughts of urban based person SYF1, regarding IHV programmes in rural areas. See document F1M (p. 35 – l. 4-6).

⁴⁷³ Person SHM1B again reported frustration with an urban colleague. See document F1M (p. 69, l. 1-2).

⁴⁷⁴ Here person SHM6B reported this to persons GNF1A and GVF4B. see document F1M (p. 69, l. 21-23).

Another example was where an individualistic senior SSA health worker and some UEHVs had clashed over their roles and been very direct with each other which threatened team harmony. Here a VPO administrator intervened to indicate that a *suggestive* approach rather than a *telling* approach would be better appreciated.⁴⁷⁵ Thankfully, the UEHVs took the VPO administrator's advice and when faced with direct instruction from the senior SSA health worker approached the matter by stating something along the lines of:

*Yes, I will do that, but in the UK, we usually say please.*⁴⁷⁶

Eventually this had the desired effect and relations between all parties improved with cultural tension avoided. A further example was where cultural incompetence emanated from good intention of an UEHV. Here I was alerted by a VPO administrator that there was unrest amongst patients being treated on an IHV programme as they wished to be paid. It appeared that one of the UEHVs had been giving the equivalent of \$1 to children who had a simple surgical procedure undertaken for *being good*. The rest of the patients were unhappy because they were not getting \$1. Luckily on this issue I was culturally competent, and I realised that \$1 was the equivalent of a day's wages for a rural worker locally and that what the UEHV perceived as a token gesture represented much more in the rural setting of the IHV programme. A simple word from me, as programme leader, to the UEHV both educated them culturally and stopped this happening whilst the VPO administrator explained to the patients that the UEHV was just expressing kindness and it would now stop, with cultural order being restored.⁴⁷⁷ These small day-to-day interventions by members of the wider volunteering team can seem trivial. I would contend these actions are essential to managing the inevitable cultural incompetence that happens in the IHV phenomenon in the two SSA countries, despite it largely being underpinned by reasonable cultural competence.

⁴⁷⁵ Person SPM1 told UEHVs (persons GVF6 and GVF9) to use this approach to manage cultural issues with person SHM8B. See document F1M (p. 76, l. 3).

⁴⁷⁶ As expressed by person GVF9. See document F1M (p. 51, l. 41 – p. 52, l. 2).

⁴⁷⁷ In this situation person XVM1 was the donor and person SPM1 mediated with the patients. See document F2M (p. 69, l. 6-38). When AP discussed the matter with person XVM1 they instantly understood the unintended consequence of their generosity and the real value of \$1 in rural areas of Country 1. Person XVM1 reported to AP: *But that's next to nothing...Oh, I understand now exactly, and it won't happen again*. See document F2M (p. 69, l. 6-7).

Both study NGOs I observed after each day on an IHV programme had as normal practice a de-brief session and this was most important as it helped unpack and educate on mutual cultural issues as UEHVs, VPOs and some SSA health workers were all present so many from diverse backgrounds were able to mutually advise in a safe and supportive setting. Much in the way of culture shocks were addressed for new UEHVs, for example:

*These people have nothing but appear so happy.*⁴⁷⁸

And:

*The poverty here is so much more than my last IHV programme in a REDACTED LARGE SSA CITY.*⁴⁷⁹

The collaborative group would deal with cultural issues that had occurred during the day. For example, a patient attended on one IHV programme with an undiagnosed and obviously untreatable late-stage cancer. Palliative care was arranged by the senior SSA health worker on the IHV programme which turned out to be arranging transport to the patient's home village with stronger painkillers so they could die amongst their kinfolk.⁴⁸⁰ This caused great disquiet with some UEHVs until at de-brief some African actors explained that choosing to die at their home village was important in African culture and was what was wanted and expected in this instance rather than the impersonal nature of a hospital.⁴⁸¹ Compassionate and careful explanation here enhanced the UEHVs cultural competence.⁴⁸² This collective de-brief, cultural humility, and the effectiveness of culturally diverse IHV programme leadership teams appears paramount to continual improvements in cultural competence in IHV in the two SSA countries.

⁴⁷⁸ Person GVF17 reported this in document F4M (p. 43, l. 16-17). This type of experience can spark conversations about different cultures given the diverse nature of the group.

⁴⁷⁹ Person GVM3 here was able to gain support from other more experienced UEHVs, SSA health workers and VPO personnel regarding their experience in a rural setting. See document F4M (p. 43, l. 12).

⁴⁸⁰ This view had been expressed to AP by person SCF1 regarding a close relative. They reported that it was *important for him to die amongst his family*. See document F4M (p. 50, l. 13).

⁴⁸¹ Persons SPF1, SPM4 and SPM6 supported the UEHVs. See document F4M (p. 43, l. 1-8 and Fn. 251).

⁴⁸² It was not only African actors that could play a part in handling these sensitive cultural issues. Those from the the UK and Europe had a role. When another terminal cancer was diagnosed in someone else later in fieldtrip 4, AP noted that *quite a number of the volunteers were upset and AP had to take persons GVF17, GVF18 and GVM10 outside separately to talk them through the issues until they were in a state that they could resume*. See document F4M (p. 91, l. 19-20).

In my study, the fieldtrips I undertook involved largely effective volunteer teams but even these would occasionally have individuals who were worryingly culturally incompetent, some of which I have described above. Whilst I was fortunate to be involved in effective teams culturally others were less fortunate. Some IHV programmes in the two SSA countries are plagued by issues of cultural incompetence and resultant cultural tension. In some cases, this required swift and decisive actions by IHV NGOs or VPOs to manage these situations and protect programme integrity and reputation with other collaborators. One UK clinical lead reported on one of their programmes that an UEHV was so culturally incompetent that they were:

*Sent home to the UK after only one night in REDACTED SSA COUNTRY.*⁴⁸³

Another example was where a UK member of an IHV programme leadership team showed themselves to be a poor cultural role model by inappropriate language and behaviour such that other UEHVs and African actors expressed concern. I was informed by an NGO clinical lead that they *will not be coming out again*.⁴⁸⁴

Cultural competence is a key influence for all IHV actors in ensuring that programmes bring some intended benefits to local communities. Programmes where volunteer teams are reasonably culturally competent and relate well to each other and to local communities appear to problem solve better and work better as a team. This may be related to cultural competence enhancing mutual trust and reducing suspicion which I will address in the next section.

4.4 Trust and suspicion in volunteering

As put by one senior SSA health worker I observed, for a SSA health professional being the *trusted* health worker in an African community:

⁴⁸³ Person GVF4B reported this together with AP's reflective note. See document F4M (p. 82, l. 1-2 and Fn. 310).

⁴⁸⁴ This was reported by a clinical lead. See document F1M (p. 39, l. 18). Given the sensitive content of this data item, I have redacted the identifiers.

*This is the highest compliment.*⁴⁸⁵

During my third fieldtrip I reflected at the time that for an UEHV on an IHV programme in the two SSA countries:

*Being trusted in SSA is the ultimate accolade.*⁴⁸⁶

The opposite appears to be true also in the two SSA countries, as being deemed untrustworthy in the IHV phenomenon is in effect a censure for an IHV programme. As one SSA government leader reports of some NGOs:

*They said one thing but did something else and were untrustworthy.*⁴⁸⁷

As many involved in IHV are health professionals, most are familiar with ethical codes that put trust at the heart of professional relationships in all cultural settings. Additionally, African culture, as already discussed, values trust highly and so mutual trust is essential between all in the IHV phenomenon. I found though that trust sometimes was not easily achieved particularly at the start of IHV programmes as instead suspicion permeated programmes with trust requiring to be earned. For example, I found several senior SSA health workers to be very suspicious of me and the UEHVs at the start of an IHV programme which I took to be quite understandable given their unfamiliarity with me, as the programme lead, and the programme itself combined with the arrival of a team of unfamiliar foreigners. As most of the wider team usually exhibited reasonable cultural competence, trust was slowly engendered by everyday culturally appropriate actions and words, as the programme progressed, such as appropriate greetings, demonstrations of compassion and acting in a dignified manner. Essentially most, regardless of whether from Africa or representing an IHV NGO in some capacity, enhanced trust by behaving in a culturally competent manner and within the basic values of African culture. For example, I noted things in terms of greetings like

⁴⁸⁵ Reported by person SEM1B in document F3M (p. 80, l. 36-27).

⁴⁸⁶ Reflected by AP in document F3M (p. 80, Fn. 397).

⁴⁸⁷ Here person SEM1A reported this regarding IHV NGOs (not the study NGOs) generally. See document F3M (p. 31, l. 34-35).

warm prolonged handshakes all round⁴⁸⁸ between four individuals, and UEHVs being greeted with a traditional REDACTED LOCAL ETHNIC greeting.⁴⁸⁹

In terms of compassion one VPO leader informed senior SSA health workers regarding the UEHVs:

*I tell you I have never seen such compassion.*⁴⁹⁰

Suspicion was thus ultimately replaced by a degree of trust in most situations. Sometimes when this point was reached it would be obvious as a previously suspicious SSA health worker stated simply to me *I trust you.*⁴⁹¹ At other times it would be less obvious, being unspoken, and would require cultural competence to understand trust was present in an interpersonal relationship. Take the senior VPO administrator who took me by the hand to discuss a difficult situation with me. I reflected at the time that in African culture doing this was an indication that this was:

*A symbol of implicit trust between two people. By doing this the REDACTED VPO ADMINISTRATOR is effectively telling me I trust you as a friend.*⁴⁹²

Or at the start of an IHV programme I observed African health workers and UEHVs travelling in a different vehicle from one another, if there were two, or sitting apart if there was one on journeys to and from rural health facilities. Imperceptibly by the second and third day of a programme usually there was much more integration as trust and shared values became more prominent with the IHV programme collaborating as a single team.⁴⁹³

⁴⁸⁸ AP observed this in document F3M (p. 45, l. 15) Those involved in the handshakes were AP and persons SCM7, SCM8 and SPM3.

⁴⁸⁹ Person SPM5 provided this greeting. AP reflected at the time that this was a greeting of respect. See document F1M (p. 74, l. 5-6 and Fn. 255).

⁴⁹⁰ Person SPM5 directed this comment to persons SHM1A, SHM5A, SHM6A, SHM7A and SHM8A. See document F1M (p. 14, l. 5-6).

⁴⁹¹ Person SHM3A reported this in document F2M (p.98, l. 22).

⁴⁹² See document F1M (p. 30, l. 45 and Fn. 74). Here person SPM5 is using African cultural non-verbal communication to indicate implicit trust to AP. AP has sufficient cultural competence, in this instance, to understand this.

⁴⁹³ See for example in fieldtrip 2. See document F2M (p. 55, l. 38-40).

However, I did find examples in my research where some actors were *untrustworthy*. This was usually those who were more culturally incompetent although these were outweighed by positive examples of trust and reasonable cultural competence. Those who had occasional lapses in cultural competence sometimes were less trusted for a while, but some of them had the insight to rebuild trust. Take two examples of undignified behaviour, which are seen negatively in African culture. In the first example, a senior SSA leader in a public meeting on an IHV programme, directly and personally criticised a district host of the programme, behaviour which generated wide disapproval from an African perspective. They did not apologise and most people on the programme, including non-Africans, lost trust and were highly suspicious of the individual. This was resolved only by the person concerned leaving the programme early due to their apparent illness, a move which transformed programme dynamics positively.⁴⁹⁴ In the second example, two usually reasonably culturally competent individuals, one African and one an UEHV, had an undignified public argument criticising each other over a clinical matter. This led to a loss of mutual trust and cultural tension between the pair as the public display of indignity provoked wider disapproval. For the entire group, trust was lost until both publicly apologised for their lack of dignity to the group and each other.⁴⁹⁵

Trust once gained can be lost, which on occasion can cause detriment to an IHV programme, particularly if this involves members of a programme leadership team. One IHV NGO programme lead reported to me of their experiences where another trusted member of the programme leadership team failed to support them following an incident that required management of some culturally incompetent behaviour of an UEHV. They stated that:

*I would never go on another IHV programme with them...they didn't support me over a difficult situation and that was it for me, breach of trust, and you can't have that out here.*⁴⁹⁶

⁴⁹⁴ This relates to person SYF1. See document F1M (p. 31, l. 14-16) regarding the public criticism of person SEM4. See document F1M (p. 37, l. 37 – p. 38, l. 1) regarding early departure and document F1M (p. 39, l. 4) where AP notes *a much calmer atmosphere* after person SYF1 departed.

⁴⁹⁵ See document F1M. Accusations were publicly exchanged between persons GNF1B and SHM6A in document F1M (p. 67, l. 46 – p. 68, l. 1). Order was restored by a public apology from both three persons. See document F1M (p. 72, l. 45-46).

⁴⁹⁶ One clinical lead reported this regarding another clinical lead. I have redacted the person identifiers given the sensitive nature of this data. See document F1M (p. 81, l. 23-24).

Whilst protracted suspicion can occasionally be involved in a loss of trust, I found with reasonable cultural competence a degree of suspicion was largely helpful in managing problems on IHV programmes. In effect my position as a reasonably culturally competent programme lead allowed me to see behaviour that was at times culturally incompetent or out of character from my expectations of team members. This allowed me to avert tricky situations and problem solve more effectively with the team. For example, on one IHV programme I found that one VPO site administrator was behaving strangely but when I asked them if there were issues, I was informed there were none. I remained suspicious and eventually drew out the issue being that usually the VPO would pay a courtesy visit to show respect to district officials long before the IHV programme started, by way of a formal introduction. Another VPO site administrator had not done this as the district offices were distant from the health facilities, located up an unpaved road meaning access was difficult. The site administrator on the actual IHV programme was concerned that this failure to show respect would incur displeasure and risk the support of the district.⁴⁹⁷ Being suspicious here allowed an apology to be issued and a visit to take place to ensure further apologies, formal introduction, and due respect given. This guaranteed that the district and community trusted the IHV programme, in line with culturally accepted norms.

My research indicates that behaving in a reasonably culturally competent manner enhances trust in the IHV phenomenon. If there is sufficient trust between team members, this sometimes enables IHV interest-holders to negotiate cultural incompetence better and reduce cultural tension in programmes. I found suspicion is evident at the start of IHV programmes and where it is excessive, I contend that this can affect trusting relationships. However, there are benefits to having a degree of suspicion, particularly within IHV programme leadership teams, as this allows issues to be unearthed that may affect trust in how the IHV programme is perceived in local communities.

⁴⁹⁷ Person SPM6 reported this issue to AP regarding the omissions of persons SPM2 and SPM4. See document F4M (p. 26, l. 6-11 and Fn. 122 and 124).

4.5 Ethnicity and racism in volunteering

In this section I will address the potentially divisive issues of ethnicity and racism in the IHV phenomenon in the two SSA countries and the cultural issues that can occur during IHV programmes regarding these facets of the phenomenon. It is important to remind the reader that as mentioned in Section 2.3.8, I chose to observe two African individuals involved in the IHV phenomenon whom I knew were members of non-predominant ethnic groups more closely as they were lesser in number.⁴⁹⁸

I have used the term *ethnicity*⁴⁹⁹ rather than *tribalism* to discuss matters relating to how ethnic groups can affect cultural competence and cultural tension and their influence on the IHV phenomenon in the two SSA countries. *Tribalism* is a contested term that evokes differing opinions in Africa. Some consider the term derogatory and reflective of colonialism, preferring the term ethnicity (Appiah, 1999). As a colonial myth, *tribalism* can sometimes present Africans as primitive and barbaric (Dami, 2022). Others however argue that the *tribalism* should be retained as removing it makes kinship studies less relevant, and, in any event, it continues to be used in everyday life in Africa, including in government and academia (Ekeh, 1990). I chose to prefer the term *ethnicity* as this term is less divisive and viewed as non-derogatory even though for some it is an inadequate term.

Ethnic groups in the two SSA countries in common with other SSA countries are mostly based on kinship communitarian values and shared ancestry. However, in modern African society the concept of a particular geographic locality where a specific ethnic group may live has become blurred by social movement, conflict, the historical drawing of colonial borders, and the effects of wider socio-economic change. Nevertheless, ethnic groups in SSA may sometimes bring with

⁴⁹⁸ I observed more closely persons SPM1 and SPM5 (both during fieldtrips 1 and 2). There were in addition some other persons from minority ethnic groups who were observed ordinarily. For example, person SHM9 (see document F1M, p. 43, l. 1-7) and person SHF5 (see document F4, p. 65, l. 19-24) were ordinarily observed.

⁴⁹⁹ I originally used the code *tribalism* rather than the alternative term *ethnicity*. When I did my initial categorisation of codes, I changed the name of this code from *tribalism* to *ethnicity* (see Section 2.3.7). My original coding on the data still uses the term *tribalism* which is evident in the exemplar coding in Appendix 4 (taken from document F1M, p. 74, l. 5-6). The explanation why I did this is detailed later in the same paragraph that produced this footnote.

them connotations that group members have a shared character and consciousness with allegiance to the group, which sometimes has the potential to be viewed as negative (Nwaigbo, 2005).

Ethnicity in my study was evident at IHV programme level in the two SSA countries variably and was largely dependent on geographical location of the programme. This meant that in some instances patients from minority ethnic groups attended alongside patients of a majority ethnic group.⁵⁰⁰ The difficulty for IHV actors, both UEHVs and those from Africa, was that in some instances little was known about the minority group including language barriers, values and greetings. Particularly, this was the case if the ethnic group was nomadic and had not encountered the majority population much before. It was simply impractical to be culturally competent sufficiently in these instances. The only solutions that presented were to try to broach the language barrier to a degree by those from VPOs trying to find someone locally who had a degree of commonality of language with group members.⁵⁰¹ On one occasion I was faced with such a patient from a minority ethnic group, who presented with life-threatening infection requiring immediate treatment. I, and other SSA health workers were unable to persuade them to accept treatment, as we discovered they were terrified because in their culture this would be managed by traditional healthcare and culturally, they had no experience of modern healthcare. All were culturally incompetent of the patient's needs, but the oldest senior SSA health worker intervened and with cultural humility patiently and compassionately managed the situation effectively.⁵⁰² Here the commonality in African culture of respect for elders and an unquestioning notion of not challenging them appeared to transcend the cultural incompetence.

Sometimes the behaviour of different ethnic groups was uncomfortable for UEHVs. For example, on one occasion I dealt with a clinical matter for one ethnic group member and was completely unprepared for the response. I noted:

⁵⁰⁰ For example, in fieldtrip 4 there were more patients from minority ethnic groups due partly to the proximity of one of the health facilities to a national border. See document F4A7 (p. 3, l. 5-7).

⁵⁰¹ For example, person SHF5 who was of a similar ethnic group to such a patient was able to assist as reported in document F4M (p. 92, l. 1-2).

⁵⁰² Person SHM7A managed this situation effectively. See document F1M (p. 42, l. 10-17). AP and person SHM9 were unable to do so.

*They burst into tears, knelt on the floor, kissed my feet and repeated continually thank you in their language.*⁵⁰³

I found this emotionally quite disturbing and humbling. I was wholly culturally incompetent regarding this group, as were other UEHVs who witnessed the incident. From an African perspective, Africans present appeared to be much less disturbed and able to accept the culturally unexpected, better, even when behaviour was unfamiliar to them. As one said to me after this situation:

*This is just rural REDACTED COUNTRY I.*⁵⁰⁴

This was true of other situations. For example, patients from some ethnic groups had paternalistic notions of consent where a man would consent to treatment for his wife with her appearing to have no agency but being entirely accepting of the situation. Culturally this created some tension for UEHVs as this would be unacceptable in the UK and Europe. Here acceptance of how others from ethnic groups behave was evident from all African health workers and VPO staff but harder to achieve with UEHVs. Occasionally, I sensed cultural tension from some UEHVs towards SSA actors for their seeming acceptance of such a situation. This was usually resolved by later private discussion or debriefing about ethnic cultural differences, with those UEHVs most affected facilitated by programme leadership teams.⁵⁰⁵ The culture of ethnic groups is inevitably varied and so cultural competence is realistically unachievable within an IHV programme. However, with sensitivity, compassion and understanding IHV teams from the UK/Europe and SSA actors appear to manage these cultural issues well, with some SSA actors being better equipped to do so than UEHVs.

During my study, I observed a change in leadership in one VPO with the new leader being from a minority ethnic group. In childhood this person had left

⁵⁰³ This interaction was between a patient and AP. See document F2M (p. 92, l. 45 – p. 93, l. 2). At least person SHM3A was able to translate the local dialect word for *thank you*.

⁵⁰⁴ Person SPM6 reported this at the daily debrief regarding AP's experience. See document F2M (p. 96, l. 17-19).

⁵⁰⁵ For an example, AP supported person GVF8 come to terms with an upsetting situation. See document F2M (p. 93, l. 41 – p. 94, l. 1).

that group for a time to get an education which was unsupported by their family informing that:

*My father beat me with a stick as it meant one less person to tend the goats.*⁵⁰⁶

Estranged from the group, but later reconciled, this person inevitably brought elements of their culture to the VPO. I observed this person over two fieldtrips at close quarters. Their greetings were different to the others, their tone being more forthright but, in my opinion, they largely led well and supported their staff well. Unfortunately, the VPO found it hard to accept the person, particularly in a leadership role, with the person reporting to me that things were *very hard*.⁵⁰⁷ I sensed ethnicity had a part to play particularly regarding the acceptance of taking instructions.⁵⁰⁸ I reflected in my field notes on some VPO interactions with this person that ethnicity may be the reason for cultural tension. Shortly after this was confirmed to me, as an IHV NGO decision maker informed that there had been *a lot of tension* between this person and some other VPO staff, so the VPO had let them go.⁵⁰⁹ In other instances, where I observed SSA actors such as health workers or indeed other lower grade VPO staff or SSA health workers from minority ethnic groups, I found no evidence of either cultural incompetence or cultural tension, but they were not in a leadership role.⁵¹⁰ My research is thus inconclusive regarding the effect of being in a minority ethnic group on cultural tension in IHV and this may warrant further study.

I personally encountered no racist behaviours during my fieldtrips although I observed cultural humility from programme leadership teams or other Africans to enhance cultural competence and avoid tension, largely regarding how UEHVs were addressed. For example, particularly in rural areas, the inoffensive term

⁵⁰⁶ Person SPM5 described this personal experience. See document F1M (p. 9, l. 13-14).

⁵⁰⁷ Person SPM5 indicated this in document F1M (p. 9, l. 36).

⁵⁰⁸ Person SPM6 felt person SPM5 *instructs me* and does not listen putting person SPM6 in a position where they were unable to for example, maintain the appropriate supplies for an IHV programme. AP sensed *ethnicity* in the resultant tension. See document F2M (p. 65, l. 13 – 17 and Fn. 244).

⁵⁰⁹ Person GNF2 indicated this occurred not only between person SPM5 and person SPM6 but also between person SPM5 and person SPM2. See document F2M (p. 103, l. 20-21).

⁵¹⁰ For example, persons SHM9 and SPM1.

*muzungu*⁵¹¹ would sometimes be directed towards UEHVs. The explanation that the terms were inoffensive required careful explanation at the start of programmes for some UEHVs. Another example I observed was on an occasion during a formal visit, an official on a fieldtrip made the incorrect assumption that one UEHV, who was part of the African diaspora, was from the host country. They were addressed accordingly with the UEHV looking puzzled and tense. The mistake was quickly corrected with cultural humility to no detriment.⁵¹²

Whilst rare, when racism is evident in IHV its effects can be very negative in relation to the programme itself and for the person(s) exhibiting the racist behaviour. In my research on one IHV programme, it was reported to me by an IHV NGO programme lead who investigated the matter, that an UEHV exhibited alleged racist behaviour. In this instance the UEHV's use of language towards a senior SSA health worker, whilst unintentional, appeared to be inappropriate and showed cultural incompetence resulting in *racist and demeaning comments*.⁵¹³ The senior SSA health worker was obviously insulted and responded accordingly,⁵¹⁴ with other UEHVs expressing concerns informally and formally.⁵¹⁵ Here the IHV NGO programme continued with no cultural humility and cultural tension throughout between members of the leadership team. For the UEHV concerned and the NGO programme leadership team this incident ended their IHV with the NGO, which had effective procedures in place to deal with racist behaviours of UEHVs. However, from an African perspective there is no evidence that the senior SSA health worker who was the alleged victim of this incident ever received an apology or appropriate support from the IHV NGO or VPO. Perhaps this procedural aspect requires strengthening to better manage the effects of racist behaviours on victims.

Internalised racism is where individuals adopt negativity about their racial identity and self-esteem which may emanate from reinforcement of perceived social and racial hierarchies (Adhikari *et al.*, 2025). There were instances, in this research, where it was evident that some lower grade SSA health workers or VPO

⁵¹¹ *Muzungu* is a term for *foreigner* which commonly in the two SSA countries is a white person.

⁵¹² Person SEM8 made the comment to person XVF2 but quickly demonstrated cultural humility for their error. See document F2M (p. 45, l. 33-36).

⁵¹³ See document F1M (p. 39, l. 17). Identifiers were redacted due to the sensitivity of this data.

⁵¹⁴ See document F1M (p. 39, l. 22-27). Identifiers were redacted due to the sensitivity of this data.

⁵¹⁵ See document T1 (p. 25, l. 30-32). Identifiers were redacted due to the sensitivity of this data. Some of whom themselves were from an ethnic minority.

staff lacked self-worth rather than what I perceived to be issues of racial identity. One example I have already discussed in Section 4.3 was where an inexperienced SSA VPO staff member lacked confidence following a difficult experience on a previous IHV programme.⁵¹⁶ Another example was where I sensed a group of lower grade health workers to be very nervous and unsure of themselves around UEHVs. I asked a middle grade health worker about this and was informed that what I sensed was accurate as:

*They are trying to impress you (the UEHVs).*⁵¹⁷

I thus have no convincing evidence of internalised racism in IHV in the two SSA countries in this study and put these observations down to a combination of unfamiliarity, cultural incompetence and hierarchy at the time. On later reflection I am less certain of my interpretation here and wonder if they may represent some features of internalised racism.

Ethnicity and racism are both issues that have the potential to disrupt effective collaborations and create cultural tension within IHV NGO actors both from Africa and the UK/Europe. Reasonable cultural competence and cultural humility are helpful traits for all involved to have, although particularly regarding ethnicity a degree of cultural incompetence is inevitable. Whilst rare, incidents involving racist behaviours can and do occur in IHV in the two SSA countries with effective management of individual incidents being difficult and problematic for those concerned.

4.6 Cultural tension in volunteering

Throughout this chapter I have already given some examples of cultural tension particularly in the absence of reasonable cultural competence or the presence of cultural incompetence. It is my view that given the complexity of IHV in the two SSA countries, with many actors from different cultural backgrounds involved in the IHV phenomenon some degree of cultural tension on IHV programmes is an inevitability. Inevitable as reasonable cultural competence is not

⁵¹⁶ Person SPF1. See for example, document F4M (p. 30, l. 11-15) where person SPF1 indicated that given their low position in the professional hierarchy people would not talk to *someone like me*.

⁵¹⁷ Person SHF1A reported this to me in document F1M (p. 43, l. 10-11).

always realistic, and inevitable too as there is a mix of actors within IHV that have different values all occurring within an environment that is highly pressurized and partially unfamiliar to most whether from Africa or the UK/Europe. This is thus an important influence on IHV in the two SSA countries. As cultural tension can be damaging to IHV programmes, the key is to limit the damage and resolve matters quickly and equitably with all concerned.

From an African perspective when cultural tension occurs between IHV African actors, I found that appropriate resolution is often deeply rooted in African values and cultural humility. When it remains, it is sometimes because at least one of the actors chooses to operate outside accepted African cultural parameters. For example, on one IHV programme the programme leadership team was invited to attend a welcome meeting at the host district hospital which was a non-government faith based funded institution. The IHV programme involved task-shifting lower grade health workers in the district to undertake specific health techniques with nobody at the host hospital currently trained to carry out the techniques. Just prior to the meeting the VPO leader, who I had already sensed was avoiding the hospital director, informed me that the district government had not selected anyone from the hospital to be trained and that they were not going to the meeting.⁵¹⁸ Culturally the senior SSA health worker on the programme, the VPO leader and the hospital director were from very different cultural backgrounds with the hospital director speaking a different ethnic language as their first language and from a different faith than the others. I observed tension and resolution within the public forum of a hospital meeting.

The hospital director to the senior SSA health worker:

*Understand better that REDACTED DISTRICT HOSPITAL needs a trained staff member.*⁵¹⁹

The hospital director then introduces the senior SSA health worker to the staff:

⁵¹⁸ Person SPM2 made themselves unavailable and uncontactable. AP took the initiative by suggesting that person SPM6 should attend the meeting, thus saving the VPOs reputation with the hospital which was acceptable to person SYM1. See document F4M (p. 35, l. 4-7).

⁵¹⁹ Within the public meeting person SYM1 told this to person SHM1A. See document F4M (p. 36, l. 1-3).

*We are very honoured to have REDACTED SENIOR SSA HEALTH WORKER here... they will tell us of the importance of REDACTED SPECIFIC HEALTH TECHNIQUE in REDACTED DISTRICT.*⁵²⁰

The senior SSA health worker responds:

*I am honoured to be in REDACTED DISTRICT...I have been here before on the public bus carrying some equipment to do some voluntary outreach...am pleased that the district was selected to have six lower grade health workers trained and this will improve health in the district...Regarding training someone from the hospital, it was just not possible to do this at this time, but we plan to visit again and will make sure that this is done next time.*⁵²¹

The hospital director replies:

*It was a mistake that there was no REDACTED LOWER GRADE HEALTH WORKER selected to be trained from the district hospital, but I am glad that this will be rectified next time.*⁵²²

Here, the African cultural values demonstrated of dignity, respect, and ultimately collective solidarity, by these two individuals in a public forum appear to transcend their cultural differences. Cultural tension though, persisted between the VPO administrator and particularly the hospital director. The former's failure to attend the meeting was seen as disrespectful by the latter and tension remained, at a low but noticeable level to others throughout the programme, for example by only cursory handshakes by way of greetings.⁵²³

In my research there were more evident instances of cultural tension from UEHVs and VPOs towards other African actors than the opposite. An area of cultural tension amongst UEHVs and VPOs was the African notion of the *per diem*

⁵²⁰ Person SYM1 then formally introduced person SHM1A to the audience, largely hospital staff. See document F4M (p. 36, l. 17-20).

⁵²¹ Person SHM1A replied to person SYM1. See document F4M (p. 36, l. 22 – p. 37, l. 7).

⁵²² Person SYM1 then replied to person SHM1A. See document F4M (p. 37, l. 16-17).

⁵²³ See for example greetings between person SYM1 and person SPM6 in document F4M (p. 33, l. 13-14).

rate.⁵²⁴ The *per diem* is a payment that a SSA government employee receives when they are working but absent from their usual base, varying in amount with seniority. The difference between African culture and Western culture is that whilst receiving a *per diem* they will still be paid from their normal role, in effect being double paid. This contrasts with the UK, where expenses for travel and subsistence may be received if absent from base, but there is no double payment and indeed claiming such is seen as unprofessional, on occasion causing regulatory issues for individual health professionals. The *per diem* culturally is seen as recognition that a person's time is being truly valued in their additional role and is deeply embedded in African culture. Thus, IHV NGOs pay *per diems* to all grades of SSA health workers involved in IHV programmes in the two SSA countries and most funders do not fund *per diems*, meaning that they are a not inconsiderable cost from unrestricted funds for IHV NGOs.⁵²⁵ Here an IHV NGO programme lead who has cultural differences with some senior SSA health workers focuses their cultural tension on this issue:

*All they (the senior SSA health workers) cared about was their per diem, it's their people that we are trying to help, and they didn't care about them at all.*⁵²⁶

In another example two senior SSA health workers are perceived by a VPO leader as not performing well so they weaponize the *per diem*:

*I want to ask for the per diem back from these two.*⁵²⁷

Fortunately, here an UEHV was culturally competent enough to realise that this would be an unwise move likely to create more cultural tension and stopped the

⁵²⁴ The *per diem* rate may be called different names in the two SSA countries and in other SSA countries.

⁵²⁵ I observed that IHV NGOs usually paid the *per diem* rate asked of them without negotiation. I further observed person XNF1 (part of NGO leadership but also a part of the African diaspora) indicate that IHV NGOs could reduce costs stating *just negotiate the per diem, haggle with them, that's our culture*. See document C3 (p. 1, l. 25-26).

⁵²⁶ Person GVF4B reported this in document F1M (p. 80, l. 31-33).

⁵²⁷ Persons SHM5A and SHM6A had not attended one of the IHV programme days. In person SHM5A's case this was for religious reasons. Person SHM6A gave no reason. Person SPM5 was responsible for handing over the *per diem* payments, in advance. He expressed this in document F1M (p. 43, l. 27-28).

VPO leader proceeding with their plan with cultural humility.⁵²⁸ In these instances, reasonable cultural competence and cultural humility would suggest that for UEHVs, whatever their personal views on the rights and wrongs of *per diems*, that simple acceptance of the cultural views of African hosts in deeply ingrained cultural areas is better for IHV programme dynamics than cultural tension.

Sometimes quite simple and mundane things would create cultural tension in UEHVs and VPO staff towards some African actors. For example, African health workers being late or disappearing off mid-morning for breaks during programmes seemed to create considerable cultural tension. I observed one VPO administrator indicate that:

*Disappearing off for chai by the REDACTED SSA HEALTH WORKERS and their lateness was a source of great frustration.*⁵²⁹

Even in rural accommodation, UEHVs often oozed cultural tension when things like food arriving very late was evident, as culturally in the UK the expectation was of promptness.

Lack of cultural competence was partly responsible for the cultural tension here as both these above examples required a bigger picture view of the realities of IHV programmes in rural areas in the two SSA countries. In the first example, lateness and taking breaks was usually due to the other commitments of SSA health workers as often their regular role did not cease just because of their participation in an IHV programme. For example, a lower grade SSA health worker reported:

*I delivered two babies last night so had only two hours sleep.*⁵³⁰

In the second example a VPO senior administrator informed me regarding food lateness in UEHV accommodation:

⁵²⁸ Person GNF1A suggested to person SPM5 that a better way forward would be to put in their report to person SEM 16, a senior government leader, some text regarding the suboptimal engagement of persons SHM5A and SHM6A. This defused the situation. It is unknown what appeared in person SPM5's report.

⁵²⁹ Persons GNF1A and SPM7 indicated this in document F1M (p. 75, l. 29-34).

⁵³⁰ Person SHM25 indicated this in document F4M (p. 53, l. 24-25).

*I will show you the cooking facilities here tomorrow morning and you will see why things are late.*⁵³¹

They duly did and I in turn showed the UEHVs (see Figure 16). These facilities were the best they could be in an area with virtually no electrical power and in the only accommodation available in the area which was able to cope with the numbers on the IHV programme. Whilst in both these examples cultural tension occurred, enhancing cultural competence thereafter by explaining the reasons for specific issues to UEHVs was a good means of defusing it.



Figure 16: The cooking facility in accommodation for UEHVs in rural SSA.

Cultural tension emanating from SSA actors towards UEHVs was less common, perhaps because the vast majority I sensed had *ubuntu*. On the occasions I observed cultural tension it arose from individuals who I perceived had more individualistic cultural values. Take for example a senior SSA national professional association leader visiting an IHV programme whom I observed state to a member of the VPO team about the IHV NGO team:

⁵³¹ Person SPM6 showed these facilities to AP at dawn who in turn showed them to most of the UEHVs before breakfast. See document F4M (p. 30, l. 22-25 and Figure 4).

*Your volunteers are not volunteers they must be being funded.*⁵³²

This individual remained negative with a closed mindset throughout their visit, inducing tension in the wider team and not just the IHV NGO team with seemingly different cultural values than others whether African or from the UK/Europe. This tension was relieved only when their visit came to an end. This is a concern as it appears that it only takes one individual with markedly different cultural values to threaten an IHV NGO programme by cultural tension related discord.

Cultural tension was evident in my research between Africans. In some cases, this was about working with IHV NGOs in the first place. One senior SSA health worker reported of their African *bosses* asking them aggressively:

*Why do you work with foreigners?*⁵³³

And instructed them:

*Just get the foreigners to give you money.*⁵³⁴

Whilst generally welcoming of IHV programmes the mere presence of an IHV NGO team can stir up cultural tension amongst some in SSA.⁵³⁵ The reasons for this are unclear but regardless IHV NGOs and those in the two SSA countries who see the benefits of programmes to SSA health services need to face the reality that not everyone involved in the IHV phenomenon in the two SSA countries will be supportive and the presence of disruptors is inevitable.

In other cases, cultural tension occurred between Africans as a programme progressed. Initial respectful behaviour would give way to dissonance as true cultures of individuals were revealed. In many cases SSA health workers are thrown together within IHV teams and were unknown to each other previously. For

⁵³² AP observed person SYF1 stating this to person SPM1. See document F1M (p. 34, l. 33).

⁵³³ Person SEM21, a regional health official, questions SHM1A. See document F4M (p. 108, l. 32).

⁵³⁴ Person SEM20, a senior government leader, instructs SHM1A. see document F4M (p. 108, l. 32-33).

⁵³⁵ This happened to AP, GVF6 and GVF9 whilst at a market in a rural village where AP reflects that a market stall holder, person SCM9, was upset that foreigners were in their village. See document F1M (p. 58, l. 19-20).

example, I observed two senior SSA health workers, with very different cultural backgrounds, at the start of an IHV programme appearing to have much in common. However, over the days of the IHV programme problematic issues were dealt with in different ways. One behaved in an individualistic manner with a poor work ethic the other was highly motivated, compassionate, and kind and their differing backgrounds resulted in cultural tension between the two. I reflected at the time of their relationship deteriorating that:

*The REDACTED HIGHLY MOTIVATED HEALTH WORKER distanced themselves from the other as the programme continued.*⁵³⁶

Cultural tension is a key influence for all IHV actors in the two SSA countries. Whilst it is predominantly seen as a negative, cultural tension is an inevitability to some degree. Reasonable cultural competence is at times an impossible goal in the IHV phenomenon in the two SSA countries given the variety of cultures present amongst individual actors. Cultural competence is interlinked though with cultural tension, as programmes where there is much cultural incompetence risk excessive cultural tension. In the next section I will discuss improving relationships in IHV in the two SSA countries.

4.7 Improving relationships in volunteering

Resolving the negatives of cultural tension within IHV in the two SSA countries can at times seem an insurmountable task particularly if culture is seen as static and homogenous (Nathan, 2015). Culture though can be viewed as dynamic, complex and contextual (Markus and Conner, 2013). This view of culture fits better with my experiences of culture within the IHV phenomenon in the two SSA countries. Moreover, this dynamic theory of culture is based on culture being related to interactions between individuals rather than residing within an individual (Liu, Volcic and Gallois, 2011). Thus, it is individuals and their interactions that can dynamically change culture and that relates very much to my experiences in this study. This will take time and experiential learning, just as someone becoming reasonably culturally competent or developing cultural humility takes time so there

⁵³⁶ The highly motivated person SHM1A distanced themselves from the more individualistic person SHM8A. See document F1M (p. 10, l. 10 and Fn. 21).

is no quick fix to cultural tension within IHV in the two SSA countries. Meaningful change will require individuals within the IHV phenomenon to focus on positive interactions that take account of cultural heterogeneity between individuals.

In my study I was privileged in my leadership roles on fieldtrips to witness over the course of a fieldtrip developing cultural competence and sometimes development of cultural humility in others. Take for example my observation in Section 4.2.2 where I noted an UEHV's motivation for volunteering was to raise their *profile*.⁵³⁷ Here an individualistic motivation, with minimal cultural competence related to either the SSA setting or IHV, quickly resulted in culture shock with the same individual expressing their sentiments to first exposure of an IHV programme in an SSA setting as:

*I'm a bit overwhelmed...this was nothing like I expected...I just didn't know people had so little.*⁵³⁸

With the help and support of reasonably culturally competent IHV leadership teams comprising individuals from the UK/Europe and SSA, who had enough cultural humility to support the UEHV, they started to operate better on the IHV programme and express more communitarian notions like *we all want to be together*.⁵³⁹ Ultimately, by the end of the IHV programme a reasonably culturally competent and effective UEHV emerges, still with many of their own individualistic traits, still wanting to be high profile, but having a degree of cultural humility. Moreover, they have the insight to realise their own transformative change:

*I've never seen anything like these two weeks; it's put my whole life into perspective. I just am so thankful I got this opportunity.*⁵⁴⁰

This is also seen in SSA actors on fieldtrips. For example, on one fieldtrip a lower grade SSA health worker was finding adaptation to an unfamiliar environment challenging with no commonality of language with the predominant

⁵³⁷ Person GVM1 discussed this in document F2M (p. 27, l. 1-2).

⁵³⁸ Person GVM1 reported this in document F2M (p. 51, l. 41-43).

⁵³⁹ Person GVM1 reported this in document F2M (p. 36, l. 8).

⁵⁴⁰ Person GVM1 told AP this in document F2M (p. 121, l. 29-30).

ethnic group in the area. They had a degree of cultural incompetence regarding the district where the programme was situated. Here the programme leadership team recognised amongst other things their struggles as they were *Communicating...poorly*.⁵⁴¹ This allowed identification of a specific senior SSA health worker, for having similar values, to train and mentor the individual. By the end of the programme the individual *was doing much better*.⁵⁴² Additionally, the challenge and consequent success of this approach resonated well with the trainer and mentor who expressed:

*I am so glad that you (the programme leadership team) gave me REDACTED LOWER GRADE SSA HEALTH WORKER as they are very gentle and would do badly with someone aggressive...I am glad and proud.*⁵⁴³

I claim that my observations in this study demonstrate that having a diverse and effective IHV programme leadership team together bring the reasonable cultural competence and cultural humility which individually nobody possesses in the IHV phenomenon. Such a team has advantage as members bring their individually different cultural experiences to an IHV programme, being drawn from the range of collaborators on site. This allows the “known unknowns” and “unknown unknowns” (Rumsfeld, 2002, online)⁵⁴⁴ of culture in remote and rural areas of the two SSA countries to be better negotiated, and problem solved by the mutuality of the leadership team. Selection of the diverse leadership team to be an effective one is the crux of improving relationships in IHV in the two SSA countries. Cultural humility and reasonable cultural competence are both important traits of leaders in this setting.

Lasker *et al.* (2018) in a scoping review of 27 guidelines related to IHV trips, noticed that greater than 50% mentioned the need for training in cultural competence. Indeed, taken together guidelines that mention cultural competence in

⁵⁴¹ Person SHF1A indicated this regarding person SHM9. See document F1M (p. 43, l. 3). AP and person SHF1A identified person SHM1A as a potential trainer.

⁵⁴² Person SHM1A mentored person SHM9. See document F1M (p. 50, l. 1-3).

⁵⁴³ Person SHM1A reported this about person SHM9. See document F1M (p. 55, l. 22-23).

⁵⁴⁴ See Rumsfeld (2002) transcribed at:

<https://web.archive.org/web/20160406235718/http://archive.defense.gov/Transcripts/Transcript.aspx?TranscriptID=2636>

IHV discuss issues like cultural humility, understandings of culture, language, history and health priorities of the host nation (Lasker *et al.*, 2018). This is all laudable but from an African perspective guidelines predominantly focus on the host nation as a single cultural entity. This is an inaccurate representation of the cultural variations of African culture evident within nations, regions, districts, villages and ethnic groups. Additionally, most guidelines cover little in the way of specificity regarding cultural competence training and tend to be focused on training GNHVs rather than actors from host countries. Cultural competence is important for all involved in IHV in the two SSA countries and not just UEHVs. It is no wonder then that cultural competence training is a confusing picture for those involved in the IHV phenomenon in the two SSA countries. Indeed, most guidelines regarding IHV are unobserved in actual IHV programmes (Rozier, Lasker and Compton, 2017).

The development of further guidelines is likely just to add to confusion. Instead, I suggest that given my understandings of cultural competence in IHV in the two SSA countries derived from this study, some basic principles regarding cultural competence and cultural tension may be helpful for all those involved in IHV in the two SSA countries in improving relationships in volunteering. I have therefore proposed seven principles that I believe are important in improving relationships in IHV in the two SSA countries and wider region and hope that some will seek to adopt these, with appropriate adaptation for specific circumstances, in due course. Given the overarching nature of these principles, I will present these in my thesis recommendations (see Section 6.3),⁵⁴⁵ rather than in this part of my thesis.

4.8 Chapter conclusion

In this chapter I have given the reader some background about African culture and its interplay with cultural competence, cultural incompetence and cultural tension in the IHV phenomenon in the two SSA countries. I have presented cultural humility to potentially improve cultural interactions and suggested that things like culture shock are not purely something that affects those from the UK and Europe but can affect Africans in the IHV phenomenon in the two SSA

⁵⁴⁵ See also Appendix 7.

countries. I have also explored the potentially divisive issues of ethnicity and racism in the IHV phenomenon and how these may relate to cultural competence and cultural tension in IHV in the two SSA countries.

I have shown that cultural competence is a key influence for all IHV actors in ensuring that IHV programmes bring some intended benefits to local communities. Programmes where volunteer teams are reasonably culturally competent and relate well to each other and to local communities appear to be able to problem solve better and work better as a team. This may be partially related to cultural competence enhancing mutual trust and reducing suspicion. At a strategic level, cultural competence appears to be helpful to the enhancement of collaboration within collaborative networks in IHV. In volunteering, collaborative networks appear to work better when most behave in a culturally competent manner. Understanding mutual cultural rules in the strategic context may influence effective decision making within collaborative networks.

I have discussed cultural incompetence which appears to sometimes create cultural tension between Africans and those from the UK and Europe in the IHV phenomenon but also within these groups. There is a tendency for UEHVs to view those from the two SSA countries as homogeneous groups and *vice versa*. From an African perspective, I have shown evidence that some Africans in the IHV phenomenon are culturally incompetent regarding some SSA communities that IHV programmes seek to serve. In essence, UEHVs may not understand that Africans, particularly those from VPOs, are unable to help them better understand some remote and rural local communities. This is because sometimes *all* involved are culturally incompetent of cultural variation in these loci.

I contend that volunteer teams work best when indigenous and foreign actors are both reasonably culturally competent with the perfect storm being when both are culturally incompetent. However, indigenous groups and foreign groups themselves are not homogeneous culturally so complicating this influence may be that within the groups cultural incompetence and thus cultural tension can result. I have stressed the importance of having a diverse and effective programme leadership team who demonstrate mutuality, cultural humility and are reasonably culturally competent.

I have shown that cultural tension is not just detrimental to the smooth and effective running of an IHV programme, but ultimately it can be reputationally damaging to all those involved and is thus a major influence on IHV in the two SSA countries. Lastly, I have developed seven principles (presented in Section 6.1) that all involved in IHV in the two SSA countries and wider SSA should consider, which focus on cultural competence and cultural tension with the aim to improve relationships in volunteering. Chapter 5 will discuss and present my final set of important interlinked influences from my research in the IHV phenomenon in the two SSA countries which are power, hierarchy, respect, and neo-colonialism.

CHAPTER FIVE - Power, hierarchy, respect, and neo-colonialism

Chapter Introduction

My final interlinked themes to answer my research question are those of power, hierarchy, respect and neo-colonialism. I again used a deductive approach to link these themes from my categories. I had significant pre-existing knowledge of all these ultimately interlinked themes from both my background in SSA and from prior experiences in IHV in the two SSA countries and wider SSA all backed up by my research data. Following back and forth analysis of the data, I relatively easily realised the linkage between power and hierarchy, eventually focussing on the importance of neo-colonialism with these two as interlinked themes. I was confident that respect was a *main* influence on IHV in the two SSA countries and particularly important for foregrounding an African perspective due to African cultural values. After much more recursive reflection, I realised, much later in my research, that it was respect that maintained the power-hierarchy in IHV in the two SSA countries.⁵⁴⁶ Section 5.2 will discuss the interactions between these interlinked themes in more detail. I have already given the reader some background to respect in IHV in Section 4.2, 4.2.1, 4.2.2 and 4.2.3 on African culture. In addition, it is worthy of note that I as the researcher made participant observations within this study from a position of power, being reasonably high in the IHV NGO hierarchy and from a role that was likely to command respect in IHV in the two SSA countries. I discussed this in Section 2.3.4 in relation to part of the reasons that I did not use semi-structured interviews as a data collection method, but the reader should note that being in a powerful situation in IHV could increase the risk that some people I observed may behave differently in my presence.

In this chapter I will again foreground an African perspective in IHV as once again literature concentrates on Global North interest-holders with sub-optimal consideration given to African aspects. For example, it is evident that the operations of some organisations operating in SSA within global health initiatives

⁵⁴⁶ See Section 2.3.7 for full details of my categories and themes.

can maintain power imbalances, be perceived as having colonial attitudes and have systems which locate resources within institutions in the Global North despite claims of trying to do the contrary (Abimbola, 2018; Richardson, 2020). Additionally, I linked these themes, as power imbalances within IHV can sometimes threaten African notions of hierarchy and respect, with neo-colonialism being an influence that is given as a reason for power imbalances. I will draw these interlinked themes together to show their considerable influence on the IHV phenomenon in the two SSA countries.

I will discuss power imbalances both at strategic level and programme level although I will concentrate more on those at strategic level as I found that to be the primary locus of power imbalances in IHV. This will involve particular focus on the donor-recipient relationship within IHV in the two SSA countries. I will consider hierarchy from both an African health service and wider IHV perspective. Within this discussion on hierarchy, I will present my observations on gender inequality within African health services as they appear to influence the IHV phenomenon. I will explore respect in IHV in the two SSA countries. To do this it will be necessary to consider examples of disrespect, which help draw out why respect in the IHV phenomenon in the two SSA countries is an important influence.

In this chapter I will discuss neo-colonialism in IHV in the two SSA countries, for which I will give the reader context and background to better frame this influence. I will then explore neo-colonialism relating to UK and European actors whilst trying to draw out an African perspective. As neo-colonialism is predominantly considered to be largely negative, I will propose areas where it could be better addressed by IHV interest-holders by considering decolonization strategy.

5.1 Definitions

Power, as a concept, is a highly contested term that has been the subject of much philosophical debate from the time of Aristotle (Parietti, 2022). More recently, the definition of power has been debated around the differing theories of Habermas, Bourdieu and Foucault (Christensen, 2024). In daily living, power is

usually thought of as possessed by a person or entity termed powerful and exerted over another person or entity termed powerless (Christensen, 2024). This is too simplistic a definition. Bourdieu discusses material power and symbolic power, with material power being predominantly economic whilst symbolic power is a construct of material power seen through social groups that give it legitimacy (Cronin, 1996). For the powerless, power can be seen as negative but for the powerful, power can bring possibilities (Parietti, 2022). In the absence of agreement, I have chosen to define power in this study as:

The concept of power can be thought of as a material and/or symbolic attribute within individuals, groups and organisations, who have the possibility to exercise degrees of control over other individuals, groups and organisations (adapted by me from Bourdieu, 1977, p. 185; Cronin, 1996, p. 65; Parietti, 2022, p. 59; Christensen, 2024, p. 182).

Hierarchy is a less contested term that I have taken to mean, for the purposes of this study, a system of organising individuals within an organisation or society by ranking them according to factors such as level of importance, role and social status. It is important to realise that ranking is not limited to these factors in some organisations or societies. For example, in African culture respect for elders is such that an elder of equal rank in other aspects of life is likely to be considered as higher in a hierarchy than a younger person. Respect for elders is seen as fundamental to relationships and social order in African culture (Adegbite, 2024).

Respect has already been touched upon throughout this thesis and particularly in Sections 2.3.3 and 4.2.2 without me defining it fully. Respect is extraordinarily difficult to define as it is multi-faceted. Respect can be encapsulated as respect for individuals, societies, government, communities and regulations. In healthcare it can be framed as respect of staff, patients and trainees at all hierarchical levels irrespective of role(s). My working definition of respect in this research is:

Respect is an attitude where there is unbiased appreciation, behaviour, care, consideration, understanding and positive regard for the rights,

values, beliefs, and effects of all (adapted by me from Spelman, 1978, p. 156 and Toledo-Pereyra, 2005, p. 282)

Two other aspects of respect are worthy of note. Firstly, disrespect is a lapse or absence in part of respect. Being disrespectful can be viewed as breaching informal societal rules which are necessary amongst individuals for societal harmony. Secondly, self-respect, just like the respect of others, requires respect for oneself as a moral duty based on our human dignity (Dillon, 2022).⁵⁴⁷

The term neo-colonialism was first used by Ghana's first post-independence president Kwame Nkrumah to describe the continuation of imperialism following independence of African states. Nkrumah (1965) suggested that neo-colonialism was where independent states which outwardly look to have international sovereignty have their economic system and thus political strategies controlled by outside influences. This definition has broadened over time, and many iterations exist with largely consensus in the basic concept of neo-colonialism but with much variation in definition. My definition of neo-colonialism for this study is:

The process by which the Global North either directly or indirectly seeks to control and/or dominate the Global South, economically, politically, socially and culturally (adapted by me from Nkrumah, 1965, p. ix; Murrey and Pouo Moutsouka, 2024, p. 2).

5.2 Interaction between power, respect, hierarchy and neo-colonialism

This small section aims to focus the reader on how intertwined these themes are in my research. There is considerable interaction between power, respect, hierarchy and neo-colonialism in my research of IHV in the two SSA countries. The section also challenges me to reflect on my positionality within the research process. An example of this was seen in my first fieldtrip. I was part of the IHV NGO leadership team and had several interactions with a middle grade SSA health worker. This person oversaw lower grade SSA health workers on the IHV

⁵⁴⁷ Dillon (2022) draws from the arguments of Kant (1785) on this subject.

programme and was also part of the programme leadership team. These lower grades were being trained by mostly senior SSA health workers. The trainees were persistently late to clinic, but one day they were very late. Ordinarily I would expect the middle grade to manage the situation, but I was approached by them. They suggested (regarding the lower grades) that I *tell them off*⁵⁴⁸ rather than them, as it would be much more effective coming from me. I agreed to do this and simply said to the late lower grades:

*Your REDACTED SENIOR SSA HEALTH WORKERS are here to train you and in being late you show them disrespect.*⁵⁴⁹

The lower grades were never late again on that IHV programme. I have reflected much on this seemingly simple interaction, and it perhaps represents the crux of how these themes are interlinked. On reflection, I realised my position in the pyramidal health and IHV programme hierarchies was higher than the middle grade and they were right that coming from me a *telling off* would indeed be more effective. I had much respect for the middle grade, so whilst it was their job to give the *telling off*, I did not want to disrespect them so agreed. The *telling off* needed to succeed so the higher grades had respect for the power of the middle grade over the lower grades and to be assured of maintenance of the hierarchical order.

Undoubtedly, I knew I was in a powerful and dominant position and behaved in a neo-colonial manner towards the more powerless lower grades. Worse, I knew how important being seen as respectful was to the lower grades, particularly in front of the higher grades in the hierarchy. Accusing them of disrespect was the ultimate part of the *telling off* ensuring success in the purpose of getting them to the clinic on time. However, for me, I realised that self-reflection was needed as to how I may have been perceived in this instance by others.

Undoubtedly interactions like this one above require me, as the researcher, to reflect on my positionality. Whilst I have already discussed my horizon as a hermeneutical concept in Section 1.9.3 regarding white saviourism and regarding bias in Section 2.3.4 stating my positionality is important. Positionality is defined by Rowe (2014) as a tool that describes both the standpoint and overall worldview

⁵⁴⁸ Person SHF1A asked AP to do this. See document F1M (p. 50, Fn. 180).

⁵⁴⁹ AP reported this. See document F1M (p. 50, l. 21-23).

of the researcher. It is evident then that the research process is governed by the researcher's values, assumptions and beliefs (Guillemin and Gillam, 2004). Indeed it is likely my position within IHV in the two SSA countries that allowed me to investigate the IHV phenomenon in the first place. As Rowe (2014) indicates positionality affects what is researched, how research is conducted and how it is analysed and written up. As a white male from a former colonial power who was both high in the health hierarchy and of an age where I would engender respect in African culture I mostly researched as an insider from a position of power. Ozano and Khatri (2018) describe insiders as powerful and outsiders as powerless. For the majority of my research I was in a powerful position but even on occasions as an outsider I would likely be viewed as powerful by participants so in my case I disagree with the view of Ozano and Khatri (2018) regarding outsiders. An example would be that I would be an outsider to several community members in areas where fieldtrips took place. However, to those community members I would be someone who is powerful and this could potentially alter their behaviour like I may be unchallenged if they disagreed with any of my decisions. As an insider participants could have altered behaviour towards me and I to them particularly where the hierarchical gap was large it would be likely that neither them or me would feel able to talk freely.

My positionality requires that I address my biases and in this study I have attempted to do this by several means such as bracketing and constant critical reflexivity. However reflexivity has limitations as it relies on the premise that researchers are transparent and knowable with known motivations (Rose, 1997). This though is inherently a false premise as reality suggests that there is inherent "unknowability" (Rose, 1997, p.309). So, despite reflexivity there is uncertainty throughout research as to the positionality and biases of the researcher. As discussed by Virhia (2020) the researcher may never truly understand their own positionality and the effects of the relative power dynamics between researcher and participant has had on their research. Nevertheless I have some awareness that my positionality, how I conducted my research and my research question inevitably reflect aspects of who I am.

In my research these themes of power, respect, hierarchy and neo-colonialism often occur together, and they can sometimes appear intimately

intertwined in their influence on the IHV phenomenon in the two SSA countries. Sometimes all are involved like the example at the start of this section. At other times two or three themes seem to co-exist better. For example, in IHV in the two SSA countries power and hierarchy are linked together, as the concept of being powerful likely helps perpetuate the rigidity of pyramidal health and other similar hierarchies in the two SSA countries. In another example, respect is a theme that is influential in African culture and important to an African perspective. It is unsurprising then that respect for those more powerful or higher in a hierarchy thread throughout observations in my research.

With continued recursive reflection further interlinkages of these themes are seen. For example, it is evident that for the powerless in IHV in the two SSA countries, challenging either the hierarchy or the powerful may be viewed as disrespect, so challenge comes with risks for the challenger irrespective of their role in the IHV phenomenon. However, for the powerful, the respect for their hierarchical positions protects them from challenge, wards off rare challenges and in so doing maintains their power. This dominant powerful position may on rare occasions contribute to abuse of power.

Then there is the intimate interlinkage of neo-colonialism with power, as it is often driven by power inequality with powerful Global North actors of which positionality suggests I am one. Understanding the relationship between power and neo-colonialism and their intersectionality may offer a means to better explore their effect on health policy in LMIC situations (Parashar *et al.*, 2023). The need for decolonization is evident in my study, being important for Global North actors to continually address. Sadly, decolonization can be hindered by pyramidal hierarchies although the flatter more inclusive hierarchies of well-run IHV programmes can sometimes alter hierarchical perceptions and affect positive decolonizing changes. The reader will note that these interactions are complex, and my research has merely scratched the surface of that complexity. From an African perspective, I hope in time that an African researcher involved in IHV in one of the two SSA countries, and the African health hierarchy can research these interlinked themes more as this may simplify or clarify this complexity.

5.3 Power imbalances in volunteering

The exercise of power at programme level and at strategic level was evident in my research, for example, an UEHV and member of an IHV programme leadership team describes perceived arrogance in senior SSA health workers as being related to power indicating that:

*People who get into power there, really know how to use it.*⁵⁵⁰

At a strategic level IHV NGOs sometimes require adaptation to changing circumstances to survive or take forward different opportunities. Sometimes this results in decisions being made in the UK or Europe with no or minimal consultation with some SSA actors who are impacted by the decision. In effect, there is a power imbalance in IHV in the two SSA countries where UK/European actors can impose their will on SSA actors against principles of mutuality and collaboration. For example, in my study I observed a decision by one IHV NGO that changed the nature of a VPO, for sound and logical reasons, but with suboptimal consultation. Power here was clearly in the hands of the IHV NGO whose decision maker informed me that a different VPO:

*Will take over all the REDACTED VPO's staff.*⁵⁵¹

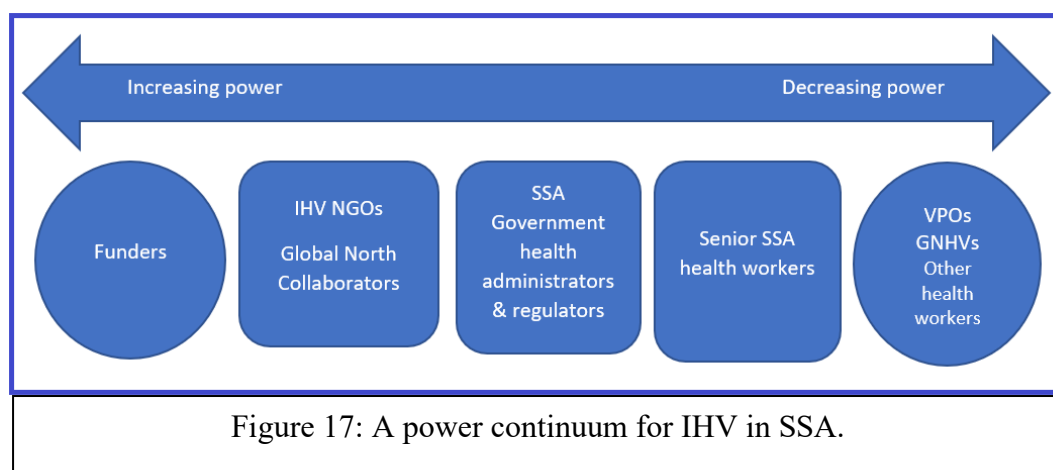
From an African perspective, the original VPO was powerless to influence the strategic decisions of the IHV NGO which had negative consequences for some individuals.⁵⁵² Power imbalance seems then to influence the donor-recipient relationship in IHV in the two SSA countries, sometimes reinforcing a perceived notion that the donor is powerful and the recipient powerless. Other examples of the power imbalance I observed were when IHV NGOs minimized the decisions VPOs could take on operational matters rather than better involving them in strategic decisions.

⁵⁵⁰ Person GVM5B reported this in document F2M (p. 17, l. 4-7). In this instance *there* refers to one of the two SSA countries.

⁵⁵¹ Reported by person GNF2 in document F2M (p. 103, l. 21).

⁵⁵² Ultimately two members of staff were let go.

In IHV, power imbalances are seen most clearly around matters of funding. I have already discussed funding and underfunding in Section 1.7 as it pertains to running IHV programmes in the two SSA countries. However, looking at funding in terms of influencing power in IHV in the two SSA countries there is often a power hierarchy between IHV NGOs and SSA interest-holders, with Global North interest-holders being generally more powerful and SSA interest-holders being generally less powerful along a continuum (see Figure 17):



In IHV in the two SSA countries, it often seems it is with money where power lies and despite notions of mutuality there is an economic gap between donor and recipients. As a result of this economic gap, from an African perspective, there is a risk that some SSA interests appear to be subservient to those of the Global North, and this could be framed as a form of neo-colonialism.

For example, in choosing sites for IHV programmes I observed a VPO decision maker and a regional government official suggesting various areas for future programmes:

The VPO decision maker:

*We will go to REDACTED SPECIFIC REGION next year.*⁵⁵³

The regional government official:

⁵⁵³ Here person SPM5 indicated firmly his plans in document F1M (p. 17, l. 2). Person SPM2 had apparently promised this to person SHM5B, a regional government official from that region. Being relatively powerless person SPM5 had made a promise that was not theirs to give unilaterally.

*“I give this request to you that next year we have at least four to six programmes to train REDACTED LOWER GRADE HEALTH WORKERS in the remaining district councils with no REDACTED SPECIFIC services.”*⁵⁵⁴

In both cases neither of these were planned to take place and indeed far fewer programmes were planned. Due to inadequate funding, the IHV NGO was powerless to run the number of programmes anticipated,⁵⁵⁵ as adequate funding sits at the top of a power hierarchy in IHV in the two SSA countries. The programmes planned were situated elsewhere and appeared more related to the IHV NGOs priorities rather than those of African interest-holders. Ultimately if not appropriately communicated or listened to or presented with realistic options by IHV NGOs there is a risk that African interest-holders feel powerless and disappointed. I contend that better management of the power hierarchy between all collaborators is necessary to provide a mutual collaboration, better understanding of power dynamics and to empower those lower in the power hierarchy.

Sometimes though there are exceptions in the power dynamic. On my second fieldtrip I led an IHV NGO team to a specific district to run an IHV programme, likely chosen for SSA political interests by SSA government actors rather than the IHV NGO. Here the power dynamic was upended and the IHV NGO was powerless to African political masters. On arrival I was informed by a VPO senior administrator of our responsibilities as:

*We must do it right as it's the REDACTED SENIOR POLITICIAN'S district.*⁵⁵⁶

⁵⁵⁴ Person SHM1B stated this to NGO 1 in a video recorded during fieldtrip 4. AP was asked by person SPM6 to interview person SHM1B in this video with the video being uploaded for a time onto NGO 1's website. See document F4M (p. 75, l. 25-27 and Fn. 473). AP (who was the *you*) reflected at the time (see Fn. 473) that he felt the request was *personal* as person SHM1B looked directly at AP during this statement rather than person SPM4 who was recording the video. Person SHM1B finished the interview with a reiteration of the request *pointing* to the districts. See also document F4M (p. 76, l. 14-16 and Figure 23).

⁵⁵⁵ Unfortunately, an expected grant was not forthcoming so less programmes were planned.

⁵⁵⁶ Person SPM6 reported this in document F2M (p. 34, l. 34).

Where individual SSA actors can sometimes grasp power in the IHV phenomenon appears to be related to IHV NGOs being granted necessary permissions or MOUs from Africans to run programmes. Here I reflected on one fieldtrip about the importance of a senior SSA health worker who I described as:

*They seem to know everybody; they can unlock many doors.*⁵⁵⁷

Ultimately, in this instance my reflections proved to be correct as this person unlocked the door with the appropriate gatekeeper whom I, with others, met to seek permission to run an IHV programme with a senior government leader. They informed:

*We must fast-track this through.*⁵⁵⁸

For the IHV NGO, knowing who to contact to arrange meetings with gatekeepers to allow programme facilitation is essential for smooth running of the programme. Real power here is in the hands of the person who controls that information. In the IHV phenomenon in one of the two SSA countries, I reflected during a fieldtrip that I was:

*Convinced that in terms of REDACTED SPECIFIC HEALTH AREA, REDACTED GATEKEEPER (and possibly others like them) are controlling the information that all interest-holders⁵⁵⁹ see.*⁵⁶⁰

I went on to pose a rhetorical question in my field notes:

*Are all the interest-holders⁵⁶¹ being played like a violin by the gatekeeper?*⁵⁶²

⁵⁵⁷ AP reported this to person GNF2 regarding person SEM1B, a polymath, and the embodiment of the *Local Hero effect* (*Local Hero*, 1983). See document F3M (p. 26, l. 5).

⁵⁵⁸ Person SEM17 reported this in document F3M (p. 99, l. 38-39). AP and persons GNF2 and SEM1B met with person SEM17 facilitated by person SEM1B. Without the gatekeeper role of person SEM1B it is likely that a meeting with person SEM17 would not have taken place nor the IHV prioritized.

⁵⁵⁹ The actual term I used in my reflection, at the time, was *stakeholders*. This term is a colonial term used to indicate when a person placed a stake into the earth to demarcate an area of land that was being stolen or forcibly occupied from indigenous persons (Reed, *et al*, 2024). In decolonizing this work, I am using the more appropriate term *interest-holders* which is an alternative term gaining increasing use in health research contexts (Akl, *et al.*, 2024).

⁵⁶⁰ AP was referring to person SEM1B and possibly others. See document F3M (p. 83, Fn. 406).

I am unable to answer my rhetorical question with certainty due to insufficient data. Nevertheless, instances like this upset the power hierarchy seen in Figure 17 and do seem to sometimes put considerable power in the IHV phenomenon in the hands of some individual Africans. In my view though this is a poor solution to empowering Africans as it disadvantages most collaborators in the IHV phenomenon, particularly those from Africa and the Global North trying to set up new collaborations. In addition, it may potentially mean that the individual views of a handful of powerful individuals outweigh the collaborative views of many interest-holders. Perhaps development of a system that allows representatives of IHV collaborations drawn from African interest-holders and IHV NGOs to seek permissions together more easily from decision makers may help level the power dynamics in IHV in the two SSA countries.

At programme level in the day to day running of IHV programmes my observation of power was that it was largely in the hands of mostly effective leadership teams. In many instances having a diverse range of collaborators drawn from senior SSA health workers, the IHV NGO and the SSA VPO brought with it a supportive and relatively collegiate approach to power rather than a power imbalance. This was not always the case, as not all IHV NGOs adopt a diverse and collaborative approach to power and leadership. For example, I and a VPO administrator observed a different IHV NGO running a programme on a fieldtrip. The NGO being observed operated a model where power was predominantly in the hands of individuals from the NGO with minimal input from Africans. My VPO colleague whispered to me on a disordered scene within the health facility:

*Give me a pen, paper and some stickers and I could have this place running much better in five minutes.*⁵⁶³

I contend again that power shared amongst diverse actors drawn from interest-holders within a collaboration is not only a good model for running effective IHV programmes but is a way of reducing power imbalances and levelling

⁵⁶¹ *Stakeholders* has again been replaced by *interest-holders*. See footnote 561 above.

⁵⁶² AP reported this. See again document F3M (p. 83, Fn. 406).

⁵⁶³ Person SPM3 reported this in document F3M (p. 48, l. 9-12).

the power hierarchy. It does not mean that this model is perfect as with the responsibility of power comes the possibility of abusing that power. For example, on my first fieldtrip the VPO administrators discussed with me and the VPO senior administrator the behaviour of some senior SSA health workers, I noted that:

They were progressively harassed by senior SSA health workers who were speaking to them in inappropriate tones and expecting them to be their servants.⁵⁶⁴ One VPO administrator commented that they have a superiority complex.⁵⁶⁵

Here I found myself, in my leadership role, powerless to do little more than flag the issue with the most senior SSA health worker as I felt uncomfortable in intervening in a matter between two different groups of African interest-holders. Perhaps my concern was that if I better addressed the issue I would be perceived as abusing my power or as behaving in a neo-colonial manner.

From an African perspective, abuse of power was evident in my study and sometimes emanated from senior SSA health workers in the IHV phenomenon. Examples of this took the form of trying to prioritize treatment of district officials and their families on IHV programmes and using their power to try, via threat, to stop the IHV programme to pressurize IHV NGOs with unrealistic demands. For example, I observed a demand for expensive and unnecessary items of PPE where two senior SSA health workers demanded that the NGO provide the PPE. One of the IHV NGO leadership team members asks for clarification:

So, what you are saying is that for the programme to continue in REDACTED SPECIFIC COUNTRY we must provide this PPE?⁵⁶⁶

One senior SSA health worker confirms their view:

This is our recommendation.⁵⁶⁷

⁵⁶⁴ Persons SPM1, SPM7 and SPM8 discussed this with person AP and person SPM6 in document F1M (p. 51, l. 34-37).

⁵⁶⁵ Person SPM1 intimated this. See document F1M (p. 51, l. 37).

⁵⁶⁶ Person GNF1A asked this question to persons SHM5A and SHM7A. See document F1M (p. 66, l. 38-39).

A different senior SSA health worker responds:

*The REDACTED NGO should provide them for our nation; you will need to expand your budget.*⁵⁶⁸

This resulted in the IHV NGO taking this externally to SSA government officials who backed the NGO and admonished the senior SSA health workers. Undoubtedly such unnecessary conflict would likely leave feelings of resentment and mistrust between IHV NGO and some senior SSA health workers, which is unhelpful for future collaborative relationships. I recursively reflected much on why senior SSA health workers in my study appeared to be the group where most examples of abuse of power originated. I felt that this group of people, particularly in rural areas, feel unsupported and forgotten by African decision makers and health service funders, as put by one senior SSA health worker on my last fieldtrip saying that they:

*Are frustrated by REDACTED GOVERNMENT AUTHORITIES as they hold the power and the budget, and their⁵⁶⁹ budget is low.*⁵⁷⁰

The same person, later in the IHV programme, reported:

*My bosses don't understand me, if I do nothing, I will wait my whole life for REDACTED SPECIFIC HEALTH services in REDACTED SPECIFIC REGION.*⁵⁷¹

Perhaps seemingly powerful senior SSA health workers are powerless or constrained in much of their work. The arrival of an IHV NGO in their area may present a possibility to attempt by whatever means to exercise their aura of power to improve their lot and the health services they are responsible for. I hope that my

⁵⁶⁷ Person SHM7A reported this to AP and persons GNF1A and GVF4A. See document F1M (p. 66, l. 41).

⁵⁶⁸ Person SHM5A reported this to AP and persons GNF1A and GVF4A. See document F1M (p. 67, l. 11-13).

⁵⁶⁹ In this reported speech *their* likely relates to both person SHM1A's budget *and* the budget of the redacted government authorities.

⁵⁷⁰ Person SHM1A reported this in document F4M (p. 103, l. 22-23).

⁵⁷¹ Person SHM1A reported this to AP and person SEM1J in document F4M (p. 109, l. 2-5). Here person SHM1A is likely trying to also gain support and advice from person SEM1J.

recursive reflection of this power dynamic increases understanding and empathy for the difficulties faced by senior SSA health workers amongst IHV interest-holders, as they are a group crucial to IHV programme success.

Power imbalances influence the IHV phenomenon in the two SSA countries and whilst power is weighted towards funders, government and IHV NGOs as seen in Figure 17, power imbalances occur that challenge this largely vertical notion of power. A more collegiate notion of power spread between actors drawn from a diversity of collaborators is helpful in IHV collaborative partnerships but is imperfect. Some form of power abuse is an almost inevitable occurrence in IHV in the two SSA countries if excessive power remains in the hands of a few individuals. All these situations challenge the harmony of IHV collaborations and require to be handled sensitively by IHV interest-holders. In my next section I will explore the influence of hierarchy on IHV in the two SSA countries.

5.4 Hierarchy

Hierarchy is evident as a ubiquitous concept throughout human society with people situating themselves, sometimes unconsciously, into positions of superiority and inferiority (Bunderson, 2003). Hierarchy in organisations establishes a “chain of command” (Hage, 1995, p.212). Thus, it is generally accepted that hierarchy enables stability and efficiency within organisations (Magee and Galinsky, 2008). Hierarchy though is controversial with evident tensions between hierarchy and initiatives promoting equality (Kolodny, 2023). Hierarchies are not static and can change but are notoriously difficult to change (Satterstrom, 2016).

In healthcare, hierarchy is crucial as it affects how health services are delivered and structured (Essex *et al.*, 2023). Furthermore, within healthcare hierarchy pervades collaborative attitudes (Filizli and Önlér, 2020), communication (Green *et al.*, 2017) and can affect individual contributions within healthcare teams (Stocker *et al.*, 2016). In their scoping review, Essex *et al.* (2023) note that hierarchy can create inter- and intra-professional splits between the powerful and the powerless regarding communication. In IHV in the two SSA countries, programmes are delivered by interest-holders with one commonality being their involvement in healthcare hierarchies. However, the diversity of individuals and

groups, the differences in Eurocentric and Afrocentric hierarchies, together with the potentially unfamiliar hierarchy of an IHV programme in the two SSA countries can make negotiating hierarchical issues problematic in the IHV phenomenon.

In Section 1.11, I discussed the predominantly pyramidal structure of health services in the two SSA countries and some of the issues in these services. For the UEHV and IHV NGO based in the UK the pyramidal structure in SSA seems *prima facie* very familiar. Traditionally health services structures in the UK are pyramidal and often rigidly so (Kanaris, 2023). A feature of pyramidal structures is that they sometimes incorporate rigid hierarchical leadership styles that may be autocratic and transactional (Sfantou *et al.*, 2017). Not only is the structure of health services in the two SSA countries predominantly rigidly hierarchical but many of the actors themselves attending IHV programmes, regardless of whether they are from SSA or the UK/Europe, operate effectively in their normal roles, out with IHV, within these types of hierarchies. Furthermore, most are entirely familiar with their individual positions within their normal role but may be unfamiliar with their role on an IHV programme. For example, on my second fieldtrip one UEHV was high in the pyramidal hierarchy within their normal role but on the IHV programme they were both being exposed to Africa for the first time and were not in a leadership role. They remarked to me at the start that:

*It would be great for once not to be in a leadership role.*⁵⁷²

I observed that at first, they appeared to struggle a little with their differing hierarchical position, but adapted very quickly, perhaps partly because the IHV programme had a more collegiate approach to leadership and a flatter and less rigid hierarchy. For the UEHVs the environment of an IHV programme is within an unfamiliar hierarchy but most accept and embrace differences.

However, from an African perspective, SSA actors mostly maintained their normal hierarchical power structures during IHV programmes. Essentially an IHV programme usually takes place within the constraints of an existing African health service, so for the SSA health worker their familiar pre-existing rigid pyramidal hierarchy seems to apply. This can sometimes be problematic. Take for example

⁵⁷² Person GVM2A reported this. See document F2M (p. 11, l. 21-23).

the predicament of the most senior SSA health worker on an IHV programme that I observed. Here this person, part of the IHV programme leadership team, was a middle grade SSA health worker in an acting role as the district had no senior SSA health workers.⁵⁷³ When the programme was visited by an uninvolved senior SSA health worker, I observed that the senior ordered the middle grade to undertake some procedures that were not usually part of the programme. Here, the middle grade, being lower in the hierarchy and less powerful, felt obligated to try to accede to the uninvolved senior, putting them at odds with the aims of the IHV programme.⁵⁷⁴ In the next subsection, I will consider hierarchies in African health services in more detail.

5.4.1 Hierarchies in African health services

The pyramidal nature of health services in the two SSA countries is seen through its structure (see Section 1.11) but it is seen also through its health workers. With a lack of trained doctors and other health professions educated to degree level, health services are commonly provided by people with varying amounts of health-related training. Complicating matters is that some are then task-shifted (sometimes with the help of IHV NGOs) to develop additional skills not ordinarily associated with their cadre for example providing optical glasses, managing HIV-AIDS related conditions and conducting important health surveys. In non-nursing health professions nomenclature varies throughout SSA but for patients the hierarchy is simpler. Whether someone is titled as a medical assistant, a clinical officer, an assistant medical officer or a medical officer to the patient they are *the doctor*, with a high place in a community hierarchy. In nursing professions, whether they are enrolled or registered matters little to the patient, they are the *nurse* again held high in a hierarchy. But within health services these grades are ranked, and a rigid hierarchy exists even though some lower down the hierarchy will be in administrative acting roles usually reserved for higher grades. In IHV in the two SSA countries, the hierarchy within African health services can appear somewhat

⁵⁷³ Essentially this person had two roles on the IHV programme as SHF1A (middle grade health worker) and SHF1B (district government official) which put them in the IHV programme leadership team. This is evident throughout document F1M.

⁵⁷⁴ This example related to person SHF1A/SHF1B being pressurized by person SYF1 who whilst also a senior SSA health worker only has an observational role on the IHV programme. See document F1M (p. 29, l. 21-29)

opaque to outsiders such as IHV NGOs or UEHVs even though it is familiar to SSA health actors who operate largely successfully within the hierarchy.

My findings about the African health hierarchy, from observations of SSA health workers in the two SSA countries, largely confirmed the rigid structure of the hierarchy. But I also found that this hierarchy did not necessarily dovetail well with the needs of IHV programmes that tried to operate with mutuality and with a flatter hierarchy. For example, confirming the SSA health hierarchy in the two SSA countries, and fully accepting it, I found a middle grade health worker telling me about a senior health worker:

*REDACTED SENIOR HEALTH WORKER does no clinical work and makes me do all the work.*⁵⁷⁵

The rigid hierarchy, at times, does seem to stifle ambition and career progression. This was evident from the frustration of a highly competent district health official trained to diploma level,⁵⁷⁶ who indicated that they would be unable to become a regional health official as they were not educated to degree level.

Most of the IHV programmes that I was involved in required training of lower grade SSA health workers. This necessitated trainers who were competent at teaching some clinical skills. As not all trainers, whether SSA health workers or UEHVs, were experienced in training weaker trainees, to do so sometimes required creative problem solving by IHV programme leadership teams. It was here where I found the rigid SSA in the the two SSA countries hierarchy most frustrating as it seemed to work against IHV programme aims. For example, in trying to get appropriate training for a weaker trainee the leadership team wanted to use a competent middle grade health worker as a one-to-one trainer, but this was ultimately not enacted as I reflected at the time:

⁵⁷⁵ Person SHF1A reported this about person SEM3B. See document F1M (p. 29, l. 31).

⁵⁷⁶ In this instance this represented one year less of undergraduate training for this cadre (five years instead of six). This related to person SHF1B in document F1M (p. 54, l. 10-11).

*Hierarchically they cannot train one-to-one as it would cause offence culturally to the REDACTED SENIOR SSA HEALTH WORKERS.*⁵⁷⁷

This hierarchy remained rigid even though one senior SSA health worker took the view that they were *not a teacher* and that middle grade SSA health workers were quite capable of doing the additional training required.⁵⁷⁸

Hierarchies in the two SSA countries health services appear complicated further by other factors such as age. I observed health workers of equal rank deferring to those who were older, reflecting African cultural values. As an example, on my fourth fieldtrip I noticed that if any of the IHV leadership team talked to a group of lower grade health workers, they all looked at one lower grade health worker first who answered and then the others spoke. At first, I was puzzled so I asked the spokesperson why, and they answered:

*They are just giving me my place as I am the oldest and have been a health worker for the longest time it is respectful for me to speak first.*⁵⁷⁹

It seemed to me that firstly hierarchy is related to respect, another important influence on IHV in the two SSA countries and important for those who have *ubuntu*. Secondly, it is not just age that is important in hierarchy, it is length of service. This rigidity of hierarchy would be familiar amongst those within some military organisations, where officers of equal rank are sometimes distinguished in hierarchy by length of service.⁵⁸⁰

Yet this appeared to occur in most SSA health worker ranks. Take for example a group of senior SSA health workers that I observed during my first fieldtrip, one of whom was older than the others. I noted that this person was:

⁵⁷⁷ This related to the potential offence caused to persons SHM1A, SHM5A, SHM6A, SHM7A and SHM8A were the training lead (AP) to persuade the leadership team (which included person SHF1A) to allow person SHF1A to do this. See document F1M (p. 39, l. 10-11).

⁵⁷⁸ Person SHM6A describes himself thus and indicates the capabilities of middle grades. See document F1M (p. 56, l. 21-23).

⁵⁷⁹ Person SHM26 indicated this in document F4M (p. 47, l. 27-28).

⁵⁸⁰ For example, the British Army keeps seniority lists that distinguish personnel of equal rank by *inter alia* order of commission date and service number (the lower the number the longer the person has been in service). This is believed pivotal to the chain of command and ceremonial duties. See British Army (2025).

*Revered and respected by the other REDACTED SENIOR HEALTH WORKERS by my interpretation of how they addressed them and at times the others bowed to them.*⁵⁸¹

Whilst this person was quiet, when they spoke the others listened. On one occasion there was a debate regarding a method of sterilisation of instruments, where some senior SSA health workers were arguing to maintain an outdated method during an IHV programme, whereas the UEHVs suggested change. This person eventually settled the issue by addressing their fellow senior SSA health workers:

*We must change it as the REDACTED IHV NGO are correct, even the WHO says our method is wrong.*⁵⁸²

Later the person took me aside,⁵⁸³ away from the group, and thanked me for addressing the sterilisation issue. They said to me:

*I think there are many things that we do that are old fashioned; you must tell me if there is a better way.*⁵⁸⁴

I sensed the group simply were not prepared to go against their hierarchical leader; on this occasion the leader's intervention effected positive change and showed open-mindedness towards further change. It seemed to me on recursive reflection that this person was aware of their position in the hierarchy and the additional responsibilities that brought. But I also found exceptions as sometimes entrenched views of an older hierarchical leader stifled positive change.

On one occasion, a senior SSA health worker was unprepared to share their own views but deferred to a hierarchical leader with a closed mindset to change and reiterated some negative views on part of an IHV programme apologetically as:

⁵⁸¹ This related to person SHM7A. The *others* referred to here are persons SHM1A, SHM5A, SHM6A and SHM8A. See document F1M (p. 11, l. 26-27).

⁵⁸² Person SHM7A reported this. Their view was accepted without further debate by persons SHM1A, SHM5A, SHM6A and SHM8A. See document F1M (p. 16, l. 14-16).

⁵⁸³ As I was the IHV NGO teaching lead on the programme. Person SHM7A was likely respecting my hierarchical position on the IHV programme by doing this.

⁵⁸⁴ Person SHM7A told me this in document F1M (p. 16, l. 19-20).

*They have been very senior for 10 years and I am just trying to say, what I have been told.*⁵⁸⁵

Here I realised that the hierarchy and respect for elders and seniority seems to trump independent viewpoints and can, on occasion risk, stifling change in IHV in the two SSA countries.

In my exploration of hierarchy as an influence on IHV in the two SSA countries I will now address gender equality in African health services. In Sections 2.3 and 2.3.8 I introduced to the reader that women are underrepresented in most health professions in African health services, with nursing and midwifery being an exception. Indeed, SSA has the lowest proportion of female health workers in the world with only 28% of physicians being women (Boniol *et al.*, 2019). Additionally, Belaid *et al.* (2017) describe a gender-power relationship that affects both health professional recruitment and retention, meaning that women often must move with husbands for work due to cultural norms and marriage rather than the opposite. There is under-representation of female health workers in decision-making and managerial roles within SSA health services. Most are concentrated in lower grade and lower paid roles (Uneke and Uneke, 2021), together with some evidence of women health workers being subjected to harassment and discrimination (Newman *et al.*, 2011).

In my study, women involved in IHV in the two SSA countries represented a similar small percentage as indicated above and most were in lower grade health worker posts although a small number were in higher grade and decision-making roles. This though was at odds with the IHV NGO teams in my study where UEHVs had proportionately more women than men, including those in IHV NGO leadership teams. Indeed, on my first fieldtrip I was the only male on the IHV NGO team. One unexpected benefit of this was that SSA women health workers had female role models in leadership roles, albeit those from the UK/Europe rather than Africa. I observed one such female SSA health worker liaise after the IHV programme had ended with a female UEHV and leader who essentially became a mentor and role model for her and with whom she could communicate in a non-

⁵⁸⁵ Person SHM1A reported this regarding person SYF1. See document F1M (p. 68, l. 37-38). Here person GNF1A shows cultural humility to person SHM1A by indicating that they *understand that* in document F1M (p. 68, l. 40).

hierarchical manner.⁵⁸⁶ Additionally, having IHV NGOs with female trainers allowed female to female one-to-one training of lower grade female health workers which was helpful as I observed that sometimes the lower grade female health workers came on IHV programmes with low self-esteem.⁵⁸⁷ I reflected at the time that this may be due to previous negative hierarchical prejudice.

However, I observed in my research that the hierarchical nature of SSA health services in the two SSA countries very occasionally disadvantaged women with perceived gender norms on IHV programmes. I observed occasional but concerning examples of encounters on IHV programmes where a small minority of males more senior in the health service hierarchy in the two SSA countries interacted with females of lesser hierarchical status in a concerning manner. These interactions were different from how they interacted with males of the same lesser hierarchical status.

Examples of the behaviours I observed and/or reflected on included:

*A male senior SSA health worker being rude and obnoxious throughout to a female lower grade SSA health worker that they were training.*⁵⁸⁸

*Excluding a female middle grade SSA health worker from decision making and feedback sessions.*⁵⁸⁹

Overwhelmingly though, the behaviour towards SSA female health workers from male SSA health workers was respectful, encouraging and positive despite hierarchical seniority of most of the males within the health service hierarchy in the two SSA countries. Indeed, I observed on my second fieldtrip the sole female lower grade SSA health worker trainee amongst five males growing within the IHV

⁵⁸⁶ For example, person GNF1A acted in this role for person SHF1A. See document F1M (p. 87, l. 12-29).

⁵⁸⁷ For example, person XVM1 noted some initial hesitancy from person SHF2 (see document F2M (p. 57, l. 6-7). AP and person GVF1B changed the trainer pairings for the following day so person SHF2 was trained by person GVF1A. See document F2M (p. 58, l. 33 and Fn. 236). By the end of the IHV training programme person SHF2's confidence and self-esteem was much improved that she was one of the strongest trainees (see document F2M, p. 71, l. 3).

⁵⁸⁸ A senior SSA health worker behaved like this towards a lower grade female SSA health worker. See document F1M (p. 51, l. 1). Identifiers were redacted due to the sensitivity of this data.

⁵⁸⁹ Person SHF1A was excluded by the group of senior SSA health workers. See document F1M (p. 36, l. 11-12).

programme. From being unconfident at the starting point, she ended up volunteering and running a peer led tutorial for her male colleagues surpassing them in every aspect with positive encouragement from other SSA health workers (her peers included) and UEHVs alike.⁵⁹⁰

I observed a small number of women in senior and significant decision-making roles within African health services in the two SSA countries, all of whom interacted with the IHV phenomenon. I did not observe any gender inequality issues within the IHV phenomenon relating to these women. Indeed, their status within the pyramidal hierarchy commanded respect from male colleagues, IHV NGOs and others involved in IHV, equivalent to their male peers of similar standing. Positively I did observe opportunity being given to one of these women by her selection to represent her government in visiting an IHV NGO programme in another African country to determine its suitability for their own country.⁵⁹¹ My research though is limited by the small number of senior SSA women observed and further study is needed to draw firmer conclusions.

Improvement in gender equality is an important issue in African countries as can be seen in its prominence in national political discourses and media (see Figure 18).



Figure 18: A roadside sign showing the prominence of gender equality issues in the two SSA countries.

⁵⁹⁰ The performance of person SHF2 is reported in document F2M (p. 101, l. 23-25 and Figure 50).

⁵⁹¹ Person SEF1A was selected by SEM18 to represent their SSA country as an observer (in her *alter ego* role as person SEF1D) to visit an NGO 1 programme in the othe SSA study country. See document F3M (p. 100, Fn. 460).

It is thus important for IHV NGOs working in the two SSA countries to reflect the importance of these issues to dovetail with their host's priorities. I believe that IHV NGOs and individual UEHVs sometimes have the potential to be an exemplar by having women in leadership roles, and by role-modelling to better promote gender equality whilst tactfully calling out inappropriate behaviour on IHV programmes in the two SSA countries. It is however important from an African perspective that this is done within the constraints of African cultural and hierarchical values. A simple example of this during my research was that in one of the IHV NGOs I observed there were female trustees appointed who were from the African diaspora.⁵⁹²

Often in African health services there are different levels of training and thus rank amongst health professionals of the same health profession. On the IHV programmes that I observed, there were two distinct hierarchical levels of SSA health professional within my own health profession with roles on the IHV programme in both countries of study. Sometimes there was evident hierarchical tension between these ranks which I will term middle grade and senior. One senior referred to the middle-graders as:

*They have in the past had a reputation of being rude and unprofessional.*⁵⁹³

Additionally, seniors did not allow middle grades to join their professional associations so access to things like peer support and CPD was limited for middle grades. Perhaps with lesser numbers of seniors and considerably more middle grades the powerful seniors felt threatened by the seemingly powerless middle grades. In any event the seniors in the pyramidal hierarchy appeared to be exhibiting exclusivity and control of the middle grades despite recognition from a representative of the national professional association that the middle grades were *the backbone*⁵⁹⁴ of the profession specific health services in the country. Unsurprisingly, I observed middle grades on IHV programmes who were somewhat disgruntled with seniors:

⁵⁹² NGO 1 appointed person XNF1, who had an association with Country 1 (see document C3, p. 1, l. 25) and XNF2, who had an association with another SSA country and Country 2 (see document C3, p. 5, l. 18).

⁵⁹³ Person SEM1D reported this in document F3M (p. 51, l. 4-5).

⁵⁹⁴ Person SEM1D reported this in document F3M (p. 65, l. 18-19).

*All we hear is REDACTED seniors, they have forgotten about us here in the districts.*⁵⁹⁵

*They do not respect us; they do not equip our health facilities.*⁵⁹⁶

It was often necessary for IHV NGOs and UEHVs to work with both seniors and middle grades from SSA on the same programme with both often being in leadership roles. I observed that seniors and middle grades on IHV programmes generally coped well with the flatter hierarchy and more collegiate approach of IHV programme leadership. Perhaps they were simply putting differences aside for programme duration. On occasion tension would occur which risked team dynamics and harmony. For example, I observed the pyramidal and professional hierarchy being reinforced by one senior, refusing to undertake a task as they felt the task was *middle grade's work*.⁵⁹⁷

Those involved in developing and running IHV programmes in the two SSA countries need awareness of the rigid pyramidal hierarchy in African health services and how it may interact with flatter more collegiate hierarchies within IHV programmes. The influence of these hierarchies presents positive opportunities for mutual understanding and learning whilst at the same time it can present possibilities of team disharmony and tension on IHV programmes. I will now look at other hierarchies evident in the IHV phenomenon in the two SSA countries.

5.4.2 Other hierarchies in volunteering

Hierarchies exist throughout the wide range of interest-holders in the IHV phenomenon in the two SSA countries. Looking at UK IHV NGOs, most have some form of charitable status and are required by regulators to follow a charity governance code (The Charity Commission, 2023). This code sets out a loose hierarchical structure which usually involves a trustee board being responsible for ensuring that the NGO is governed effectively to meet aims and comply with charity law. Operationally and independent of the trustee board, some IHV NGOs

⁵⁹⁵ Person SHM19 indicated this in document F3M (p. 76, l. 28-29). The *districts* here refer to remote and rural areas of SSA.

⁵⁹⁶ Person SHM27 indicated this in document F3M (p. 77, l. 4-5).

⁵⁹⁷ Person SHM28 reported this. See document F4M (p. 72, l. 18).

will have employed staff or self-employed contractors and others will be volunteer led. There is usually some form of hierarchy within these positions. Thus, the hierarchies of IHV NGOs vary from more pyramidal to flatter dependent on the make-up, diversity and skill-mix of trustee boards and operational staff, contractors or volunteers. There is no one-size fits all and indeed with turnover of personnel and changing priorities and collaborations IHV NGO hierarchical structures can change with time.

The difficulty from an African perspective is that SSA interest-holders will often have sub-optimal knowledge and understanding about the hierarchy of the IHV NGOs that they are collaborating with. Some will behave very mutually, and others less so, and the IHV NGOs may change how they behave hierarchically towards SSA interest-holders over time. For example, I observed one of the NGOs in my study to have more of a pyramidal hierarchical structure, by employing SSA staff directly, then later exhibiting increasing mutuality with a VPO and following the Covid-19 pandemic evolving into a very mutual and collaborative organisation with a wider range of SSA collaborators.⁵⁹⁸ Undoubtedly in this instance hierarchical progression to more mutuality emerged through a combination of leadership change, restructuring and trustee turnover to a more diverse board, together with external pressures from funders and SSA collaborators. For the African interest-holders in IHV, negotiating IHV NGO hierarchies can be difficult and sometimes they seem to place themselves lower in the hierarchy than the IHV NGO. Take for example the VPO lead who I observed exhibiting hierarchical subservience to an IHV NGO misinterpreting a simple phone call as:

*I'm sure they are just checking up on me.*⁵⁹⁹

Another example I observed was of a different VPO lead feeling lower in the hierarchy to a different IHV NGO lead as they inform that they felt when faced with difficulties the IHV NGO lead *blames them*.⁶⁰⁰ Perhaps these feelings reflect perceptions of neo-colonialism which I will explore later in this chapter.

⁵⁹⁸ This relates to NGO 1.

⁵⁹⁹ Person SPM2 reported this. See document F4M (p. 21, l. 8 and Fn. 93). They here was person GNF2.

⁶⁰⁰ Person SPM5 reported this. See document F1M (p. 84, l. 42). The person who allegedly was attributing blame to person SPM5 was person GNM2.

Within VPOs I observed a more rigid pyramidal hierarchy than that within the IHV NGO programmes that the VPOs were involved in. Whilst this hierarchy largely resulted in an ordered and effective team sometimes it presented problems in the daily running of IHV programmes. For example, the rigid hierarchy sometimes would not delegate power at all, so senior people were unable to source readily available basic supplies necessary for IHV programmes. This caused shortages and crises as permission to buy was delayed or not forthcoming as expressed to me by a VPO senior administrator:

*I am not often allowed to buy what is needed.*⁶⁰¹

I observed also that the VPO leadership hierarchy sometimes retained information essential to the running of IHV programmes and thus senior VPO administrators could sometimes be unaware of problems until the actual IHV programme commenced. For example, a VPO senior administrator informs that a VPO leader had withheld, amongst other things, information necessary to provide safe accommodation for UEHVs leading to a rather chaotic start to an IHV programme in a remote location:

*This happens so much now, REDACTED VPO LEADER does not tell me things I should know.*⁶⁰²

I observed this inability to delegate decision-making at strategic level within some government organisations in IHV in the two SSA countries. Like the VPO hierarchy, the pyramidal hierarchy in these organisations only seemed to empower those at the top of the pyramid to have the power to make meaningful decisions. Those further down the pyramid seemed sometimes unable to approve things that were usually approved at that level in the UK/Europe. This led sometimes to collaborative inertia as there were unnecessary bureaucratic delays in basic permissions, agreeing MOUs and managing regulatory processes in a timely manner. I have insufficient data to reason why there was lack of delegation, but I

⁶⁰¹ Person SPM6 reported this in document F2M (p. 31, l. 21). Person SPM6 alleged that person SPM5 would not delegate the purchasing of supplies in the redacted large city where the VPO was based. Throughout fieldtrip 2 there were supply issues that AP and person SPM6 had to manage which was all the more difficult because fieldtrip 2 was in a remote location and most supplies were unavailable locally. Supply issues thread through document F2M.

⁶⁰² Person SPM6 reported this. See document F4M (p. 61, l. 12-14).

did wonder if indeed there is, in reality, an actual lack of delegation. Perhaps in some instances the person lower in the hierarchy does not want the responsibility or the potential blame of decision making involving IHV projects or simply it may be a show of African cultural respect for someone senior in the hierarchy. For example, a senior government official passing the decision-making responsibility for a simple decision resulted in an eventual tardy:

*My director has since directed me to...*⁶⁰³

Both responsibility and potential blame are evident in the above opening remark.

Yet sometimes at strategic level this more rigid hierarchy with decisions coming only from the top of the pyramid manages to move IHV programmes forward when there had been collaborative inertia. For example, I observed some non-engagement with an IHV programme by a group of SSA health officials. Engagement improved immediately when they were directed to provide evidence of their engagement by their overarching director in SSA government.⁶⁰⁴

There are multiple hierarchies influencing IHV in the two SSA countries with most interest-holders operating rigid pyramidal hierarchies within their organisations. Yet to allow mutuality at both strategic and programme level a flatter hierarchy is helpful within collaborative partnerships and during IHV programmes in the two SSA countries. Whilst IHV interest-holders and actors largely cope with the unfamiliar IHV hierarchies and provide effective programmes, at times the hierarchies can present problems in the two SSA countries. Better mutual understanding of each other's hierarchical differences and similarities amongst all interest-holders may be helpful for all involved.

⁶⁰³ Person SEM17 indicated this. See document F3A10 (p. 7, l. 34). Here person SEM18 was the *director* although SEM17 was also a senior government official, but a little lower in the hierarchy.

⁶⁰⁴ See document F1M (p. 74, l. 18-26). Here person SPM5 informed that person SEM16 issued an edict to this effect to all regional health officials in one of the SSA countries including SHM1B, SHM5B, SHM6B, SHM7B and SHM8B.

5.5 Respect in volunteering

Already in Section 4.2.2 I have discussed respect in African culture as a pivotal component of *ubuntu* philosophy. Additionally, I have mentioned in the preceding sections of this chapter its interlinkage with hierarchy in IHV in the two SSA countries. Respect is a major influence in IHV in the two SSA countries as without respect effective collaborations based on mutuality between interest-holders would be impossible. Moreover, in the absence of respect reasonable cultural competence would be difficult to achieve, risking cultural tension.

The predominance of my observations shows evidence of the presence of respect throughout the IHV phenomenon in the two SSA countries during all fieldtrips from most actors and interest-holders. I present some examples directly observed or where I reflected on others behaviour, at the time, during IHV programmes:

I noted respect for a middle grade SSA health worker from lower and higher grades on an IHV programme:

*Very helpful, good teacher, embraced their role, respected by lower grade and senior grade health workers.*⁶⁰⁵

A village elder informs the whole IHV programme team:

*I was fearful but was treated so respectfully. I was amazed and cannot believe that you people have such good hearts.*⁶⁰⁶

A different village elder from a different area to me and a VPO leader after we both paid a courtesy visit to show respect to a village chief during an IHV programme:

⁶⁰⁵ AP was asked by person GNF1A to comment on person SHF1A's abilities during the IHV programme. See document F1M (p. 78, l. 4).

⁶⁰⁶ Person SCM1 reported this (translated from the local language by person SHM1A) to the whole IHV programme team (Africans and those from the UK and Europe). See document F4M (p. 125, l. 21-22).

*It is good you see our chief; they are in charge, and they must be given our respect.*⁶⁰⁷

My reflections on another UEHV were that they:

*Came across as a deep thinking, respectful, polite, and very astute person.*⁶⁰⁸

These relatively mundane examples influence and contribute to the harmony of IHV programmes in the two SSA countries, given the esteem that respect has in African culture. For SSA interest-holders and actors, respectful behaviour is an indicator of the potential trustworthiness of IHV NGOs and their UEHVs. On one fieldtrip, I and an IHV NGO decision maker had several meetings with various senior SSA interest-holders like government officials and regulators to try to set up a new IHV programme and collaborative partnership. After one such meeting, I reflected:

*Meetings in Africa are time consuming and can be frustrating, but they are not difficult because Africans will always show mutual respect and courtesy when it is shown to them. Simply arranging the meeting says, I respect you enough to ask your permission. A positive answer is much more likely.*⁶⁰⁹

On the same trip, a meeting was arranged with a person who was not directly going to be involved in the proposed IHV programme. As the person was a senior official it was felt important to inform them about potential IHV activity in their nation and seek their views. After a positive and helpful meeting, I reflected:

Meeting the REDACTED SENIOR OFFICIAL will have no bearing whatsoever on the IHV Programme, but they are the REDACTED MOST SENIOR OFFICIAL IN A SPECIFIC HEALTH FIELD. The meeting shows that the REDACTED NGO respects them, values their views and in all honesty the REDACTED NGO may need them in later years, and they will

⁶⁰⁷ Person SCM7 (elder) directed this comment to person SPM3 regarding person SCM8 (chief) in document F3M (p. 45, l. 7).

⁶⁰⁸ This related to person XVM1. See document F2M (p. 33, l. 11-12).

⁶⁰⁹ My reflection is evident in document F3M (p. 102, Fn. 467).

*remember that these foreigners came to see them and showed them respect and courtesy.*⁶¹⁰

Whilst uncommon, disrespect did occur during my fieldtrips. I have already presented some examples in Section 1.10 in relation to regulation and IHV and concerning cultural tension in Section 4.6. As respect is almost akin to a universal cultural currency in IHV in the two SSA countries from all involved, when disrespect occurs it can be viewed very negatively. Perhaps one of my biggest fears as a clinical lead on IHV NGO programmes was having a disrespectful UEHV on the team, as I worried that disrespectful behaviours would risk reputational damage for the IHV NGO in the two SSA countries and bring programme disruption. In my mind, a single disrespectful UEHV was likely to destroy the respectful behaviour of everyone else given the importance of respect in African culture. I was fortunate that I did not directly encounter such a person. One former member of an IHV NGO leadership team informed me of a situation on a previous programme when an UEHV:

*Didn't follow requests or guidelines or even commands when it got down to that level...it was hard for the REDACTED CLINICAL LEAD.*⁶¹¹

This was viewed as disrespect to the NGO clinical lead by SSA actors on the programme, who should command respect by their position in the hierarchy, leading to a dysfunctional programme fraught with tension and later recrimination.⁶¹² Disrespect does not need to be verbal. I observed a SSA national association leader, who was visiting an IHV programme, being *blanked* by two district officials, whom they had earlier verbally disrespected. I reflected that given the importance of greetings in African culture that being *blanked* was the ultimate

⁶¹⁰ AP reflected on this courtesy visit to see person SEF3A. See document F3M (p. 102, Fn. 468 and p. 104, Figure 54). Persons GNF2 and SEM1D also visited person SEF1A with AP. Person SEF3A was needed *in later years* and was helpful in attempting to seek out some important information for the NGO. See document C3 (p. 4, l. 33-34).

⁶¹¹ Person GVF5 reported this in document T1 (p. 29, l. 8-10) regarding the experiences faced by the clinical lead (person GVM6) in trying to manage a disrespectful UEHV.

⁶¹² Redacted recriminations are evident throughout document T1.

disapproval.⁶¹³ It was only when this happened that they realised the level of their disrespect to the officials, informing:

*I have overstepped the mark.*⁶¹⁴

The difficulty about disrespect is that on IHV programmes I sometimes failed to observe it, as at times it was quite nuanced. In consequence, some disrespectful behaviour during my fieldtrips may have gone unnoticed. For example, on one fieldtrip I noticed that the relationship between lower grade SSA health workers and senior SSA health workers appeared strained. A middle grade SSA health worker later informed me that the lower grades felt that the seniors were disrespectful to them as they did not greet them on arrival on the first day of the programme but simply left to go to the village to drink chai. I observed the seniors going for chai but did not see the impact this had on the juniors at the time.⁶¹⁵ Despite being lower in the hierarchy, the lower grades would expect appropriate greetings from their seniors given the importance of respect and greetings in African culture. Appropriate greeting strategies in African culture are of paramount importance to show respect and are thought to contribute to social harmony (Wójtowicz, 2021). Negotiating the potential minefield of cultural values from the many individuals and groups involved in IHV in the two SSA countries, even with reasonable cultural competence, is likely an impossible task. Disrespect, in my view, at a low-level, is an inevitability in the IHV phenomenon in the two SSA countries. Cultural humility is perhaps one way to try avoiding disrespect negatively influencing IHV in the two SSA countries. Additionally, recognising and praising respectful behaviours whilst offering support for those exhibiting disrespectful behaviours may, according to Toledo-Pereyra (2005), help in healthcare settings.

Self-respect is required by both individuals and organisations to give purpose and a personal value within society (Toledo-Pereyra, 2005). For the most part individuals and organisations within IHV in the two SSA countries appeared to

⁶¹³ Person SYF1 was *blanked* by persons SEM4 and SEM5. See document F1M (p. 32, l. 8-10 and Fn. 88). This also appears in Appendix 4 of this thesis as part of my example of coding to a data sheet for the code *respect*.

⁶¹⁴ Person SYF1 informed this in document F1M (p. 32, l. 13).

⁶¹⁵ I was informed by person SHF1A regarding my omission. See my reflection on the matter in document F1M (p. 28, Fn. 69).

show self-respect. However, I did observe some exceptions amongst individuals who appeared to struggle with self-respect related to themselves and the organisations they were involved with in the IHV phenomenon.

From an African perspective, I did wonder if working with an IHV programme helped or hindered the self-respect of some SSA health workers. Take for example a SSA middle grade health worker acting in an additional administrative role. For them, working on some IHV NGO programmes meant for the duration of the programme they interacted with different people, had an important role and felt what they were doing was worthy. But following the programme they would be back to working in an area far from family, working with inadequate equipment, were under-funded and over-worked being powerless in their acting up role due to their hierarchical position. I reflected that here the IHV programme gave them a glimpse of an unachievable lifestyle and may have raised unrealistic expectations, thus contributing to loss of self-respect.⁶¹⁶ However for another, the loss of self-respect from the daily grind of being a senior SSA health worker in a remote under-funded area, having to take on other additional and unwanted roles due to lack of recruitment and retention, was transformed positively by involvement with some IHV programmes. Here working with an IHV NGO allowed that person to regain self-respect and continue to work with the NGO post-programme, putting into place their own ideas for health improvement in their region.⁶¹⁷ Ultimately, I have insufficient data to determine with certainty the relative importance and influence of self-respect in the IHV phenomenon in the two SSA countries. This facet of respect perhaps warrants further study.

Respect influences IHV in the two SSA countries as it is such an important cultural requirement in African culture. An awareness of the part respect plays in African society is an essential requirement for all interest-holders as respect underpins collaborations and many inter-personal interactions on IHV programmes. By the same token, disrespect threatens collaborations and can disrupt IHV programmes in the two SSA countries. I will now address neo-colonialism which is the last interlinked theme in this chapter.

⁶¹⁶ AP explored this issue that related to person SHM3A in document F2M (p. 67, l. 30 and Fn. 257 – p. 68, l.23 and Fn. 258).

⁶¹⁷ This related to person SHM1A who was later pivotal in leading an IHV programme in their region supported remotely by the IHV NGO. See document C3 (p. 4, l. 8).

5.6 Neo-colonialism

This section (and Subsections 5.6.1 and 5.6.2) builds on the theme of neo-colonialism which I introduced to the reader earlier in this chapter in Sections 5.1 and 5.2. At the start of this section, I am conscious that I am a non-African researcher from the UK who is studying issues concerning Africa. From my privileged position I may thus be reinforcing the academic dependence of the Global South and influence of the Global North and in so doing be sustaining the power dynamics of neo-colonialism (Alatas, 2003). Indeed, looking at my research area of IHV in the two SSA countries this may be seen as a product of neo-colonialism. IHV has sought legitimacy of purpose from both the Millenium Development Goals (MDGs) and SDGs, yet the MDGs have been criticised as a form of neo-colonialism that tries to reinforce Global North power and controls the language of development (Durokifa and Ijeoma, 2018). Ogunrotifa (2012) goes further indicating that the MDGs themselves are a type of neo-colonialism as they do not promote development in SSA. Similarly, it is questionable as to whether the SDGs promote policies which help poor countries grow (Langan, 2018) and may thus facilitate neo-colonialism.

In terms of health, the influence of the Global North is evident as modern medicine has for the most part overwhelmed traditional healthcare in SSA (Arowolo, 2010). Whilst neo-colonialism is commonly expressed as economic and political domination, things like access to universal healthcare and access to affordable vaccines are basic health issues that put health in contested areas impacted by neo-colonialism. For example, in the Ebola virus crisis of 2013-2016 there was an inadequate global response that involved lesser standards of care due to health service weaknesses that had arisen from exploitative neo-colonialism (Frankfurter *et al.*, 2019).

Global North governments, some of whom were historic colonial masters, still espouse the importance of international development in the health sector in Africa. For example, the Scottish Government currently aims to strengthen health

systems and address health inequality in three SSA countries⁶¹⁸ through their health partnership programme (Scottish Government, 2025). Prior to the Covid-19 pandemic, strengthening African health services, addressing the shortage of health workers in Africa, and capacity building in health were areas where collaborations were often funded by Global North governments. IHV NGOs often relied on grant funding to play their part in creating and delivering IHV programmes in SSA that helped address these issues alongside SSA interest-holders. This was the case in the the two SSA countries of study. However, following the Covid-19 pandemic, some Global North governments cut funding to development assistance in health in SSA meaning that they reneged on global commitments to facilitate achievement of the SDGs, equity, and health security (MacPherson, Nliwasa and Choko, 2025). This behaviour looks like neo-colonialism with the dominant Global North making unilateral decisions which keep their SSA collaborators underdeveloped. Additionally, in the UK, the NHS relied on the migration of health workers, particularly in nursing and midwifery, to help with health workforce shortfalls (Ciupijus *et al.*, 2022). With European Union health workers leaving post-Brexit, the UK Government migration infrastructure instead recruited health labour from LMICs in Asia and Africa (Ciupijus *et al.*, 2022). In doing this, some in Africa argue that the UK Government is behaving in a neo-colonial manner by degrading already weakened SSA health services by recruiting their trained health workers (Acha, 2023). For IHV NGOs, many originating from the UK and Europe, it can seem futile to be involved in collaborative training of African health workers to improve health services in SSA for them to be later recruited to instead work in richer UK and European health services.

It is in this environment that IHV NGOs operate in Africa, with most being acutely aware that reputationally they do not want to be accused of behaving in a neo-colonial manner. The difficulty for IHV NGOs is that in many cases their role, often in collaboration with or led by SSA governments or communities, is about capacity building, training or *task-shifting* African health workers. The resultant skills to be transferred are thus often initially in the hands of the UEHV rather than the SSA health worker with the interpersonal power dynamic travelling from Global North to Global South. Even in reasonably sustainable IHV programmes in SSA, the dependency is with the African trainee until they are trained and even

⁶¹⁸ Malawi, Rwanda and Zambia.

then, they may have some resource or financial dependency on the IHV NGO. In consequence, the UEHV or IHV NGO risks being viewed as dominant and powerful and are sometimes open to accusations of neo-colonial behaviours, partially by the nature of their roles. In observing neo-colonialism, it is important to realise the difference between actual neo-colonial behaviours or those that are perceived as such by others but may simply reflect the nature of a trainer to trainee dynamic. I will now explore neo-colonialism in UEHVs and IHV NGOs.

5.6.1 Neo-colonialism in volunteers and volunteer organisations

On my third fieldtrip to SSA, I was in a position of power representing the IHV NGO in strategic discussions with senior SSA interest-holders regarding a future collaborative partnership. Sometimes greetings with those lower in the perceived hierarchy addressed me as *baas*. *Baas* is a word derived from Afrikaans that literally means *boss* but is usually used by indigenous Africans towards white people. *Baas* is historically an uncomfortable term as it represents to some a colonial social hierarchy and has associations with the apartheid era in South Africa. I reflected with disquiet that my mere presence in the position I was in may be considered a form of neo-colonialism. I later expressed this disquiet to a senior SSA government leader who told me:

*They are being respectful; they do not see the meaning that you and I see.*⁶¹⁹

I was only partly reassured by the senior SSA official. I recursively reflected that even when trying to be as mutual and collaborative as possible, the UEHV may be perceived differently by some in the two SSA countries. This is particularly evident when in a position of authority, so much self-awareness is needed to try to minimize these perceptions.

Occasionally I observed that discourse involving IHV NGOs and GNHVs reflected colonial hierarchies involving militaristic or religious language. For example, some IHV NGOs had assets⁶²⁰ located throughout SSA with religious

⁶¹⁹ Person SEM1A reported this to me. See document F3M (p. 24, l. 9-22).

⁶²⁰ For example, things like boats, ships or clinics.

names such as *Hope*⁶²¹ or *Mercy*⁶²² that could be construed to represent the dominant Global North providing charity to, rather than equitable collaboration with, their African collaborators. Discourse that could be construed as neo-colonialism sometimes occurred during IHV programmes but also, in publications in grey literature or on social media or video monologues. Some of this discourse would be seen by African actors as it was commonplace for UEHVs to stay in online contact with those from Africa who they knew from IHV programmes. Some of these behaviours risk being perceived as a form of neo-colonialism. For example, a term I observed being used by some UEHVs was *mission*. As one UEHV put it, the IHV programme they were volunteering for *was a mission*⁶²³ although I had perceived it as a collaborative programme with SSA actors. Occasionally, UEHVs would put something into the public domain that simply exuded neo-colonialism, reflecting a dominant Global North position and a helpless Global South together with inappropriate or inflammatory language. Take for example the very effective and seemingly reasonably culturally competent UEHV whom I observed later putting into the public domain that they:

*Went to Africa with REDACTED IHV NGO for a REDACTED IHV mission where they taught REDACTED HEALTH WORKERS in a local tribe to care for their natives in remote areas.*⁶²⁴

This comment related to a collaborative IHV programme where lower grade SSA health workers of several different ethnicities, were being *task-shifted* to undertake an additional surgical skill by UEHVs, middle grade and senior SSA health workers. This was part of an MOU with a SSA national association and with SSA district, regional and national government support and approval. This would likely capacity build for better health access to local communities within a specific district. Putting such a comment into the public domain is potentially damaging for the reputation of the IHV NGO, who have no control on the UEHV's public views.

⁶²¹ See for example, persons SPM2 and SPM3 sometimes works in a clinic originally set up by person GVM4B and others at NGO 1 called *Hope* (see document F4M, p. 131, Figure 71) which AP visited. Person SHM8A reported in document F1M (p. 11, l. 4) previous interactions with another IHV NGO who provide health clinics from a boat called *Hope*.

⁶²² See for example, person GVF15 was a UEHV on a ship, operated by another IHV NGO, called *Mercy* that berthed in ports in SSA. See document V6 (p. 9, l. 1-2).

⁶²³ Person GVF17 indicated this in document F4M (p. 128, l. 17).

⁶²⁴ An UEHV posted this publicly. See document F2A7 (p. 5, l. 24-22 and Fn. 9). AP has redacted the person identifier due to the sensitive nature of the content.

Occasionally, rather than use of inappropriate language an UEHV may allow something to be put into the public domain that reinforces the dominant position of UEHVs and potentially risks being viewed as neo-colonialism. In the example below a local newspaper interviewed a returning UEHV following an IHV programme in SSA and reports that the UEHV whilst in SSA:

*Often carries out things they would not do in their normal job like REDACTED SURGICAL PROCEDURES and anaesthetics.*⁶²⁵

In this case, the UEHV was from a cadre of health professionals who were untrained and not allowed by their UK regulator to carry out the tasks the newspaper article alludes to. Not only is this an example of neo-colonialism, but it shows disrespect towards SSA communities and persons by undertaking procedures that may be harmful when carried out without appropriate training. Contrast these examples of potentially inflammatory type neo-colonial behaviours from a minority of UEHVs with that from SSA actors, the majority of UEHVs and IHV NGOs where terms like *joint project* or *programme* were used. From the majority I observed behaviours before, during and after IHV programmes that expressed mutuality, respect and collaboration rather than neo-colonialism. Additionally, credit was given from, for example IHV NGOs to African interest-holders and *vice versa* reflecting similar mutuality, respect and collaboration:

From an IHV NGO to a SSA interest-holder:

*“The standard on this trip is the best I’ve ever seen...I have to thank the REDACTED SENIOR SSA HEALTH WORKER, I’m very grateful for his input because he is the one who has got them to such a good standard before we even started.”*⁶²⁶

⁶²⁵ An UEHV apparently told this to a reporter, and this was published in a printed article reporting their alleged statement. See document V6 (p. 8, l. 18-19). AP has redacted the person identifier due to the sensitive nature of the content.

⁶²⁶ AP transcribed this interview from the NGO 1 website. It was conducted in Country 1 between persons GFV21B, SPM1 and SHM29. When discussing an IHV programme person GFV21B stated this regarding person SHM29. See document S1 (p. 15, l. 18-20).

And from a SSA national health leader to the IHV NGO:

*“We need your support, we need your hand...more than 70% are missing basic REDACTED SPECIFIC healthcare, so your support is highly needed.”*⁶²⁷

IHV is sometimes viewed historically as the provision of aid from the Global North to the Global South. Smilak and Putnam (2022) discuss that the concept of *aid* is sometimes viewed as neo-colonialism although it may be better considered as *modern aid* or infrastructure development. In any event the concept of aid is problematic ethically and morally with concerns about the extent to which aid should be provided (Skinner, 1996). Unsurprisingly, my observations of IHV NGOs were that they did not want to be seen as providers of aid. This however is sometimes difficult as several IHV NGOs have aid in their name. I observed one such IHV NGO discuss the possibility of rebranding to a different name because of this, rebranding being not without risk of losing identity with funders and supporters and being expensive financially. In this instance I observed that the IHV NGO chose to first seek advice from their African collaborators on whether to rebrand, showing good collaborative practice, which meant that they stuck to their original name:

An IHV decision maker argues that:

*We need to rebrand...It's not about aid anymore, we don't want to be seen as white saviours.*⁶²⁸

The IHV NGO debated the issue and asked their SSA collaborators in the two SSA countries who responded:

*The name is irrelevant it's about what you do and the respect you show.*⁶²⁹

⁶²⁷ AP transcribed this interview from the NGO 1 website. It was conducted in Country 1 between persons GVM11 and SEM16. When discussing an IHV programme person SEM16 stated this. See document S1 (p. 11, l. 14-16).

⁶²⁸ Person GNF2 reported this in document C4 (p. 63, l. 27-30). The *we* in this case is person GNM2 who was of a similar view to person GNF2 as seen in document C4 (p. 63, l. 13 and l. 21). Others present disagreed.

Whilst I largely observed behaviours from UEHVs and IHV NGOs that exhibited the principles of reasonably equal collaborations, neo-colonial behaviours were evident at a low-level. However, when neo-colonialism did occur it had the potential to be reputationally damaging for IHV NGOs. Thus, the influence of neo-colonialism on IHV has the potential to be viewed as disrespectful to SSA collaborators and a disruptor to effective collaborative partnerships. Unfortunately, the IHV NGO has vulnerability from the rogue UEHV who can long after an IHV programme potentially disrupt relationships by behaving in a neo-colonial manner. For IHV NGOs, better training of their staff and UEHVs in culturally appropriate communication verbally, online and in traditional written word may help to reduce their vulnerability. Similarly, IHV NGOs may want to consider reflecting on the naming of buildings, facilities and their own hierarchies and programmes to avoid names that reflect militaristic or religious symbolism or make Africans feel helpless and those from the Global North dominant. In essence, seeking the views of Africans in these types of decisions at the inception of collaborations is a potential way to alter the power dynamic in favour of an African perspective. It is also a small step to decolonization in IHV which I will discuss in more depth in the following section.

5.6.2 Decolonization in volunteering

When considering decolonization in IHV in the two SSA countries, it is necessary to examine what areas of IHV require decolonization. Most IHV NGOs are Global North based organisations, and they and their volunteers and funders primarily comprise those from the Global North. IHV NGOs' operations are primarily subject to Global North regulators and their laws, importantly working in health systems based on Western medicine. They have the privileges of access to technology and medicines that can be out of reach of health systems in the two SSA countries. Yet IHV programmes often take place in environments in the two SSA countries where there is a paucity of trained staff, lack of health infrastructure, supplies, medicines, and facilities. IHV programmes thus occur at the front line of neo-colonialism in the area where for the UEHV the dominance of Western

⁶²⁹ Person GNM2 reported that persons SEF1A, SEM1D and SEM20 were consulted. See document C4 (p. 66, l. 27-30). Person GNM2 indicated that they *all said the same thing* (l. 27). Person GNM2 indicated that it was person SEM1D who reported this comment.

healthcare is a stark contrast to the relative underdevelopment of African health services. In short, there is likely room for change in many aspects of health services in Africa and so in IHV in the two SSA countries decolonization should be at the forefront of priorities for IHV NGOs in all areas that they can impact or influence.

Most of the IHV NGO programmes that I observed involved training, with the direction of travel being training from UK and European interest-holders towards learners from the Global South, albeit with much collaboration. In effect, even in collaborative IHV programmes infused with mutuality, the Global North is dominant, powerful and high in the health hierarchy whereas the Global South is less dominant, less powerful and most are lower in the health hierarchy. There must be room for decolonization in this area. Take for example my observations during the Covid-19 pandemic of a collaboration which included both study NGOs to create some health promotion resources with SSA interest-holders for use in one of the two SSA countries. Both UEHVs and SSA actors decided to put an extra quality control step into the resource creation process. Here, I reflected and remarked on the benefit to course relevance of this extra step which was to get all health teaching resources:

*Sense checked for cultural appropriateness and local relevance by
REDACTED SENIOR SSA HEALTH WORKERS AND
ADMINISTRATORS.⁶³⁰*

This enabled a considerable amount of south-north learning which according to Basu *et al.* (2017) aids mutual learning opportunities and is locally responsive. This very simple decolonizing change made the resource more applicable to the communities for which it was intended as it better respected their context. Additionally, it is a good example of co-creation of IHV programmes between collaborators which has a higher potential for being sustainable (Pérez Jolles *et al.*, 2022). As an example, the health resource had a section on healthy eating and a photograph of a chicken, produced by an UEHV and used elsewhere in SSA by one of the IHV NGOs. As one of the SSA quality controllers informed:

⁶³⁰ See document V13 (p. 1, l. 7-9). This task was largely undertaken by persons SEF1B and SEM1D. Some help specifically creating health promotion resources in a regional language came from persons SHM2A and SHM19 as others were not fluent in this language.

*We can't use that chicken (A rather large round white chicken) nobody would recognise it as a chicken...instead use this chicken.*⁶³¹

The photograph of the replacement chicken was instantly recognisable as a breed and stature commonly seen in rural parts of Africa, the intended locus of the teaching (see Figure 19):



Figure 19: Inclusion of this more appropriate chicken breed helped decolonize some teaching resources by south-north learning.

In this instance, the replacement chicken allowed a further critical look at all the healthy and unhealthy eating resources, and many were modified to the extent that the resources were made slightly different to reflect cultural variation in some areas until the teaching resources appeared decolonized fully. Just as important, the whole interactive process between collaborators flattened hierarchies, altered power dynamics a little and perhaps contributed to an improved and slightly more decolonized collaboration.

I observed that IHV NGOs that are involved in capacity building, training or upskilling usually bring with them resources to assist the process. Most of these resources have been developed by highly skilled and committed UEHVs but may be more Eurocentric in nature rather than Afrocentric. For example, they may suggest best practice improvements based on Global North healthcare which do not necessarily meet the needs of local communities as described by Yanful *et al.* (2023).

⁶³¹ Person SEM1D felt a plump broiler breed of chicken was inappropriate for use in a health promotion resource in rural areas of their SSA country. See document V13 (p. 1, l. 18-22).

Similarly, there is a paucity of black skin tones used in teaching resources in clinical healthcare settings (Abduelmula, Akuffo-Addo and Joseph, 2022). I observed examples of these in my research and observed over the course of my research as IHV NGOs worked collaboratively to better meet local needs and thus start the decolonizing process. For example, on one IHV NGO programme I observed an experienced clinician and teacher, but inexperienced UEHV, give a lecture to a group of SSA health professionals on a health subject. This topic was one where there were considerable management differences between Western healthcare and healthcare in the two SSA countries. I observed that the talk was:

*Global North oriented, and some things were inapplicable.*⁶³²

The SSA health professionals culturally were respectful to the lecturer who would be higher in the health hierarchy than them so no feedback or suggestions to improve were given. Some months later though I observed the IHV NGO work more collaboratively and produce much more locally relevant resources on the same subject and in doing so decolonizing their curriculum. I observed one IHV NGO over the course of my years of study move from a situation where clinical teaching resources had virtually no examples of black skin tones to more decolonized teaching material where nearly all resources used black skin tones for clinical teaching in the two SSA countries (see Figure 20):⁶³³



Figure 20: A clinical teaching slide in a black skin tone; the slide highlights a cancerous lymph node.

⁶³² Person GVF19 delivered this resource. See document F3M (p. 61, l. 6).

⁶³³ Consent for teaching and publication of this photograph was given by the patient, being obtained by me and facilitated by a senior SSA health worker (person SHM1A) in the local language of the area consistent with national regulations.

It is not just visual teaching materials that I observed being decolonized by IHV NGOs, but written teaching materials such as problem-based learning resources, assessments, online communications and discourse, which became increasingly decolonized through the course of this study.⁶³⁴ The example detailed in Figure 21 shows some problem-based learning resources developed for an IHV programme by UEHVs and SSA actors which is totally applicable to the local situation and fully decolonized:

Teaching others to teach:

For your first position after internship, you have been posted to a District Hospital in a remote and rural area of REDACTED COUNTRY. You are the only REDACTED SENIOR HEALTH WORKER, and you are to lead REDACTED health in the district. You work with and manage two experienced MIDDLE GRADE HEALTH WORKERS who are very busy dealing with acute problems and have little time for prevention. There are no other REDACTED health personnel in the district. REDACTED health in the district is poor. You decide to do some outreach to remote areas and are faced everyday with queues of people needing managed like in the photo. You realise that there is little REDACTED health literacy in the district. You decide to plan a programme to train others in these remote areas to deliver key REDACTED health messages to the rural population



Your task: Describe how you would plan an effective programme to train others to teach key REDACTED health messages to the rural population in this district?

Hints: Information needed; who will you train; what teaching resources will you need; consider budget and how you will obtain money; what problems may you have; where do you think would be best to train to maximise numbers; how will you support trained REDACTED health promoters; what risks, pitfalls and benefits are there? Sustainability?

Figure 21: A decolonized problem-based learning resource

for early career health workers.⁶³⁵

⁶³⁴ This photograph in Figure 20 was taken by AP on fieldtrip 4. See document F4M, (p. 40, l. 17-31) where AP and SHM1A managed the clinical situation. This photograph appears as part of a decolonized teaching resource produced by a collaboration between NGO 1, NGO2 and multiple health professional, HEI and government interest-holders in SSA together with others from UK and Europe. This was part of a 12-module course to upskill middle grade health workers in one of the SSA countries. The resources were written by AP and persons GNF1A, GNF3A, GNF4, GNM3A, GVF10, GVM10, SEF1A, SEM1D, SHM2B and SHM19. See document V12 (slide 16) for figure 21 and document V9 (slides 50-63) which explains the course in more detail.

⁶³⁵ This resource was developed by collaboration between AP and persons GNF4, SEF1A and SEM15 for use in one of the SSA study countries in an HEI and on IHV programmes. Person GVM4A then adapted it to account for cultural variations for IHV programmes in the other SSA study country. See document V11 (slide 19 and associated text in the entirety of that page).

Sometimes the decolonization would occur on IHV programmes and addressed controversial clinical issues where there was obvious disagreement between collaborators. Without a forum for discussion and a respectful collaboration to address the issue, if unresolved, may risk cultural tension. An example of this was on my last fieldtrip, where the controversial topic was regarding whether to prescribe or not prescribe antibiotics prophylactically in rural settings in the two SSA countries. A literal round table forum was set up which included all on-site IHV programme collaborators and ultimately a locally relevant decolonized solution was thrashed out. Detailed below is an excerpt from that discussion which was carried out non-hierarchically and respectfully:

Senior SSA health worker from one SSA study country:

*You are never sure in a rural situation if a patient can come and see you in a few days, so if they have complications, they often cannot come so you must prescribe antibiotics.*⁶³⁶

Senior SSA health worker from the other SSA study country:

*We have so few facilities, that it may be many months before a patient can come back, many have undiagnosed diseases like TB, like HIV-AIDS, so of course I will give them antibiotics if they are travelling from far away, it is my duty.*⁶³⁷

UEHV:

*So that's a very clear view but different from in the UK.*⁶³⁸

Senior SSA government official from one SSA study country:

*And in OUR COUNTRY, we must not prescribe too many antibiotics.*⁶³⁹

⁶³⁶ Person SEF1B reported this. See document F4M (p. 110, l. 31-32).

⁶³⁷ Person SHM1A reported this. See document F4M (p. 111, l. 3-5).

⁶³⁸ Person GVM3 indicated this. See document F4M (p. 111, l. 9).

⁶³⁹ Person SEM1A reported this. See document F4M (p. 111, l. 13).

Lower grade SSA health worker from the other SSA study country:

*No, I think this is wrong too we must protect antibiotics.*⁶⁴⁰

UEHV:

*Perhaps, we're going to have to agree to differ. (General Laughter).*⁶⁴¹

A different UEHV:

*What should we do with large swellings and very unwell patients, should they be referred?*⁶⁴²

IHV NGO leadership team member:

*That depends on how quickly they can be referred.*⁶⁴³

A different lower grade SSA health worker the other SSA study country:

*In my local REDACTED health post, I would start them on intra-venous antibiotics then phone the REDACTED SENIOR SSA HEALTH WORKER for advice. I would not send them as it is too far away from the REDACTED DISTRICT HOSPITAL, they would not afford it and would go get local medicine if I cannot do it.*⁶⁴⁴

Ultimately, this very healthy round table debate (see Figure 22)⁶⁴⁵ resulted in a solution that meant the *prescription of antibiotics should be at the discretion of the*

⁶⁴⁰ Person SHM4 reported this. See document F4M (p. 111, l. 17).

⁶⁴¹ Person GVM3 indicated this. See document F4M (p. 111, l. 21-23).

⁶⁴² Person GVF20 indicated this. See document F4M (p. 111, l. 27).

⁶⁴³ Person GVF3B reported this. See document F4M (p. 111, l. 31).

⁶⁴⁴ Person SHM23 indicated this. See document F4M (p. 111, l. 33-37).

⁶⁴⁵ The whole arrangement of the round table was non-hierarchical, being facilitated by a lower grade health worker (person SHM4) and an UEHV (person GVM3) and *not* the programme leadership team. AP and person SHM1A had discussed this with the two facilitators beforehand. All were invited to share views, although some chose only to listen.

*attending health professional at their health centre or dispensary.*⁶⁴⁶ This solution is far from many UK/European guidelines on antibiotic prescribing which leave little wiggle room for discretion. However, in the rural setting of an IHV programme this is locally relevant and from an African perspective this type of forum empowers African views and produces a solution free from the shackles of neo-colonialism. An IHV NGO that is serious about decolonization should consider innovative solutions like this to help enhance mutuality, promote south-north learning and decolonize some aspects of their programmes.



Figure 22: A round table forum during an on-site IHV programme in SSA.

Some IHV NGO programmes in the two SSA countries are more concerned with clinical treatment rather than teaching and here I observed that there is need for decolonization in some aspects of these types of programmes. For example, the focus on clinical treatment sometimes means, as put by one UEHV on such a programme that:

*We don't give health talks and we don't have time for health talks.*⁶⁴⁷

Yet disease prevention is often at the heart of SSA government policies in the two SSA countries, so in omitting prevention such an IHV NGO is not listening to its African collaborators and may be lacking in its approach to decolonization. Similarly I observed some IHV NGOs bringing equipment for use on their programmes that was unavailable in an African setting. For example, I observed the

⁶⁴⁶ The combined view of the round table is seen in document F4M (p. 111, l. 43-44).

⁶⁴⁷ Reported by person GVF4A in document T1 (p. 47, l. 27).

use of a particular European anaesthetic delivery system that was both beyond the economic means and unavailable in the parts of the two SSA countries where the IHV programme was taking place. This was perhaps used for UEHV familiarity or safety reasons. For the local SSA health workers left to manage patients for long after the IHV NGO had departed, patient management would now be harder and patient expectations higher without this system.⁶⁴⁸ I argue that using this delivery system reinforces the dominant economic and hierarchical position of the IHV NGO over SSA collaborators, reflecting notions of neo-colonialism. Another example was reported to me by a senior SSA health worker regarding an IHV NGO who tried to donate them equipment that was relevant only to healthcare in a high-income Western setting. They respectfully refused, indicating that the offered donation was not locally relevant. The reported reaction of the IHV NGO to the refusal was described to me by the senior SSA health worker as *colonial behaviour*.⁶⁴⁹ The NGO apparently indicated to them:

*You should just take what we give you; you are ungrateful.*⁶⁵⁰

I assert that this reported behaviour is disrespectful, suggestive that Africans are helpless, reinforces Global North dominance and power and is overtly neo-colonial. In addition, in my observations of IHV NGOs using exclusively treatment based models in the two SSA countries, I noticed that they sometimes had less SSA collaborators, may not be collaborating with a VPO and may not even interact with local health workers. Africans were used primarily for interpreting and as such had a lesser role in the IHV programme.⁶⁵¹ This again emphasizes Global North dominance and minimizes Africans in decision-making roles which can be best described as exhibiting features of neo-colonialism. I argue that there is much room for improvement in decolonization for some IHV NGOs. Perhaps these NGOs should collaborate more with IHV NGOs who are further along the road to enhancing decolonization and working more equitably with SSA collaborators. In

⁶⁴⁸ I discussed this in relation to the *sustainability-dependency conundrum* in Section 3.8. See document F3M (p. 37, l. 21-23)

⁶⁴⁹ Person SEM1A reported this. See F3M (p. 89, l. 18). Worryingly, person SEM1A indicated that this behaviour occurs *frequently* (l. 18).

⁶⁵⁰ Person SEM1A reported this. See document F3M (p. 89, l. 20-21)

⁶⁵¹ For example, see Section 3.6 where in Figure 12 I illustrate such a collaboration. This is sourced from my observations in document C3 (p.5, l. 19-31).

effect, IHV NGOs by collaboration could be positive role models to others in this area.

In the UK there is an under-representation of black people on charity trustee boards (Moss, 2024). As many IHV NGOs are registered as charitable organisations it is evident that at a strategic, decision-making level IHV NGOs have some way to go to decolonize. In my study, one of the IHV NGOs actively sought to address this problem and to improve diversity and thus decolonize its strategic decision-making body by giving voice to indigenous Africans⁶⁵² or those from the African diaspora.⁶⁵³ The extent of under-representation of Africans on the boards of IHV NGOs working in Africa is unknown but more African trustees are likely required. Similarly, strategy in IHV NGOs can be shaped by patrons and advisors. I argue that increasing the numbers of Africans in these groups would help address some of the disparities of power and dominance associated with neo-colonialism in the IHV phenomenon. Furthermore an IHV NGO working in the two SSA countries may be registered in a country like the UK but its purpose is usually to serve the African countries that it works in. I would argue that to decolonize even more, an over-representation of Africans is needed on trustee boards so that the needs of those countries are better represented. This would alter the power dynamic and would show real decolonizing intent.

For most IHV NGOs, addressing the structural economic and power imbalances associated with inequality and neo-colonialism at government or multinational corporation level is beyond their influence and means. Yet an IHV NGO should recognise that it has an influencing role in Africa within its scope of operation in the health sector. Decolonization of IHV NGOs needs to be a process of continuous improvement in Africa. If IHV NGOs can be exemplars or champions for decolonization they may in time help to influence positive changes in other institutions that currently perpetuate the inequitable distribution of power which works against African interests.

⁶⁵² This related to person SHM1D in NGO 1.

⁶⁵³ This related to persons XNF1 and XNF2 in NGO 1.

5.7 Chapter conclusion

This chapter explored the influences of power, hierarchy, respect and neo-colonialism in the IHV phenomenon in the two SSA countries. I argued that the themes of power, hierarchy, respect and neo-colonialism are both individually and as interlinked themes important influences on IHV in the two SSA countries. I have given the reader some background to some of these influences, but primarily to hierarchy and neo-colonialism to better contextualise these influences as they apply to IHV in the two SSA countries. Within the section on hierarchy in African health services I have addressed gender equality in the IHV phenomenon in the two SSA countries. I noted evidence of the under-representation of women in health services in the two SSA countries and particularly in leadership roles. Similarly, I noted a lack of women in the higher grades of the pyramidal health service hierarchies in the two SSA countries and in decision-making roles in IHV NGOs, suggesting the need for improvement in this imbalance. I indicated that as IHV NGOs have many women UEHVs, that positive role modelling particularly for lower grade SSA health workers may be helpful to improve their self-esteem. I further highlighted the importance of gender inequality issues in political discourse in the two SSA countries and thus the need for those involved in IHV in the two SSA countries to better address these issues.

I contended that despite outward appearances of mutuality, a power imbalance can exist in IHV in the two SSA countries as power in the IHV phenomenon is mostly in the hands of funders, government and IHV NGOs. Perhaps this may be because, as power brings possibility, the needs of the more powerful sometimes outweigh the needs of the less powerful. This chapter did however give examples of disruptors to this notion which I presented as power being sometimes invested in a small number of people. I suggested that this can be problematic and unhelpful to mutual collaborations in IHV in the two SSA countries, as the views of the powerful small minority have the potential to outweigh the collaborative majority. Instead, I suggested, whilst sometimes problematic, that a collegiate concept of power involving a more diverse range of IHV programme collaborators is likely beneficial for IHV collaborations. I discussed in this chapter some observations of power abuse which can be a

disruptor on IHV programmes in the two SSA countries together with the need for tact to manage these effectively.

I discussed the nature of the rigid pyramidal hierarchy in African health services. I suggested that there is an essential need for awareness, particularly by collaborations that develop and run IHV programmes. I discussed that it is important to better understand how this hierarchy affects the flatter hierarchies seen in IHV collaborations and *vice versa*. I intimated how these hierarchies dovetail and can give potential for more mutuality, including opportunity for mutual learning. I further discussed that the interactions of these types of hierarchies in IHV in the two SSA countries can sometimes be involved in cultural tension and discord in the IHV phenomenon. I further identified that there are many other hierarchies that operate within the various interest-holders involved in IHV in the two SSA countries. Whilst most of these hierarchies are pyramidal, they all vary and there is thus unfamiliarity within collaborations of each other's hierarchical structures. I contended that most involved in IHV adapt well to operating with and within different hierarchies to allow smooth running of IHV programmes, but that the hierarchical clash can sometimes be problematic. There is however room for improvement through recognition by all involved of the hierarchical variations that exist in IHV in the two SSA countries, so there are better acceptance and respect of each other's hierarchical systems and values.

I have reiterated in this chapter that respect influences IHV in the two SSA countries as it is a cornerstone of African culture. I stressed the need for awareness of the importance of respect amongst all involved in IHV in the two SSA countries as it helps build strong and effective collaborative networks and collaborations. I provided the reader with some examples of disrespect in the IHV phenomenon. I discussed that disrespect could endanger these collaborations and on occasion, if not managed effectively by IHV leadership teams, can upset the delivery of IHV programmes in the two SSA countries.

I presented some background information on neo-colonialism in this chapter to better frame this concept for the reader. I discussed that health inequality appears to be a contested area in Africa which is impacted by neo-colonialism. I debated the concerns of the Global South regarding Global North governments who made

unilateral decisions to cut funding for health projects in Africa whilst recruiting trained African health workers for work in Western healthcare settings, and in so doing have reinforced a colonial power imbalance that can be framed as neo-colonialism. I discussed that IHV NGOs in the two SSA countries operate in an environment where they are at the forefront of Global North and Global South interactions and are vulnerable to perceptions of neo-colonialism partly due to the power dynamics of their role.

I drew attention to the need for IHV NGOs to try to avoid being perceived as neo-colonial. I suggested that IHV NGOs should take care with various types of discourse and naming of assets that symbolise helplessness whilst avoiding religious and military symbolism that could lead to accusations of neo-colonialism. I advised that training of NGO staff and UEHVs in appropriate communications may help reduce vulnerability to accusations of neo-colonialism. I stressed the importance of decolonization of training materials in IHV, giving suggestions of strategies like promotion of South-North learning, round table discussions and the use of locally relevant equipment. I asserted that IHV NGOs should try to incorporate more indigenous Africans involved in IHV in SSA, together with those from the African diaspora into strategic decision-making roles like IHV NGO trustee boards, advisor networks and as NGO patrons. This participatory decision-making approach may contribute in a small way to start righting some power imbalances in IHV and enhance decolonization. As put by Abimbola (2024) the people best placed to generate equitable and important solutions to health issues are those who live and work within that context. Additionally, I contended that where possible IHV NGOs should take the opportunity to influence some of the institutions of neo-colonialism to promote decolonization by being positive examples of good practice in decolonization.

My final chapter will present conclusions from my thesis and discuss its implications and recommendations for the IHV phenomenon in the two SSA countries. Additionally, I will give some suggestions regarding areas of the IHV phenomenon where further research would be most helpful to enhance understanding of this multi-faceted and complex phenomenon.

CHAPTER SIX - Thesis conclusions, implications and recommendations

6.1 Conclusions

My research has produced several overarching conclusions to answer my research question. The reader should bear in mind that my conclusions are borne from my analysis and interpretations and can be best considered as a partial answer to my research question. Whilst I have constructed a methodologically valid and reflexive account there were limitations, exclusions and compromises that I had to undertake to complete this study which I have already detailed in Chapter 2. Therefore, this research neither offers a complete interpretation nor claims to list *all* the main influences of the IHV phenomenon in the two SSA countries. Inevitably, whilst this study has reached an ending it rather presents a beginning towards a fuller understanding of this subject area. I detail my conclusions below in answer to my research question:

In this research I found the main influences on IHV in the two SSA countries to be my interlinked themes of collaboration, sustainability, and dependency (as discussed in Chapter 3); of cultural competence and cultural tension (as discussed in Chapter 4); and of power, hierarchy, respect, and neo-colonialism (as discussed in Chapter 5). My overarching conclusions are primarily drawn from these interlinked themes and my chapter conclusions, and it is to those chapter conclusions that I signpost the reader for more detail and completeness. The following paragraphs represent the broader conclusions of my research.

Effective collaborative networks appear to be essential to running successful IHV programmes in the the two SSA countries. Important in these networks are formal and informal collaborative relationships between all individuals. Furthermore, collaborative networks setting ground rules at the start of their IHV collaborations can enhance sustainability and smoother transitions to empower SSA actors to independently develop their own sustainable health programmes. Unfortunately, not all collaborative networks in IHV are problem free

so there is a need for them to work towards collaborative advantage rather than collaborative inertia to be or remain effective. When there is disrespect in the IHV phenomenon it can threaten IHV collaborations, and if managed ineffectively programme delivery can be negatively affected. Ultimately, there is a need for all actors involved in IHV in the two SSA countries to be aware of the need for mutual respect to help strengthen IHV collaborations.

Collaborative networks in IHV in the the two SSA countries appear to try to work towards embedding some form of sustainability into IHV programmes despite the different notions of sustainability amongst different IHV interest-holders and individual actors. However, given differing interpretations of sustainability in the IHV phenomenon, collaborative networks can view dependency as sometimes necessary, wanted or needed in IHV in the two SSA countries, particularly from an African perspective. Importantly, positive individual interactions between those from the UK and Europe and SSA actors have the potential to enable some SSA actors to embed sustainable health gains in their own communities. Framing IHV programmes around the priorities of the SDGs has a mixed response. Doing this appears important to collaborative networks at strategic level although some actors within the networks view the SDGs less favourably at programme level.

Cultural competence is a key influence for all IHV actors in ensuring that programmes bring some intended benefits to local communities in the two SSA countries. Specifically cultural competence is helpful to the enhancement of collaboration within collaborative networks in IHV at a strategic level. Furthermore, at strategic level in IHV the understanding of mutual cultural rules can influence effective decision making within collaborative networks. Therefore, collaborative networks work better when most IHV actors conduct themselves in a culturally competent manner.

At programme level, in situations where actors are reasonably culturally competent and relate well to others, problem solving and teamwork are enhanced. In addition, IHV programmes are more effective when indigenous and foreign actors are both reasonably culturally competent and less effective when both are culturally incompetent. Importantly, a diverse programme leadership team, drawn from a range of collaborators, who demonstrate mutuality, cultural humility and are

reasonably culturally competent is important to effective IHV programmes in the two SSA countries.

Cultural incompetence can sometimes create cultural tension between IHV actors. Unfortunately, excessive cultural tension in IHV programmes is detrimental to the smooth and effective running of programmes and can be reputationally damaging to all involved. Some of the reasons for this are that in IHV, groups of SSA actors and UK/European actors are not themselves homogeneous culturally so *within* each of the groups cultural incompetence and thus cultural tension can result. Understanding of this can be worsened as sometimes UEHVs view those from each of the two SSA countries as homogeneous cultural groups and *vice versa*. From an African perspective, some SSA actors are culturally incompetent regarding some communities in the two SSA countries where IHV programmes are located. When this occurs, *all* involved may be culturally incompetent regarding the cultural norms of local communities in these loci. The good news though is that it appears that exhibiting cultural humility can improve cultural interactions between IHV actors. I developed seven principles related to cultural competence and cultural tension in IHV in the two SSA countries. These are both an important conclusion of my thesis and an important recommendation for use by IHV interest-holders. I will present these in Section 6.3 as recommendations.⁶⁵⁴

A power imbalance exists in IHV in the two SSA countries as power in the IHV phenomenon is mostly in the hands of funders, government and IHV NGOs, with the priorities of the powerful sometimes overriding the interests of the less powerful. In addition, sometimes power in IHV in the two SSA countries is invested in a few individuals. This may be troublesome to collaborative networks. Unsurprisingly, abuse of power can be a disruptor to IHV programmes in the two SSA countries. However, a more collegiate concept of power involving a more diverse range of IHV programme collaborators and a more participatory approach to decision-making is likely to be beneficial for IHV collaborative networks.

IHV interest-holders and actors within IHV collaborations can have unfamiliarity of the hierarchical structures of other collaborators. That said most actors adapt well to different hierarchies. However, when there are hierarchical

⁶⁵⁴ These are also displayed in a shortened pictorial form, in Appendix 7, for ease of display and dissemination.

clashes, these can sometimes affect smooth running of IHV programmes. The interplay between rigid pyramidal hierarchies in African health services and flatter hierarchies seen in IHV collaborations is complex. How these interact has potential to bring more mutuality and learning but equally can bring discord and tension. Similarly, when there is disrespect in the IHV phenomenon it can threaten IHV collaborations, and if managed ineffectively programme delivery can be negatively affected. Ultimately though, there is a need for all actors involved in IHV in the two SSA countries to be aware of the need for mutual respect to help strengthen IHV collaborations.

IHV NGOs are vulnerable to perceptions of neo-colonialism partly due to the power dynamics of their role within the IHV phenomenon. In consequence, it is important for IHV NGOs to reflect on *potential* perceptions of neo-colonialism within their own organisations and be exemplars of good practice in decolonization.

It is my hope that my thesis conclusions will encourage *all* those involved in IHV in the two SSA countries to offer tentative steps toward more equitable, mutual and effective IHV strategies and programmes that bring more benefits and less harms. The final sections of this study address the implications of my research and my recommendations for IHV in the two SSA countries. I will additionally foreground some recommendations that highlight an African perspective regarding how to embed and make others more aware of that perspective. In addition, I will present some recommendations for further research in this still under-researched phenomenon. Finally I will critically reflect on the thesis findings.

6.2 Implications

My thesis has implications for all those involved in the IHV phenomenon in the two SSA countries, both in the Global North and the two SSA countries, and particularly for IHV NGOs who send GNHVs to these countries. It has implications for SSA actors and interest-holders whose position I have attempted to foreground in the two SSA countries. To truly realise its implications, it is incumbent on me, as principal researcher, to ensure dissemination of parts of this thesis by further publication in academic literature and presentation in appropriate settings in the Global North and the two SSA countries and wider SSA. This is essential to focus

IHV interest-holders on the main influences on IHV in the two SSA countries so that IHV strategy and programmes can be mutually shaped by collaborative interest-holders to better support existing African health policies and priorities.

One way of looking at potential implications of this work was for me to consider the concept of a counterfactual (Mahoney and Barrenechea, 2017). I thus briefly considered the question:

What if international healthcare volunteering just stopped?

I had some real-life exposure to this theoretical rhetorical question as one unintended consequence of the Covid-19 pandemic was that for a short period of time on-site IHV in the two SSA countries mostly stopped.⁶⁵⁵ During this time, I observed some communities in the two SSA countries were suddenly without some health assistance and resources that had become normalised. Inevitably some VPOs had to make staff redundant as their primary funder was no longer running programmes and sending funds. Some IHV NGOs ceased operations permanently and others had to change plans radically and shrink their future operations in the two SSA countries. For governments in the the two SSA countries dealing with the pandemic, amongst the raft of other health inequalities, issues such as HIV-AIDS became a priority once more. For Global North governments and funders, priorities became more national rather than international and funding cuts meant there were less funds available for IHV. IHV thus became less important for governments in the two SSA countries, who had to focus their limited resources on their own health priorities, as no IHV NGO was likely going to be able to practically assist and even if they did so post-pandemic, it may well be smaller scale help than pre-pandemic.

The enforced hiatus in IHV allowed some IHV NGOs to pause and reflect on how they could better approach IHV in the two SSA countries, enabling some to be a motivator for positive change. By a similar token the two SSA countries became more self-reliant regarding health workforce and facilities as with no IHV forthcoming they had only themselves to rely upon. I observed for example that in one of the countries, post-pandemic, there was an increase in health professional

⁶⁵⁵ Documents C1, C2, C3 and C4 describe in their entirety some of the issues in the IHV phenomenon in the two SSA countries during and after the Covid-19 pandemic.

training places and an increase in distribution of health facilities in rural areas in my own health profession than pre-pandemic.⁶⁵⁶ However, whilst on-site volunteering ceased, collaborations did not. Instead, collaborations continued and arguably became more focused by online interactions that relied on IHV NGOs and SSA interest-holders working towards IHV programmes that were primarily delivered by SSA actors rather than UEHVs. When on-site IHV resumed during my study, NGOs' programmes were markedly changed.⁶⁵⁷ From a positive point of view programmes were even more geared towards government and community priorities in the two SSA countries with an important but facilitatory role for IHV NGOs and UEHVs.

A complete discontinuation of IHV in the two SSA countries is likely to bring negative consequences to some underserved areas of their health services currently. This would leave some SSA actors bereft of the skills and knowledge of some in the Global North who bring with them new ideas and suggestions that they can consider for local adaptation and implementation into health services in the two SSA countries. That said, the partial ceasing of IHV activities that occurred during the Covid-19 pandemic suggests a changing and decreasing role for IHV in forthcoming decades as SSA actors are more than capable of managing most of their own health issues and problem-solving and prioritising most issues within health services in the two SSA countries.

The implication of my research is that it will hopefully assist IHV interest-holders in finding a modern and appropriate role and purpose in the two SSA countries by having an understanding around its main influences. In foregrounding an African perspective, it will allow both Africans to self-reflect on what they want and hope for from IHV in the two SSA countries and Global North interest-holders to better appreciate the roles of Africans in IHV. Ultimately, my research implies that IHV can no longer simply be based on a donor to recipient unidirectional power-based relationship. In addition, it can neither be dominated by the Global North nor more for the benefit of IHV NGOs or GNHVs. Instead, my research implies that in IHV in the two SSA countries Global North IHV NGOs and other volunteer groups should work collaboratively with SSA governments, SSA interest-

⁶⁵⁶ Person SEM20 reported this in document C4 (p. 61, l. 1-2).

⁶⁵⁷ See for example, document V8, which describes such an IHV project in Country 2 involving NGO 1 and 2 and other collaborators from Country 2 and the UK and Europe.

holders, and other actors and interest-holders to help in the implementation of programmes that contribute to achieving health gains in the two SSA countries. These programmes should be aligned to African set health priorities in a reasonably sustainable manner. Many of these implications may likely have some applicability to wider SSA given that IHV NGOs operate throughout SSA in a similar manner to the two SSA countries studied together with the commonalities of African culture across the region.

6.3 Recommendations

There are several recommendations that the findings of my thesis suggest are important to positively influence IHV in the two SSA countries. In this section I will give some recommendations when my conclusions require them to be more generally focussed. In the following two sections thereafter, I will suggest some recommendations that specifically foreground an African perspective in IHV in the two SSA countries.

- *Form collaborative networks: I recommend that where possible IHV interest-holders should try to form themselves into collaborative networks or partnerships with other interest-holders.*

Undoubtedly these will vary regarding their purpose. Sometimes collaboration could be focussed on a specific health area or perhaps to tackle a specific illness or around a particular health project. Therefore, some will involve a minimal number of professions and skillsets and others many. Some will be in a specific small locus, and others may address a regional or national issue. Collaboration should be inclusive rather than exclusive and may often commence informally at first with the potential for more formal collaborations. Whilst there will likely be a diversity in the nature of the collaborative networks there will be many shared goals, as the aim of the collaborative network should be to run successful programmes or projects that positively impact health in the two SSA countries based on SSA government and community priorities. So collaborative networks should strive for collaborative advantage.

- *Adopt inclusive, collegiate leadership: I recommend that, where possible, IHV interest-holders should adopt inclusive, collegiate leadership practices when forming partnerships or collaborative networks.*

To do this I suggest that the collaborative networks should be led by a diverse leadership team representative of the main players using a more collegiate approach than the more pyramidal health service hierarchy. Both leadership teams of collaborative networks and IHV programmes should demonstrate mutuality, cultural humility and be reasonably culturally competent. Ground rules for the collaborative networks should be set from the outset, being regularly reviewed and dynamically altered, when necessary, given the changing needs and priorities in the IHV phenomenon, and to set expectations, end points and exit strategies.

- *Embed sustainability into IHV programmes: I recommend that collaborative networks should seek to enhance and embed a degree of sustainability into IHV programmes whilst recognising the necessity of a degree of dependency at times.*
- *Promote positive interactions: I propose that collaborative networks and others involved in IHV should promote positive interactions between interest-holders and actors from the two SSA countries and those from the Global North.*

This could take several forms which include, but are not limited to, mutual mentoring to promote bilateral learning, bilateral positive role modelling particularly amongst women actors, and development of a supportive ethos and culture. This type of positive environment could mean that ideas for change are considered and potentially embraced regardless of the hierarchical position of the proposer.

- *Adopt key principles regarding cultural competence and cultural tension: I recommend adoption of seven principles regarding cultural competence and cultural tension which are detailed below:*

Principles for cultural competence and cultural tension in IHV in SSA:

Principle 1: In IHV in SSA diversity of culture should be celebrated and encouraged with cultural humility.

Principle 2: All actors in the IHV phenomenon in SSA, at a strategic level, should share important aspects of their cultural behaviours and differences with each other. This means that any training given to others in culturally appropriate behaviours is as relevant as possible with the limitations of effectiveness of training being recognised.

Principle 3: Global North actors should consider focusing any cultural competence training on culturally appropriate behaviours acceptable within African culture. They should stress that there is much in the way of cultural variation and that on some IHV programmes there will be encounters with individuals from cultures of which little is known. From an African perspective, all SSA actors should do the same but instead focus their training on Western culture.

Principle 4: IHV programme leadership teams in SSA should be selected carefully by IHV collaborative partnerships to ensure that all individuals selected have reasonable cultural competence, exhibit cultural humility, and represent the diversity of all collaborators represented on specific programmes.

Principle 5: Where IHV programmes are in areas where little is known about local cultural variations, programme leadership teams should actively try to find out as much about these as they can. This should be done as early as possible within a programme so appropriate information can be cascaded to the entire IHV team promptly. These leadership teams should promote de-briefing of cultural issues for all and additional targeted mentoring and on-site training for those actors struggling with culture shock, significant cultural incompetence and/or cultural tension.

Principle 6: If there is opportunity to visit an IHV programme site before a programme commences, visitors should not just focus on seeking permissions and planning logistics with government and community leaders. They should also seek their advice on cultural variations in their locality.

Principle 7: It is incumbent for all individual actors involved in IHV in SSA to try to develop sufficient insight, willingness and cultural humility to play their part in the effective resolution of cultural tensions that may result. IHV programme leadership teams and others in strategic leadership roles should actively participate in encouraging swift resolution of cultural tension between individuals and/or groups.

These principles should be helpful on IHV programmes for all actors, whether from UK/Europe, or the wider Global North or the two SSA countries studied or wider SSA, in negotiating successfully the potential cultural issues that sometimes occur on IHV programmes. The aim of these principles is for IHV actors to self-direct their own learning around them and is so doing improve their personal cultural humility, enhance their cultural competence and be able to facilitate the reduction of discord and tension on IHV programmes where they are involved. I hope others involved in the IHV phenomenon will adapt these for their own use and specific circumstances. I have summarised these, in a shortened pictorial form for ease of display and dissemination (See Appendix 7).

- *Redress power imbalances in IHV: I recommend that all interest-holders work towards trying to redress power imbalances inherent in IHV in the two SSA countries underpinned by the African cultural notion of respect.*

The collegiate flatter hierarchy of leadership within collaborative networks may be a good starting point to righting power imbalances and ensuring that the interests of those who are powerless are highlighted in IHV strategies and programmes. I will return to power imbalance when highlighting this from an African perspective in sections 6.3.1 and 6.3.2. Collaborative network leadership teams require to make efforts to spread power more evenly than a few individuals and deal with abuse of power and disrespect effectively and fairly amongst IHV actors. This will likely be difficult given the existing power imbalances, hierarchical variations, and lack of familiarity with other hierarchies amongst collaborators. It will require collaborative network leadership teams to promote respect, mutuality, cultural humility, and learning amongst its constituents.

Hopefully strong leadership will facilitate harmony and minimize discord and tension amongst IHV interest-holders and actors.

- *Reflect on perceptions of neo-colonialism: I suggest that IHV NGOs and collaborative network leadership teams should regularly reflect on their structures and operations to determine if they are being perceived as behaving in a neo-colonial manner and seek to make changes if required.*

For IHV collaborative networks to be highly regarded and valued in the two SSA countries some change will be likely inevitable to some of their practices. Specifically, for IHV NGOs, funders, and Global North governments involved in IHV in the two SSA countries I recommend that reflection, learning and decolonization take place if indicated. If this occurs not only, will they be good role models, but they will be demonstrating more mutuality and respect for others and perhaps even helping to redress power imbalances.

6.3.1 Recommendations for raising awareness of an African perspective in volunteering

Whilst I hope that my research will raise some awareness of an African perspective in IHV for the reader, the Global North perspective remains dominant in IHV in the two SSA countries. Given the power dynamic discussed in Chapter 5 it is funders and IHV NGOs who may hold the key to raising awareness of the differing perspectives of SSA interest-holders. I would argue that IHV NGOs can play their part by foregrounding the roles of SSA interest-holders that they collaborate with. In effect, I suggest that positive discrimination towards Africans sometimes at the expense of Global North interest-holders is necessary in areas like IHV NGO publicity, journal articles on IHV and grant applications for IHV initiatives. This in some way would additionally counteract notions of neo-colonialism directed at some IHV NGOs. Funders can play their part too by encouraging grant applications from, and giving donor funding to, IHV NGOs who can demonstrate that they actively collaborate with African interest-holders who are involved in decision-making leadership roles within their organisational structures. If this happens sufficiently perhaps more reluctant IHV NGOs will follow the positive role modelling of others, thereby raising an African perspective in IHV.

In the IHV phenomenon in the two SSA countries, finding appropriate platforms for dissemination of research conclusions such as this study is important in raising awareness of an African perspective. It is not just research conclusions that warrant awareness raising. Finding platforms to promote lessons learnt from successful and less successful IHV programmes and collaborations in the two SSA countries should focus on the role of SSA collaborators to highlight their perspectives. In my opinion this should involve dissemination to SSA health professional societies, decision makers in SSA Ministries of Health and Education and publications and presentations regarding IHV in the two SSA countries and wider SSA to high-impact African and Global North journals and regional conferences, to demonstrate the pivotal roles that Africans play in the IHV phenomenon. Furthermore, dissemination of both positive and negative experiences of IHV from an African viewpoint to transnational bodies such as WHO African region would be helpful. Given that there are many IHV programmes in the two SSA countries and wider region this may help to highlight common issues with IHV in the region to allow a more coherent structured African approach to IHV. This may be helpful in several aspects of the IHV phenomenon such as better focussing of the role of IHV within African health services, embedding a degree of sustainability in programmes and raising quality standards of all interest-holders.

Raising awareness of African perspectives and the pivotal roles of Africans in IHV is critically important in the Global North. Changing the narrative from highlighting the perspectives of the returning GNHV or IHV NGO to instead foregrounding SSA interest-holders has potential to change power dynamics and hierarchies in IHV. Stories about IHV are then less focussed on the GNHV or IHV NGO but are more centred on an African perspective. To do this requires several changes such as having Africans from recipient countries in leadership roles *within* donor IHV NGOs in host countries. Furthermore, it should be Africans, and not those from the Global North, who should be advocates for collaborative IHV programmes that take place in their countries *within* conversations taking place in the Global North. An African perspective is undoubtedly more powerfully articulated by an African in strategic meetings with Global North IHV interest-holders, funders and regulators than any non-African can hope to deliver. In simple terms, strategy meetings, publicity websites and webinars, presentations, and

funding campaigns, where possible should place African interest-holders at their heart. Undoubtedly, these changes may take time and may be considered by some as currently aspirational goals.

Finally, the identification and mentoring of African champions who are already collaborating with IHV interest-holders is paramount to raising an African perspective in IHV. Not only does this start to embed sustainability into IHV programmes (see Section 3.9) but it can facilitate the shaping of IHV programmes by Africans so that an African perspective is at the forefront of programmes.

6.3.2 Recommendations for better embedding an African perspective in volunteering practices

Currently there are many IHV NGOs who already try to better embed an African perspective into the IHV phenomenon. For those IHV NGOs who adopt a Global North approach to IHV programmes and strategic leadership, change is required. If Africans are included from a range of SSA collaborators within leadership teams, then an African perspective is inherently deeply embedded and is likely to be at the forefront of the IHV programme. The pace of change though could be speeded up by grant funding organisations asking more searching questions related to this topic when considering whether to fund a specific IHV NGO, collaborative network or programme. Several potential grant funders provide feedback on unsuccessful grant applications. Change may be nudged faster were reasons given for not funding applications to relate to a lack of Africans in leadership roles.

Often IHV NGOs send reasonably large teams of UEHVs to undertake programmes. Sometimes this means that the numbers of UEHVs is considerably higher than the combined number of Africans, in various roles, on an IHV programme. By sheer weight of numbers, the Global North perspective may appear more dominant to African host communities. Put very succinctly, when discussing a potential post-Covid-19 pandemic IHV collaboration with African interest-holders, I observed an IHV NGO decision-maker indicate that what is needed is to:

*Include minimum volunteers and maximum indigenous Africans.*⁶⁵⁸

This approach to IHV programme design is exactly the type of change required that better embeds an African perspective in IHV whilst also raising the profile of Africans for host communities.

Undoubtedly there is a need to enforce stricter regulation on IHV NGOs and others seeking to provide IHV programmes within the the two SSA countries. This is important to ensure that IHV programmes have a minimum acceptable standard that requires adherence to national and local regulations, ethical codes, appropriate permissions and alignment to specific health priorities for the area of health that the IHV programme hopes to address. This requires African interest-holders to enforce their own rules better. Existing regulatory systems in the two SSA countries need to manage transgressors consistently and fairly to raise quality of IHV practices. Doing this will help embed an African perspective in IHV in the two SSA countries, whilst at the same time deterring the types of often well-intentioned but mostly irrelevant IHV programmes that may be harmful and burdensome for African communities.

Ultimately, the promotion of South-South volunteering and in-country *outreach* by SSA actors are likely to both better embed an African perspective in volunteering whilst enhancing sustainability. Global North IHV NGOs have a part to play in promotion and facilitation of these currently less frequent forms of IHV and HV in the two SSA countries. IHV NGOs have a wealth of experience in running IHV programmes to share with African collaborators and this should be freely shared. Information sharing of things like training resources and ideas on seeking funding for projects together with appropriate mentoring is likely to embed an African perspective in these more sustainable forms of volunteering over time.

Lastly, and perhaps an aspirational goal, inverting the power dynamic in IHV by trying to get grant funders to directly fund governments or local NGOs or VPOs in the two SSA countries so that they choose the NGO and not *vice versa* for a project may be a radical way to effect change. An alternative and a little less

⁶⁵⁸ Reported by person GNM3A. See document C3 (p. 6, l. 9). This approach also has the potential to reduce the environmental impact that IHV brings with it and is likely an appropriate decarbonization strategy.

radical approach would be for grant funders to fund the management group of a collaborative network for specific projects and not the IHV NGO. If the collaborative network leadership group had sufficient African representation, then true collaborative working would likely better embed an African perspective into project volunteering practices.

6.4 Further research

I have commented on several occasions within this thesis that the interpretation of IHV involves study of a complex multi-faceted phenomenon and is an area of research which has a diverse range of actors and interest-holders. I have presented some main influences that hopefully shed significant light on the IHV phenomenon in the two SSA countries and additionally foreground the under researched African perspective in IHV in the two SSA countries. That said, there remain many lacunae in the literature and a legion of areas for further research. I have thus been selective in my recommendations for further research. These are inevitably partly based on my own interpretations of areas that I felt are potentially important influences in IHV in the two SSA countries, and those that my study was either unable to address or only partially addressed.

My research was only able to discuss the main influences in IHV in the two SSA countries. This inevitably suggests that a similar study would be helpful in other SSA countries where there are commonalities of culture and in differing cultural environments such as parts of Southeast Asia and Central America, hopefully drawing out indigenous perspectives. Additionally, I could not include in my study in the two SSA countries IHV that emanated from North America, as a donor, given their often-different approaches to IHV which I discussed in Sections 2.3.8 and 2.3.9. Consideration of this as a research area is important as there is much IHV taking place in both SSA and elsewhere in the world that is sent from North America and uses a dissimilar approach.

I have made it clear throughout my research that there are limitations that I have as a non-African in attempting to foreground an African perspective. To remind the reader I have, *inter alia*, a degree of cultural incompetence regarding African cultures and come from a country that was a former colonial power and is

sometimes implicated in neo-colonialism towards SSA countries including the two SSA countries studied. Inevitably, my research will have only partially highlighted an African perspective, given my own constraints, horizon and positionality, but I hope that at least I have made a helpful and constructive start in this area.

Undoubtedly an African researcher involved in both IHV in the two SSA countries or wider SSA, and the African health hierarchy, should consider researching the IHV phenomenon in either the two SSA countries or wider SSA as this may offer a more complete African perspective.

In my selectivity of areas for further research I have tried to highlight in each of my main interlinked themes one area where further research may be helpful to further enlighten interpretations of the IHV phenomenon in the two SSA countries. There will likely be other areas of my research that may leave a reader with unanswered questions, or which may warrant further study, but I have chosen these areas as worthy of further research as I felt them to be important to better understanding of the main influences of IHV in the two SSA countries. For example, in Section 4.5 I indicated that my own research did not sufficiently illuminate the effect of being in a minority ethnic group on cultural tension in IHV. Undoubtedly further research in this area may be warranted, but I felt this less important than others that I will recommend for further research. I will detail in the following paragraphs the need for further research into collaborations and the sustainability-dependency conundrum, principles of cultural competence and cultural tension, and power imbalances in IHV in the two SSA countries.

In Chapter 3 I stressed the important influence of collaborative networks in IHV in the two SSA countries. At the same time, I discussed the influence of the sustainability-dependency conundrum on IHV in the two SSA countries from an African perspective. For this latter influence, I was able only to highlight it as an influence due to insufficient data. Nevertheless, these two influences are inescapably linked, as the degree of sustainability or dependency expected in collaborative networks influences many things in those networks, such as exit strategy of IHV NGOs, extent of SSA actor involvement in training, and ongoing support and/or funding of programmes. Further research in this area is imperative. I recommend research into various collaborative networks in IHV to better determine the nature and constitutions of collaborative networks to enhance efficacy in IHV

settings in the two SSA countries. To do this will inevitably necessitate an investigation of the particular and differing notions of sustainability and dependency that the various IHV actors and interest-holders bring to the collaborative network.

I proposed some principles regarding cultural competence and cultural tension that could be adopted for use in IHV programmes in the two SSA countries and wider SSA.⁶⁵⁹ As I feel these are important influences, I have already annotated these principles into a more visually engaging form in Appendix 7 of this thesis. As I hope that IHV interest-holders in the two SSA countries and wider SSA will adopt these principles, research into whether they are of benefit in future IHV programmes in the region would be helpful. For example, this could take the form of an assessment of baseline knowledge of culture pre-programme amongst involved IHV actors and interest-holders. Thereafter, dissemination of the principles and training of IHV actors and interest-holders during programme orientation regarding the practical application of the principles would take place. This would be followed by reassessment of cultural problems faced and their management during the programme once the programme has been completed, to try and determine if the principles had been helpful. Once evaluated these principles, just like the dynamically changing nature of culture, could be altered and modified, if necessary.

In Section 5.2 I discussed power imbalances in IHV in the two SSA countries at both strategic and programme level. In Figure 17 of that section, I proposed a basic power hierarchy for IHV in the two SSA countries. I concluded in Chapter 5 that a more collegiate approach to power may be helpful to try and address power imbalances in IHV, where power currently is often in the gift of funders, government and IHV NGOs. Further research is indicated around whether a more collegiate approach to power in IHV in the two SSA countries would be of practical benefit or not. Part of this research would need to address to what extent such a collegiate approach would be acceptable from an African perspective within existing hierarchies and notions of respect. Perhaps research in this area is best centred around existing collaborative networks in IHV in the two SSA countries, as in these loci, a collegiate approach to power already partially exists.

⁶⁵⁹ I detailed these in full in Section 6.1.

IHV in the two SSA countries remains an area of study that has much more to reveal to the researcher. Personally, I have found this research has been fulfilling in that I have uncovered important influences to answer my research question. Nevertheless, there is much more to study, and my recommendations for further research represent an incomplete picture of opportunities to further develop interpretations of IHV in the two SSA countries and beyond. I hope my efforts have engaged the reader sufficiently to inspire them to take their own projects forward to add to research in this field. In the next section I will critically reflect on my thesis findings.

6.5 A critical reflection on thesis findings

In this section I discuss a summary of the key findings of the thesis in the context of the literature, a reflection of the thesis strengths and limitations, and a reflection on how the findings hold up to reflective scrutiny.

Key findings:

My research adds to the academic literature regarding the IHV phenomenon in the two SSA countries which may have some use in wider SSA given the paucity of empirical evidence in this phenomenon. My research should be seen within the context of a body of literature that too often is reliant on editorials, case reports, reflections and personal correspondence and thus may be partly fundamentally flawed. Furthermore, the literature frequently takes on an IHV NGO or Global North perspective and omits or minimises African voices from any account. Much literature is focussed on other parts of the Global South which is then sometimes extrapolated to SSA without reference to the cultural context. In contrast to some of these accounts, my study presents systematically collected data from two SSA countries which partly involves data collection by participant observation from indigenous interest-holders. It has been subjected to analysis with methodological rigour using an interpretive approach. This has allowed me to present *an* account of the IHV phenomenon in the two SSA countries meaning that my key findings have reasonable credibility.

The key findings in my study were that the main influences on IHV in the two SSA countries were the interlinked themes of *collaboration, sustainability and dependency; cultural competence and cultural tension; power, hierarchy, respect and neo-colonialism*. It is from these three groups of interlinked themes that conclusions and recommendations regarding IHV in SSA were derived. Detailed below I further reflect on what these groups of interlinked themes add to the stock of existing knowledge:

- *Collaboration, sustainability and dependency:*

Collaboration and sustainability appear within existing literature on IHV as facilitators and necessities for IHV interest-holders to embed in IHV programmes in the Global South. Fewer papers relate to SSA but those that do nevertheless draw similar conclusions. Dependency, on the other hand, is largely seen negatively in academic literature in the IHV phenomenon, being an unwanted trait for which sustainability is the favoured counterpoint.

My study adds to the literature in that it not only agrees with existing literature regarding the importance of collaboration in the IHV phenomenon, but it recommends the formation of collaborative networks. By listening to *an* African perspective my research also suggests how collaborative networks may be structured to better level power disparities and allow for more collegiate leadership amongst IHV interest-holders. My research reinforces the need to embed sustainability into IHV programmes which is seen in much literature. However, my study drew out different notions of sustainability amongst SSA actors and mixed responses to SDGs in the two SSA countries and this adds to the body of knowledge. Furthermore, I found that dependency was sometimes necessary, wanted and needed by indigenous actors in the IHV phenomenon in the two SSA countries which is in contrast to other literature and warrants more research.

- *Cultural competence and cultural tension:*

The need for cultural competence in the IHV phenomenon and other global health experiences in LMICs is seen throughout academic literature, grey literature and guidance or advice from regulators, governments and NGOs. However, advice

and guidance seen in the literature is usually focused on the cultural competence requirements of the UEHV, GNHV or IHV NGO rather than any cultural competence needs of interest-holders or actors in IHV phenomenon in the two SSA countries.

My study adds to the literature in that it highlights the deficiencies in cultural competence of most involved in the IHV phenomenon *regardless* of whether they are UK/European actors or from the two SSA countries. Arising from my interpretations I have developed seven principles⁶⁶⁰ which I hope will be useful for all actors in the IHV phenomenon in the two SSA countries and may have use in wider SSA to improve cultural competence and alleviate cultural tension. Cultural tension is rarely discussed in the literature. My research thus highlights cultural tension as an addition to the body of knowledge and something that has the potential to, at times, affect all involved in the IHV phenomenon in the two SSA countries. Derived from my interpretation and further adding to the literature in this area is the need for actors in the IHV phenomenon to promote positive interactions with each other and to be mindful of the seventh principle⁶⁶¹ that I derived.

- *Power, hierarchy, respect and neo-colonialism*

Power and neo-colonialism and its predecessor colonialism are seen abundantly in wider global health literature and to an extent in academic writing on IHV in both the wider Global North and SSA. My research adds weight to the consensus notion that in the IHV phenomenon that Global North interest-holders and funders are most powerful and SSA governments and actors are less powerful despite calls for mutuality. Similarly my findings showed evidence of neo-colonialism in the IHV phenomenon in the two SSA countries and the need to decolonise. These findings are in keeping with available literature. Where I add to the literature is that given the empirical nature of my research I am able to give more specific recommendations on redressing power imbalances in the IHV phenomena to SSA actors in the two SSA countries and IHV NGOs based on sound interpretive evidence. The same holds true for neo-colonialism where I am able to

⁶⁶⁰ See Section 6.3.

⁶⁶¹ See Section 6.3. This calls for all IHV actors to develop sufficient insight, willingness and cultural humility to play their part to resolve cultural tensions on IHV programmes. When cultural tensions occur to try resolve matters swiftly with cultural humility.

suggest to IHV NGOs the need to reflect on how they are perceived and to suggest decolonization strategies that may help them.

Other than discussions on African health services regarding its pyramidal hierarchies, hierarchy features minimally in the largely Global North weight of academic literature in the IHV phenomenon. My study thus adds to the knowledge base regarding hierarchy in the IHV phenomenon in the two SSA countries. My findings are of particular importance to IHV interest-holders and actors involved in collaborative networks as to ensure more inclusive approaches to leadership in the IHV phenomenon collegiate rather than pyramidal hierarchies are a likely more appropriate model. Respect is evident in studies and reflections from largely African based researchers, often in relation to African culture. This is lacking in Global North literature and has not been applied to the IHV phenomenon in the two SSA countries previously. My findings regarding the importance of respect in the IHV phenomenon reinforces and adds to the knowledge base but more importantly allows me to synthesize the existing knowledge base with my findings to highlight the influence of respect in the IHV phenomenon in the two SSA countries to interest-holders.

Strengths and limitations:

My thesis has several strengths. Firstly, I endeavoured to adopt a research paradigm that approached my research question with sufficient methodological rigour to meaningfully interpret the IHV phenomenon in the two SSA countries for the reader. Secondly, my positions as an insider within IHV in the two SSA countries meant that I had access to the IHV phenomenon at strategic and programme level which allowed me to obtain sufficient data to more thickly describe and more comprehensively analyse and interpret the data than originally planned. Thirdly, the Covid-19 pandemic, whilst problematic for me, presented much opportunity to study the IHV phenomenon in the two SSA countries during and after the pandemic that added much to my interpretation. Again, this could not have been envisaged at the start. Finally, I am confident that the resultant interlinked themes, conclusions and recommendations of my study represent *an* appropriate and robust interpretation of the main influences on IHV in the two SSA

countries and have been obtained by a methodology that optimises validity and a study that has been conducted with rigour.

In addition to these strengths, my research has much in the way of added value as a strength. I have been able to highlight African voices in the account in so far as is possible given my limitations as a non-African. Embedding *an* African perspective brings a more complete picture of the IHV phenomenon. This is an important feature of this research as this is an under-researched facet of the IHV phenomenon both in the two SSA countries and wider SSA.

However, my thesis has limitations. There are influences on the IHV phenomenon in the two SSA countries that due to things like insufficient data that I could only give passing mentions to and warrant further study. My final interlinked theme selection required me to select themes for which I had sufficient evidence and were relevant to my research question for validity and rigour. This makes these interlinked themes robust but this involved discarding other themes that may warrant further exploration. In effect, my interlinked themes give *an* account to answer my research question but they do *not* claim to tell *all* or give *the* only account to answer my research question. This is the very nature of an ethnographic approach to study.

With regard to highlighting *an* African perspective I am conscious that in respect of the two SSA countries that were the locus of this study my horizon and positionality is one of a privileged foreigner from a former colonial power. I am additionally high in the health hierarchy and of an age and professional position that leaves me largely unchallenged in African culture in these two SSA countries. Whilst I have a reasonable notion of African culture and have been privileged to live for a number of years in SSA I cannot possibly know the nuances of African cultural values nor fully understand what it means to live there in a less privileged position. This positionality likely limited what I could *see* when I observed the IHV phenomenon to highlight *an* African perspective. Undoubtedly an indigenous African would likely give *a* different perspective but not necessarily *the* African perspective as other African perspectives will likely exist based on the horizon and positionality of the researcher.

Reflective scrutiny of my findings:

When I now reflect on my findings, I realise that I had to take into account findings that challenge my main influences that answered my research question. Respect is one of the areas where I had disconfirming evidence as I had reasonable evidence of disrespect whilst having sufficient data on respect to know it was a main influence. Thematic analysis as a methodology allows inclusion of such disconfirming evidence so this is not hidden but discussed such that respect and its counterpoint disrespect are part of the final research report. Some of my findings were surprising. It was unexpected to find the importance of dependency as part of an interlinked theme. Dependency was something that was not on my horizon at the start of my research whereas sustainability was something I thought was likely to feature given my pre-existing knowledge. Incorporating dependency as part of an interlinked theme made me have to interpret more deeply, and do more recursive reflection to handle a more complex dataset as it challenged my initial interpretations.

My findings are themselves limited by the limitations of my study which are largely discussed in Section 2.3.8. Designing and conducting a study to explore IHV in the two SSA countries meant at times having to undertake fieldwork in largely challenging, resource-limited, remote and rural health facilities with inadequate basic utilities and supplies. Compromises thus had to be made in terms of participant observation and opportunities were sometimes limited by an onerous participant role. In effect, the field in which the fieldwork took place was less than ideal and thus I could not observe *all* I wanted to. Nevertheless, I feel that I observed *enough* and was reflexive *enough* to produce *a* valid and rigorous account that answers my research question. Hopefully my thesis gives *an* account that contributes to and enhances the body of academic literature in the IHV phenomenon in the two SSA countries.

6.6 An African proverb revisited

In the preface of this thesis, I tempted the reader with an African proverb that helped motivate me to undertake this research which I reiterate below:

*Why be a goat when you can be a cow?*⁶⁶²

Only the reader can decide whether my thesis is persuasive and rigorous enough, with sufficient value, to realise my potential to become a cow rather than remain as a goat.

⁶⁶² Spoken to me by person SEM1B.

Appendices

Appendix 1 - List of participants observed who were quoted or referred to in this thesis

In my participant list a meaningful identifier is attached to each of the participants who were quoted or referred to in this thesis (Column 1). To give context for the reader where the participant was observed is noted in Column 2, for example on a fieldtrip or specified if not a fieldtrip. Participant role(s) are specified in the 3rd column.

Key to the list:

Identifier:

All letters in identifiers are in capitals.

The first letter relates to where the actor is *primarily* based:

G	=	UK or European actor
S	=	Sub-Saharan African actor
X	=	Other actor. For example, African diaspora actor from UK/Europe

The second letter relates to the actor's *primary* role in the IHV phenomenon. It is:

C	=	Local community actor
E	=	Government actor
H	=	Health care worker
N	=	IHV NGO leadership actor
O	=	Observer
P	=	VPO actor
V	=	Volunteer actor
Y	=	Other role actor

The third letter relates to the actor's gender:

F	=	Female
M	=	Male

The only number in the identifier appears after the three letters and this is to differentiate those from similar groups for example, SPM1 and SPM2 etc.

In a small number of people who had multiple roles, which I termed in the *Preface* as the *Local Hero effect* (*Local Hero*, 1983) a fourth letter appears, so for example Person GNF1 is referred to as GNF1A or GNF1B or GNF1D depending on the role they are taking during a particular period of observation:

A	=	Actor adopting primary role
B	=	Actor adopting secondary role
D	=	Actor adopting tertiary role
J	=	Actor adopting quaternary role

The relevant roles are then specified in column three titled *Role(s)*.

So, for example if someone was observing me, my primary hypothetical identifier would be for example GVM666. On my 3rd fieldtrip I visited Country 2 where I took on an additional NGO leadership role. If someone was observing me under my scheme I would thus appear as:

Identifier	Fieldtrip	Country	Role(s)
GVM666A	1,2,3,4, online	1, 2	UEHV
GVM666B	1,2,3,4, online	2	NGO leadership

No fourth, fifth or sixth letter will appear if an observed actor has only one role.

Fieldtrip:

In the second column the location where the actor is observed appears. Most are identified by the letter F (Fieldtrip) and then a fieldtrip number (1 to 4 in chronological order). If the person has been observed elsewhere, for example, in online meetings it is specified.

Country:

The country or countries observed is specified in the third column.

Role(s):

A brief description of role(s) is provided in the fourth column.

List of participants observed who were quoted or referred to in this thesis:⁶⁶³

Identifier(s)	Fieldtrip(s) / other	Country	Role(s)
GNF1A	1	1	NGO 1 leadership
GNF1B	1	1	UEHV
GNF1D	Online	1, 2	Collaborator with NGO 1 and 2
GNF2	1, 3, online	1, 2	NGO 1 leadership
GNF3A	3, online	2	NGO 2 leadership
GNF3B	3, online	2	UEHV
GNF4	Online	1, 2	NGO 1 leadership
GNM1	2	1	NGO 1 leadership
GNM2	Online	1, 2	NGO 1 leadership
GNM3A	3, online	2	NGO 2 leadership
GNM3B	3, online	2	UEHV
GNM4	1, 2, 3, online	2 3	NGO leadership - non-study NGO
GNM5	Online	1, 4 ⁶⁶⁴	Former NGO 1 leadership
GNM6	Online	2	NGO 1 leadership, IT expert
GOF1	2	1	Observer of NGO programme
GOM1A	2	1	Observer of NGO programme
GOM1B	Online	2	Collaborator with NGO 1 and 2
GVF1A	2	1	UEHV NGO 1 leadership
GVF1B	2, online	1, 2	
GVF2	4	1	UEHV
GVF3A	4	1	UEHV NGO 1 leadership
GVF3B	4	1	
GVF4A	1	1	UEHV NGO 1 leadership
GVF4B	1, online	1	
GVF5	1, online	1	NGO 1 leadership

⁶⁶³ This includes those referred to in *any* appendix.

⁶⁶⁴ NGO 1 ran a single pilot programme in another SSA country.

Identifier(s)	Fieldtrip(s) / other	Country	Role(s)
GVF6	1	1	UEHV
GVF7	2	1	UEHV
GVF8	2	1	UEHV
GVF9	1	1	UEHV
GVF10	2, online	1, 2	UEHV and health promotion/infection prevention and control trainer
GVF11	2	1	Former UEHV
GVF12	2	1	Former UEHV
GVF13	4	1	UEHV
GVF14	Online	3 ⁶⁶⁵	UEHV
GVF15	Online	Other ⁶⁶⁶	UEHV
GVF16	Other ⁶⁶⁷	1	NGO 1 leadership
GVF17	4	1	UEHV
GVF18	4	1	UEHV
GVF19	3	2	UEHV
GVF20	4	1	UEHV
GVF21A	Online	1	UEHV NGO 1 leadership
GVF21B	Online	1	
GVM1	2	1	UEHV
GVM2A	2	1	UEHV NGO 1 leadership
GVM2B	Online	1, 2	
GVM3	4	1	UEHV
GVM4A	Online	1	UEHV NGO 1 leadership
GVM4B	Online	1, 2, 4	
GVM5A	2	1	UEHV
GVM5B	2	1	NGO 1 leadership
GVM6	1	1	Former UEHV/NGO 1 leadership
GVM7	2	1	UEHV
GVM8	2	1	UEHV/NGO 1 leadership

⁶⁶⁵ An UEHV with a different NGO operating in Country 3.

⁶⁶⁶ An UEHV with a different NGO operating from a hospital ship berthed in African ports in various SSA countries.

⁶⁶⁷ A clinical lead from prior to this research project who led an IHV programme that AP participated in as an UEHV.

Identifier(s)	Fieldtrip(s) / other	Country	Role(s)
GVM9A	2, online	2	NGO leadership - non-study NGO
GVM9B	Online	1, 2	UEHV/NGO 1 leadership
GVM9D	Online	2	Independent UEHV
GVM10	4	1	UEHV
GVM11	Online	1	NGO 1 leadership
GYM1	Online	1, 2	Health industry leader
GYM2	Online	2	Health equipment engineer
SCF1	4	1	Retired hospital director and benefactor
SCF2	2	1	Hotel worker in small town
SCF3	1	1	Village cook
SCF4	Online	2	Community health promoter
SCM1	4	1	Village elder
SCM2	1	1	Village ⁶⁶⁸ executive
SCM3	2	1	Patient with life threatening infection
SCM4	4	1	Senior religious community leader
SCM5	4	1	Religious community leader
SCM6	Other ⁶⁶⁹	1	Traditional healer
SCM7	3	2	Village elder
SCM8	3	2	Village chief
SCM9	1	1	Market stall holder
SEF1A	3, 4, online	2	Senior government leadership
SEF1B	3	2	Senior health worker
SEF1D	4, online	1, 2	Observer of NGO 1 & 2 programmes
SEF2	4	1	Local medical administrator
SEF3A	3, online	2	Senior government leadership
SEF3B	3	2	Senior health worker
SEF4	Online	1	Senior government leadership

⁶⁶⁸ A collection of villages and surrounding agricultural land is known as a *ward* in Country 1; in Country 2 it is called an *extension*.

⁶⁶⁹ Person SCM6 helped a patient on an IHV programme in 2015 in which AP was a participant.

Identifier(s)	Fieldtrip(s) / other	Country	Role(s)
SEM1A	3, 4, online	2	Government leadership
SEM1B	3	2	Senior health worker
SEM1D	3, 4, online	2	Representative of national association
SEM1J	4, online	1, 2	Observer of NGO 1 & 2 programmes
SEM2	3, online	2	Senior government leadership
SEM3A	1	1	Regional government official
SEM3B	1	1	Senior health worker
SEM4	1	1	Local council executive
SEM5	1	1	Local politician
SEM6	2	1	Local politician
SEM7	2	1	Local medical administrator
SEM8	2	1	Local council executive
SEM9	2	1	First president Country 1
SEM10	2	1	Current ⁶⁷⁰ president Country 1
SEM11	2	1	Senior government leadership – Prison service
SEM12	4	1	Local council executive
SEM13	4	1	Local politician
SEM14	Online	2	Senior government leadership
SEM15	Online	2	Senior government leadership
SEM16	1, 2	1	Senior government leadership
SEM17	3	2	Senior government leadership
SEM18	3	2	Senior government leadership
SEM19	3, online	2	Senior government leadership
SEM20	Online	1	Senior government leadership
SEM21	4	1	Regional health official
SHF1A	1	1	Middle grade health worker
SHF1B	1	1	District government official
SHF2	2	1	Lower grade health worker
SHF3	1	1	Lower grade health worker
SHF4	1	1	Lower grade health worker
SHF5	4	1	Lower grade health worker

⁶⁷⁰ At the time of fieldtrip 1.

Identifier(s)	Fieldtrip(s) / other	Country	Role(s)
SHM1A	1, 4	1	Senior health worker
SHM1B	1, 4	1	Regional government official
SHM1D	Online	1, 2	NGO 1 leadership
SHM2A	3	2	Middle grade health worker
SHM2B	3, online	2	Representative of national association
SHM3A	2	1	Middle grade health worker
SHM3B	2	1	District government official
SHM4	4	1	Lower grade health worker
SHM5A	1	1	Senior health worker
SHM5B	1	1	Regional government official
SHM6A	1	1	Senior health worker
SHM6B	1	1	Regional government official
SHM7A	1	1	Senior health worker
SHM7B	1	1	Regional government official
SHM8A	1	1	Senior health worker
SHM8B	1	1	Regional government official
SHM9	1	1	Lower grade health worker
SHM10	1	1	Lower grade health worker
SHM11	1	1	Lower grade health worker
SHM12	2	1	Lower grade health worker
SHM13	2	1	Lower grade health worker
SHM14	2	1	Lower grade health worker
SHM15	2	1	Lower grade health worker
SHM16	2	1	Lower grade health worker
SHM17	2	1	Lower grade health worker
SHM18	1	1	Senior health worker
SHM19	3, online	2	Middle grade health worker
SHM20	3, online	2	Middle grade health worker
SHM21	3	4	Senior health worker
SHM22	3, online	2	Middle grade health worker
SHM23	4	1	Lower grade health worker
SHM24	Other ⁶⁷¹	1	Senior health worker

⁶⁷¹ Person SHM24 was on an IHV programme in 2015 in which AP was a participant.

Identifier(s)	Fieldtrip(s) / other	Country	Role(s)
SHM25	4	1	Lower grade health worker
SHM26	4	1	Lower grade health worker
SHM27	3, online	2	Middle grade health worker
SHM28	4	1	Senior health worker
SHM29	Online	1	Senior health worker
SPF1	4	1	VPO administrator
SPM1	1, 2	1	VPO administrator
SPM2	1, 2, 4	1	VPO leadership
SPM3	3, 4	1, 2	VPO leadership
SPM4	4	1	VPO administrator
SPM5	1, 2	1	VPO leadership
SPM6	1, 2, 3	1	VPO senior administrator
SPM7	1	1	VPO administrator
SPM8	1	1	VPO administrator
SPM9	3	2	VPO leadership
SPM10	3	2	VPO volunteer leadership
SYF1	1	1	Representative of national association
SYM1	4	1	District hospital director
SYM2	Online	2	Country 2 director non-health NGO
SYM3	1,2	1	Driver
SYM4	Online	2	Leader of health profession HEI
XHM1 ⁶⁷²	Online	2	UEHV – African diaspora
XNF1	Online	1	NGO 1 leadership – African diaspora
XNF2	Online	2	NGO 1 leadership – African diaspora
XPM1 ⁶⁷³	2	1	Former VPO administrator – African diaspora
XVF1	4	1	UEHV – African diaspora
XVF2	2	1	UEHV – African diaspora
XVM1	2	1	UEHV – African diaspora

⁶⁷² Person XHM1 was formerly a middle grade health worker in one of the SSA study countries before moving to the UK.

⁶⁷³ Person XPM1 was formerly a VPO administrator in one of the SSA study countries before moving to the UK.

List of participants observed whom I selected purposively for closer observation:

Identifier(s)	Reason	Role(s)
GNF1A GNF1B GNF1D	Multiple roles Rich data Opportunity	NGO 1 leadership UEHV Collaborator with NGO 1 and 2
GNF2	Position of power Rich data Opportunity	NGO 1 leadership
GNF3A GNF3B	Position of power Rich data Opportunity	NGO 2 leadership UEHV
GNM3A GNM3B	Position of power Rich data Opportunity	NGO 2 leadership UEHV
GOM1A GOM1B	Position of power Rich data Opportunity	Observer of NGO programme Collaborator with NGO 1 and 2
GVF4A GVF4B	Position of power Rich data	UEHV NGO 1 leadership
SEF1A SEF1B SEF1D	Position of power Rich data SSA Gender balance Opportunity	Senior government leadership Senior health care worker Observer of NGO 1 & 2 programmes
SEM1A SEM1B SEM1D SEM1J	Multiple positions of power in SSA Rich data Opportunity	Government leadership Senior health care worker Representative of national association Observer of NGO 1 & 2 programmes
SHF1A SHF1B	Rich data SSA Gender balance	Middle grade health worker District government official
SHF2	SSA Gender balance	Lower grade health worker
SHF3	SSA Gender balance	Lower grade health worker

Identifier(s)	Reason	Role(s)
SHM1A SHM1B SHM1D	Positions of power in SSA and UK Rich data Opportunity	Senior health care worker Regional government official NGO 1 leadership
SPF1	SSA Gender balance	VPO administrator
SPM1	SSA Ethnicity	VPO administrator
SPM5	SSA Ethnicity	VPO leadership
SPM6	Rich data Opportunity	VPO senior administrator
SYF1	Rich data Position of power Disconfirming evidence	Representative of national association
XVF1	African diaspora	UEHV – African diaspora
XVF2	African diaspora	UEHV – African diaspora

Appendix 2 - Document indexing system and inventory for data

This appendix details the document indexing system and inventory for data. Most of the data relates to fieldtrip data and reflective field notes included in four documents (F1M, F2M, F3M and F4M). In my document list a meaningful identifier is attached to each document (Column 1). A brief description of the data related to the document is noted in Column 2.

Key to the list:

Document identifier:

All letters in identifiers are in capitals.

The first letter relates to where the data was obtained from:

B	=	Bracketing interview
C	=	Covid-19 pandemic and post Covid-19 pandemic data
F	=	Fieldtrip data
S	=	Social media or website data (Some appears in fieldtrip appendices)
T	=	Meeting, email & phone data (Some appears in fieldtrip appendices)
V	=	Other IHV data
Note	-	<i>WhatsApp</i> data appears in main documents and fieldtrip appendices

A number relates to document number in chronological order. For example, the fieldtrips will be labelled F1, F2, F3 and F4.

For fieldtrip data *only* a second letter appears after the number. This related to whether the document was the main field notes or an Appendix:

A	=	Appendix
M	=	Main document

For fieldtrip data *only relating to appendices* a second number appears after the second letter. This simply gives the Appendix number to the main field notes document.

See the worked example below:

F = Fieldtrip
1 = 1st fieldtrip
A = Appendix to the main document
2 = The 2nd appendix to the main document

Document identifier	Description of data
F1A2	MOU
V4	Observations on IHV NGO strategy meetings

V = Other IHV data
4 = 4th document

Document indexing system and inventory for data:

Document identifier	Description of data
B1	Bracketing interview transcript of AP
C1	E mail correspondence around start of Covid-19 pandemic
C2	E mail correspondence from April 2020 to December 2020
C3	Post Covid-19 observations - includes NGO 1 and NGO 2 and associated appendix (social media)
C4	Covid-19 strategy observations
F1M	Main document field notes
F1A1	A proposal from a senior SSA health worker
F1A2	MOU in Country 1
F1A3	Letter from a national health professional association
F1A4	Debriefing with an NGO leader following a national health professional association conference
F1A5	Debriefing with the VPO and UEHV following fieldtrip 1
F1A6	Ideas from clinical advisors re IHV programmes
F1A7	Updates from NGO 1 to clinical leads prior to fieldtrip 1
F1A8	SSA Country 1 manual for task-shifting lower grade health workers in a REDACTED area of health
F1A9	NGO 1 manual for task-shifting lower grade health workers in a REDACTED area of health
F1A10	Guide to teaching infection prevention and control on task-shifting programmes
F1A11	Guide to teaching a REDACTED area of health promotion on task-shifting programmes

Document identifier	Description of data
F1A12	Regional profile of region that was the locus of fieldtrip 1
F1A13	Updates from NGO 1 to clinical leads up to fieldtrip 1
F2M	Main document field notes
F2A1	A blog from an observer to the NGO programme
F2A2	A blog on a health company website from an UEHV from fieldtrip 2
F2A3	A blog from an NGO 1 leader who observed the NGO programme
F2A4	A blog from another observer to the NGO programme
F2A5	Letter from an NGO 1 leader to clinical leads
F2A6	UEHV feedback on fieldtrip 2
F2A7	<i>WhatsApp</i> volunteer group for fieldtrip 2
F2A8	VPO administrator interviews for use on NGO 1 social media
F2A9	Assessment of lower grade health workers on task-shifting programme
F2A10	Country 1 government strategic health plan of region that was the locus of fieldtrip 2
F2A11	Report by AP for an external UK body regarding fieldtrip 2
F2A12	Original contributions for a published refereed journal article authored by AP, and three others regarding IHV which partially relates to fieldtrip 2
F2A13	Published refereed journal article authored by AP, and three others regarding IHV in which partially relates to fieldtrip 2
F2A14	Grey literature published article authored by AP regarding IHV which partially relates to fieldtrip 2

Document identifier	Description of data
F2A15	Debriefing of clinical lead (AP) and deputy clinical lead with NGO 1 following fieldtrip 2
F2A16	A blog on the NGO 1 website from an UEHV from fieldtrip 2
F3M	Main document field notes
F3A1	Modifications to a presentation regarding a potential IHV collaboration by AP and two other people
F3A2	Final presentation regarding a potential IHV collaboration by AP and one other person
F3A3	Final presentation regarding a potential IHV collaboration by an African collaborator
F3A4	Feedback from IHV collaborative conference from middle grade health workers
F3A5	Questionnaire regarding task-shifting for lower grade health workers
F3A6	Correspondence from an IHV NGO to the leader of an association for middle grade health workers
F3A7	Transcript of an interview conducted by AP of a SSA government leader for publication in a magazine of a UK university
F3A8	Blog by AP regarding fieldtrip 3
F3A9	Briefing of NGO 1 clinical leads by AP regarding fieldtrip 3
F3A10	Selected email correspondence regarding fieldtrip 3 and proposed IHV collaborations
F3A11	Transcript of a talk recorded by NGO 1 of a SSA government leader discussing health needs and IHV collaborations with other potential collaborators

Document identifier	Description of data
F3A12	Concept paper for a SSA government regarding IHV collaborations
F3A13	Introductory letter from an IHV NGO leader to middle grade health workers regarding NGO 1
F3A14	Selected social media posts and meetings regarding fieldtrip 3 and IHV collaborations
F3A15	Letter of invitation to attend a conference to discuss IHV collaborations
F3A16	MOU discussions regarding a potential IHV collaboration
F3A17	REDACTED health promotion materials developed for use in SSA
F3A18	Transcript of a publicly available video between NGO 1 and a REDACTED health industry leader regarding funding of IHV activities of NGO 1
F4M	Main document field notes
F4A1	District profile of region that was the locus of fieldtrip 4
F4A2	Selected social media posts of a VPO and NGO 1 related to fieldtrip 4
F4A3	Questions from a member of NGO 1 leadership team for AP to address on fieldtrip 4. Answers from AP are included in the document
F4A4	Transcript of video filmed by the VPO on fieldtrip 4 of three UEHVs for use on social media
F4A5	AP report regarding the visit of observers of fieldtrip 4
F4A5	AP second report regarding the visit of observers of fieldtrip 4
F4A6	AP report on African leadership in fieldtrip 4
F4A7	Debriefing of clinical lead (AP) and deputy clinical lead with NGO 1 following fieldtrip 4

Document identifier	Description of data
F4A8	Draft report to an African Secretary of State for Health with related e mails regarding observation of NGO 1 on fieldtrip 4
F4A9	Proposal for funding of a mobile health unit from a senior SSA healthworker to NGO 1 for use in the region that was the locus of fieldtrip 4
F4A10	Selected e mail and <i>WhatsApp</i> correspondence between AP and other SSA health workers
F4A11	A blog on a health company website from an UEHV from fieldtrip 4
S1	Selected observations on transcripts of interviews/monologues published on study NGO websites and/or social media regarding IHV
S2	Selected social media IHV posts related to study NGOs
T1	Correspondence between two NGO clinical leads and AP regarding IHV in the two SSA countries
T2	Email correspondence between an NGO clinical lead and AP regarding IHV in the two SSA countries
T3	Observations on NGO 1 clinical lead meetings
T4	Observations on an online NGO 1 clinical lead meeting
T5	E mail correspondence 2018 2019
T6	E mail correspondence 2021
V1	Engaging young REDACTED health workers in IHV report for NGO 1
V2	Volunteer survey data from NGO 1 including an appendix
V3	Observations on possibilities for improved monitoring and evaluation of IHV programmes

Document identifier	Description of data
V4	Observations on IHV NGO strategy meetings
V5	Observations on IHV NGO management meetings
V6	Observations on a governance issue involving a REDACTED IHV NGO
V7	Presentation to WHO African region
V8	Presentation about NGO 1 and 2 collaborations
V9	Presentation about a multi sector collaboration
V10	Volunteering experiences by an African health worker
V11	Workbook for health professional learners in the two SSA countries
V12	A module of a SSA health worker online training course
V13	Field notes on an online health worker training course

Appendix 3 - An example of coded fieldtrip data and reflective coded fieldtrip notes

This appendix gives an example of how I coded my fieldtrip data and my reflective field notes. To put in sufficient exemplar material the example relates to Document F2M (from my second fieldtrip which took place in Country 1). I have put in data and reflective notes from the original coding of data as part of my thematic analysis from page 46 of F2M continuously to page 59.

Key to Appendix 3:

The document has been redacted. The redactions mean that the line numbers may differ slightly from the original data. The structure of this document being embedded in the thesis as an appendix means the footnote numbers in this appendix are different than in the original data in page 46 to page 59 of F2M. In the original data the codes appeared as *Add Comments* in the *Word* document. To comply with thesis writing guidance in this appendix they are situated as detailed below.

Fieldtrip data:

Appears in the main part of the document. UoAs are highlighted in light blue. See below: Codes for a UoA are situated next to the UoA and are capitalised and in PURPLE. See below:

2	AP and SPM6 thought that the visits were over given the time and we could go to
3	REDACTED IHV PROGRAMME SITE but then SEM7 announced:
4	
5	SEM7:
6	
7	Now we must visit the District Commissioner (SEM6). ⁷⁵
8	
9	[SPM6 raised his eyes at AP saying nothing]. AMBITION; SELF INTEREST
10	
11	This time SEM7 instructed his driver to wait and travelled with the team sitting at the front
12	of the bus. It was very short drive to SEM6'S Office, an impressive building.
13	
14	SPM6 whispered to AP:
15	
16	"No photos here". ⁷⁶ CULTURAL COMPETENCE; PROTECTIVE
17	
18	AP passed this around the team

Reflective field notes:

Appear as footnotes. UoAs are highlighted in **yellow**. Codes for a UoA are situated next to the UoA and are capitalised and in **PURPLE**. See below:

⁷⁵ AP Comment: District Commissioners are politicians and would be appointed from within the REDACTED political ruling party. They are the local Government spokesperson. It is likely being a District Commissioner in REDACTED TOWN (as it is A REDACTED SENIOR POLITICIAN's home District) would be a high profile position and it is likely SEM6 has greater political ambitions in the future.
AMBITION, SELF-INTEREST

⁷⁶ AP Comment: SPM6 occasionally does this. If he says this then photos must be inappropriate as he is usually OK with the team taking photos. **CULTURAL COMPETENCE, PROTECTIVE**

⁷⁷ AP Comment: Note embellishment of thanking the Government and Ministry. This is because SEM6 has a political role. **POLITICISATION**

The following exemplar pages detail data, reflective field notes and open coding from F2M (Pages 46-59):

AP and SPM6 thought that the visits were over given the time and we could go to REDACTED IHV PROGRAMME SITE but then SEM7 announced:

SEM7:

*Now we must visit the REDACTED LOCAL POLITICIAN (SEM6).*⁶⁷⁴

[SPM6 raised his eyes at AP saying nothing]. AMBITION; SELF-INTEREST

This time SEM7 instructed his driver to wait and travelled with the team sitting at the front of the bus. It was very short drive to SEM6's Office, an impressive building.

SPM6 whispered to AP:

*No photos here.*⁶⁷⁵ CULTURAL COMPETENCE; PROTECTIVE

AP passed this around the team

SEM7 strode out of the bus onto the verandah and was greeted by SEM6, the REDACTED LOCAL POLITICIAN. A very warm long handshake between the two and gesticulations during conversation from SEM6 towards the bus. GREETINGS; RESPECT; HIERARCHY

SEM7 asked the team to come out and each of us shook hands with SEM6. We were ushered upstairs into his office, which was plushier than normal for a REDACTED GOVERNMENT office, and the well-rehearsed routine of signing the visitors book took place.

SEM6 asked AP to speak, and AP gave almost the same speech that he had done to SEM8, embellished a bit more for SEM6's role.

AP:

We would like to thank SEM6 for his hospitality and the hospitality of the REDACTED Government of COUNTRY 1 and the Ministry of Health⁶⁷⁶ and are pleased and privileged to be here assisting the District Medical and REDACTED HEALTH Officers in training local health workers in REDACTED SPECIFIC SURGICAL PROCEDURES and REDACTED SPECIFIC health education. RESPECT; POLITICISATION; APPRECIATION (UoA 1); CULTURAL COMPETENCE (UoA 2)

⁶⁷⁴ AP Comment: REDACTED LOCAL POLITICIAN's would be appointed from within the REDACTED political ruling party. They are the local government spokesperson. It is likely being a LOCAL POLITICIAN in REDACTED TOWN (as it is A REDACTED SENIOR POLITICIAN's home District) would be a high profile position and it is likely SEM6 has greater political ambitions in the future. AMBITION; SELF-INTEREST

⁶⁷⁵ AP Comment: SPM6 occasionally does this. If he says this then photos must be inappropriate as he is usually OK with the team taking photos. CULTURAL COMPETENCE; PROTECTIVE

⁶⁷⁶ AP Comment: Note embellishment of thanking the government and ministry. This is because SEM6 has a political role POLITICISATION

SEM6 then spoke:

SEM7:

I have arranged these people to come here.⁶⁷⁷ They are very welcome and we have all the necessary permissions. They will make a big impact for the REDACTED SPECIFIC health of our people. SELF-INTEREST; HIERARCHY; OVERSIGHT
I have sent SHM3B to go with them⁶⁷⁸ to TWO REDACTED WARDS⁶⁷⁹ and they will provide many many new people to work with us. UNTRUTH

AP notices SPM6 raising his eyes at AP.

SEM6 then reciprocated:

Thank you for arranging this⁶⁸⁰, my good friend.⁶⁸¹ (Looks at SEM7 then turns to team)⁶⁸² Welcome, welcome, welcome as you know REDACTED SPECIFIC HEALTH is our government's priority. APPRECIATION; POLITICISATION; UNTRUTH

He then thanked the team for coming and then launched into an apology:

SEM6 apologised for a theft of a mobile phone from one of the UEHVS on REDACTED PREVIOUS IHV NGO PROGRAMME INVOLVING NGO 1 saying:

*This will not happen again; I have discussed it with our police chief. You will be very safe here. REDACTED TOWN welcomes you.*⁶⁸³ SAFETY; RESPECT; CRIME

This time there was no group photo, and we went to the bus. SEM7's driver had arrived.

SEM7 shook hands with AP and SPM6 stating:

Thank you for paying respects to SEM6. He is very pleased and so am I.⁶⁸⁴ I will visit your programme at the FIRST REDACTED WARD SITE.⁶⁸⁵ I must go to my patient now.⁶⁸⁶ GRATITUDE; POLITICISATION; DISINTEREST

⁶⁷⁷ AP Comment: SEM6 had little to do in this process. The arranging was between SPM5/SPM6 and SHM3B. SEM6 probably had a minor rubber-stamping role but he wants credit in front of SEM7. SELF-INTEREST

⁶⁷⁸ AP Comment: Again, SEM6 is saying something he didn't do to SEM7. THE REDACTED LOCAL GOVERNMENT MINISTRY sends SHM3B in agreement with NGO 1. UNTRUTH

⁶⁷⁹ AP Comment: SEM6 points to SHM3B who nods.

⁶⁸⁰ AP Comment: AP thinks this is happening: SEM6 is taking the credit for SHM3B's work in front of SEM7. Because hierarchically SEM6 is of higher authority than a SHM3B, SHM3B is just letting it happen. He doesn't like it but is accepting it. HIERARCHY; SUBMISSIVE

⁶⁸¹ AP Comment: AP is unsure if they are good friends but this clearly is affirmation from SEM7.

⁶⁸² AP Comment: AP notices once again SPM6 raising his eyes at AP and SHM3B looks a little crestfallen. SUBMISSIVE

⁶⁸³ AP Comment: This was a very minor issue 2 years previously. It was however clearly an embarrassment for the officials in REDACTED LOCAL TOWN given SEM7's reaction. RESPECT

⁶⁸⁴ AP Comment: This was clearly the visit where SEM6 needed to show off, NOT the visit to SEM8. AP is uncertain as to why but clearly there is some health politics going on here. POLITICISATION

The team and SEM7 went their separate ways.
The bus headed on the 40 minute drive to FIRST REDACTED WARD SITE with much hilarity and relief from the team about the handshaking and repetition of the same introductions eg.:

GVF7:

[Laughs] Yeah, I know this off pat by now, Hi, I'm GVF7 and I'm a UEHV from REDACTED COUNTRY, thank you for the welcome we have had in REDACTED LOCAL TOWN, and we are really looking forward to helping. HUMOUR

GVM2A:

[Laughs] Well that was more schmoozing than the REDACTED UK HEALTH Conference. POLITICISATION

AP chatted to GPM6 as with a 30 minute drive we were going to arrive at 1030am, and it would be likely well after 11am that we could start.

AP decided to use the drive to discuss arrival and unpack with the team. All listened attentively. The drive was good except the last 5 minutes where the road was appalling and unsuited to a coaster bus and was like a 4 wheel drive experience. Again, the team took this in good humour. SYM3 was not phased at all by the road.

TRANSPORT; ORGANISATION; LEADERSHIP

[AP thoughts at this time: AP thought that the team were great, facing everything with good humour and even though they had yet to see a patient AP thought that there are unlikely to be any great team problems]. HUMOUR; TEAMWORK

On arrival there were over a hundred patients waiting outside the health centre. OVERWORKED The building looked sizeable but dark and there were other buildings around 100 metres away. UTILITIES

GVM5A said:

AP, that's definitely the building we used.

F2M Figure 11: It took SPM1 less than 15 minutes to organise the patients into some form of order and register enough to get started. ORGANISATION; LEADERSHIP; TEAMWORK⁶⁸⁷

⁶⁸⁵ AP Comment: In the event SEM6 did not visit the Programme and that was the last that any of the team heard or saw of him on this DVP. DISINTEREST

⁶⁸⁶ AP thoughts (kept to himself): AP felt at the time that SEM6 was taking a big risk by leaving the Hospital when the REDACTED SENIOR GOVERNMENT POLITICIAN's RELATIVE had just been admitted with a REDACTED SERIOUS MEDICAL ISSUE and instead *buttering up* SEM7. In the event local News later reported that the REDACTED SENIOR GOVERNMENT POLITICIAN's RELATIVE HAD recovered.

⁶⁸⁷ Note the UoA here is the photograph and AP's interpretation of it; this derives the codes.



AP, GVF1B and SPM6 got off the bus to see what state the building was in. Inside was a large room with all the LOWER GRADE HEALTH WORKERS. They greeted SHM3A (who had travelled on the bus) and shook hands with AP, GVF1B and SPM6.

LEADERSHIP; GREETINGS

There were 4 rooms and AP, GVF1B and SPM6 decided that all UEHV TRAINERS could go in the large room with AP *hot desking* on the largest table and GVF1B would go in a separate referral room. AP designated a changing room and a sterilisation room.

LEADERSHIP; COMMUNICATION

The rooms were dark and musty with bat and gecko droppings all around. It looked underused. Confidential patient notes were scattered throughout.

CONFIDENTIALITY; UTILITIES; SAFETY

AP went back to the bus and asked the team to come in, introducing them all to the LOWER GRADE HEALTH WORKERS. AP paired up XVM1/GVM1, GVF1A/GVM7 and GVM5A/GVM2A to set up their tables so XVM1, GVF1A and GVM5A could mentor. AP asked the UEHVS WHO WERE NOT CLINICAL TRAINERS to change into scrubs then would mentor them through sterilisation set up. SPM6, SHM3A and SYM3 unloaded the bus and SPM1 started trying to order the patients into a queue so that we could start.⁶⁸⁸

TEAMWORK; ORGANISATION; GREETINGS

It became a busy hive of activity, and all went smoothly until it came to setting up the sterilisation burners. GVM6 was distracted and he didn't seem to understand that the UEHVs needed help.

AP said to SPM6:

SPM6, you do know that all the REDACTED UEHVS DOING STERILISATION are new, so we have one less than normal and no returners?

⁶⁸⁸ AP Comment: AP was impressed with the instant teamwork including SHM3A who helped at anything.

1 SPM6:

2
3 *Oh, now I understand, SPM5 didn't tell me*⁶⁸⁹ COMMUNICATION; OVERSIGHT

4
5 He immediately assisted apologising profusely.

6
7 It then became rapid problem solving, there was no water. AP told EM and it
8 magically appeared. UTILITIES; INITIATIVE

9
10 By 11am AP had the LOWER GRADE HEALTH WORKERS paired with the
11 CLINICAL TRAINERS.⁶⁹⁰ HIERARCHY; GENDER EQUALITY

12
13 Pairings:

14
15 GVM1/SHM13; XVM1/SHF2; GVM2A/SHM14
16 GVF1A/SHM15; GVM5A/SHM16; GVM7/SHM17

17
18 The clinic was ready, the clinic had the rudiments of a sterilisation room, and the
19 first patient was called and then all the LOWER GRADE HEALTH WORKERS
20 called patients in.

21
22 AP, SHM3A, SPM6 and SPM1 had a discussion about the large numbers with the
23 loss of time from the morning politics.

24
25 SPM1:

26
27 *We have massive numbers of people maybe 150 here.*

28
29 SHM3A:

30
31 *We must treat as many as possible.* OVERWORKED; WORK ETHIC;
32 PROFESSIONALISM

33
34 After discussion agreement was for 120 patients to be given numbers for today and
35 50 for tomorrow. NEGOTIATION; PLANNING

36
37 SHM3A agreed to start straight away treating people WORK ETHIC and once AP
38 had got the clinic and sterilisation flowing he would *hot desk* a chair at the end of
39 somebody else's.

40
41 AP discussed with SHM3A that a morning and afternoon HEALTH PROMOTION
42 talk to the patients was essential, but as the LOWER GRADE HEALTH
43 WORKERS were not yet trained one of the UEHVS DOING STERILISATION

⁶⁸⁹ AP Comment: AP assumed that this information would have got to SPM6 considering all the correspondence with GVF10 before the IHV PROGRAMME. AP thought – note to self – always check – never assume! COMMUNICATION; OVERSIGHT

⁶⁹⁰ AP Comment: AP/GVF1B had discussed this the night before and decided that the female LOWER GRADE HEALTH WORKER (SHF2) should go with an experienced teacher as sometimes female LOWER GRADE HEALTH WORKER's due to hierarchical prejudice in SSA can have low self-esteem hence allocation to XVM1. This proved to be unfounded. SHF2 proved to be confident and highly skilled but this was AP/GVF1B's concern at the time. HIERARCHY; GENDER EQUALITY

would need to give it. SPM1 suggested this was done once he and SYM3 had given out the numbers so he could interpret.⁶⁹¹ LEARNING; COMMUNICATION

IB delayed the local mama to bring the lunch at 2pm so the team could break the back of the numbers. PROBLEM SOLVING

The UEHV's DOING STERILISATION had got into a routine with sterilisation so AP suggested that they decide who would give the talk. They decided on GVF7.

Day 1 and 2 are generally slow as there is lots of demonstrating to LOWER GRADE HEALTH WORKERS so AP and SHM3A tried to bear the patient treatment burden and the morning flew in. As local anaesthetic was taking⁶⁹² AP checked on the CLINICAL TRAINERS and did this throughout the day. WORK ETHIC; PROFESSIONALISM; LEADERSHIP There was little time for observation, but AP managed to speak to all through the course of the day.

GVM1:

GVM1 had started off with two child patients who were anxious.⁶⁹³ He told AP that he was feeling:

A bit overwhelmed...this was nothing like I expected

I just didn't know people had so little.

I didn't realise how bad oral health was here. POVERTY; ORIENTATION; OVERWHELMED (UoA 1); COURAGE (UoA 2)

It's really really hard teaching someone. You forget that they don't know things that are really basic. LEARNING

AP encouraged GVM1 that he could *do it*⁶⁹⁴ and he then just flew. REASSURANCE; LEARNING

XVF2:

Was quite emotional.

I'm just stunned at the state of people's REDACTED SPECIFIC HEALTH.

She got very upset whilst assisting a 3 year old having A REDACTED SIMPLE SURGICAL PROCEDURE as he's:

The same age as my grandson. CULTURAL COMPETENCE; OVERWHELMED

⁶⁹¹ AP Comment: In the event SPM6 interpreted for GVF7 and SPM1 for AP who was running the 8th chair. COMMUNICATION

⁶⁹² AP Comment: This bought 2 or 3 minutes between patients.

⁶⁹³ AP Comment: Lots of screaming. These patients would be sent for a general anaesthetic in the UK. COURAGE

⁶⁹⁴ AP Comment: A confidence boosting pep talk trying to be positive.

1 AP ended up taking her away from the clinic out of sight of others to talk this
2 through with her. REASSURANCE; COMPASSION; LEADERSHIP

3
4 AP would agree with GVM1 and XVF2 and go as far as to say that he had never
5 seen worse SPECIFIC REDACTED HEALTH anywhere and at any time than in
6 THIS REDACTED DISTRICT today. AP thought that this was a bit of a baptism
7 of fire for the team.

8
9 GVM7:

10
11 GVM7 was very hesitant at first, AP noticed GVF1A quietly advising and
12 encouraging him and he was steadfastly getting on with teaching and treating and
13 being very patient with SHM17. WORRY; REASSURANCE; RESILIENCE

14
15 GVM7 also remarked:

16
17 *The state of REDACTED SPECIFIC HEALTH here is unbelievable.*

18
19 GVF7:

20
21 Was very upbeat and happy. She gave the SPECIFIC REDACTED HEALTH
22 PROMOTION talk.

23
24 *I was a bit nervous giving the talk, I didn't think I could do it, but SPM6 translated.*

25
26 *I've never seen people so happy to have someone talk to them about SPECIFIC*
27 *REDACTED HEALTH PROMOTION.*⁶⁹⁵ COMMUNICATION; WORRY

28
29 GVM2A:

30
31 Looked a bit downbeat initially.

32
33 *I'm a bit embarrassed. I keep having REDACTED COMPLICATIONS*⁶⁹⁶ *DOING A*
34 *SPECIFIC REDACTED SURGICAL PROCEDURE. I'm normally good at THIS*
35 *SPECIFIC REDACTED SURGICAL PROCEDURE.*

36
37 AP had noticed he had had a run of DIFFICULT REDACTED SURGICAL
38 PROCEDURES and tried to bolster him, told him not to worry and refer to AP or
39 SHM3A, his role was primarily teaching. WORRY; REASSURANCE

40
41 GVM5A joined in using a different approach (which was more successful than
42 AP's) in shouting out to SHM3A:

43
44 *Dr SHM3A, that's GVM2A MESSED UP (ACTUAL WORD USE REDACTED)*
45 *another, he owes you a few beers*⁶⁹⁷ *now.*

⁶⁹⁵ AP Comment: XVF2 had a very big audience.

⁶⁹⁶ AP Comment: The actual word used by GVM5A for "MESSED UP" (WHICH IS A REDACTION) is a UK expression for MESSING UP A PROCEDURE FROM A SPECIFIC ETHNIC REGION OF THE UK. As 5 of the team (including AP) were either from or had been a student or worked in THE SPECIFIC ETHNIC REGION the humour was well understood. HUMOUR; CULTURAL COMPETENCE

⁶⁹⁷ AP Comment: GVM2A bought SHM3A a beer that evening.

It became a standing joke, and GVM2A became less concerned and more focused on the teaching. HUMOUR; LEARNING

Later GVM2A states:

I'm really enjoying myself now, SHM14 is a great lad,⁶⁹⁸ he's not at all academic but his hearts in the right place. LEARNING; ROLE MODEL; FRIENDSHIP

Finally, GVM2A states:

I'm absolutely bloody knackered, that's the hardest days' work I've ever done, standing all day.

AP replied:

Oh well, look on the bright side it'll be harder tomorrow!

GVM2A:

"And I actually know you're not joking." EXHAUSTION; HUMOUR

XVM1:

XVM1 was never flustered, he was calm, focused, oblivious to the noise and mayhem and methodical.

When AP asked how he was doing, he said:

SHF2 is doing great, she's learnt how to use SOME REDACTED BASIC INSTRUMENTS AND CAN DIAGNOSE A REDACTED SPECIFIC DISEASE LEARNING; ROLE MODEL

Essentially, each time AP asked it was all about the LOWER GRADE HEALTH WORKER. It was if XVM1's needs were irrelevant. ALTRUISM; COMMITMENT

GVM5A:

Gave good clear solid instructions and kept calm. His mentoring of GVM2A by general banter was absolutely spot on. Again, when asked his focus was all about the LOWER GRADE HEALTH WORKER:

SHM16 is doing well but he needs to ask more in depth questions. LEARNING; MENTORING

⁶⁹⁸ AP Comment: SHM14 and GVM2A related very well to each other. They were of similar build and didn't take things too seriously.

GVF1A:

Had quietly got on with her teaching of her LOWER GRADE HEALTH WORKER and mentoring of GVM7. She was serenely calm and unflustered and patiently dealt with difficult patients well.

She states:

“GVM7 is doing really well.” LEARNING; ROLE MODEL; MENTORING

GVF8:

Gave the afternoon OHT talk. Was positive throughout and said:

A PREVIOUS UEHV(GVF11)⁶⁹⁹ told me I can explain some things, but you won't know what it's like until you're there and she was right. ORIENTATION; REALISM

Wow, that REDACTED SPECIFIC HEALTH PROMOTION talk was brilliant, the patients just lap it up.

SHM3A:

AP was so impressed with SHM3A. He just got on quietly with the job in hand. He was respectful and not rude and impressively showed great skill in DIFFICULT REDACTED SURGICAL PROCEDURES.

SHM3A states at the end of the day:⁷⁰⁰

That was a very hard day.

[AP thoughts at the time: AP has enormous respect for SHM3A given the daily conditions he works in]. RESPECT; EXHAUSTION

The local mama arrived on time at 2pm and AP and SPM6 ushered the team and LOWER GRADE HEALTH WORKERS out to eat. AP and SHM3A finished off the morning clinic and then SHM3A went for lunch. AP and SPM6⁷⁰¹ both adopt the Hal Moore⁷⁰² approach to things and would wait for everyone else to eat before they did. ALTRUISM; LEADERSHIP; ROLE MODEL

This left time for AP and SPM6 to talk:

AP started with the usual question:

⁶⁹⁹ AP Comment: GVF11 is a former UEHV who works with GVF8 in the UK and has been on an NGO 1 programme twice in Country 1 doing a similar role to GVF8.

⁷⁰⁰ When AP was writing up his field notes he wrote this UoA not in chronological order by mistake (it should be at debrief two pages or so later; AP's mistake was likely due to late night or early morning fatigue after a long tiring day).

⁷⁰¹ AP Comment: For safety reasons, because the burners are on and there are valuables always two people stay in the building.

⁷⁰² Harold (Hal) Moore was a USA Lieutenant Colonel in the Vietnam War. He led by being the first in and last out. See Moore and Galloway (1992).

1 *Are there any problems?*
2
3 SPM6:
4
5 *There are no problems.*
6
7 AP:
8
9 *You always tell me there are no problems.* PROTECTIVE; REALISM
10
11 SPM6:
12
13 *There really are no problems this time, this team is great.* TEAMWORK
14
15 AP:
16
17 *But it's only Day 1*
18
19 SPM6:
20
21 *And they have already done more work than some teams do in the 1st week. I*
22 *cannot believe THE REDACTED STERILISATION/HEALTH PROMOTION TEAM*
23 *are new.* APPRECIATION; WORK ETHIC
24
25 AP:
26
27 *Surely not*
28
29 SPM6:
30
31 *[small pause] Well, on GVM8's team⁷⁰³ they wouldn't let us go over 70 patients a*
32 *day, SPM1 kept saying to me we are leaving people untreated, and I spoke with*
33 *GVM8, but he wouldn't take any more, he liked his time in the hotel too much.*
34 WORK ETHIC; PROFESSIONALISM; CULTURAL TENSION
35
36 GVF1B and SPM1 relieved AP and SPM6 and very quickly with no messing the
37 afternoon clinic was started.
38
39
40 SPM1 asked AP to give an interview for NGO 1 *Facebook*⁷⁰⁴ which he conducted
41 outside.
42
43 SPM1 says:
44
45 *Tell them everyone is well and we are busy.* IMAGE; OVERWORKED
46
47 *As the clinic wound up 122 patients had been seen and each CLINICAL TRAINER*
48 *despite being tired individually gave feedback to their LOWER GRADE HEALTH*
49 *WORKER.*

⁷⁰³ AP Comment: GVM8 had been a clinical lead on a team recently returned from an NGO 1 programme.

⁷⁰⁴ The transcript of this is in document F2A8 of the *data corpus*.

OVERWORKED; WORK ETHIC; FEEDBACK

We were fairly late and AP planned a debrief⁷⁰⁵ on the bus but the LOWER GRADE HEALTH WORKERS asked for a ride and were dropped off at various villages on the way to REDACTED TOWN except SHM14 who was staying in REDACTED LOCAL TOWN.⁷⁰⁶ CONFIDENTIALITY

We got back in the dark, 10 minutes to freshen up and straight to debrief and a drink then dinner.

Debrief took place in the hotel dining room. The team were the only guests.

GVM1 rearranged all tables to make a single round table, GVM7, GVF7 and SPM1 helped.

The format of a debrief is for AP to go around the table, ask people about their day, ask them to comment on how their LOWER GRADE HEALTH WORKERS are progressing, how they are feeling and any problems or issues.
[Debrief are therefore comments that individuals want to share with the group]

AP started with GVF1A who was sitting on his left and worked around the table clockwise.

GVF1A:

GVF1A said that she had been paired up with SHM15 who had done well with his patients without being too *pushy*. He had started giving anaesthetics and the odd REDACTED SURGICAL PROCEDURE with much assistance.

GVM7:

Said that he had felt very cautious to begin with⁷⁰⁷ but had got into the swing of things⁷⁰⁸ and felt SHM17 was progressing well with assistance. WORRY; LEARNING

XVF2:

Reported that she had had a good day but had found a 3 year old child having a REDACTED SURGICAL PROCEDURE distressing and hadn't realised how bad REDACTED SPECIFIC HEALTH was.

The group rallied round XVF2 with empathetic comments perhaps realising how affected XVF2 had been regarding this which she had chosen to share with the group.⁷⁰⁹ SUPPORT EMOTIONAL; POVERTY

⁷⁰⁵ AP Comment: The NGO programme involves debriefing everyone about their experiences and how the LOWER GRADE HEALTH WORKERS are doing. This is done daily. It is good for team bonding and allows mutual support if anyone is struggling.

⁷⁰⁶ AP Comment: It would be inappropriate to debrief in front of the LOWER GRADE HEALTH WORKERS. CONFIDENTIALITY

⁷⁰⁷ AP thoughts (kept to himself): GVM7 was the most nervous pre-programme about his own ability, and this perhaps reflects that. WORRY

⁷⁰⁸ AP Comment: AP had noticed GVM7's confidence improve very quickly as to his own ability (within the first 2 hours). LEARNING

GVF8:

She said that she loved the teamwork and *all in it together* approach. She felt that day one had been a *steep learning curve* for her. TEAMWORK; LEARNING

GVM1:

GVM1 felt that there had been a bit of a language barrier between him and SHM13.⁷¹⁰ COMMUNICATION; MISUNDERSTANDING

That said he felt SHM13 was a *good lad*. GVM1 found explaining identification OF REDACTED INSTRUMENTS difficult to SHM13. GVM1 told the group that *teaching is very hard*.⁷¹¹

XVM1 offered some advice to GVM1 on careful simple explanation. GVM1 was very attentive to GA. TEACHING; ROLE MODEL; INSIGHT

XVM1:

XVM1 only discussed SHF2 and her progress at debrief.⁷¹² He stated that initially she wouldn't engage XVM1 with eye contact but was a quick learner and had progressed very well throughout the day, was giving good anaesthetics and had UNDERTAKEN SOME REDACTED SURGICAL PROCEDURES with assistance. LEARNING; GENDER EQUALITY; HIERARCHY

GVF7:

Said that she was initially very anxious⁷¹³ about delivering the REDACTED SPECIFIC HEALTH PROMOTION MESSAGES to the crowd but *they were so attentive*, and she loved doing it. GVF7 said she loved the teamwork. WORRY; TEAMWORK

GVM5A:

GVM5A said that SHM16 was *very bright* and *seems to know a lot* but felt that he had a bit of an attitude problem as he was on his mobile phone a lot and was perfunctory with regard to REDACTED SPECIFIC ORAL HEALTH PROMOTION.

⁷⁰⁹ AP Comment: XVF2 had previously discussed this with AP alone.

⁷¹⁰ AP thoughts (kept to himself): AP wondered if there was a language barrier or if it was GVM1's initial teaching style. TEACHING

⁷¹¹ AP Comment: GVM1 had shared this individually previously with AP, now he was sharing it with the group.

⁷¹² AP Comment: AP felt XVM1 was very focused on the *raison d'être* and that SHF2 had been his days focus.

⁷¹³ AP Comment: GVF7 Showed no sign of nerves at all. AP thoughts that she is very good at hiding anxiety.

GVF8⁷¹⁴ then chipped in to say that he had been *vacant* during his REDACTED SPECIFIC ORAL HEALTH PROMOTION training. PROFESSIONALISM; DISINTEREST

SPM6:

Said that he had had a very busy day. He had enjoyed translating the talk for GVF7 and that he had *no problems and no concerns*. COMMUNICATION

GVM2A:

States that:

I've had an interesting day and a difficult day...SHM14 has had a fantastic day...He's not an academic and his REDACTED ANATOMY AND INSTRUMENTATION KNOWLEDGE is very iffy but he's very smiley and engaging with the patients and practically he's great... I've given him some homework to do.

JM went on to say that he struggled with REDACTED DIFFICULT TYPE OF injections⁷¹⁵ and he felt that this was *because he was left-handed*.

GVM5A then stated that he is ambidextrous and offered to train SHM14 as he could demonstrate THE REDACTED INJECTION left-handed. SUPPORT; COMMUNICATION; RESPONSIBILITY

GVM2A indicated that he had felt a bit embarrassed by STRUGGLING WITH SOME SURGICAL PROCEDURES and keeping SHM3A and AP busy and that's why it had been difficult. OVERWORKED; OVERWHELMED; SUPPORT

AP told GVM2A not to be concerned and that his focus was on the training and he was doing great, AP and SHM3A would sort out any tricky clinical matters. Others joined in to agree which GVM2A seemed to appreciate.

GVM2A states finally: *I'm completely bloody knackered and I'm glad I've got this in my hand [raises a bottle of beer]*.

SPM1:

SPM1 said that he felt that the introductions had gone well and that SEM7 had phoned him to tell him that the REDACTED LOCAL POLITICIAN (SEM6) and REDACTED LOCAL COUNCIL EXECUTIVE (SEM8) were very impressed with the team. SPM1 states that *it is very important that we introduced ourselves*. APPRECIATION; RESPECT; CULTURAL COMPETENCE

SPM1 then told a patient story:⁷¹⁶

⁷¹⁴ AP Comment: GVF8 had done some one-to-one SPECIFIC REDACTED HEALTH PROMOTION training with SHM16. Interestingly she did not mention this when she debriefed but only when SHM16 was being discussed by GVM5A.

⁷¹⁵ AP Comment: A REDACTED TYPE OF INJECTION is technically very demanding, and UK REDACTED UNDERGRADUATE STUDENTS find this tricky to master. AP would expect a CO to have difficulty early in the Programme so was relatively unconcerned.

He said that a patient had come, who had had PAIN for 2 years and could not afford TREATMENT. She is a tailor and couldn't work as the pain was so bad. She was so relieved because she was out of pain and *could feed her family as her husband was dead.*

POVERTY; RESOURCES; GRATITUDE

AP then summarised the debrief:

AP thanked everyone for the day's efforts and told them that start time for breakfast was 7am, leaving the hotel at 730am. Nobody moaned but just accepted this early start.

Dinner was very sociable, with the food being rice, beans, fish heads and tails and fruit. Again, the atmosphere was upbeat, and AP felt that there was very good team bonding. TEAMWORK; NUTRITION GVM1 was the first to go to bed then everyone else quickly followed except SPM6 and GVF1A.

AP had a short meeting with GVF1B discussing allocations for Day 2 deciding to put GVM5A with SHM14 due to the left-handed issue and GVF1A with SHF2⁷¹⁷ with the others randomly allocated.

AP and GVF1B discussed mentoring GVM1's teaching a bit more and trying to point him in the right direction using XVM1 as his role model. MENTORING

GVF1A then headed to bed leaving just AP and SPM6.

AP and SPM6 briefly discussed the day and SPM6 said that SEM7 had *put on quite a performance [laughs]...but we have to do these things.* IMAGE; AMBITION

SPM6 wanted then to talk about his UK visit. He was thankful to GVF5 and GVF12 for giving him the opportunity and inviting him.⁷¹⁸ He was looking forward to spending time with XPM1 and catching up with him and GVF5 was going to show him all the sights in London. AP reiterated that he would find time to see him when he visited GVF12.

AP asked how XPM1⁷¹⁹ was doing. SPM6 said that he had taken a time to settle and still missed COUNTRY 1 but had *many more opportunities in REDACTED PART OF THE UK*. SPM6 was unsure what XPM1's job was.

Fairly late now SPM6 and AP went to their respective rooms. AP still had a lot of paperwork to do and the pre-course exam to mark.

⁷¹⁶ AP Comment: Part of SPM1's role for NGO 1 is to collect *patient stories* which can be used in the NGOs social media communications. IMAGE

⁷¹⁷ AP Comment: AP and GVF1B both felt female-female teaching would be helpful on day 2 for SHF2. GENDER EQUALITY

⁷¹⁸ AP Comment: Almost certainly GVF5 and GVF12 are funding SPM6's trip as it would be out with his economic means.

⁷¹⁹ AP Comment: XPM1 was formerly a VPO administrator in Country 1 before moving to the UK. AP had been on two IHV programmes with XPM1 before this research. SPM6 and XPM1 were great friends.

1 AP marked the examination noting that the main issues were the LOWER GRADE
2 HEALTH WORKERS widespread lack of REDACTED ANATOMY AND
3 INSTRUMENTATION KNOWLEDGE. SHM14 had performed worst and SHF2
4 best.

5
6 AP finally went to bed shortly after 2am – a long day. OVERWORKED

Appendix 4 - An example of organisation of coded fieldtrip data regarding a specific code

This appendix follows on from Appendix three and gives the reader an example of how I organised my coded fieldtrip data for each code. I have redacted this data.

The example I give will relate to the code *respect*. I have put in a part of a data sheet for this code related to my first and part of my second fieldtrip. This comprises ten pages of coded data.

Key to the data sheet:

Thematic Analysis: AP ← Person who has done the coding.

Code: Respect ← Code presented in Unit of Analysis (UoA) in this data sheet.

Document identifier Page identifier Identifier of participant UoA is in this column, direct from the data

Doc	Pg	Ln, Fn	Quote/Comment	Code 1	Code 2	Code 3
F1M	10	12	SHM1B felt that he was “not respected” by his medical colleagues.	Respect	Hierarchy	
F1M	11	26-27 & F27	SHM7B was revered and respected by the other REGIONAL GOVERNMENT OFFICIALS by AP’s interpretation of how they addressed him. Footnote 27: He was greeted as “ <i>Shikamo</i> ” rather than “ <i>Habari</i> ” ▲ A REDACTED LOCAL LANGUAGE greeting of respect	Respect	Greetings	
F1M	11	27	at times the other REGIONAL GOVERNMENT OFFICIALS bowed to SHM7B. Footnote 28: “Bowing” in REDACTED culture shows respect. It is reserved for a “ <i>Mee</i> ” - REDACTED LOCAL LANGUAGE for a respected figure.	Respect		

Line/footnote identifier Code 1 for this data sheet from UoA is *respect* Other codes presented from this UoA

Footnotes are my reflective field notes and can be part of a UoA or a standalone UoA.
Highlighted in yellow here purely to emphasize reflexivity to the reader

Abbreviation key: Doc = Document; Pg = Page; Ln = Line; Fn = Footnote

Maximum 3 codes from a UoA; sometimes there are more so UoA coded again if needed. Some examples of this are seen in the following 7 pages.

Ten pages of the REDACTED data sheet for the code *respect*:

Thematic Analysis: AP

Code: *Respect*

Key:

Doc: Document Ln: Line

Pg: Page Fn: Footnote

Doc	Pg	Ln/Fn	Quote/Comment	Code 1	Code 2	Code 3
F1M	10	12	SHM1B felt that he was <i>not respected</i> by his medical colleagues.	Respect	Hierarchy	
F1M	11	26-27 & F27	SHM7B was revered and respected by the other REGIONAL GOVERNMENT OFFICIALS by AP's interpretation of how they addressed him. Footnote 27: He was greeted as <i>Shikamo</i> rather than <i>Habari</i> – A REDACTED LOCAL LANGUAGE greeting of respect	Respect	Greetings	
F1M	11	27	at times the other REGIONAL GOVERNMENT OFFICIALS bowed to SHM7B. Footnote 28: Bowing in REDACTED culture shows respect. It is reserved for a “ <i>Mzee</i> ” - REDACTED LOCAL LANGUAGE for a respected figure.	Respect		
F1M	14	2-3	SPM5 was very respectful to the REGIONAL GOVERNMENT OFFICIALS with profuse thanks for their attendance	Respect	Gratitude	
F1M	14	21-22	SHM6B said little throughout the day but when he did speak the other REGIONAL GOVERNMENT OFFICIALS listened very respectfully and seemed not to question his views	Respect		
F1M	19	3-4	SPM5 informed all that we had to pay a <i>formal courtesy visit</i> to the REDACTED LOCAL COUNCIL EXECUTIVE ⁷²⁰	Respect	Collaboration	
F1M	28	7	NGO and VPO team introduced themselves to the LOWER GRADE HEALTH WORKERS	Respect	Cultural competence	

⁷²⁰ Person SEM4.

Doc	Pg	Ln/Fn	Quote/Comment	Code 1	Code 2	Code 3
F1M	28	F69	SHF1A later informed AP that the LOWER GRADE HEALTH WORKERS felt the REGIONAL GOVERNMENT OFFICIALS ⁷²¹ were disrespectful to them as they did not greet them on arrival but simply left to go to the village to get Chai.	Respect		
F1M	30	7-8	<i>As a REDACTED ETHNIC GROUP, I find her disrespectful and I have never been spoken to like this by anyone before. She wants to shut us down.</i> ⁷²²	Respect	Gender equality	Worry
F1M	31	14-16 and F82	According to SPM5, SYF1 had publicly insulted SEM4 for: <i>Not employing SPECIFIC REDACTED MIDDLE GRADE HEALTH WORKERS in REDACTED DISTRICT.</i> Footnote 82: It is a REDACTED LOCAL COUNCIL EXECUTIVE's responsibility to hire and fire government employees and decided appropriate staffing. This includes REDACTED HEALTH Staffing.	Respect	Criticism	Insult
F1M	32	8-10 and F88	AP noted that both SEM4 and the SEM5 completely <i>blanked</i> SYF1. Footnote 88: Blanking someone is very rare in COUNTRY 1. It would be regarded as an ultimate disapproval.	Respect	Insult	
F1M	35	9-10	<i>I am a sensitive man.</i> ⁷²³ <i>I see what she</i> ⁷²⁴ <i>is doing. I want to apologize that she is disrespectful to you. Please do not leave us we need you desperately</i>	Respect	Dependency	
F1M	35	19-21	SPM5 informed AP that SPM6 will drive and he will be a passenger but that SPM6 was very angry with SYF1 for the manner in which he had been spoken to by SYF1.	Respect	Anger	

⁷²¹ All of whom were also SENIOR HEALTH WORKERS.

⁷²² Person SPM5 said this.

⁷²³ Person SHM1B.

⁷²⁴ SYF1.

Doc	Pg	Ln/Fn	Quote/Comment	Code 1	Code 2	Code 3
F1M	39	16-18	REDACTED told AP that in a recent REDACTED PROGRAMME/DATE that REDACTED OTHER PERSON had made some <i>racist and demeaning comments and they will not be coming out again.</i> ⁷²⁵	Respect	Racism	
F1M	41	10-11	SHF1A is a better teacher and clinician than all of the SENIOR HEALTH WORKERS but hierarchically she cannot train 1 to 1 as it would cause offence culturally to the SENIOR HEALTH WORKERS. ⁷²⁶	Respect	Hierarchy	Cultural competence
F1M	41	17-18	If SHM9 fails, this will need careful handling as we ⁷²⁷ will fail him in his home Dispensary amongst his people.	Respect		
F1M	41	24-25	The REGIONAL GOVERNMENT OFFICIALS and VPO team were very respectful. ⁷²⁸	Respect		
F1M	45	F155 (UoA3)	<i>Both GVM6⁷²⁹ and I felt very wounded and unable to work with an organisation that treated us thus.</i>	Respect	Trust	
F1M	50	21-23	AP to LOWER GRADE HEALTH WORKERS: Your SENIOR HEALTH WORKERS are here to train you and in being late you show them disrespect	Respect	Professionalism	Neo-colonialism
F1M	52	35-38	AP sympathised and assured SHM10 that it would be changed tomorrow but that SHM8A was an experienced SENIOR HEALTH WORKER, and it was important that he tried to respect that he could learn a lot from SHM8A and that sometimes we can learn from those that we don't necessarily have a good rapport with. SHM10 accepted this.	Respect	Compassion	

⁷²⁵ Given the content of this UoA I have also redacted the identifiers.

⁷²⁶ Being persons SHM1A, SHM5A, SHM6A, SHM7A and SHM8A.

⁷²⁷ AP and person GNF1A.

⁷²⁸ Person GVF6 asked for activities to stop for a minute's contemplation for Remembrance Day.

⁷²⁹ Person GVF6 discusses an incident involving a former UEHV (GVM6) who has ceased involvement in IHV.

Doc	Pg	Ln/Fn	Quote/Comment	Code 1	Code 2	Code 3
F1M	53	13-15	SHM11 was so pleased to be being trained as he could now manage REDACTED SIMPLE SURGICAL PROCEDURE himself, and it would mean he would be held in higher regard.	Respect	Learning	
F1M	54	2-4	SHF1B recommended: <i>When you come back to REDACTED REGION go to NEIGHBOURING DISTRICT as the DISTRICT GOVERNMENT HEALTH OFFICIAL there, he is very good.</i>	Respect	Communication	
F1M	54	32-33	SHM6B informed that SEM3A was visiting REDACTED WARD IN DISTRICT OF F1 this afternoon anyway so GNF1A could invite him directly.	Respect	Cultural competence	
F1M	56	F215	This indicates a “formal” visit. SEM3A was showing in effect Regional approval and was showing respect to SCM2, whose Ward ⁷³⁰ he was visiting. He had visited THE REDACTED OTHER WARD on the launch day.	Respect	Politicisation	
F1M	56	9-12	GVF9 and GVF6 were not looking forward to dinner, neither were some of the VPO team as they felt the SENIOR HEALTH WORKERS had continued to demean them throughout. GNF1A suggested we put a brave face on it and be polite and respectful.	Respect	Teamwork	Cultural tension
F1M	56	16	SMH8A was late, SHM7A did not attend with no excuse relayed.	Respect		
F1M	59	9-10 & F229	SHM6A had left to go to REDACTED LARGE CITY when AP, GVF6, GVF9 and SPM7 were at the market without waiting for the presentation. SHM8A ate lunch then left without waiting for the presentation. Footnote 229: Not before trying to coerce SPM8 into driving him to THE REDACTED LOCAL TOWN	Respect	Harassment	

⁷³⁰ A collection of villages and associated agricultural land.

Doc	Pg	Ln/Fn	Quote/Comment	Code 1	Code 2	Code 3
F1M	59	22-23	SHF1B was the centre of attention and the remaining REGIONAL GOVERNMENT OFFICIALS being SHM1B, SHM5B and SHM7B seemed happy that this was SHF1B's role and not theirs.	Respect	Hierarchy	
F1M	60	13	Final goodbyes included handshakes all around with LOWER GRADE HEALTH WORKERS and the REGIONAL GOVERNMENT OFFICIALS	Respect	Cultural competence	
F1M	60	25	SPM6: <i>I am a calm man, but these REGIONAL GOVERNMENT OFFICIALS show no respect and later SYF1 should go to REDACTED INSULTING PLACE.</i>	Respect	Insult	
F1M	62	5	<i>SHM1B giving speech at CO ceremony.</i> ⁷³¹	Respect	Leadership	
F1M	74	5-6 & F255	We were greeted outside REDACTED HOTEL IN LARGE CITY with a traditional REDACTED ETHNIC GROUP greeting. ⁷³² Footnote 255: A greeting of respect similar to a short New Zealand " <i>Haka</i> " traditionally used by THE REDACTED ETHNIC GROUP After a successful hunt.	Respect	Tribalism	Gratitude
F1M	76	2-5	GVF4B: Asked the REDACTED AFRICANS about the cultural appropriateness of telling the SENIOR HEALTH WORKERS what to do. SPM1 said that he thought that our indirect <i>suggestive</i> rather than <i>telling</i> approach was ideal and that we were perceived as polite it was just that this group of SENIOR HEALTH WORKERS were inherently uncooperative.	Respect	Cultural competence	
F1M	78	4	SHF1B: Very helpful, good teacher, embraced her role, respected by LOWER GRADE HEALTH WORKERS and SENIOR HEALTH WORKERS /REGIONAL GOVERNMENT OFFICIALS	Respect	Cooperation	Learning

⁷³¹ This is the legend of a photograph. The UoA is the photograph itself.

⁷³² By person SPM5.

Doc	Pg	Ln/Fn	Quote/Comment	Code 1	Code 2	Code 3
F1M	86	7-9	He ⁷³³ stressed that all UK volunteers must pay a visit to SEM3A as a courtesy as it would look disrespectful of SPM5 if we didn't greet SEM3A. He expressed relief when AP indicated that this would be done.	Respect	Cultural Competence	
F1M	90	F355	SPM2 is held in very high esteem by Clinical Leads as he was a good source of advice when out on REDACTED IHV NGO PROGRAMMES over specific problematic situations which as a REDACTED FORMER SSA SENIOR HEALTH WORKER he can more readily help – the mood of the leads <i>SPM2 is a big loss to NGO I.</i>	Respect		
F1A2	2	7.1.1	The REDACTED HEALTH MINISTRY will: Provide formal introduction to Regional Health management team (RHMT) bar REDACTED HIGHER MANAGEMENT TEAM in new regions where training is proposed. Normal communication channel through REDACTED MINISTRY FOR LOCAL GOVERNMENT ⁷³⁴ to be utilised. ⁷³⁵	Respect	Cultural Competence	Communication
F1A2	2	7.2.6	The REDACTED MINISTRY FOR LOCAL GOVERNMENT will ensure that: Provide full introduction to RHMT in new regions where training is proposed. ⁷³⁶	Respect	Cultural Competence	

⁷³³ Person SPM5.

⁷³⁴ This relates to an MOU between the NGO and several SSA collaborators

⁷³⁵ With the benefit of hindsight and later reflection this should have had a second UoA coded as *collaboration* of which this is an exemplar.

⁷³⁶ Again, with the benefit of hindsight and like the UoA in the coded data item immediately above this one (marked above as Doc. F1A2, Pg. 2, Ln. 1.7.1). In this UoA *collaboration* should have been put in Code 3.

Doc	Pg	Ln/Fn	Quote/Comment	Code 1	Code 2	Code 3
F1A4	3	d	And use photos very carefully. E.g. we have photos of SENIOR HEALTH WORKERS working without gloves on, these would be highly inflammatory, as would any photos of UEHVs doing anything similar. ⁷³⁷	Respect	Cultural tension	
F1A5	1	21-22	They ⁷³⁸ were rude to the NGO and the VPO teams and very demanding, consistently spoke in negative terms about the programme to the VPO team	Respect	Professionalism	Insult
F2M	15	16-19	Regarding a courtesy visit to the REDACTED LOCAL DISTRICT OFFICIALS: <i>We had to visit the LOCAL POLITICIAN⁷³⁹ and LOCAL MEDICAL ADMINISTRATOR⁷⁴⁰ on the second morning and had loads of handshakes and pictures taken so we ended up late to clinic</i>	Respect	Politicisation	
F2M	31	28-29	We travelled 30 minutes into REDACTED CITY, being driven by SYM3 ⁷⁴¹ who was delighted to see AP and welcomed him like a long lost friend.	Respect	Greetings	
F2M	32	24	SPM5 greeted AP with a traditional REDACTED ETHNIC GROUP greeting.	Respect	Greetings	

⁷³⁷ GNF1A reports this.

⁷³⁸ *They* in this UoA are the SENIOR HEALTH WORKERS that is persons SHM1A, SHM5A, SHM6A, SHM7A, SHM8A as indicated by person GNF1A in a report to NGO 1 based on their interpretation of debrief discussions with UEHVs and the VPO immediately after fieldtrip 1.

⁷³⁹ Person SEM6

⁷⁴⁰ Person SEM7

⁷⁴¹ Person SYM3 had known AP from fieldtrip 1 and previous programmes prior to this research.

Doc	Pg	Ln/Fn	Quote/Comment	Code 1	Code 2	Code 3
F2M	34 35	39-46 & F149 1-8	SPM6 said that we must do lots of meeting and greeting tomorrow in REDACTED TOWN before going to site: <i>We must do it right as it's the REDACTED SENIOR GOVERNMENT LEADER'S District.</i> AP asks: <i>Who must we meet?</i> SPM6: <i>The LOCAL MEDICAL ADMINISTRATOR (SEM7), the LOCAL COUNCIL EXECUTIVE (SEM8) and the LOCAL POLITICIAN (SEM6).</i> (Footnote: AP Comment: Usually there is a requirement to meet the LOCAL COUNCIL EXECUTIVE (SEM8) only. This is slightly over the top but if SPM6 considers it necessary, AP would support this). AP told IB that he is aware that this is all considered necessary and that it is non-negotiable and that the team will be OK with it. (AP had already forewarned the team at orientation that this was likely to happen).	Respect	Politicisation	Cultural competence
F2M	37	36 & F166	SHM3B recognised GVM5A and they had a particularly warm handshake. Footnote: AP Comment: SHM3B had been A REDACTED GOVERNMENT OFFICIAL/MIDDLE GRADE HEALTH WORKER when SHM3B last visited REDACTED TOWN.	Respect	Greetings	Friendship
F2M	45	4-8	<i>Can Dr SHM3B take us to the District Offices.</i> ⁷⁴² SPM6: <i>No, we must wait. SEM7 must do it, he wants to do it to show he has organised the trip.</i>	Respect	Politicisation	Hierarchy
F2M	45	41-43	<i>We would like to thank SEM8 for his hospitality and are pleased and privileged to be here assisting the REDACTED DISTRICT SPECIFIC HEALTH SERVICES in training local health workers in REDACTED SPECIFIC SURGICAL PROCEDURES and REDACTED SPECIFIC health education.</i> ⁷⁴³	Respect	Cultural competence	

⁷⁴² AP states this.

⁷⁴³ AP's speech at district offices. This was directed to person SEM8, but many others were present.

Doc	Pg	Ln/Fn	Quote/Comment	Code 1	Code 2	Code 3
F2M	46	5-20	SEM8: <i>Do you want the photo in front of the father of our Nation or our Nation's president?</i> [There were two pictures on opposite walls. One of REDACTED PERSON, the first President of COUNTRY 1 and known as the <i>father of the Nation</i> and the other of A DIFFERENT REDACTED PERSON, The current president of COUNTRY 1, from THE REDACTED LOCAL TOWN and the person who had directly appointed SEM6 to his office]. AP paused AP felt this was a bit of a political lose-lose trap as he may insult SEM8 by saying the wrong thing, eventually AP said: <i>I am sure your President would want us to show respect to the father of your Nation.</i> SEM8 smiled and ushered everyone under the photo of THE FIRST REDACTED PERSON IN THIS UoA for the photo. SEM7 missed the photo as his mobile rang, and he had to phone the Hospital.	Respect	Politicisation	Cultural competence
F2M	47	20-22	SEM7 strode out of the bus onto the verandah and was greeted by SEM6, the REDACTED LOCAL POLITICIAN. A very warm long handshake between the two and gesticulations during conversation from SEM7 towards the bus.	Respect	Greetings	Hierarchy
F2M	47	31-36 & F197	AP: <i>We would like to thank SEM7 for his hospitality and the hospitality of the Government of COUNTRY 1 and the Ministry of Health</i> (Footnote: AP Comment: Note embellishment of thanking the Government and Ministry. This is because SEM7 has a political role). <i>and are pleased and privileged to be here assisting the REDACTED DISTRICT SPECIFIC HEALTH SERVICES in training local health workers in REDACTED SPECIFIC SURGICAL PROCEDURES and REDACTED SPECIFIC health education</i> ⁷⁴⁴	Respect	Politicisation ⁷⁴⁵	Appreciation

⁷⁴⁴ AP speech to a redacted local politician (SEM7).

Doc	Pg	Ln/Fn	Quote/Comment	Code 1	Code 2	Code 3
F2M	48	16-19 & F204	SEM7 apologised for a theft of a mobile phone from one of the UEHVs on a REDACTED PREVIOUS IHV NGO PROGRAMME INVOLVING NGO 1 saying: <i>This will not happen again; I have discussed it with our police chief. You will be very safe here. REDACTED TOWN welcomes you.</i> Footnote: AP Comment: This was a very minor issue 2 years previously. It was however clearly an embarrassment for the officials in REDACTED TOWN given SEM7's reaction.	Respect	Safety	Crime
F2M	54	17-27	SHM3B: AP was so impressed with SHM3B. He just got on quietly with the job in hand. He was respectful and not rude and impressively showed great skill in REDACTED SURGICAL PROCEDURES. SHM3B states at the end of the day: <i>That was a very hard day.</i> [AP thoughts at the time: AP has enormous respect for SHM3B given the daily conditions he works in].	Respect	Exhaustion	
F2M	72	F271	Footnote 271: AP Comment: SHM3A later told AP that this health worker ⁷⁴⁶ (SHM12) was the one who was <i>too lazy</i> to be trained on the IHV NGO PROGRAMME.	Respect	Hierarchy	
F2M	73	F273	Footnote 273: AP Comment: This was after GVF1A had tried to stop him ⁷⁴⁷ continuing with REDACTED SURGICAL PROCEDURE which he then CAUSED A REDACTED COMPLICATION after refusing to stop and GVF1A had to TAKE REDACTED REMEDIAL ACTION. ⁷⁴⁸	Respect		

⁷⁴⁵ See a second separate UoA from this data excerpt. This is in the data sheet for *cultural competence*.

⁷⁴⁶ Person SHM12.

⁷⁴⁷ Person SHM13.

⁷⁴⁸ See a second separate UoA for F273 in the data sheets for *insight, learning, and gender equality*.

Doc	Pg	Ln/Fn	Quote/Comment	Code 1	Code 2	Code 3
F2M	73	2-5	AP discussed the issues with GVF1A, who was clearly not enjoying her day with SHM13, and suggested that this was one for SHM3A to manage. AP spoke to SHM3A and SHM3A took SHM13 away from the clinic. KJ continued to manage the patients and about 30 minutes later SHM13 returned looking rather sheepish.	Respect	Cultural competence	Hierarchy
F2M	73	16-18	We needed SEM7's permission, so SHM3B phoned him and AP spoke to him. He was delighted to help and thanked AP again for visiting SEM6 and SEM8 on Wednesday.	Respect	Hierarchy	Regulation ⁷⁴⁹

⁷⁴⁹ See a second separate UoA for lines 15-18 in the data sheets for *teamwork, collaboration and problem solving*.

Appendix 5 - List of codes derived from the data

This list represents the codes derived from the data by open coding related to the IHV phenomenon in the two SSA countries.

The list of codes is arranged in alphabetical order:

A	B	C
Accessibility	Brutality	Collaboration
Accusation	Bureaucracy	Commitment
Accommodation	Burnout	Communication
Addiction		Compassion
Altruism		Competence
Anger		Conciliation
Appreciation		Confidentiality
Authoritarian		Confrontation
		Cooperation
		Corporate social responsibility
		Corruption
		Courage
		Crime
		Criticism
		Cultural competence
		Cultural tension

D	E	F
Decolonization	Effectiveness	Feedback
Dependency	Emotional	Friendship
Digital learning	Entrepreneurism	Funding
Disability	Enthusiasm	
Disinterest	Exhaustion	
Double standards		

G	H	I
Gender equality	Harassment	Image
Good intention	Harms	Inclusivity
Governance	Health	Influencing
Gratitude	Helpless	Initiative
Greetings	Hierarchy	Innovation
Guilt	Humour	Insight
		Insult

J K	L	M
-	Leadership	Maintenance
	Learning	Materialism
		Mentoring
		Mindset-Closed
		Mindset-Open
		Misunderstanding
		Monitoring
		Moral luck
		Motivation
		Myth

N	O	P
Negotiation	Organisation	Partiality
Neo-colonialism	Orientation	Partnership
Nutrition	Overwhelmed	Paternalism
	Oversight	Planning
	Overworked	Politicisation
		Positivity
		Poverty
		Power
		Prioritisation
		Problem solving
		Professionalism
		Protective

Q	R	S
Quiet	Racism	Safety
	Readjustment	Scepticism
	Realism	Self-interest
	Reassurance	Submissive
	Recruitment and retention	Success
	Regret	Supplies
	Regulation	Support
	Religious motivation	Suspicion
	Resilience	Sustainability
	Resources	
	Respect	
	Responsibility	
	Restructuring	
	Role model	

T	U	V
Teaching	Unpredictability	Vision
Teamwork	Untruth	Volunteerism
Telecommunications	Utilities	Voluntourism
Threat		
Transport		
Tribalism ⁷⁵⁰		
Trust		

W	XYZ
Weather	-
Work ethic	
Worry	

⁷⁵⁰ I named this code as *tribalism* in my open coding process. This would have been better termed *ethnicity* but at the time I was culturally incompetent regarding the negative connotations of the word *tribalism*. I discuss *ethnicity* in Section 4.5, much of the data that informs my interpretations being derived from this code. In Section 4.5 I give more complete reasoning as to my preference of the word *ethnicity* over the word *tribalism*.

Appendix 6 - University of Glasgow MVLS ethics approval letter

My ethical approval letter (Project number: 200160134) is detailed below. This was received from the University of Glasgow MVLS College Ethics Committee. I detail some explanatory notes:



I
Dear Dr Al Dowie

MVLS College Ethics Committee

Project Title: *Is international healthcare volunteering fit for purpose?*

Project No: 200160134

The College Ethics Committee has reviewed your application and has agreed that there is no objection on ethical grounds to the proposed study. We are happy therefore to approve the project, subject to the following conditions:

- Project end date as stipulated in original application.
- The data should be held securely for a period of ten years after the completion of the research project, or for longer if specified by the research funder or sponsor, in accordance with the University's Code of Good Practice in Research:
(http://www.gla.ac.uk/media/media_227599_en.pdf)
- The research should be carried out only on the sites, and/or with the groups defined in the application.
- Any proposed changes in the protocol should be submitted for reassessment, except when it is necessary to change the protocol to eliminate hazard to the subjects or where the change involves only the administrative aspects of the project. The Ethics Committee should be informed of any such changes.
- You should submit a short end of study report to the Ethics Committee within 3 months of completion.

Yours sincerely

**Signature of approver has
been redacted by AP**

Dr Terry Quinn

Terry Quinn
MD, FRCP, BSc (hons), MBChB (hons)
Senior Lecturer / Honorary Consultant

**Contact details of the
approver namely address,
email address and telephone
number have been redacted by
AP**

The University of Glasgow, charity number SC004401

I have redacted the image of the actual signature and contact details (address, email address and telephone number) of the approver. This is to comply with the *Data Protection Act 2018*. The letter was never dated on the document received but had the filename *ethics_approval_letter_130617* suggesting that it was written on 13th June 2017. The title on the ethical approval letter indicates a broad initial project title at the commencement of research namely *Is international healthcare volunteering fit for purpose?* The ethics approval letter is addressed to the primary supervisor as is the MVLS College protocol for ethical approval.

Appendix 7 - Principles for cultural competence and cultural tension in IHV in SSA

This appendix details the seven principles for cultural competence and cultural tension in IHV in SSA, in a shortened⁷⁵¹ pictorial form, for ease of display and dissemination.



⁷⁵¹ These were presented in Section 6.3 in *full*.

Glossary

This glossary gives a description and/or translation of non-English terms. This glossary is arranged in alphabetical order:

Non-English term	Description and/or translation
<i>Azungu</i>	Literally a wanderer. Commonly used to describe a foreigner or white person
<i>Alter ego</i>	An alternative personality
<i>Baas</i>	Boss. This term has associations with colonialism and the apartheid era in South Africa.
<i>Bona fide</i>	Genuine or real
<i>Botho</i>	A guiding principle or behavioural code firmly rooted in African consciousness and culture
<i>Coda</i>	A concluding section
<i>Data corpus</i>	A large collection of work usually organized into datasets
<i>En</i>	Non-gendered pronoun meaning he and she
<i>Engai</i>	Refers to the Maasai deity known as <i>The Unified One</i>
<i>Epoché</i>	Setting aside assumptions or bias; suspension of judgement
<i>Habari</i>	An informal greeting
<i>Haka</i>	A traditional dance of the Maori people of New Zealand
<i>Hutu</i>	Also known as <i>Abahutu</i> the <i>hutus</i> are an ethnic group based largely in Burundi, Rwanda and Uganda
<i>Hunu</i>	A guiding principle or behavioural code firmly rooted in African consciousness and culture
<i>Inter alia</i>	Amongst other things
<i>isiXhosa</i>	An African language of the Bantu group of languages
<i>Luo</i>	An African language of the Nilo-Saharan group of languages also known as Dholuo
<i>Musongo</i>	Literally a wanderer. Commonly used to describe a foreigner or white person
<i>Musungu</i>	Literally a wanderer. Commonly used to describe a foreigner or white person

Non-English term	Description and/or translation
<i>Muzungu</i>	Literally a wanderer. Commonly used to describe a foreigner or white person
<i>Mzee</i>	A title of respect usually for an elder
<i>Mzungu</i>	Literally a wanderer. Commonly used to describe a foreigner or white person
<i>Nguni</i>	Nguni languages are a group of related Bantu languages in Southern Africa
<i>Nsima</i>	Corn meal maize porridge
<i>Ó</i>	Non-gendered pronoun meaning he and she
<i>Oratio obliqua</i>	Indirect speech
<i>Per diem</i>	An allowance payment made for each day
<i>Prima facie</i>	At first sight
<i>Persona non grata</i>	An unwelcome person
<i>Pro bono</i>	Work or services provided without payment or charge
<i>SeSotho</i>	An African language of the Bantu group of languages also known as Southern Sotho
<i>Shikamo</i>	A respectful greeting primarily reserved for elders
<i>Shona</i>	An African language of the Bantu group of languages
<i>Status epilepticus</i>	A medical emergency condition with continuous or multiple seizures and insufficient recovery time between seizures
<i>Swahili</i>	An African language of the Bantu group of languages
<i>Tutsi</i>	Also known as <i>Abatutsi</i> the <i>tutsis</i> are a minority ethnic group based largely in Burundi and Rwanda
<i>Ubuntu</i>	A guiding principle or behavioural code firmly rooted in African consciousness and culture
<i>Ugali</i>	Corn meal maize porridge
<i>Umntu</i>	A guiding principle or behavioural code firmly rooted in African consciousness and culture
<i>Utu</i>	A guiding principle or behavioural code firmly rooted in African consciousness and culture
<i>Verstehen</i>	A degree of empathetic and deep understanding
<i>Vice versa</i>	The reverse of what is written or spoken is also true
<i>Yena</i>	Non-gendered pronoun meaning he and she

Non-English term	Description and/or translation
<i>Yeye</i>	Non-gendered pronoun meaning he and she
<i>Yorùbá</i>	An African language of the Kwa group of languages

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