



# **Voices from the Global South: Exploring the Lived Experiences of Ugandan Health Workers Hosting British Volunteers**

Submitted in partial fulfilment of the requirements of the Degree of Doctor of  
Philosophy (PhD)

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## **Abstract**

Over the last few decades, volunteering in the global South by medical professionals from the global North has become a widespread phenomenon. Evidence suggests that this activity has been studied almost exclusively from volunteer or sending country perspectives. Comparatively, very little is known about volunteer hosts in the global South. Although emerging studies highlight the importance of global South voices in 'development' more generally, volunteer stakeholders report difficulty in building more sustainable relationships in global South settings. This study therefore sought to bring forth volunteer host perspectives, focusing on the lived experiences of Ugandan health workers hosting British volunteers employed primarily but not exclusively in the National Health Service (NHS).

The study utilised exploratory research design informed by the traditions of constructivist grounded theory. Ugandan voices were collected using observational research, focus group discussion, and interviews with 46 Ugandan health professionals (17 nurses, 15 midwives, 4 doctors, 4 biomedical engineers, 3 health facility leaders, 2 clinical officers, and 1 anaesthetist officer). Data analysis was conducted concurrently using thematic analysis.

The findings provided an in-depth understanding of Ugandan experiences and illuminated the existence of parallel and reciprocal relationships with invaluable contributions to the personal and professional development of Ugandan health workers and volunteers. Further, the findings highlighted three key themes relating to Ugandans' perceptions of volunteers, their motivations of engaging with them, and contextual barriers to relationship building and learning. Collectively, these themes drew attention to the diverging priorities of Ugandan health workers, and the interplay between hierarchies (positionalities), volunteer engagement, and learning.

Contextual issues and host perspectives are important considerations in volunteer placements, and this study highlighted the importance of considering Ugandans' perceptions and motivations for more collaborative, sustainable, and positive outcomes for all stakeholders.

## Chapter One: Introduction

### 1.1 Setting the Scene

In recent years, international voluntarism has grown significantly (Lasker, 2016). Whether it involves gap year students or people taking time out from work and/or retirement, evidence suggests a considerable growth of volunteering by people from the global North mainly in Europe and North America (Lough, 2013; United Nations Volunteers, UNV, 2011; Mosler, 2003). Lewis (2005) attributes this growth to 'globalisation', while Ziemek (2002) points to increased desire by people of the global North to participate in global causes or movements. Despite the increase in the popularity of volunteering trips to global South settings, there has been relatively little research on this topic (Arya, and Nouvet, 2017; Perold et al., 2013).

Devereux (2008) suggests research on international voluntarism has built on previous research on national voluntarism, for example John Wilson's (2000) work and Anheier and Salamon's (1999) article on 'volunteering in cross-national perspective'. This research and many others (e.g. Palacios, 2010; Lough, McBride and Sherraden, 2009) identify three main research foci (and stakeholders): the volunteers, the volunteer sending organisations (VSOs), and the volunteer hosting organisations (VHOs). Research that presents the perspectives of volunteers (e.g. Ackers, and Ackers-Johnson, 2017; Ahmed, Ackers-Johnson, and Ackers, 2017; Wearing and McGehee 2013; Withers, Browner, and Aghaloo, 2013; Conran, 2011; Ackerman, 2010; Crump and Sugarman, 2008; Abes, Jackson and Jones, 2002; Porter and Monard, 2001) suggests that there are a wide variety of motivations and benefits associated with volunteering overseas. Yet we know comparatively little about individuals and/or organisations that host volunteers in the global South, making them the least understood stakeholders in international voluntarism research (Lasker, Rozier and Crompton, 2014; Lupoli et al., 2014; Taplin, Dredge, and Scherrer, 2014; Martiniuk et al., 2012; Lough et. al., 2009; Maki et al., 2008). Margaret Sherraden and colleagues stated researching the perspectives of volunteer hosts has "*become an extremely challenging endeavour*" and suggested that host experiences are "*integral to the advancement of effective international volunteering policy and practices*" (2008, p.400).

Benjamin Lough added “...*there is little strong evidence regarding the impact of international volunteering on intended beneficiaries*” (2008, p.83). These findings collectively highlight a gap in existing research on international voluntarism: the missing voices of volunteer hosts. In an attempt to address this gap in knowledge, this study brings forth the voices and experiences of Ugandan health workers hosting British volunteers in the Ugandan public health system. This introductory chapter first provides a clarification of key terms to guide the reader through common terminologies used in the field of international voluntarism, and development more generally. This is followed by a brief history of international voluntarism, its different styles and stakeholders. The background to the study and the rationale for undertaking it is then discussed. The aim and objectives of the study are outlined, and an overview of the research strategy provided. The chapter concludes with an outline of the remaining seven chapters that make up this study.

## **1.2 A clarification of Key Terms**

Throughout this study, a number of key terms are used. It is worth clarifying at this point how I intend them to be understood. The first clarification concerns the use of the terms ‘low-income countries’ (LICs), and ‘high-income countries’ (HICs). As of July 2016, LICs are defined as countries with a Gross National Income (GNI) per capita, calculated using the World Bank Atlas method of \$1,025 or less; and HICs as countries with a GNI per capita of \$12,436 or more (World Bank, 2016). Uganda, the context of this study, is classified as a ‘low-income country’ (LIC) by the World Bank. References to Uganda as a ‘lower-middle-income country’ (LMIC) exists in some texts (e.g. Kane et al., 2016; Schwartz et al., 2014) despite the marked differences in GNI per capita between the two classifications<sup>1</sup>. Broadly speaking, however, countries in the ‘low-income’ classification face greater health related challenges and attract international attention including global health volunteers (Martiniuk et al., 2012).

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<sup>1</sup>According to the World Bank (2016), a LMIC has GNI per capita of more than \$1,026 but less than \$4, 035.

The second clarification relates to the terms 'global North' and 'global South' or simply 'North' and 'South'. The United Nations Development Programme (UNDP) Annual Report (2011) refers global North to countries with a high Human Development Index (HDI) of above .8. These include fifty–seven countries most, but not all of which are in the Northern Hemisphere (Bailey and Dolan, 2011). Most of the countries that make up the global South are in the Southern Hemisphere, and include countries in Africa, Asia, South and Central America (Bailey and Dolan, 2011). Some of these countries have a medium HDI less than .8 but greater than .5; and others have a low HDI of less than .5.

The third and final clarification relates to the term 'volunteer host' or simply 'host'. It is worth stating here that this term has different meanings in different contexts. Importantly, it is used in this study to refer to individuals, organisations, or countries in the global South (including Uganda) that receive volunteers from the global North<sup>2</sup>.

### **1.3 International Voluntarism: A brief History**

International voluntarism has its roots in the 19<sup>th</sup> century European churches and missionary work (McBride and Daftary, 2005). Faith groups travelled overseas to spread their religion with the twin mission of contributing to human and colonial development (Ehrichs, 2000). Post–World War I marked the start of a non–missionary philanthropic activities by non–governmental bodies (Lough, 2008). For example, Service Civil International (SCI) was founded in 1920 by Swiss engineer Pierre Cérésolle to help with the reconstruction efforts in many parts of the world including the 1934 earthquake in Bihar, India. The birth of the United Nations (UN) after the end of World War II saw an increase in people (predominantly from the global North) volunteering overseas (Ehrichs, 2000). Many of today's non–governmental organisations (NGOs) grew out of AID operations in post–war Europe. For example, Oxfam, started in 1942 by volunteers in England to fight starvation in occupied Greece (Poulton and Harris, 1998). Voluntary Services Overseas (VSO) was founded in 1958; the US Peace Corps in 1961; and the United Nations Volunteers (UNV) in 1970.

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<sup>2</sup> Further discussion on host(s) (i.e. volunteer hosting organisations) in the context of this study is provided in 1.4.3.

A common denominator among these NGOs is their use of volunteers as a vehicle to reach out to people in poorer countries and address a wide range of global challenges such as health, education, and poverty (Devereux, 2008; Ehrichs, 2000).

Despite this potent history, there is still no universal definition of voluntarism (Wright, 2013; Bussell and Forbes, 2008). Conventional definitions of voluntarism often evoke altruism – helping others without expectations of rewards (Braham, 1999; Smith, 1981). The UN General Assembly, as part of the 2001 International Year of Volunteers, puts forward three criteria that can be applied to a wide range of international volunteering programmes. Firstly, actions are carried out freely and without coercion; secondly, monetary gain is not the primary motivation; and thirdly, actions must benefit volunteer hosts (UNV, 2010; Devereux, 2008). Further, Davis–Smith (2001) suggests that voluntarism takes on different meanings in different settings, and is strongly influenced by the history, politics, religion and culture of a region. In the context of global North, Smith and colleagues (2010) suggest that voluntarism encompasses both ‘altruistic’ and ‘self–orientated’ dimensions. Writing from an African perspective, Mati (2016) states that voluntarism forms part of ‘prosocial’ scheme, and a way of ‘giving’ and ‘receiving’ help, or simply put, helping ‘others’ and ‘helping the ‘self’. Evidently, this altruism–self–interest dimension of voluntarism is recognised by many stakeholders across contexts and informs much of the current discourse on voluntarism (Yeung, 2004; Clary and Snyder, 1999). Despite the clarity brought about by such two–dimensional views of voluntarism, there is little consensus over the features of a typical volunteer or volunteer programme (Bussell and Forbes, 2002). Within the field, however, there is a recognition that the term [international] voluntarism implies a unilateral flow of volunteers from the global North to the global South (Devereux, 2008)<sup>3</sup>. Benjamin Lough suggests a scholarship on international voluntarism that can be divided into three categories or types:

1. Voluntourism.
2. Short–term international voluntarism.
3. International voluntarism for development, or long–term international voluntarism.

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<sup>3</sup> While North–South flows dominate much of our understanding of international voluntarism, the emergence (or rather the recognition) of ‘South–South’ flows of volunteers provides a counter narrative to the North–South imaginaries of international voluntarism (Baillie Smith, Laurie and Griffiths, 2017).

(Lough, 2013, p.3).

Lough suggests these forms of voluntarism are not mutually exclusive but are rather categories generally distinguished by variations in ‘length of stays’, and ‘reciprocity’. International voluntarism programmes may vary in duration from one–week to years. Generally speaking, ‘voluntourism’ involves short stays – lasting from a few days to a few weeks (Palacios, 2010). Voluntourists typically stay together and cover the cost of their placements. Although there are certainly many exceptions, there is a growing recognition in the field that volunteers who spend days or weeks in the global South are considered ‘short–term volunteers’ (Engle and Engle, 2003; Beckers and Sieveking, 2001), and this extends to voluntourists (Lough, 2013). Some scholars suggest that this type of voluntarism can undermine host capacity particularly when emphasis is placed on ‘supply’ rather than ‘demand’ (Perold et al., 2011). Much of this critique, however, centres on perceived relationships between length of stays, relationship building, and learning. While such perception, to varying degrees still holds, emerging evidence highlights the importance of ‘regular’ contacts rather than ‘duration’ of stays. For example, Ackers (2015) stresses on ‘continuity’, and highlights the importance of ‘repeat’ stays as means to facilitating knowledge and network generation. She writes:

*“...what is more important than duration of stays is the continuity of contact, placing an emphasis on regular and, where possible, repeat stays. Frequent stays have a value greater than the actual duration of stays, as each visit is accompanied by a flurry of communication both before and afterwards that helps to maintain motivation and momentum.”*

By contrast, ‘international voluntarism for development’ emphasises relationship–building and involves longer stays. Long–term volunteers are typically required to participate in orientation and training sessions lasting a few weeks to a few months prior to deployment (Lough, 2013). In addition, volunteers often receive sustained training and support by both sending and hosting organisations during their placements. Long–term volunteers may receive a stipend during their placement and an ‘award’ or fellowship after they finish the service placement – particularly if supported by public agencies (Allum, 2007).

International voluntarism for development placements are more likely to be 'demand' based with host communities requesting volunteers with specific skills or abilities (Lough, 2013; Devereux, 2008). The British volunteers hosted by Ugandan health workers considered in this study fall under this category of voluntarism both in terms of length of stays and engagement styles (i.e. long placements in response to priority areas identified by Ugandans themselves).

Such style of voluntarism appears to be popular among international NGOs partly due to its perceived potential to facilitate learning and knowledge exchange (Burns et al., 2015; VSO, 2015). For example, the VSO operates in over twenty global South countries and relies almost exclusively on long-term 'skilled' volunteers. An overview of the VSO websites reads:

*"...our approach is unique; sending skilled volunteers from sectors such as health, education and business, to work with partners who have requested our help. VSO enables a two-way exchange that benefits the volunteer and the community they serve far beyond the life of the placement."* (2015).

The overview touches on the theme 'two-way exchange' which sees volunteers and hosts benefiting from the volunteering experience. It also points to the importance of relationships for successful volunteer placement and sustainable change. This way of making sense of volunteering is echoed in many development texts. Fowler (2001, p.11) Summarises:

*"...good development work needs alliances, contracts, counterparts, compacts, fellowship, sisterhood, solidarity and straight forward, honest to goodness international cooperation across the board."* (2001, p.11).

Collectively, therefore, these views point to the importance of 'relationships' particularly from the point of view of the various stakeholders that make up a volunteering programme.

#### **1.4 Stakeholders**

Stakeholders involve individuals or organisations who play an active role in the development, delivery, and participation of volunteering programmes. The three key stakeholders considered in this study are volunteers, volunteer sending organisations, and volunteer hosting organisations.



### 1.4.1 Volunteers

In an era of rapid globalisation, people frequently travel overseas to volunteer. While precise data on international voluntarism is hard to come by, it is estimated that some 50,000 Northern volunteers participate in development projects in the global South every year (Georgeou and Engel, 2011). Historically, international volunteers tend to be young, educated, middle class and white (McBride and Lough, 2007; McPherson and Rotolo, 1996).

Older people seeking opportunities for productive aging (Lough and Xiang, 2016), people with disabilities, and members of the Black and Minority Ethnic (BAME) groups may have less opportunity to volunteer abroad (McBride et al., 2007). Some volunteers participate in faith-based voluntarism but evidence linking religious affiliation and voluntarism remains largely inconclusive (Baillie Smith et al., 2013; Sherraden et al., 2008). Expatriates living in HICs (i.e. the diaspora) may volunteer in their countries of origin to contribute to development by offering their skills and expertise. Some overseas volunteering projects seek diaspora volunteers to provide the benefits of increased efficiency in their service due to linguistic and cultural familiarity with their countries of origin (Terrazas, 2010).

The composition of the volunteering programmes and styles affects volunteer profiles. Sherraden and colleagues (2006) compared four volunteer programmes designed to promote international understanding with four volunteer programmes designed to promote international development. The findings highlighted that the former attracted short-term volunteers, while the latter attracted long-term volunteers. Similarly, the profile of volunteers may affect volunteer outcomes. For example, highly skilled and internationally mobile volunteers may bring technical expertise to a project (Ackers, 2015; Lough, 2013; Dumélie et al., 2006; Mitka, 2006), while less experienced volunteers may become a burden on hosts particularly if the volunteering relationships are based on 'supply' rather than 'demand' (Perold et al., 2011).

The volunteer stakeholders in this study were predominantly white, British, educated, and professionals employed primarily but not exclusively employed in the NHS<sup>4</sup>.

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<sup>4</sup> While the reasons for the under-representation of Black and Minority Ethnic (BAME) volunteers in the SVP remain largely unclear, evidence elsewhere suggests that these groups have less access

They were deployed in Ugandan public health facilities by the Sustainable Volunteering Project (SVP), a volunteer sending organisation based in the UK and Uganda.

#### 1.4.2 Volunteer Sending Organisations

Volunteer sending organisations (VSOs) are mainly based in HICs and range from large government bodies and NGOs to many smaller organisations that deploy volunteers in LICs and the global South more generally. Some of these organisations embed long-term volunteers in overseas projects as part of global efforts to develop a coordinated strategy to achieving sustainable change, and a volunteering experience that works for both volunteers and their hosts. The British volunteers hosted by Ugandan health workers considered in this study were deployed by the SVP. Established through recognised links between the UK and Ugandan public health system, the SVP focuses on capacity building and ‘system change’<sup>5</sup> and its objectives are twofold:

1. To support evidence-based, holistic and sustainable systems change through improved knowledge transfer, translation, and impact.
2. To promote a more effective, sustainable and mutually beneficial approach to international professional volunteering (as the key vector of change).

(Ackers et al., 2017, p.152).

The SVP does not have a focus on service delivery or workforce substitution. Rather, it prioritises learning and places emphasis on Ugandan health workers directly engaging with volunteers on identified priority areas to foster sustainable change (Ackers et al., 2017).

#### 1.4.3 Volunteer Hosting Organisations

According to Cannon, and King (2005), volunteer host organisation (VHOs) include host institutions, individuals or communities in the destination country that receive volunteers. Some relations between VHOs and volunteers involve a special kind of exchange, focusing on relationship building and working towards a common goal (Sin, 2009; Butcher, 2003).

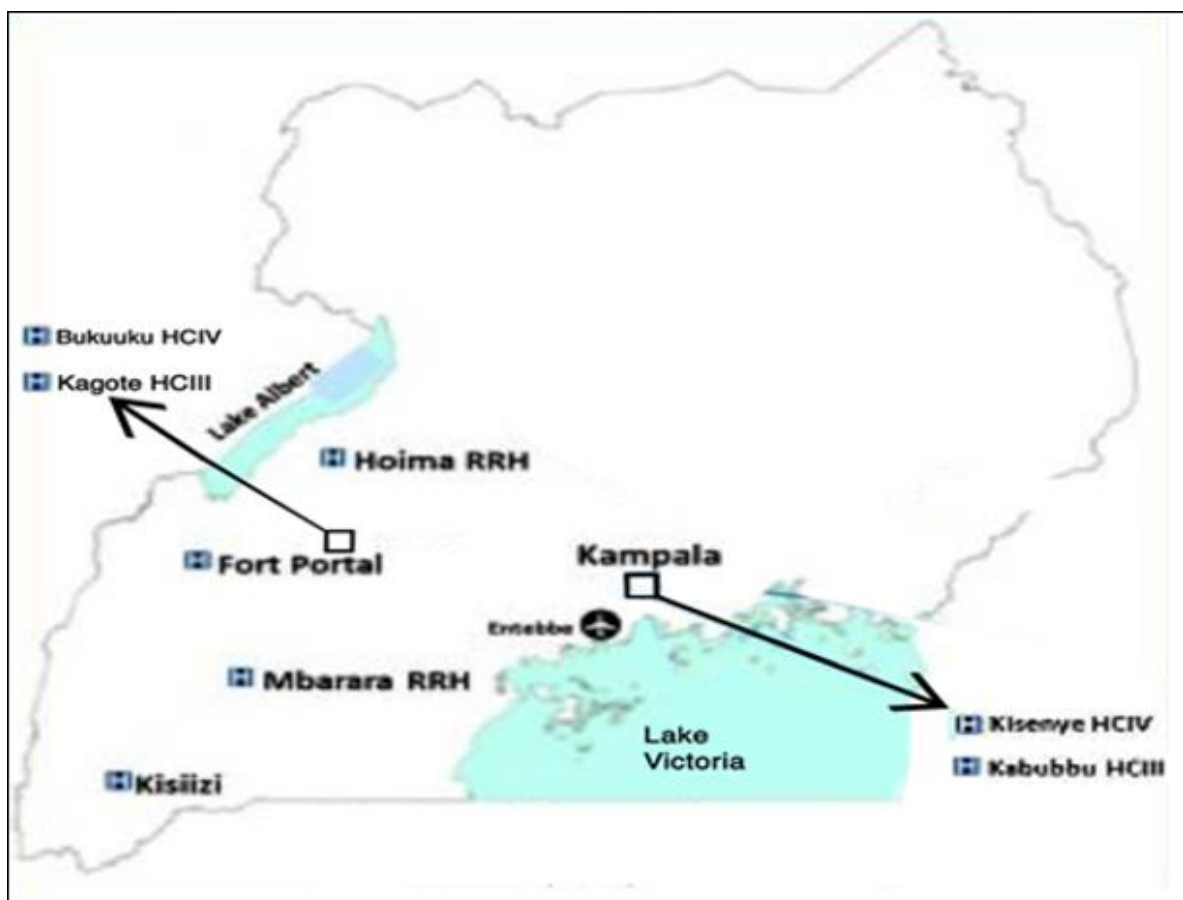
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and opportunity to volunteer abroad (McBride et al., 2007). Dispositional factors may also account for the under-representation since most BAME groups live in economically-deprived communities in the UK (Fisher and Nandi, 2015).

<sup>5</sup> The SVP’s focus on ‘system change’ is problematised by Ugandans further on in the thesis.

Of course, this does not apply to some styles of international voluntarism particularly those that focus on service delivery roles in LICs (Bauer, 2017; Guttentag, 2009; Sin, 2009). However, there is a deeper level of engagement between hosts and volunteers in development-focused voluntarism programmes. Such levels of engagement have the potential to build reciprocal relationships between people in disparate geographical, political, cultural, and economical spectrum (Brown and Morrison, 2003). The VHOs in this study comprise of Ugandan public health facilities both in urban and rural dwellings. Seven Ugandan public health facilities hosting SVP volunteers were considered in this study as shown in the Ugandan map below.

Figure 1. Ugandan public health facilities hosting SVP volunteers



All the health facilities considered follow the Ugandan Ministry of Health (MoH) referral system, and serve different purposes as outlined in Appendix 1. The Ugandan health workforce in these seven health facilities are from diverse clinical and non-clinical cadres and backgrounds. They include doctors (obstetricians and gynaecologists), nurses (including nursing officers and enrolled nurses), midwives, anaesthetist officers (AOs), and clinical officers.

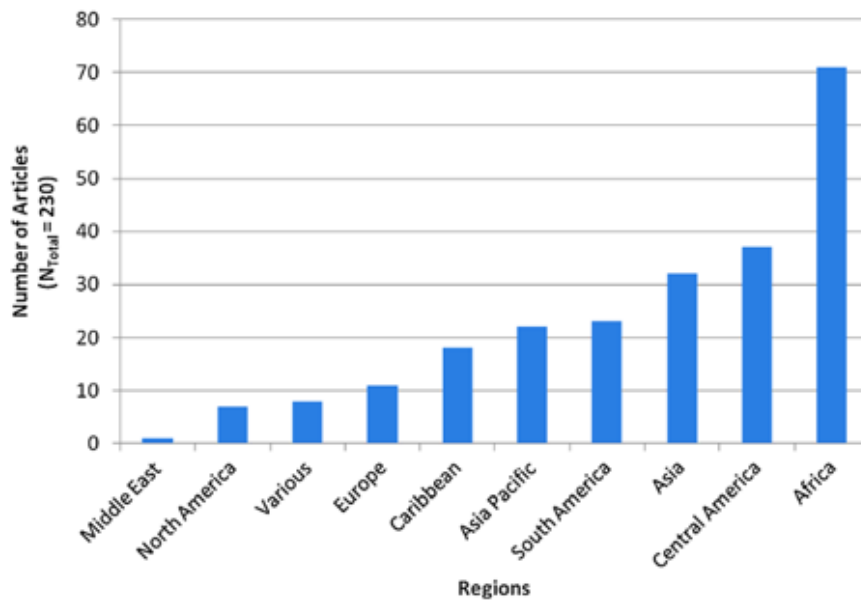
They also include leaders (some with non-clinical backgrounds), educators, and biomedical engineers. Some of this health workforce is well-established in Ugandan health system; others are 'new' and emerging. For example, biomedical engineers, previously existing as unqualified electricians, technicians or handy 'men', are gradually working towards becoming a recognised part of the Ugandan health workforce following the support of some UK health partners. The words 'Ugandans' and 'Ugandan health workers' are in parts of this study interchangeably used to aid the flow of discussion and to avoid repetition.

## **1.5 Research Context**

### **1.5.1 Uganda**

This research focuses on Uganda, a land-locked Sub-Saharan African country that lies in the Great Lakes Region in East Africa. Uganda has a gross domestic product (GDP) per capita of US\$ 511 (World Bank, 2013c), and is classified by the World Bank as a LIC (World Bank, 2016). With a population of roughly 35 million, and the fourth-highest growth rate (and the third-highest birth rate in the world), Uganda faces immense challenges particularly in relation to providing effective health coverage for its people (VSO, 2012). As outlined in the 2006 World Health Organisation (WHO) report, Uganda is among fifty-seven countries (thirty-six of those in Sub-Saharan Africa), whose health systems are identified as in 'crisis'. Among the challenges highlighted are health worker shortage, maldistribution, and weak knowledge base (VSO, 2012). These challenges, among others, attract much attention particularly from international volunteers. For example, a review of the literature by Martiniuk et al. (2012) identified Africa as the most popular destination for global health volunteers from the North (see Table 1 below), while Go Overseas identified Uganda, in particular, as the second most searched country by potential volunteers in Africa (see Appendix 2).

Table 1. Overseas volunteer destinations by region



Note: 'Various' represents placements with multiple destinations. Source: (Martiniuk et al., 2012).

The reasons for such attractions are many and include a global drive to address some of the healthcare challenges in 'crisis' countries such as Uganda (WHO, 2006). They also include a growing recognition in HICs to learn from these crisis countries (Gedde, Edjang, and Mandeville, 2011). In the UK, a recognition of both these global drives is growing. For example, 'Engaging in Global Health; The Framework for Voluntary Engagement in Global Health by the UK Health Sector', refers to international volunteering involving NHS staff as "...*opportunity to contribute to global health improvements and also to benefit from the exchange of professional learning and experiences*" (Cochrane, Chisholm, and Tomlinson, 2014, p.9). Similarly, Syed, Dadwal and Martin (2013) recognise the potential benefits of volunteering in resource-constrained settings for the NHS and put forward the notion of 'reverse innovation' – translating learning and innovation in the global South to the global North. Further, a growing number of global health volunteering programmes explicitly or otherwise deploy volunteers in the global South with the view of translating knowledge gained particularly in relation to key areas such as 'resilience' and 'efficiency' in health systems (Kumar et al., 2008).

## **1.6 Rationale of the Study**

Often, international voluntarism occurs in individuals and organisations where there is great potential to do good, but also significant potential to do harm, and there has been a call for higher attention to the many effects of volunteer presence and efforts when working within such contexts (Wright, 2013; Palacios, 2010). Attempts have been made to evaluate and understand international voluntarism, but rarely are these discussions and resulting policy decisions directly informed by the nuanced, contextual perspectives of host communities' perspectives. The field of international voluntarism draws much of its 'partial' insights from volunteer experience prompting urgent call for host voices and perspectives.

Emerging studies on host perspectives of voluntarism suggest international voluntarism has the potential for positive impacts on host communities (e.g. Graham et al., 2011; Perold et al., 2011; Devereux, 2008). However, often the conception of 'host' does not adequately represent the diversity of stakeholders that form the community in question.

Evidence of this can be observed in studies by Comhlámh (2010) and Laleman et al. (2007), where the experiences of host communities were explored either from host organisation's representatives or through the lenses of less robust research tools such as the use of 'rapid' surveys. Divergent from these studies, and many others, this study explores the views and experiences of Ugandan health workers from diverse cadres, career levels, and experiences of hosting British volunteers. It does so through the adoption of a qualitative inquiry along with a social justice approach to voluntarism to gain deeper understanding of Ugandans' voices and experiences, as well as contextual barriers to relationship building and learning. These perspectives were gathered over two distinct research phases using multiple research methods including observational research, focus group discussion, and interviews. The study contributes to international volunteer placement particularly around the relative lack of knowledge and understanding of Ugandan volunteer hosts.

## 1.7 Towards Aim and Objectives

The study was funded by Health Education England (HEE) through the Measuring Outcomes of Volunteering for Education (MOVE) project. My PhD supervisor manages both the MOVE project and the SVP which deploys British volunteers in Ugandan public health facilities. Some of these (SVP) volunteers were hosted by Ugandan health workers who participated in this study. Clearly, therefore, there is a potential conflict of interest worth reiterating here, and of which I seek to address. Firstly, the PhD was advertised by the MOVE project and with a call to add Ugandan voices to the growing body of SVP volunteer voices. My PhD proposal along with my work experiences in Africa allowed me to secure funding from the MOVE project, and subsequently embark on the PhD journey. The aim of the study reflects the call of the PhD and seeks to:

*Explore Ugandan health workers' experiences of engaging with volunteers to contribute to research on host perspectives of international voluntarism.*

The objectives of the study were conceived during the scoping phase of the study and after the first few interviews with Ugandan health workers hosting SVP volunteers. Initial discussions with Ugandan health workers helped refine research focus and provided ideas for the subsequent interviews.

These ideas centred on four key areas – perceptions, motivations, benefits, and barriers. In line with traditions of grounded theory (GT), and to avoid making assumptions (Strauss & Corbin, 1990), the key areas were reworked and synthesised. The following six discrete objectives emerged from the synthesis of these key areas:

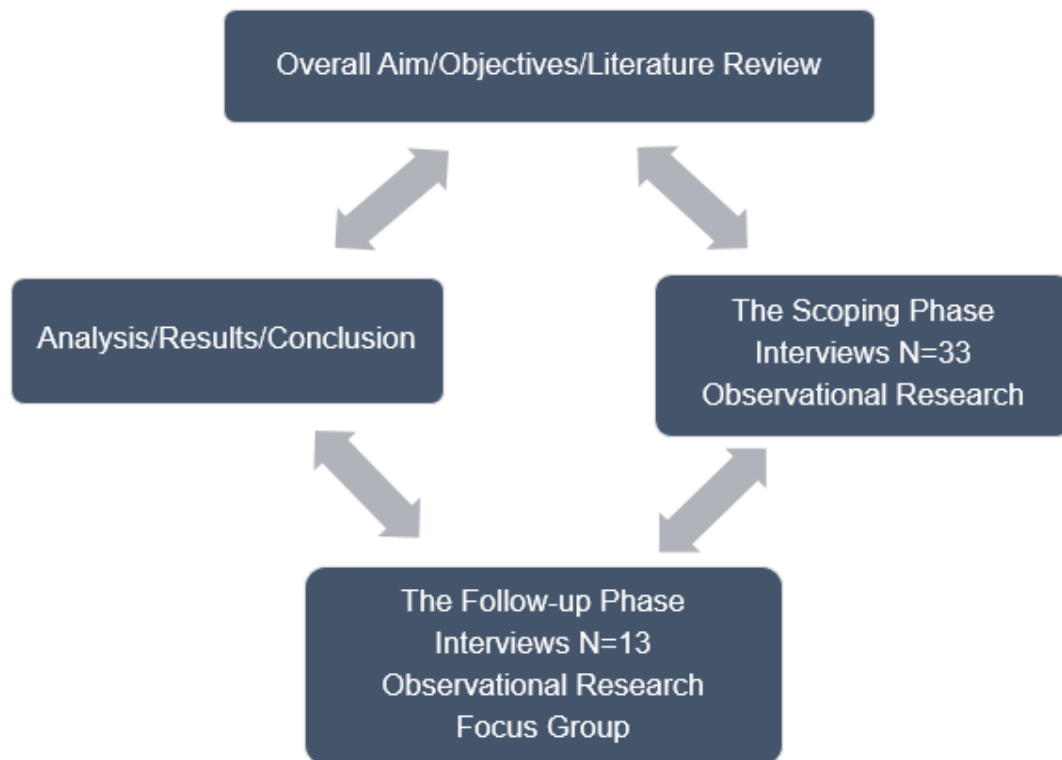
- 1. To explore how Ugandan health workers perceive volunteers' presence in their health facilities.*
- 2. To examine factors that influence Ugandan health workers to engage with volunteers.*
- 3. To investigate how important Ugandan health workers perceive volunteer presence in their development or practice.*
- 4. To investigate how important Ugandan health workers perceive their presence in volunteers' development or practice.*
- 5. To identify whether there are challenges that may be associated with hosting volunteers.*

6. *To propose new ideas as to how to better engage with Ugandan health workers.*

### 1.8 Overview of the Research Strategy

Due to the exploratory nature of this study, the rationale and the gaps in the literature, the data collection consisted of two distinct phases – scoping and follow-up phases conducted within the frameworks of qualitative research approach. The overall research strategy is presented in Figure 2. The research strategy illustrates the cyclical relationships between the different stages of the study. The overall research design is discussed in Chapter 3.

Figure 2. The Research Strategy





## **1.9 Outline of the Thesis**

This study is divided into eight chapters. The following outline is a presentation of the journey through the research process for this study.

Chapter Two reviews the scope of research of the field which will help add further understanding of the perspectives of Ugandan hosts. The first section of this chapter outlines the choice and the rationale of the literature review approach adopted for this study. The second section examines existing literature on host perceptions of global North volunteers and their motivations of hosting them. This is followed by a note on 'development' and its relationships with voluntarism. The benefits of voluntarism for stakeholders (i.e. volunteers and hosts) are then explored. The chapter concludes with a note on the social justice approach to voluntarism, and why it is appropriate for this study.

Chapter Three outlines the overall research design adopted for this study. The chapter sets the scene with a brief reflection of how I found the field to locate myself in this study, and to be transparent about the assumptions that I brought to it.

It then discusses the philosophy underpinning the study to provide both direction and guidance to the overall research design. The chapter further explores research methodologies and identifies the appropriate methodology adopted to achieve the objectives of the study. Finally, issues relating to reflexivity are explored, including an awareness of the importance of positioning myself in the wider scope of the research process.

Chapter Four outlines some of the research methods utilised in the field of international voluntarism which inform the research methods employed in this study. A blend of data collection methods including observational research, focus group discussion and interviews utilised in this study is outlined. A detailed discussion on the interview processes, and the rationale of sampling, the management of data, and the coding processes is provided. Finally, issues relating to research ethics along with how research quality is maintained throughout the study are outlined.

Chapter Five is the first of three findings chapters. It responds to objectives one and two of this study. The chapter examines Ugandan perceptions of volunteers and their motivations for hosting volunteers.

Two main perception themes: helping and personal and/or professional development along with six main motivations themes: validating existing skills; improving curriculum vitae (CV); supporting community development; gaining new skills, gaining intercultural exposure and learning, as well as accessing further training are discussed in the light of the existing literature.

Chapter Six is the second of three findings chapters. It answers objectives three and four of this study. The chapter discusses Ugandans' perceptions of the benefits that hosting volunteers have for volunteers and for themselves. Seven main themes: context-specific skills; professional networking; securing resources; gaining recognition and credibility; good practice; health worker supervision; and local empowerment and participation are discussed in this chapter.

Chapter Seven responds to objectives five of this study. The chapter discusses barriers associated with hosting volunteers experienced by Ugandan health workers. Five main themes: responsibility without authority; health worker absenteeism; heavy workload; prevailing volunteering styles; and volunteer avoidance are examined and discussed in the light of existing literature.

Chapter Eight summarises the findings of the study directly responding to the research aim and demonstrating how the objectives have been met. In bringing the findings together, the chapter provides an overview of key points made in each of the empirical chapters and the contribution to knowledge that this study adds to our understanding of host perspectives of international voluntarism. Further, the chapter considers the potential strengths and weaknesses of the study and proposes constructive recommendations for practice and future research focus. Finally, the chapter concludes the study with a reflection of the lessons learned including the different ways the PhD journey contributed to my personal and professional development. The next chapter presents the literature review of the study and situates existing evidence underpinning this study.

## **Chapter Two: Literature Review**

### **2.1 The Introduction**

The previous chapter introduced the study and the six objectives it seeks to achieve. These objectives are addressed to create an understanding of the experiences of Ugandan health workers hosting British volunteers. In order to achieve these objectives, a review of the existing concepts and theories in the field is needed. Chapter two, therefore, presents a review of the literature from diverse fields including international voluntarism and development. The chapter is structured as follows: the first part gives an overview of the literature and identifies the different approaches to reviewing existing research in the field. This is followed by an outline of the choice and the rationale of the literature review approach adopted for this study. The second part examines existing literature on host perceptions of global North volunteers and their motivations of hosting them. Discussions on 'development' and its relationship with voluntarism then follows. The perceived benefits of voluntarism for stakeholders (i.e. volunteers and hosts) are then explored. The chapter concludes with a discussion on the social justice approach to voluntarism, and why it is appropriate for this study.

### **2.2 Literature Review Methods**

A literature review refers to a review of scholarly articles, books, and other sources relevant to a particular field of study by identifying existing research (Bourner, 1996). It involves eliciting information that helps us identify the scope and any gaps in the body of (academic) work (Cronin, Ryan, and Coughlan, 2008). How this information is extracted from the existing pool of evidence is determined among other things by the research approach (i.e. qualitative versus quantitative), and the epistemology underpinning such approach (i.e. constructionism as in the context of this study). There are several approaches to reviewing literature, and some are appropriate in some contexts more than others (Cronin et al., 2008). Narrative, and systematic approaches tend to be used in research on international voluntarism (Studer and von Schnurbein, 2013; Wilson, 2001).

A 'narrative literature review' describes a broad search of relevant literature summarised with a narrative in mind but without a systematic critical appraisal (Green, Johnson, and Adams, 2006).

It involves non-exhaustive ways of extracting information from both published and unpublished sources, and without 'ranking' knowledge based on quantitative outputs (Cronin et al., 2008). As such, narrative review provides the researcher with a comprehensive background of the topic under study and helps identify inconsistencies or knowledge gaps (Paré et al., 2015; Whitemore et al., 2014; Cronin et al., 2008). By contrast, a 'systematic review' describes a detailed and systematic method to identify and appraise relevant literature based on scoring systems (Paré et al., 2015; Cronin et al., 2008). It requires researchers develop systematic and clearly formulated questions to determine list of literature which is included in the review (Green et al., 2006).

The narrative approach to reviewing existing literature was chosen for this study. In line with the constructionist epistemology adopted (see 3.4), along with the scarcity of literature on host perspectives of voluntarism more generally, it was important that I adopt a broad rather than a narrow approach to reviewing the literature. In this way, I could review literature from a range of disciplines including global health, international voluntarism, development, and weave them together to provide a broader view of existing evidence in the field. This inclusive way of reviewing the literature allowed me to identify knowledge gaps and helped position my research objectives. Literature searches were run at the start of the PhD journey, and again after the data analysis to ground the 'emergent' data in existing literature. Both sets of the literature searches were woven together using the evaluation tool created by Long and Godfrey (2004) outlined in Appendix 3. The emergent literature review covered the following five questions:

1. How do people or organisations in the global South perceive global North volunteers?
2. What are the motivations of people or organisations in the global South to host global North volunteers?
3. How is 'development' conceptualised by its actors or stakeholders?
4. How does 'development' inform voluntarism?
5. How does voluntarism benefit its stakeholders?

Further to this, and due to the dominance of 'development' approaches to researching international voluntarism as will be highlighted in 2.5 and 2.6, a social justice approach to voluntarism is explored and a rationale for its utility in this study provided in the light of existence literature.

### **2.3 How do people or organisations in the global South perceive global North volunteers?**

Pearsall and colleagues (2005, p.1306) define perception as: "...*the way in which something is regarded, understood, or interpreted.*" Among other things, perceptions are influenced by culture and individual values, which people learn from their experiences and environment. John Locke (1689, p.239) once stated: "...*the power of perception is that which we call understanding.*" The need to understand host perception of volunteers is highlighted in many texts and is certainly not a new phenomenon. Irene Pinkau's research in the 1970s, and early 1980s remains one of the earliest works calling for an understanding of host perceptions of volunteers and voluntarism more generally. She cites two important messages in her research. Firstly, Pinkau argues the perceived need for international voluntarism which dominates popular imaginaries in the global North emerges from a lack of knowledge and understanding of the global South and its cultures. Secondly, the objectives of voluntarism cannot be achieved without having prior knowledge and understanding of placement communities and organisations in the global South. Pinkau (1981, p.66) summarises:

*"The major objectives of Foreign Volunteer Development Services are not only to provide skilled manpower for development projects and to participate in international cooperation for development, but also to learn from other cultures and from work experience in foreign settings and to promote understanding among the peoples of cooperating countries."*

An understanding of host perceptions of volunteers is therefore important for several reasons. Firstly, knowledge of how hosts react to the arrival of volunteers or international voluntarism more generally can inform relationships and learning. For example, prior knowledge or understanding of host disinterest of volunteers or their projects will allow organisations to take a closer look at the profiles of their volunteers or aspects of their work which can maximise local support and minimise potential negative impacts. Aguilo and Rossello (2005, P.928) posit that:

*“...If different profiles of groups within a particular community are known, development strategies can be selected that minimise any potential negative effects and maximise the overall population’s support for such alternatives, while allowing identification of those groups most likely to disagree with these strategies.”*

Put simply, voluntarism is more likely to enhance impact if host perceptions are considered and understood (Williams and Lawson, 2001). Given the importance of host perceptions in the volunteer experience, there is relatively little focus on host perceptions of volunteers and voluntarism more generally (Guttentag, 2009; McIntosh and Zahra, 2007). There are several reasons provided for this. Some researchers point to resource and time constraints which are thought to limit the scope of [short-term voluntarism] to capture host perceptions or experience (Sin, 2010). Others cite the influences of funding bodies whose centre of interest or activity is particularly on the volunteers and their exposure to a ‘third-world’ experience (Gronemeyer, 2010). For example, writing from the short-term voluntarism perspective, Pastran (2014, p.50) argues that host perceptions of volunteers are viewed as:

*“...irrelevant in the equation of development that is simply, generously, and neutrally bestowed upon [them] by Western volunteers.”*

Barbara Heron acknowledges that host perceptions of voluntarism are relevant but suggests ethical justifications for her decision not to capture [African] host perceptions of Canadian volunteers. She writes:

*“...the decision not to carry out interviews with Africans [hosts] was also consciously made...because I did not want to pit the words of African people who work with Canadian development workers [volunteers] against the views of the latter, as if to prove my points.” (2007, p.5).*

Further discussing the relatively little focus on host perceptions of volunteers and voluntarism more generally, Maria Eriksson Baaz argues discounting host perceptions of international voluntarism:

*“...risks silencing the voices that can disrupt or be an obstacle to the discursive power of development...the single focus on the donor is problematic since it tends to attribute passivity and powerlessness to those excluded from the analysis.” (2005, p.3).*

Quist-Adade and van Wyk (2007) explain how the exclusion of host voices in the volunteering experience leads to the development of misperceptions of the people of the global South and more specifically volunteer hosts in Africa:

*“people are exposed to development pornography through a plethora of visual, text and audio input via the mass media and popular culture, which present the African lifeworld as inferior and primitive, and African people as helpless, hapless, and in the throes of an unending series of epidemics on the short road to extinction”* (pp. 66).

Such misrepresentation is therefore understood to create a sense of entitlement and an obligation on the part of the volunteer to intervene for the “*betterment*” of the hosts in the global South. It is also believed to play a crucial role in shaping the ‘passive’ ways in which some people in the global South perceive themselves relative to the volunteers and the people of the global North more generally (Quist-Adade et al., 2007). Unsurprisingly, however, the few existing studies on host perceptions of volunteers reflect these global South presentations. For example, Bethina Loiseau and colleagues (2016) conducted a study examining the perceptions of short-term North American volunteers hosted by community organisations in the city of La Romana, the Dominican Republic. The city hosts hundreds of volunteers annually. The findings revealed host perception that services offered by volunteers were of ‘higher’ quality than local equivalents. Further, volunteers were perceived to bring along North American ‘quality’ services, suggesting being North American and ‘white’ had important implications in terms of social relations, and as such, strongly determined how the ‘other’<sup>6</sup> (i.e. Dominican hosts) perceive and relate to foreign volunteers. Similar perceptions of volunteers by hosts were also highlighted by Palacios (2010). In a study of short-term voluntarism in Vietnam, Mexico and Fiji, the author observed that members of local communities depicted volunteers as bearers of ‘superior Western knowledge’ and perceived them as being in a better position of power to judge and comment on developmental goals. Further, the author found that while some volunteers went along with this stereotype and presented themselves as the ‘experts’ in the relationship, others felt uncomfortable with the responsibilities attached to such an expert image, particularly given the fact that they were ‘inexperienced’ in the ‘context’ in which they were placed.

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<sup>6</sup> A brief discussion of ‘othering’ is provided in 2.4.

Furthermore, a study commissioned by Volunteer and Service Enquiry Southern Africa (VOSESA) and conducted by Lauren Graham and colleagues highlighted a 'racialised' relationship between volunteers and host organisations in Tanzania and Mozambique. In particular, the study found that members of host organisations viewed volunteers as members of a 'superior race', from rich, developed and highly skilled contexts. The authors argued that such representations of volunteers were consistent with popular African imaginaries of Europeans and colonial and post-colonial interactions between black Africans and white people more generally. The researchers cited one such perception shared in a Tanzanian group discussion:

*"White people are very wealthy; they are very developed, and their living conditions very far removed from the way we live in poor countries. They are very powerful as nations. They are very intelligent people and capable of anything."* (Graham et al., 2011, p.10).

It appears that a great deal of host perceptions of volunteers revolves around perceptions of race, which are themselves historical and cultural. However, some host representations of volunteers fall outside these common perceptions. For example, Laleman and colleagues explored the perceptions of African health managers (country experts) regarding international health volunteers deployed in Sub-Saharan Africa by thirteen different Northern NGOs. Overall, the health managers perceived volunteers as ill-prepared to work in their settings. They expressed some frustration at having to host what they described as 'inexperienced' volunteers unwilling to "...fit in local systems." (2007, p.5). The authors argued that part of this frustration could be explained by unequal relationships which put host organisations on the back foot in terms of articulating demands for the types of volunteers who could better fit in host systems. They further suggested that the frustration could also be explained the inability of some volunteer sending organisations not to provide 'sufficient' funds to hosts to cover their expenses and help manage their volunteers. By contrast, the researchers found that positive perceptions were reserved for highly skilled volunteers staying for longer periods of time. Health managers expressed that these volunteers are highly mobile (can work in rural, urban, as well as areas with political unrest or in post-conflict transition) and help leverage knowledge exchange. Further, the researchers added that these volunteers were perceived as expressions of "*international solidarity, international human relations, and cultural exchange.*" (Laleman et al., 2007, p.5).



However, the researchers noted in their conclusion that positive perceptions reserved for highly skilled volunteers was, to some extent, influenced by the funding that accompanies the arrivals of such volunteers.

It therefore becomes evident that host perceptions of volunteers are also shaped by issues relating to resources, and knowledge, in line with the global disparity between the North and the South. The following part of the chapter explores the motivations of volunteer hosts.

#### **2.4 What are the motivations of people or organisations in the global South to host global North volunteers?**

There are several definitions of motivation each varying across contexts and disciplines. For example, those of Pinder (1998) and Franco, Bennet, and Kanfer (2002); and there are other conflicting multiple definitions of varying degrees and intensities. Craig Pinder's (1998) definition is applied here. He defines motivations as:

*“...a set of energetic forces that originates both within as well as beyond an individual's being, to initiate work-related behaviour, and to determine its form, direction, intensity and duration” (1998; p. 11).*

It is widely agreed that people engage purposeful activities to fulfil certain goals and can perform the same activities to fulfil different psychological functions (Clary et. al., 1998). Simply put, different people engage in different activities to fulfil distinct functions or the same person may engage in the same activity to fulfil distinct functions at different times in their lives (Snyder, 1993). The complexity of the concept of motivation becomes evident in international voluntarism because of its diverse stakeholders with diverse volunteering 'cultures' (Hazeldine and Baillie Smith, 2015). It appears however, that such diversity is hardly celebrated. The motivations to participate in voluntary activities are studied predominately from the point of view of one stakeholder – the northern volunteer (Lo and Lee, 2011; Brown, 2008; Palmer, 2002). There has been a distinct lack of research concerning host motivations of engaging with volunteer when clearly volunteer hosts play a significant role in the volunteering experience (McIntosh et al., 2007). The limited perspectives on host motivations of engaging with volunteers is viewed by some scholars as a form of 'othering' (Palacios, 2010; Guttentag, 2009).

Othering involves conscious (or otherwise) position that leads to social distance between the self and others deemed different (Krumer-Nevo and Sidi, 2012). It carries value judgments: the 'other' is perceived as distant psychologically and physically); and knowledge judgement: the motivation of the 'other' is relatively unimportant (p. 300). More specifically, it is suggested that othering is underpinned by perceived inequalities (economic, cultural, or both), and may involve elements of objectification, marginalisation, deprivation, and misrecognition of the other (Fraser, 1997). Lough and Carter-Black (2015) expanded on this by arguing that the concepts, language, and images used in understanding host perspectives of voluntarism reinforce the othering and the voicelessness of hosts. Sarah Pink in her article, 'The White Helpers: Anthropologists, Development Workers and Local Imaginations', argues that by othering hosts, we are missing out a whole genre of perspectives, and experiences. Far from being 'subaltern', and 'passive' as implied in many texts (e.g. Pastran, 2014; Palacios, 2010), Pink argues that volunteer hosts engage in:

*"...processes of evaluating [Westerners] and using [Westerners] as case studies for their own warehouses of examples and generalisation about white people and how we can be used to advance their careers." (1998, p.11).*

Pink calls for an exploration into local people's motivations of hosting volunteers and suggests that this will shed some light onto the roles that rich foreigners play in local cultures and society (1998). Advancing this call, and in the context of Ghana, Porter (2003, p.137) found that in addition to 'welcoming foreigners', Ghanaian hosts were motivated to receive volunteers to learn with them. Further, Bethina Loiseau and colleagues found hosts in the Dominican Republic were motivated to access material resources that the volunteers bring to the community. The authors argued the primary focus on accessing material resources suggests underlying belief that *"the donations that arrive with volunteers"* were more popular than the knowledge and expertise volunteers bring to the community (Loiseau et al., 2016, p.5). Similar host motivations were observed by researchers such as Graham and colleagues in Tanzania and Mozambique, and Laleman and colleagues in several Sub-Saharan countries. The latter in particular, the need for material resources was raised by African health managers who appeared more interested in justifying the practice of long-term placements over short-term placements.

The scholars explained that long-term volunteer placements were often accompanied by an influx of resources such as funds, drugs and medical equipment hence their popularity among African health managers. Related to this, other host motivations cited in the literature included the belief that working with volunteers would enhance the image of the host organisation. Some volunteer hosts felt the presence of volunteers would “*improve social standing*” because local people were thought to “*hear and trust*” white volunteers compared to local staff (Graham et al., 2011, p.13). This view was leveraged with local people who, volunteer hosts claimed, were more likely to participate and respond to the programme if they were delivered by white volunteers. Others felt volunteers could represent and promote their local projects more favourably than they could themselves, because they may have a better understanding of donors and AID more generally.

Taken together, these studies point to the overwhelming motivations of hosts engaging with volunteers to draw material resources and perceived social standing among their communities. Such motivations indirectly pointed to the potential for creating an unsustainable overreliance and puts into question the ‘development’ role voluntarism seek to achieve in the global South.

## **2.5 How is ‘development’ conceptualised by its actors or stakeholders?**

There is a growing understanding that international voluntarism seeks (or claims) to contribute to international development (Baillie Smith and Laurie, 2011; Sin, 2010; Simpson, 2004). Yet there are different interpretations of development and how it could be achieved. This section outlines the different theories and ways of understanding this concept. In doing so, the section attempts to locate voluntarism in this context.

### **2.5.1 What is International Development?**

There are several overviews of development. As a biological concept, development involves “*a process of change where the potentialities of an object or organism are released until it reaches its natural, complete, full-fledged form.*” (Esteva, 2010, p.3). As a social science concept, it refers to broader “*expansion of human capabilities*” (Lewis, 2006, P.2).

Theoretically speaking, development is a relatively new concept. With its roots in the economic, political and sociological theories of 18th century Europe, development theory emerged in earnest at the dawn of the 20th century (Skeleton and Allen, 1999). In particular, the decades following World War II saw increased interests by some Western nations to ensure a more peaceful world and stable economic growth. Coincidentally, it was during this time that organisations such as the International Monetary Fund (IMF) and the World Bank were formed (Willis, 2005). The economic success of the Marshall plan in Europe, and later in Northern American (the United States (US) and Canada in particular) produced optimism for global economic expansion, so similar economic outcomes were sought by Northern countries for their Southern counterparts<sup>7</sup>. However, the economic success in many Northern countries was boosted by efficient ‘human’ and ‘material’ resources critical for market-oriented economy, compared to the dearth of skilled human resources and inadequate institutions in Southern geographies (Arndt, 2000). Northern countries and NGOs adopted an intervention strategy underpinned by ‘technical assistance’ (TA) and AID to counterbalance this mismatch in economic growth between the North and the South (Karikari, 2002; Arndt, 2000). The use of such means to counter ‘under-development’ in poorer countries has been the source much contention. Dambisa Moyo, in her book ‘Dead Aid: Why AID is Not Working and How There is Another Way for Africa’, argues that a culture of AID exists partly because of “*the liberal sensibility that the rich should help the poor and that the form of this help should be AID*” (2009, p.19). Referring to its impact on global poverty, Moyo adds that AID has been and continues to be a disaster politically and economically for the global poor. She concludes by contending that AID is not only ineffective, but also causes much disruption and damage. She writes:

*“Were AID simply innocuous – just not doing what it claimed it would do – this book would not have been written. The problem is that AID is not benign – it’s malignant. No longer part of the potential solution, it is part of the problem – in fact, AID is the problem.” (p. 47).*

Broadly speaking, however, United States’ President Harry Truman is credited with launching the ‘era for development’ following World War II.

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<sup>7</sup> Graham et al. (2011) contends that despite differences in knowledge and wealth, the Marshall plan induced euphoria that implied poorer countries (predominantly in the global South) ‘*needed to follow the economic and political model of Europe and America, implementing democratic systems and liberal economic policies*’ (p.6).

Devereux (2008) suggests that Harry Truman's inaugural address to congress in 1949, has 'initiated a perception of a problem in "*Southern countries and a recipe for change that to this day, still holds much support*" (p.94). He adds that while Truman's speech was well-intended, phrases such as 'living in stagnant conditions' implied that poorer countries cannot adapt the 'right' economic model (capitalism). These comments highlighted the complex socio-economic and political spaces in which development is 'constructed' and technical solutions embedded (Devereux, 2008). Truman's model of development has come to be understood in the development field as the 'modernisation theory' or what others refer to as 'catch-up development' (Graham et al., 2011) or simply the "*development project*" (McMichael, 2000, p. 7). The theory posits that all countries are on the same path to development (Sutcliffe, 1999). The rise of 'development' in the 1950s coincided with the liberation of many Southern countries from colonisation. Therefore, development in these contexts should be approached with caution on the basis that it is imbued with both past and present inequalities and injustices (Skeleton et. al., 1999).

Emerging from modernisation theory is Rostow's 'Stages of Economic Growth' which highlights the 'positive' role played by Northern countries in 'modernising' and 'leading' sustainable change in Southern countries. This theory attracted much criticism over time largely due to its 'Euro-centric' approach to development which appears to disregard aspirations of Southern communities and their developmental needs (Willis, 2005). Despite this criticism, the theory adherence to its key premises of 'linear economic trajectory', and enjoys much support from various development actors, including bilateral and multilateral donors (Hinton and Groves, 2004).

By contrast, the dependency theory of development (e.g. Frank, 1996) argues that the modernisation model of 'development' continued historical inequalities as well as injustices that have created the economic and social problems in the first place – "*the development of capitalism*" (1966, p31). The theory posited that Northern countries 'prospered' at the expense of Southern countries through unfair trade and unfavourable market policies. Moving forward and seeking alternative approaches to overcoming 'under-development', Frank (1996) advocates that Southern countries need to break free from suppressive relationships with Northern countries. However, like modernisation theory, dependency theory present Southern countries as 'passive' and dependent on 'external assistance'. Simpson (2004) summarises:

*'In the modernisation model the populous do not know what is good for them (in that they need to change social and cultural traditions to the tune of development). While in the dependency model the populous do not know what is bad for them (in that their development is permanently suppressed by structures that are beyond their control' (p.39).*

The Brazilian educator, Paulo Freire, argued that attempting to liberate the poor without their participation in the so-called modernisation is to *"transform them into masses which can be manipulated"* (1970, p.47). He suggests action 'with' and not 'to' must be achieved through a critical awareness, and people's needs and aspirations. Chambers (1983, p.3) suggests that *"the poor must help themselves"* and their development and agency should not *"...be determined by external actors with external interests, but by their own efforts with support from outside"* (Trewby, 2007, p.8). Scholars such as Amartya Sen (1999) and Quarles Van Ufford, Giri and Mosse (2003) argue that development should be a mechanism of fostering the freedoms and potentials of countries in the global South to create the space for people to channel their energy at their own pace. It should, among other things, draw on existing capacity and emphasise *"agency, in the sense of peoples' capacity to effect social change"* (Nederveen-Pieterse 1998, p.345). These emerging processes of development recognise the contribution of communities and individuals to make their own decisions about their needs and priorities (Perold et al., 2011; Clark 1991). This shift in development conception presents development as modern, morally-informed aspirations of global responsibility and change. Wilson (2012) summarises this development shift:

*"development is no longer relegated to the status of a peripheral and inconsequential leisure pursuit or dismissed as an oddity in a world largely given over to the pursuit of self-interest" (p.176).*

Further, Pinkau (1981) notes that contrary to some development agencies such as NGOs and their narrow emphasis on eliminating poverty in the global South, improving lives at local level requires a coordinated emphasis on capacity development. The Organisation for Economic Cooperation and Development (OECD, 2006, p.19) defines capacity development as the ability of *"...people, organisations and society as a whole unleash, strengthen, create and maintain capacity over time."*

Capacity development holds transformative and collaborative approach and concerns strengthening communities through increased 'social capital'.

Robert Putnam, who has been attributed with making social capital a popular focus for research and policy discussion, defines social capital as:

*"...connections among individuals — social networks and the norms of reciprocity and trustworthiness that arise from them... Social capital calls attention to the fact that civic virtue is most powerful when embedded in a sense network of reciprocal social relations"* (2000, p. 19).

These connections are positively associated with trust, cooperation and resource mobilisation, and can lead to positive change at international level (bridging capital), and at local level (bonding capital (Jones, 2005; Woolcock and Narayan, 2000; Narayan, 1999). The UNDP recognises that 'capacity' exists within individuals, as well as at the level of organizations and within an enabling environment. It outlines the importance of capacity development (through social capital) and recommends ten guiding codes for international development programmes [including those pursuing voluntarism] as means to achieving development in the global South. The UNDP codes are designed to promote good practice among development practitioners and stakeholders, and to prevent marginalisation of local people. The emphasis is on ensuring that people hosting development programmes are treated with respect, and that development programmes do not lead to their disempowerment or 'unintended consequences' (Lopes and Theisoehn, 2003, p. 30).

The 10 codes cover the following important areas:

1. Respect local values and foster ownership.
2. Challenge power differentials and mind-sets.
3. Focus on the long-term sustainable outcomes.
4. Explore globally, adjust locally.
5. Understand local motivation and establish positive incentives.
6. Align innovation and external input with local priorities and aspirations.
7. Work towards strengthening what is already there rather than creating new ones.
8. Be adaptable and flexible locally.
9. Be prepared for unplanned consequences and stay engaged.
10. Remain accountable to local stakeholders, or groups.

(Lopes and Theisohn, 2003, p. 30).

The codes call for ‘transformational’ capacity development and recognises the importance of social change and local participation in development planning as well as in practice.

These codes are increasingly becoming popular among development actors, and endorsement by the OECD suggests an acknowledgement not only of the crucial importance of capacity development but also the need to link capacity development with sustainability (Devereux, 2008). Sustainability or sustainable development (SD) calls for a broader approach to development to rectify earlier development models and also to apply a more holistic view to development. This holistic view is reflected by the World Commission on Environment and Development (WCED, 1987) which defined SD as “...a development that meets the needs of the present without compromising the ability of future generations to meet their own needs.” (p.8). This definition embodies two crucial components: the overriding priority of the poor; and the underlying technological, societal and environmental constraints to achieving present and future goals.

Also aligning with this notion of sustainability is the SVP which seeks to meet the needs of the Ugandan health system through the placement of British professional volunteers to work alongside their Ugandan counterparts to improve maternal and new born health. Sustainability in this interaction is maintained by the SVP adopting ‘supportive’ and ‘capacity’ development role ensuring that the health system is not reliant on foreigners to foster change and for Ugandans to lead their change at their own agency (Ackers, 2014). In broader terms, sustainability is achieved through participation, which itself denotes an immersion exercise, a way of gaining deeper insights into global inequalities, and creating positive change. Williams and colleagues (2003) suggest [local] ‘participation’ can be traced to the radical ‘conscientisation’ of Paulo Freire amongst others<sup>8</sup>, but more recently, it has drawn particularly on the work Michael Chambers. Participation as an engagement principle follows the common sense that:

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<sup>8</sup> Williams et al. (2003) suggested that Paulo Freire’s work on community participation in the 1970s has been important in promoting collaborative development with local communities actively participating in development processes.



*“...knowledge must be looked at relationally – that is as a product of social relationships – and not as a fixed commodity” (Long and Villarreal, 1994, p.17).*

It sets the scene for a growing recognition of ‘active citizenship’, more autonomous facilitators of knowledge in particular contexts. Green (2008, p. 15) defines active citizenship as *“...solidarity by people and governments in the rich world with the struggles of poor people and their communities within developing countries.”* He suggests that active citizens play a vital part in giving local people a voice, challenging the forces that historically excluded them from taking active part in their own development. The researcher notes some successful cases of active citizenship, such as Bolivia's Chiquitano communities who reclaimed their land through sustained community activism. Further, Green (2008) suggests that state and non-state development practitioners need to recognise that active citizens and effective states are important to building ‘meaningful’ development that challenges inequalities and work for the forgotten masses. Reflecting on his Oxfam experience, Green (2008) notes that development practitioners and active citizens are central to the achievement of successful development, and this recognition Green argues is now embedded in Oxfam’s international development policy. Wilson (2006) suggests that this recognition is important for the creation of *“learning conduits where co-production of knowledge which can contribute to broader processes of change is possible”* (p. 502). The author links such learning to the notion of ‘community of practice’ (CoP), highlighting the interactions of people in pursuit of common goals. The term CoP emerges from the work of Lave and Wenger in 1991, and in response to prevailing transmission models of learning. Wenger, McDermott and Snyder (2002, p.4) loosely defined CoP as:

*“Groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis.”*

Increasingly, and in health and social care in particular, CoP is promoted as a mechanism to enhance learning, and improve practice – adding organisational value (Chandler and Fry, 2009; le May, 2009). It suggested that CoP provide a means for knowledge to cross boundaries, diversify learning, and generate innovation and breakthrough ideas (Anand, Gardner, and Morris, 2007).

Central to CoP is the assumption that learning is more than transmitting information from a source to a recipient. Rather, learning involves a complex relationship and developing an identity within a shared space or practice (Cox, 2005). Contemporary conceptualisation of CoP extends beyond novice–expert relationship and focuses more on the interaction between people with common values, goals, and visions (Wenger, 1998). Underpinning CoP are three fundamental dimensions: joint enterprise (all on board); mutual engagement (shared learning); and shared repertoire (shared resources, information, experiences, or practice). Wenger suggests that these dimensions are characterised by a shared *domain* of focus, a *community* with a shared value and interest, and a *practice* or shared resources<sup>9</sup>.

The *domain* characteristic of CoP represents ‘common’ goals, and holds that CoP is not merely a club of friends, or social connections. Rather it is conceptualised as an identity that distinguishes members from outsiders. Membership in this context therefore serves commitment to the identity of domain. The *domain* can be local, international, or both, and its identity and expertise may not be recognised by outside groups. For example, health professionals in the South may develop a unique way of working in a resource constraint health setting – adjusting local expectations and becoming more resourceful although professionals joining them from the North may not value or even recognise their practice. Wenger (2005) calls for ‘consideration’ of and an ‘alignment’ with local *domains* for greater interaction and learning. An appreciation of such domain by outsiders such as volunteers is crucial to developing CoP, and social justice more broadly<sup>10</sup>. The *community* characteristic consists of members motivated by shared interest in the domain. These members participate in joint exercise and build relationships to facilitate learning and knowledge exchange. The act of ‘development’ does not constitute a community, but the activities of development practitioners (such as volunteers) and their interactions with their hosts may create a community – a sense of belonging and a shared vision of togetherness.

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<sup>9</sup> Li et al. (2009, P.7) suggest that as the definition of CoP broadens, “*it becomes more difficult to characterise what is and is not a CoP group. This potentially limits our ability to study CoPs as a strategy to improve clinical practice.*”

<sup>10</sup> Discussion on social justice is provided in 2.8.1.

Forming a community in this regard requires ‘engagement’, which Wenger (2005) defines as getting together with people, sharing experiences and knowledge (i.e. practice), and working towards common grounds or values. The *practice* characteristic suggests members of community may include practitioners — people in a shared interest (community), with similar identity (domain), and working towards shared repertoire of resources, experiences, and stories to address common challenges.

Further, Wenger (2000) differentiates between these three dimensions because each one requires a different style of work and attention. He suggests that, on entry to a given community, newcomers can be apprenticed to the entire CoP and with experience, some may become full participants or practitioners. In international development especially, development practitioners entering host spaces need to be aligned with local *domains* or expectations for greater participation and community development. From this end, it is incumbent on such practitioners to pay attention to the wider practices that exist in the spaces they work. In this model of learning, the levels of complexity become clear when development practitioners transitioning into host settings are placed within professionals, socioeconomic groups, societies, and cultures that are different to theirs. Wenger suggests that the CoP dimensions along with such social indicators have implications for practice and learning.

Applying ideas of CoP to international development, and in the spaces in which it unfolds has the potential to encourage development actors to reassess their policies and practices to ensure more effective and ‘sustainable’ outcomes (Devereux, 2008). It also offers an opportunity to reconcile ‘tensions’ between satisfying volunteers’ needs for personal growth and host organisations’ overall development aspirations (Li et al., 2009). Further, CoP can provide an avenue from which to conceptualise volunteering particularly within the increasingly shifting conceptions of international development.

## **2.6 How does ‘development’ inform voluntarism?**

As outlined in 2.5, there has been a dramatic transformation in development debate (Devereux, 2008; Wilson, 2006). In view of these debates, question about where voluntarism is situated emerges. Evidence suggests voluntarism is increasingly becoming a prominent feature in development discourses, and volunteers are viewed as development actors in this context (Baillie Smith et al., 2011).

Many NGOs now operate through volunteers because of the unique relational properties they provide for development with focus on relationships (Devereux, 2008). Some of these volunteers are requested for their expertise by Southern organisations and operate within the scope of their hosts in teaching and learning environment (Comhlámh, 2013). In such processes, volunteers are primarily accountable to the management of the host organisation and to their Northern senders (although feasibility of this will depend largely on the microstructures within the host organisation and to some extent, volunteering styles, Lewis et. al., 1999).

A fundamental issue regarding voluntarism is the question of whether volunteers are development workers as popular imaginaries suggest (Lough et al., 2009), or whether they symbolise corporate recruitment and CV building exercises (Baillie Smith et. al., 2011), or both. This query forms part of the wider question: is voluntarism ‘a qualified good’ in international development arena, or is it simply pure technical assistance with paternalistic undertones? As Chambers (1983) describes, “*a stronger person wants to change things for a person who is weaker; from this paternal trap there is no complete escape.*” (p. 141). From this observation, it becomes apparent that voluntarism has the potential to feed paternalistic stereotypical perceptions of ‘North’ and ‘South’ as a ‘strong’ and ‘weak’. Historically, such stereotypical distinction might be seen reflecting some styles of voluntarism, but not others (Comhlámh, 2013). The evolution and expansion of voluntarism created diverse volunteering programmes in the global South, some with long term goals for engaging citizens in both the global North and South. These programmes utilise volunteers as development workers and capacity development agents, bringing deeper and ‘localised’ developmental understanding in the global South with focus on priorities and outcomes.

A growing number of people and organisations in various sectors utilise volunteers as a key to improving their performance. The UNV Strategic Framework 2014-2017 (SF) emphasises knowledge generation, sharing and learning to make the volunteering experience both meaningful and impactful. The framework conceptualises voluntarism as a conduit from which to facilitate learning and create interactive networks. Comhlámh (2013, p.18) illustrates this point:

*“Many organisations engage in international volunteering to promote intercultural learning and these foci have been more closely aligned with current development thinking, which promotes the idea that international volunteers from developed countries could learn from the developing countries in which they serve, and that the volunteers’ purpose is not to save the host communities...”*

A noticeable area in which such conception can be observed is the growing recognition that inspiration should come from people from the global South, and that development programmes should take a closer look at host agency (Comhlámh, 2013; UNV, 2013). Such recognition can be observed in the development strategies adopted by some international volunteering organisations. A report by five UK based volunteer sending organisations; International Service, Skillshare, Progressio, Students Partnership Worldwide (PW) and VSO, (2010, no date) highlights a shared vision of volunteering that has the potential to empower people to improve their lives; encourage and promote local participation; embed knowledge and expertise; raise awareness at local and international level; and connect governments, local people and development programmes (p.16). Such vision, also shared by many volunteering organisations (both large and small) indicates a shift towards thinking about voluntarism as a factor in development, focusing on ownership and participation and a gradual shift from paternalistic notion of helping the poor and the helpless (Comhlámh, 2013; Brown and Hall, 2008). Increasingly the potential of voluntarism to put forward conceptual notions of development meaningful to local people is taking root. Such notion of development aligns with the Busan Declaration of ‘inclusive’ development that works for all but most importantly for beneficiaries (Comhlámh, 2013). The declaration recommends that local identities should take priority and define development and learning strategies. This includes considerations of local perceptions and expectations people may hold of voluntarism, as well as the complexities of their settings. The Declaration encourages development actors including volunteers to adopt a facilitative role and work towards common goals, providing results that matter to local communities. It further recommends a recognition of the diversity and complementarity of all the development participants and focus on sustainable co–development and global North–South partnerships.

### 2.6.1 North–South Partnerships

As mentioned in the previous sections, the current affairs of voluntarism and development include an emphasis on co–working and co–development in the form of partnerships (Dochas, 2010; Devereux, 2008). These principles are critically important in their own right; but taken together they form persuasive arguments in the development arena (Comhlámh, 2013; Gutierrez, 2008).

Co–development and partnerships denote reciprocal relationships between people brought about by a commitment to shared objectives, goals, or visions (Mohiddin, 1998a). Yet, some relationships may be uneven in practice, and implementation can be complex and difficult to understand for many Southern partners (Bailey and Dolan, 2011). For example, Lewis (1998) argues that ‘partnership’ is a difficult concept interpreted differently by organisations with unequal power. More specifically, it becomes problematic due to the Northern NGOs emphasis on using intermediary agencies (both local and international) as opposed to encouraging direct North–South partnerships. As such, there has been increasing moves by Northern funding bodies such as the UK’S Department for International Development (DfID) to directly fund North–South partnerships. This follows the wider recognition of inter–community cooperation and North–South partnerships as legitimate avenues for propagating ownership, empowerment, and responsibility as a prerequisite of effective development (James, Millet and Oillier, 2008; Karikari, 2002). It is also through such shift of strategies in the development circles that DfID has introduced Health Partnership Schemes (HPS) between institutions in HICs and those in LMICs<sup>11</sup> to build long–term institution–institution partnerships that typically focus on (through long–term professional volunteers) capacity building, clinical service delivery and operational research. According to the UK Office of Health Economics 1,700 UK health workers participated in long–term voluntarism in LMICs between 2011 and 2016. The Scheme was introduced by DfID and is set against eight international development goals established in 2000 following the launch of MDGs<sup>12</sup>. The eight goals are:

1. Eradicate extreme hunger and poverty.
2. Achieve universal primary education.

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<sup>11</sup> LMICs in the context of HPS denote countries in the lower-middle-income and low-income bracket calculated using the World Bank Atlas method (World Bank, 2016).

<sup>12</sup> [www.un.org/millenniumgoals/2015\\_MDG\\_Report/pdf/MDG%202015%20rev%20\(July%201\).pdf](http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20(July%201).pdf)

3. Promote gender equality and empower women.
4. Reduce child mortality.
5. Improve maternal health.
6. Combat HIV/AIDS and other diseases.
7. Ensure environmental sustainability.
8. Develop a global partnership for development.

The Millennium Development Goals (MDGs) have now been replaced by the Sustainable Development Goals (SDGs). The focus of the HPS, however, remain the same – implementing goals 4, 5 and 6 outlined above. The HPS are managed by the Tropical Health and Education Trust (THET), a specialist NGO that supports health workers through partnerships and strengthening health systems in LMICs. THET indicates the priority of working with LMICs for equal mutual benefit and emphasises the value to the UK and NHS as well as the lasting impact on these countries. These values are enshrined in eight core principles in their website (THET, 2018)<sup>13</sup>:

1. Strategic: Health partnerships have long-term aims, measurable plans for achieving them and work within a jointly-agreed framework of priorities and direction.
2. Harmonised and Aligned: Health partnerships' work is consistent with country health plans and complements the activities of other development partners.
3. Effective and Sustainable: Health partnerships operate in a way that delivers high-quality, measurable projects which meet targets and achieve long-term results.
4. Respectful and Reciprocal: Health partnerships plan, implement and learn together, listening to one another with respect and dignity.
5. Organised and Accountable: Health partnerships are well-structured, well-managed and efficient and have clear and transparent decision-making processes.
6. Responsible: Health partnerships conduct their activities in a reliable way and cultivate trust in their interactions with stakeholders.
7. Flexible, Resourceful and Innovative: Health partnerships proactively adapt and respond to altered circumstances and embrace change.

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<sup>13</sup> <https://www.thet.org/principles-of-partnership/>.

8. Committed to Joint Learning: Health partnerships monitor, evaluate and reflect on their activities and results, articulate lessons learned and share knowledge with others.

These principles guide the work of THET and encompass DFID's vision of strengthening partnerships and addressing knowledge gaps through shared learning. This vision is also reflected in THET funded projects in LMICs.

A recent grant proposal review by THET (consisting of 54 successful project proposals for health partnerships funded by THET in 2012–2013) found that half of the partnerships planned to have their highest level of focus at an individual level and half at an organisational level. Furthermore, the review showed all the 54 (100 %) of the partnerships planned to deliver training (generic and specialist skills) and just over half (56 %) aimed to strengthen local capacity while at the same providing training in priority areas (Edwards et al., 2015). The principles guiding the work of THET are intended to create an understanding of the working style, approaches and methods taken by THET in country and give an understanding of their management style. They also allow prospective agencies and volunteers understand how their work (i.e. volunteer placements) will be managed by THET, and what types of relationships or adjustment there may be within the organisational structure. The SVP draws on the aims and objectives outlined by both DFID and THET. In addition, it has its own vision and set of goals outlined in 1.4.2. More specifically, it utilises the principle of 'co-presence' to achieve these goals and objectives. The concept of co-presence is drawn from migration research to explore the role of skilled migrants within concepts of knowledge transfer (Williams, 2006). Professor Louise Ackers (Coordinator of the SVP) adapted this concept in the context of international voluntarism. Co-presence is hereby conceptualised as the practice of working together to share knowledge and is based on a recognition that learning is a two-way process (Ackers, 2014). Over the years, and working closely with Ugandan hosts, the SVP utilised co-presence not only a means to prevent lone working among volunteers, but also as a way of promoting interactive and sustainable relationships between SVP volunteers and their Ugandan hosts.



## **2.7 How does voluntarism benefit its stakeholders?**

A popular imaginary amongst volunteer practitioners, policy makers, and researchers is that voluntarism empowers individuals, encourages civic participation, and enhances social cohesion (Devereux, 2008). This view, however, is widely contested with some observers citing the self-serving motivations of volunteers (e.g. Cannon et al., 2005; Simpson, 2004). In an article, Rachel Mendelson (2008) asks, “is volunteering about saving the world or enhancing a résumé?” This is inherently a difficult question to answer.

There are lots of ‘ifs’ and ‘buts’ when answering this question. It is important to approach this from a whole life perspective, and from the point of view of stakeholders including the volunteers and their hosts.

### **2.7.1 Benefits for volunteers**

The benefits of volunteering to individual volunteers who choose to embark on an international voluntary placement are emerging as a popular research topic as the field continues to grow (e.g. Pastran, 2014; Jones et al., 2013; Baillie Smith et al., 2011). Evidence suggests the practice of voluntarism generates a number of diverse benefits for volunteers including greater participation in the community (Salamon et al., 1999); establishing new social ties (Arai, 2000); learning about diversity and tolerance (Brown, 1999); greater appreciation for civic affairs (Davis Smith, 1999; Arai, 2000); a ‘rite of passage’ generating critical (often essential) mobility/career capital (Ackers et al., 2017); social capital (McBride, Lough and Sherraden, 2012); cultural competency (Thompson, Boore, and Deeny, 2000); and awareness of global inequalities (DeCamp, 2007). Further benefits for volunteers are identified through the concept of ‘frugal innovation’ or ‘reverse innovation’ (Syed et al., 2013). Research suggests that there are multiple opportunities to learn from LMICs and LICs, for example around improved surgical procedures (e.g. Abeygunasekera, 2004), and improved skill mix with scaled use of community health workers (e.g. Kumar et al., 2008). Evidence of frugal innovation is cited in studies that explored the benefits of overseas placements for the NHS. Hague, Sills and Thomson (2015) conducted a study aimed at assessing the benefits NHS volunteers gained from overseas placements.

Building on Longstaff's (2012) toolkit for collecting evidence of knowledge and skills gained through global health volunteering, volunteers reported gaining competence in several areas of the NHS' Knowledge and Skills Framework (KSF). These included KSF competencies in communication, equality, diversity, capacity and capability, supporting findings of previous health partnerships evaluation (e.g. Longstaff, 2012). Furthermore, the volunteers reported gaining a greater confidence to adapt practice and consider resource utilisation in their NHS roles (Hague et al., 2015). Similarly, a systematic review by Jones et al. (2013) of the current research concerning international volunteering and its benefits to individuals highlighted similar outcomes. The authors used the KSF to map the benefits volunteers reported while on international placement to provide a framework indicating key outcomes of the volunteer experience. The review found 40 individual benefits to volunteers; examples of which included "*clinical skills, management skills, communication and team work, patient experience, dignity, policy, academic skills and personal satisfaction and interest*" (Jones et al., 2013, p.5). The benefits identified by Jones and colleagues (2013) correspond with emerging themes in the SVP evaluation reports (e.g. Ackers et al., 2014), which highlight diverse skills volunteers gained following their placements in Uganda. In addition to clinical skills – complex cases, exposure to diseases that are less common but present in the UK; hands-on exposure to cases that emerge in LICs due to extensive delays which NHS staff often have theoretical or limited practical exposure to are cited as key benefits of volunteering for NHS staff. Further, the All Party Parliamentary Group (APPG) on Global Health 'Improving Health at Home and Abroad' (Crisp and Hillier, 2013, p.11-13) identified three key benefits NHS staff can gain from volunteering abroad:

1. Leadership development. Working in LMICs and LICs presents an opportunity to develop leadership and management skills of NHS staff – central tenets of the Health and Social Care Act 2012.
2. Sharing innovation: It is widely acknowledged that international volunteering brings NHS staff into first-hand contact with professionals and settings across the world with novel approaches to healthcare delivery.

The report saw innovation as "the only way" to meet the current challenges of exponentially rising demand and constrained resources. This was echoed at

the King's Fund by the originator of the term 'reverse innovation', Professor Chris Trimble<sup>14</sup>.

### 3. International relationships:

*“Many individual organisations running overseas schemes noted the contribution it made to their reputation. Developing an international presence was something of a growing trend within the UK health sector, as this opened up new opportunities domestically and overseas.”* (p.13).

Similar impacts on hosts is hard to come by. However, there are a few studies that examined host impacts of voluntarism which are outlined next.

#### 2.7.2 Benefits for Hosts

Literature on the benefits of voluntarism from the perspectives of hosts is very limited (e.g. Lasker, 2016). However, there are a handful of field studies that purposefully explored the benefits of volunteering for hosts in LMICs and LICs. These studies indicate that international volunteering has the potential for positive impacts for all stakeholders (Graham et al., 2011). For example, Comhlámh's 2006 study showed host organisations in India and Tanzania associated volunteers with skill sharing and improved cultural awareness. Similar findings emerged from Tanzania and Mozambique. Graham and colleagues found that host organisations in both countries stated that international volunteers were able to view their programmes and settings with 'fresh' eyes and were able to produce technical and cultural innovation. One Mozambican host organisation cited in Graham et al.'s study stated:

*“An international volunteer brings innovation/innovative thinking and different experiences of dealing with problems. They can contribute to the improvement of certain activities that the organisation is implementing. If there is a doubt, quickly there is an exchange of ideas and things move forward.”* (2011, p. 13).

Furthermore, Laleman and colleagues (2007) conducted a study among 'African health managers' in several Sub-Saharan African countries including Uganda, the context of this study. The study explored the contributions of international volunteers placed in health systems in sub-Saharan Africa. Positive outcomes reported by African health managers included innovation and management, knowledge exchange (particularly via highly-skilled volunteers), and improved health system learning.

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<sup>14</sup> <http://www.kingsfund.org.uk/time-to-think-differently/audio-video/chris-trimble-reverse-innovation-improve-future-health>.

The African managers also suggested that foreign health volunteers facilitated international exposure, solidarity and networking. However, the authors cautioned that such benefits were limited to highly-skilled volunteers and, those with longer-term service commitments who were perceived as *“fitting well within and strengthening existing structures and having more appropriate qualifications.”* (p.8). More recently, research showed benefits to host communities manifest through advocacy and international networking. A survey of around 1,750 international volunteers undertaken by VOSESA showed that returned volunteers reported maintaining close contact with their placement hosts and international development more generally. The returned volunteers also reported linking their placement hosts with international partners, and providing resources to them directly to support their work (Perold et al., 2011).

## **2.8 Towards a Social Justice Approach to Development**

People of the global South including those who host global North volunteers continue to face challenges of varying degrees and intensities (Palacios, 2010). Global efforts to ease some of these challenges have not been successful at closing achievement and opportunity gaps for the world’s poor (Moyo, 2009; Arndt, 2000). Furthermore, a rich body of research demonstrates that people in LICs more generally are impacted by numerous social, and environmental factors, and that the current foreign development strategies do not adequately attend to the complex issues they experience daily (Sen, 2010). Some of these issues relate to resources (both human and material); others relate to conditions outside their control that affect their growth or development (Simpson, 2004). In recent years, numerous policies have been proposed to address the global inequalities that exist, but systemic injustices and barriers remain major impediments to these efforts (Framer, 2003). One of the many reasons provided for this is that there appears to be a disproportionate emphasis on improving the knowledge base in global South spaces and people through interventions diagnosed from the global North (Gronemeyer, 2010). These interventions manifest in several ways including the deployment of global North volunteers with a view to facilitating learning in global South spaces (e.g. Gedde et al., 2011). The emphasis is put on scaffolding individuals from dire situation to a more desirable social position (Wright, 2013), an emphasis on the ‘here’ and the ‘now’ and a world divorced from its past (Farmer, 2003).

More recently, however, questions of whether emphasis on learning alone can lead to sustainable change are being asked, and some have called for paying more attention to structural challenges that exist in global South spaces and its people (Loiseau et al., 2016, p.5). These calls and many others suggest ‘a get back to the basics approach’ and proposed a holistic and a more sustainable intervention in global South spaces, and from the point of view of social justice (Farmer, 2003).

#### 2.8.1 Social Justice – what is it?

Zalaquett, (2011) views social justice as a pathway to recognising ‘human rights’, ‘respect’, and a ‘just world’. Bell (1997, p.3) sees social justice as *“the full and equal participation of groups in society that is mutually shaped to meet their needs”* Merret (2004) conceptualises the term as a vehicle to address unequal access to resources, and work towards equal opportunity in societies.

A review of development literature highlighted that development practitioners view social justice as the ‘ultimate goal’ of their work (Jiranek et al., 2013). Yet social justice is rarely applied as a theory underpinning overseas development programmes such as volunteering. The act of volunteering cannot be considered content – free or context – free as it embodies one’s world views or cultures. A social justice theory to understanding volunteering shifts the focus from the act of volunteering itself to the spaces and communities in which it unfolds. In development discourses, the conceptualisation of social [in]justice can be located in the accounts of Amartya Sen that development requires justice – drawing attention not only to the relationship between justice and development, but also economics and ethics (Sen, 1987). Sen recognises complex factors affecting development including the demographics of development practitioners, histories, and cultures that exist within the spaces and communities in which they operate. The notion of [in] justice as a way of understanding social justice is also reflected in the work of Nancy Fraser. She distinguishes between socio–economic injustice (maldistribution), and cultural injustice (misrecognition), and suggests that the two are inherently intertwined. The former implies unequal power relations of the economic order and includes elements of exploitation, marginalisation, and deprivation (Fraser, 1997, p.13).

Evidence of socio-economic injustice in volunteering relationships, and a general lack of conscious recognition by volunteers of structural inequities and power imbalances between them and their host communities are noted, and scholars question whether meaningful development can be achieved without closer look at these inherent injustices (Gronemeyer, 2010; Palacios, 2010; Simpson, 2004). Further, recent evidence identified various ways that neoliberalism – an economic worldview focusing on global market efficiency is shaping international development programmes. Volunteering, in this regard, is increasingly being promoted to employers as an effective conduit to realising transnational professional development through which volunteers can improve their skills – gaining an experience in a different context (Schultz and Kelly 2007). In the UK, for example, demand for marketable skills and “*global citizenship*” in volunteers have been linked with an increase in short-term placements in the global South, often creating more problems than they solve (Lough, 2014). Baillie Smith and Laurie (2011) suggest that the increased focus on short-term youth volunteering “*presents an uncomfortable connection with colonial and development histories where the global South is a vehicle for the realisation of UK domestic and other policy needs.*” Griffiths (2014) acknowledges the power dynamics in volunteering relationships but argues that the affective and emotional experiences of volunteers can also be framed by “*...rich intersubjectivities that cannot ... be easily attributed to processes of neoliberalisation*” (p. 1). Simpson (2004) suggests economic and power inequalities produce a “*geography... that perpetuates a simplistic ideal of development*”, and in which “*...poverty is allowed to become a definer of difference ... rather than actively interacted with*” (p. 688). Drawing on faith-based volunteering in South America contexts, Baillie Smith et al. (2013, p.130) found: “*... issues of intercultural communication, language and identity are absent, as is consideration of the unequal power relations inherent in her [the volunteer’s] capacity to move in and out of “their” social and cultural spaces as they are unable to move into hers*”.

Cultural injustice, on the other, is rooted in social patterns of representation and include cultural domination (imposition of alien culture or intervention); misrecognition (invisibility in social discourses); and disrespect (subjection to negative cultural stereotypes) (Fraser, 1997, p.14). Recent evidence in the field sheds some light onto such injustice.

Kristina Diprose (2012) suggests that international volunteering can reinforce global South stereotypes and argues that increasing emphasis on volunteer development and awareness-raising in the global South underscore structural injustices and may reinforce Eurocentric attitudes and cultural domination. International voluntarism is a diverse topic, and has a wide-ranging scope or focus, but there is too often a *“lack of critical engagement with the processes through which international volunteering is produced, particularly as this connects with broader debates around neoliberalism”* (Baillie Smith and Laurie, 2011, p.548).

Amin, Massey, and Thrift (2003, p.18) draw attention to the interplay between economy and culture and refer to *“the processes of social and cultural relations that go to make up what we conventionally term the economic”* Dipesh Chakrabarty concurs with the economy-culture dynamic but critiques the ways in which particular Western conceptions of economy become universalised, crowding out alternative models of economic development despite the fact that these have often been more successful than neoliberal models in other parts of the world (Pollard, McEwan and Hughes, 2011).

Patricia Noxolo continues the economy-culture dynamic and brings to light the complex ‘moral economies’ of development volunteering. She notes two contrasting kinds of moral economy – gifting and professionalism – are shown to be part of the relationships of postcolonial responsibility bound up in transnational development volunteering. Parvati Raghuram (2009, p.29) argues that moral economy of transnational professionalism redefines professional skills from that which can be owned and ‘gifted’ by and to particular nations to the distributed product of diverse transnational interactions. While the moral economy of development volunteering as transnational professionalism allows volunteers to frame their mobility as professional development, the ‘moral economy of development volunteering’ as ‘gifting’ remains anchored in the assumption in which generous Northerners is contrasted with conspicuously needy Southerners. This in turn contributes to the differential valuing of labour that underpins the highly uneven global economy in professional mobility (Pollard et al., 2011).

It is suggested that reconciling the economy–culture dynamic is key to realising a socially just world. Several interventions aimed at achieving ‘parity of participation’ and social justice are proposed. Much of the existing social justice interventions revolve largely around ‘affirmative’ and ‘transformative’ remedies. The former seeks to redress economic and cultural injustices without upsetting the social structures that created them in the first place. The latter aims to redress economic and cultural injustices by destabilising existing social structures and group identities and differentiations (Fraser, 1997, p.24). Calls for both remedies are increasingly filtering through to development and volunteering discourses. Simpson’s (2004) social justice pedagogy, for example, calls for utilising volunteering as a medium to challenge Eurocentric attitudes and question the assumptions of modernism so often presented as a tenet in development policy; Gronemeyer’s (2010) ‘voiceless others’ emphasises the need to ensure local ownership and challenge the underlying social structures that maintain voicelessness and unequal power relations in host settings. These calls and many others highlight the impact of economic and cultural injustices and propose potential remedies for the kinds of achievements likely to be valorised.

While social justice presents an alternative (and more inclusive) medium from which to challenge Eurocentric discourses, and assumptions of economic and cultural modernism, it is fraught with shortcomings.

Most notably Connie North (2006) concludes that the relationship between socio–economic injustice and cultural injustice is multifaceted and dynamic; on the one hand, a focus on socio–economic injustice may disrupt exploitation and marginalisation of communities. On the other hand, a focus on cultural injustice may pay less attention to social systems or structures that create and maintain inequalities in societies (Bourdieu, 1990). Further, Merrett (2004) cites the inherent contradictory definitions of social justice and argues that having the same starting line for all individuals may not practically translate into equal opportunities for those who are already disadvantaged. This critique resonates with North–South health partnerships where equal footing is implied despite the inherent power and economic disparities (Abrahamsen, 2004), and post–colonial interdependence between North and South partners (Kothari, 2006).



Despite these shortcomings of social justice, the study draws theoretical groundings from social justice perspective and how it translates practically as an approach to understanding Ugandan voices and experiences. International volunteering programmes traditionally privilege socio-economic injustice (the mobility of volunteers from the global North to the global South), and recent calls have highlighted marginalisation and exploitation in host spaces by some volunteering programmes, and the need to address these injustices (e.g. Pastran, 2014; Gronemeyer, 2010; Palacios, 2010). The social justice perspective also addresses the cultural realm, and the assertion that cultural injustice is distinct from but may mutually reinforce economic injustice (and vice versa). This focus is necessary because international volunteers are historically from the global North and are predominantly white, and geography and racial injustices have become significantly embedded in how the 'West' encounter 'other' cultures (Pollard et al., 2011). Further, it allows discursive lenses, and a potential sphere of intervention from which host experiences of volunteering may be contextualised and understood.

## **2.9 Chapter Conclusion**

The narrative literature review strategy adopted for this study has provided a comprehensive background of the existing literature of the field. More specifically, it has identified six key areas of the field relevant to this study. The first two key questions have explored host perceptions of volunteers and their motivations to engage with them. It appeared that host perceptions of volunteers revolve around perceptions of race, and resources which themselves are underpinned by history, culture, and North–South colonial and post-colonial interactions. The third question has examined development and provided theoretical backgrounds to establish its evolution from ‘paternalistic’ to ‘participatory’. This theme has also highlighted how this conceptual shift in development thinking has led to the rise of a ‘new’ form of development concept that emphasises on strengthening systems and addressing knowledge gaps in LMICs and LICs. The fourth key question has explored the relationship between voluntarism and development, and how international volunteers are gaining a ‘new’ profile as development actors in the global South. The fifth key area has examined the benefits participating in voluntarism have for stakeholders (i.e. volunteers and hosts). Benefits for volunteers appeared well documented and included mobility and social capital, civic participation, and cultural awareness. Benefits for hosts were discussed in the broader scope of technical innovation and improved system learning. Finally, the chapter has explored social justice approach to voluntarism and discussed how current studies of the field focus on capturing the ‘present’ and working towards reciprocity and mutuality without paying much attention to historical injustices that shape relationships between volunteers and their hosts. The next chapter discusses the research design adopted for this study.

## **Chapter Three: Research Design**

### **3.1 The Introduction**

This chapter provides an overview of the research design adopted for this study. It begins with 'finding the field', a reflection of how I came to undertake this study. This is followed by researching the social world and its complexities including a note on research paradigms. The chapter then outlines the philosophy of the study and delineates its scope. It further explores exploratory research strategies and identifies the appropriate methodology adopted to achieve the overall aim and objectives of this study. Finally, the chapter concludes with a discussion on the importance of reflexivity including an acknowledgement of the researcher's positionality as well as being transparent about the decisions made throughout the research design.

### **3.2 Finding the Field: A Brief Reflection**

In locating myself in this study, it is important to be transparent about the assumptions that I brought to it. On reflection, these assumptions have been an asset, not because they have been validated, but because they shed some light on the divergences between them, the literature, and data. These divergences demanded that I reconstruct, and to some extent, abandon my initial ideas and embrace the constructed and embodied dimensions of social research. Asking questions about how researchers find their fields is important for both practical and ethical reasons. The characteristics that researchers share with the field and/or with its people can be assets particularly in relation to access, but they can also be potential pitfalls from an ethical point of view. My research, more broadly, touched on international voluntarism and development, and in African spaces, topics and geographies of which I had first-hand experience. The following short exegesis is my story, my journey to finding the field.

For nearly six years before beginning my PhD, I worked as 'development' officer for a NGO in Somalia and the Gambia; and as a teacher in Special Education Needs (SEN) in the UK for periods of between three months and five years. While my work experiences can be categorised broadly into development and education or simply development (since both NGOs and schools, to some extent, claim to develop the masses), they are ultimately all embodied in me, shaping my understanding of the nature of reality in the social world.

It is beyond the scope of this reflection to provide detailed narratives of my work experiences; rather I draw out some key markers which informed this study. For one thing, this account itself, was influenced by knowledge gained during my PhD in the sense that I acquired a set of terminologies to locate it, and quite a number of theories to explain it. I should, however, point out here that while I had some ideas about international voluntarism and development more generally, my understanding of the field and its complexity emerged largely during this study.

The first point is that for many years, I lived and worked with communities who were and had been passive recipients of AID by NGOs and their volunteers; and who, in my view, did not seem to mind a great deal. This experience, to some extent, normalised the work of NGOs and their volunteers for me to the extent that I felt they were making a difference, although later in the Gambia, I developed some reservations. Surprisingly however, and whilst being fairly crude in some ways, my earlier experience of NGOs and their actors (including volunteers) was not reflected in the literature on international development and voluntarism that I encountered subsequently<sup>15</sup>.

A second point is that many NGOs in Southern Somalia, at the time, rarely employed local people. My appointment by one NGO as a development officer was borne out of sheer luck, one that was facilitated by my earlier contacts with this NGO as a multilingual interpreter. It was also prompted by a need for a 'native' to advise on local political and security situation. The problem, however, was that I was not a native as such. I hailed from a family, and community on the periphery of Somali clan structures who did not have much prominence in Southern Somalia, and Somali politics more generally. To this end, therefore, I was less 'effective' in the 'development officer' role, although I excelled in the less political aspects of it such as conducting needs assessment with members of local communities. From a survival point of view, and in an environment with very few job opportunities, my role with this NGO helped put food on the table, perhaps at the expense of my freedom.

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<sup>15</sup> Most global North NGOs and their volunteers present their work as 'participatory' taking into considerations the developmental needs of communities they serve. In reality, however, priorities, and aspirations of local communities are diagnosed from the outside, and by NGOs and their volunteers with little knowledge of their contexts (Gronemeyer, 2010).

For a period of three months, I lived with foreign staff in a highly fortified compound, guarded by local militias remunerated by this NGO. While I understood the need to protect NGO staff (both local and international), I did not understand the need to detach from local communities.

A final point is that these experiences converged when I and some members of my Somalia team were transferred to the Gambia, where we joined a group of engineers, development officers as well as ‘volunteers’<sup>16</sup> based in Keneba, Kiang region of the country. Keneba has one of highest rainfalls in the country, a mixed blessing for local farming communities. The rains bring life (through increased food production), illnesses (mainly through water-borne diseases), and western researchers who are interested in studying this phenomenon<sup>17</sup>. We joined ‘water for life’ project which, at the outset, seemed rather misplaced idea in an environment that receives one of the highest rainfalls in West Africa. In reality, however, the project was much broader than building wells, aspects of it included a water purification campaign that never materialised, at least during my stay at Kaneba. The main challenge was that we did not have local partners or ‘connections’ as the Gambians liked to call it. None of us knew the area well or spoke any of the local languages. Even more bizarrely, we lived in an exclusively ‘European’ compound in a hill overlooking residents, and similar to the Somalia experience, we were totally detached.

Taken together, my NGO experience, in the context of Africa, highlight the ‘foreign’ led practices of NGOs and the exclusion of local ‘knowledgeable’ people from co-delivering projects that affect their lives. I recognised a need to reach out to these people and bring forth their voices and experiences. My interest in applying for a PhD in this field was partly to explore what development workers (volunteers in the context of this study) do in LICs and how they are perceived by communities that host them. It was also to understand theoretical underpinnings that inform their engagements and operational styles and what roles (if any) local people play.

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<sup>16</sup> The volunteers I met at Kaneba in the Gambia were UK medical professionals with backgrounds in tropical medicine and communicable diseases.

<sup>17</sup> For over 60 years, the London School of Hygiene and Tropical Medicine (LSHTM) field stations in Kaneba and nearby villages have carried out vital research on water-borne diseases while at the same time providing medical care for the local population.

The SVP provided me a platform to realise some of these goals, and from distinctively Ugandan perspectives.

### **3.3 Social World Research: A Messy Affair**

Research concerns an investigation or an inquiry that involves data collection, analysis and dissemination to contribute to a topic, field or knowledge more generally (Mertens, 2002). Attempts to define research are increasingly confronted by its diversity and messiness particularly in the social world (O’Leary, 2004). Social science is often presented as a scientific inquiry, a claim that embodies a set of beliefs and ideas about ‘ontology’ – “...*the study of being*” (Crotty, 1998, p. 10), or “*nature of reality*” (Lincoln and Guba, 1985, p. 37). Yet, this claim to science informs knowledge and the relationship between ‘knower’ and the ‘known’ (epistemology), the values of knowledge (axiology), and determines how knowledge is gathered and interpreted (Lincoln et al., 1985). Depending on researchers’ assumptions about social reality, ontology, epistemology, axiology and methodology inform each other, shaping the research design, and the position of the researcher. The particular position a researcher adopts in relation to each of these constitutes research paradigm (Lincoln et al., 1985).

#### **3.3.1 Research Paradigms**

A fundamental characteristic of paradigms is that they embody subjective ideas, constructions, and interpretations (Creswell, 2009; Bryman, 2004). Paradigms are better understood not as radical postures that demand proof, but as markers and frameworks that inform the research process (Morgan, 2007; Denzin and Lincoln, 2005). Paradigms in social research are multiple and varied, not all of which are relevant to this study, and some of which have been disregarded. A common problem in mapping paradigms is that researchers tend to deploy different terminologies to refer to the same philosophical position or the same terminologies to refer to different philosophical position. Some even ‘remodel’ concepts of existing terminologies or philosophical position to create new ones. Using Grounded Theory (GT) and its permeations which are discussed in 3.6 and 3.7) as a reference, Mills, Bonner, and Francis (2006) brought forward what they described as conceptual or methodological ‘spiral’.

In a nutshell, this concept explains the practice by researchers to move or position their core concepts to either sides of the spiral to produce new concepts (models) that retain some of the features of the core concept but nonetheless 'new' or 'different'. The confusions over paradigm terminologies nonetheless are not a new phenomenon. Lofland and Lofland were among many who observed the 'paradigm revolution' and the 'ambiguities' in their labels.

*“Social science is a terminological jungle where many labels compete, and no single label has been able to command the particular domain before us. Often...researchers simply ‘do it’ without worrying about giving ‘it’ a name.”* (1984, p.3).

This notion of 'simply doing it' shows the lack of consensus on when, and how philosophical and theoretical assumptions can be introduced into the research process or framework. Saunders Lewis, and Thornhill (2007) for example, combine philosophical and theoretical assumptions in the form of an 'onion' in which the peripheral layers (philosophy) inform the core layers (research strategies). More broadly, however, paradigms can be mapped according to the ways in which multiple and varied philosophical and theoretical assumptions inform each other (Kaglioglou et al; 1998). Michael Crotty suggests social researchers should adopt a logical and coherent strategy (i.e. methodology) capable of achieving the research objectives. Such strategy takes researchers into the realm of assumptions about reality they bring to their work. For Crotty, to ask about these assumptions is to ask about what knowledge is; what kind (s) of knowledge is out there; and what can be known about it – these are *“epistemological questions”* (1998, p.2).

At issue in these assumptions, are three basic elements (epistemology, ontology, and methodology) of research design and processes. In social research texts, much of the discussion on terminologies relate in one way or another to these three elements (Crotty, 1998). However, it is not uncommon to find different terminologies *‘thrown together in grab-bag style as if they were all comparable terms’* (Crotty, 1998, P.3)<sup>18</sup>.

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<sup>18</sup> While this claim is valid as observed in most social science research texts (e.g. Crewel, 2003), Crotty (1998) himself conflates 'ontology' with 'epistemology' arguing that the two are conceptually linked *“...to talk about the construction of meaning (epistemology) is to talk of the construction of a meaningful reality.”* (p.10).

For example, in some texts, GT and constructionism approaches are simply 'lumped' together as 'methodologies' and discussed alongside each other as if they are comparable terms. After all, GT is a *methodology*, a strategy that provides a rationale for the choice of methods and the contexts it is used. Constructionism, for its part, is an *epistemological perspective*, a philosophical stance that energises and informs the chosen methodology, providing assumptions about reality that grounds researchers' work (Crotty, 1998). With these confusions in mind, and without being too rigid about terminologies, the views, beliefs and experiences of Ugandan health workers hosting volunteers were explored by following the research string of epistemology (constructionism) – methodology (constructivist GT) – methods (observational research, focus group discussion, and interviews). The choice and the justifications behind the selection of constructionism and constructivist GT is discussed in detail in the following sections. The 'methods' of data collection and analysis are discussed in detail in chapter 4.

### **3.4 A Constructionist Approach to Social Research**

The worldview of constructionism holds that reality is a social construct which may not be understood when divorced from its context (Crotty, 1998). Constructionism is a broad and diverse school of thought, belonging to 'no one and to everyone'<sup>19</sup>. Shadish (1995, p.67) indicated that social constructionism refers to "*constructing knowledge about reality, not constructing reality itself*". This worldview rests on the notion that both the knower and the known are active participants in the creation of the meaning (Crotty, 1998; Guba and Lincoln, 1998). The underlying assumption that people tend to ascribe different meanings even when observing the same phenomenon informs much of constructionism as a "*perspective that emphasises how different stakeholders in social settings construct their beliefs*" (Schutt, 2006, p.44). The term 'constructionism' is often interchanged with constructivism, creating confusions that cannot be unravelled in the scope of this study.

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<sup>19</sup> According to Lynch (2001) the term constructionism has come to virtually mean both 'everything' and 'nothing' at the same time, it is too diverse and diffuse to define, let alone define.



To give a broader view, however, it becomes evident that some researchers use “constructivism” in generic or undifferentiated synonyms, undeterred by ontological and epistemological issues (e.g. Lynch, 1998); others use ‘constructivist’ as an adjective for both constructivism and constructionism (e.g. Creswell, 2009)<sup>20</sup>. Thus, confusions may exist because there is a ‘family resemblance’ between the two perspectives. Burr (2003) contends that both constructivism and social constructionism may in fact belong to the same extended family.

My view of constructionism is based on the assumption that social inquiry is a constructive process and the knower of such inquiry is at the heart of this process. In other words, the world and its people are indeterminate “...*they may be pregnant with potential meaning, but actual meaning only emerges when consciousness engages with them*” (Crotty 1998, p.43). There are several overviews of constructionism, but all have a family resemblance (see Burr, 2003). In this study, I draw on the work of Berger and Luckmann (1966), Burr (2003) and other writers at the heart of the tradition of ‘social constructionism’. As described in Berger et al.’s (1966) ‘The Social Construction of Reality’, social constructionism holds that people seek to draw out an understanding of the social world around, and in doing so, construct subjective meanings of their experiences (Lincoln, Lynham, and Guba, 2011; Crotty 1998). Since such meanings tend to be diverse, multiple, and contextual, constructionism suggests that social inquirers (knowers or researchers) not only acknowledge such diversity and complexity, but also embrace them, and tell the whole story (Crotty 1998). In other words, the goal is to interpret the meanings people ascribe to their experiences of the social world rather than narrowing such meanings to a few measurable outcomes (Crotty 1998). The underpinning features of constructionism are: Ontologically, a relativist where truth, rather than being absolute, consists of multiple realities constructed by individuals in a specific context<sup>21</sup>.

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<sup>20</sup> In order to avoid further ‘confusions’ about terminologies and in line with Gergen’s (1987) recommendations, the term ‘constructionist’ is used throughout this thesis.

<sup>21</sup> The relativist features of constructionism are often contrasted with realism which erroneously confounds epistemology with ontology. According to Crotty (1998), critical researchers draw on ‘extreme’ versions of ‘relativism’ and argue that ‘real world’ exists, one that contains, for example, poverty, marginalisation and other aspects of material existence – we can neutralise this argument by taking a position that *‘to say reality is socially constructed is not to say that it is not real...constructionism in epistemology is perfectly compatible with realism in ontology’* (p.63).

In view of this study, which explores Ugandans' experiences of engaging with volunteers, I consequently encountered how different Ugandans engaging with the same volunteers construct different realities (or meanings) about volunteers, their arrivals in Ugandan public health facilities, and offerings more generally.

Epistemologically, the view that:

*"...all knowledge, and therefore all meaningful realities as such are contingent upon human practices, being constructed in and out of interaction between human beings and their world, developed and transmitted within an essentially social context"* (Crotty, 1998, p. 42-3).

Simply put, knowledge emerges from the dynamic interaction and interpretations between the knower and the known. I adopted the constructionist perspective to explore how perceptions, motivations, benefits and barriers relating to volunteer engagement are constructed within a specific Ugandan context. For example, in view of Ugandans hosting volunteers, their stories, and experiences that are subject to my interpretation as a researcher, have to take into account their personal circumstances when exploring what engaging with a particular volunteer at specific time was like for the individual. Creswell (2009) suggests that meanings are created through interaction with others and through the historical and cultural parameters that exist in the social world. Thus, the emphasis is on exploring interaction among individuals relative to their contexts (Creswell 2013). Once again, such view parallels the scope of this study which explores Ugandans' experiences of engaging with volunteers from a whole life perspective – including how historical factors (i.e. colonial legacy), NGO cultures, and prevailing volunteering styles shape local constructions of volunteers, and Westerners more generally.

In order to uncover 'whole life' perspectives, Denzin et al. (2005) suggest a relational methodology that embraces interaction between the knower and the known. The following section outlines the methodology adopted for this study.

### **3.5 Choosing a Methodology**

*"Those who read or listen to our stories see everything as through a lens. This lens is the secret of narration, and it is ground anew in every story, ground between the temporal and the timeless. If we storytellers are Death's Secretaries, we are so because, in our brief mortal lives, we are grinders of those lenses."* John Berger 'and our faces, my heart, brief as photos' (1984).

Social researchers seek to expand or discover a social phenomenon through the lenses of those who live in it (Creswell, 2009). In order to achieve this, researchers need research designs, or methodologies to help them navigate through the social world and to understand meanings or reflections behind social relations (Bryman, 2004).

Crotty defines research methodology as *“the strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes”* (1998, p.3). A qualitative methodology was adopted for this study. Creswell (1998, p.15) defines this as:

*“...a process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The research builds a complex, holistic picture, analyses words, reports detailed views of informants, and conducts the study in a natural setting.”*

Consistent with the constructionist epistemology underpinning this study, a qualitative approach is used to achieve the research aim and objectives. The following discussion explores this approach in relation to quantitative and mixed method approaches.

### 3.5.1 The Different Approaches

Qualitative approaches are increasingly becoming useful tools of social inquiry (Mack et al., 2005). The purpose is to describe, interpret and understand social phenomena from the perspectives of those who reside in it, and to identify patterns in thoughts, opinions, and experiences of a phenomenon at specific space or time (Bryman, 2004). By contrast, quantitative research is concerned with observable and measurable trends that can be transformed into statistics to support or reject hypotheses, and to uncover statistically significant relationships in data (Antonius, 2003). The application of qualitative and quantitative approaches along with their perceived strengths and weaknesses have been rigorously debated, and these approaches continue to be largely dichotomous (Brown 1996). However, some researchers attempt to reconcile the two approaches to research and suggest mixed methods approach to research (Johnson, Onwuegbuzie, and Turner, 2007; Johnson, and Onwuegbuzie, 2004). Mixed methods allow the use of statistical analysis while at the same time maintaining deeper exploration, accounting for both measurable outputs and lived experiences (Bryman, 2004).

Both qualitative and quantitative research tend to be used in the field of international voluntarism. Traditionally, quantitative approaches in voluntarism research focus on 'measurable' impacts such as number of lives saved, or number of training programmes completed through the act of voluntarism (Lopez Franco, and Shahrokh, 2015). An example of the use of such approach in voluntarism can be found in the work of Benjamin Lough and colleagues. The authors designed the International Volunteer Impacts Survey (IVIS) to measure perceived impacts of international volunteering on students. Although some important findings such as perceived international understanding, intercultural relations, and community engagement were noted, the use of the survey significantly limited the depth and richness of the findings (Lough, McBride, and Sherraden, 2012). The authors acknowledged the need to incorporate open-ended qualitative responses from students to uncover and elucidate some of the limitations of the survey.

A similar approach to researching voluntarism was taken by OmniMed, in collaboration with the Ugandan Ministry of Health, the U.S. Peace Corps, and St. Elizabeth's Medical Centre in Boston, the United States of America (USA). The study utilised a randomised experimental design to examine 'measurable' improvements in the health behaviours of Village Health Teams (VHTs) trained by American volunteers in Mukono District, Uganda (see Sherman and Nichols, 2013). However, unlike Lough et al.'s (2012) survey discussed above, the authors did not acknowledge the potential shortcomings of their survey. Instead, they stressed on the perceived rigour of the tool, stating that it was developed by 'multi-disciplinary' teams and interpreted using the 'Lives Saved Impact Calculator', a DfID promoted impact assessment tool.

Despite the potential limitations highlighted above, quantitative approaches particularly surveys proved useful in accounting for demographic trends of volunteering projects. In particular, their utility to map out the broader impacts of voluntarism has helped challenge assertions that discount the important role voluntarism plays in international development (Sherman et al., 2013).

By contrast, qualitative approaches and their application in voluntarism research have particularly been successful in gaining insights into a wide range of factors such as perceptions, motivations, and benefits associated with voluntarism more generally.

Qualitative approaches are suited to uncovering these factors because participants are given the freedom to tell their stories and share their lived experiences (Bryman, 2004). This utility of qualitative approaches is made additionally relevant to this study by the works of Ackers et al. (2017), Hague et al. (2015), and Tate (2015), which demonstrated the appropriateness and effectiveness of these approaches in exploring voluntarism specifically in the context of Ugandan public health.

As briefly mentioned earlier, some research may be better explored by integrating both qualitative and quantitative approaches. In voluntarism, there is relatively little evidence of cross pollination between the two approaches. One such exception includes the work of Michael Rozier and colleagues. The authors utilised online survey and conducted interviews to compare prevailing practices of volunteer deploying organisations with the preferences of host communities. In this study, mixed methods approach was used as a complimentary design and to provide participants a choice. It is suggested that this combination approach responds to the 'multidimensionality' of human experiences, and aids researchers to adopt an integrated approach to research (Mason, 2006a, p. 11). At the same time, several limitations regarding this approach to research have been highlighted. First and foremost, and notwithstanding discussions presented in 3.3.1, Mason points out potential complications that may arise from a paradigm mismatch which, she argues, may not add up to a neat fit (Mason, 2006). Mason further raises questions about executing research that may not, by design, be in the same wavelength but also cites critical issues such as interdisciplinary backgrounds and resources which can limit a researcher's ability to adopt a combined approach in a meaningful way (Mason 2006).

Having outlined the different approaches to social research along with their key characteristics, strengths, and potential limitations, the following section outlines my journey towards a qualitative methodology.

### 3.5.2 Towards a Qualitative Methodology

As discussed in 3.5, it appears that all research approaches have strengths and limitations, but some are more appropriate in some contexts more than others. Having briefly stated the rationale for choosing a qualitative approach in 3.5, I discuss, in this section, my journey towards identifying the most appropriate qualitative approach to this study.

It is one thing choosing a qualitative approach to research, and another choosing an ‘appropriate’ qualitative approach. Researchers arrive at research methodology from different perspectives. Some align with particular research methodology because it has been ‘proven’ to work in a field; others embark on an exploratory exercise to explore the research context and make an ‘informed’ decision to adopt a particular methodology (Brown, 2006).

As a novice to the research context, and researching a field dominated by ‘commodified’ voluntarism with a focus on ‘quantifiable’ outcomes (Lopez Franco et al., 2015; Pinto, 2010), I sought to arrive at an ‘informed’ methodology through exploration – namely, a scoping visit to Uganda. Brown (2006) argues research exploration involves “*entry into unknown territory*” (p.9), to uncover what is out there and what appropriate tools to use. Consistently, this study sought to explore what it is like for Ugandan health workers to be working with volunteers and what meanings this experience has for Ugandans thus placing the researcher in the role of the explorer who sets out to discover. In respect to entering unknown territory, one important utility of exploratory research lies in its detachment from predefined research strategies or methodologies (Brown, 2006). As a consequence, the researcher is required to maintain an open–mind and flexibility to immerse himself/herself in the research context and make use of appropriate methods of gathering information available. This was the case in the scoping phase of this study where research exploration in five Ugandan public health facilities was achieved with very little prior knowledge and without subscribing to research assumptions and methodologies or methods in any dogmatic ways<sup>22</sup>. The scoping phase was conducted early on in my PhD journey, and with minimal allegiance to ‘established’ research methodologies. In fact, it was a time when I moved from deductive to inductive research and had very limited knowledge of qualitative research methodologies. The aim of the scoping phase was to gain a general overview of Ugandans hosting volunteers without being purist in any methodological sense.

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<sup>22</sup> Whilst the scoping phase fit in the notion of research as an exploration, it was more of a qualitative exercise than a quantitative one.

Thorne (1997b) notes the notion of viewing research as an exploration exercise, a 'free for all' context immersion, is particularly attractive to novice qualitative researchers such as myself because such approaches are not always an end themselves. Some are a part of a wider research process or analysis, which are developed further using appropriate research methodologies depending on the research contexts. In fact, Mason (2007) warns against adhering to one particular methodology as a means to claim privileged insights. She suggests that researchers should disrupt the notion of the privilege of the original methodology and allow to be driven by data and abide by it and not methodology or theory.

The exploratory scoping phase of this study provided the 'groundwork' for the research process from which a follow-up phase of this study was conducted. In the light of the emergent data and lessons learned from the scoping phase, and from the literature, it became evident that the follow-up phase of this study should adopt a research methodology that is responsive to:

- a. Historical, cultural and situational underpinnings of voluntarism, and the various interpretations and meanings it has for Ugandans.
- b. Ontological and epistemological underpinnings of this study which relate to the existence of 'multiple' perceptions, views, and experiences of voluntarism which are themselves constructed realities of the knower (I, the researcher), and the known (Ugandans).

This way of conceptualising exploration as a research process bears the traditions of qualitative approach, and more specifically, grounded theory.

### **3.6 The Chosen Methodology – Grounded Theory**

First proposed by Glaser and Strauss (1967), Grounded theory (GT) involves "*the discovery of theory from data*" (p.1). Underpinning the traditions of GT are the assumptions that a researcher enters a setting without a preconceived theory and develops a new 'theory' from the emergent data (Cutcliffe, 2000). Strauss and Corbin (1990) outline this position:

*"One does not begin with a theory, and then prove it—rather, one begins with an area of study and what is relevant to that area is allowed to emerge"* (p.23).

As such, GT tends to be 'exploratory' in nature, suitable for 'uncovering' perceptions and experiences of Ugandans and the role which interaction with 'volunteers' plays in developing 'meanings' (Mills et al., 2006). By its nature, voluntarism is a social process and elements of it are likely to involve social interaction. As outlined in the literature review (chapter 2), volunteering is largely volunteer-centred, and GT presents utility to this study to allow the experiences of Ugandans engaging with volunteers to emerge. GT researchers such as Melanie Birks and Jane Mills recognise a 'varied' application of GT where the ultimate goal is not to generate a theory but rather to provide a "...*description and exploration of phenomena.*" (Birks and Mills, 2015, p.30). The researchers argue that such application of GT is "*legitimate*" and "*encouraged*" but stressed that in order to preserve the credibility of researchers' work, it is important to adequately describe the GT process (p.29). The researchers cited two studies that utilised GT 'techniques'. The first relates to a study by Vågan (2009) which explored Norwegian students' perceptions of identity when learning communication skills; the second relates to a study by Bahora, Sterk and Elifson (2009) which examined recreational ecstasy use in the USA. Birks et al. (2015) report that in both studies, the authors described their methodology as 'modified' GT, "...*with findings presented as themes that provided insight into the phenomena being explored.*" (p.30).

Using the works of Melanie Birks and Jane Mills as a departure point, and the need for a 'robust' methodology informed by the scoping phase of this study, I utilised the *traditions* of GT for two main reasons: firstly, to provide a broader scope in terms of explicating, exploring and explaining the research context; secondly, to gain insights into how volunteers' presence and offerings are perceived by diverse Ugandan workforce working alongside volunteers in Ugandan public health facilities. Finally, Birks et al. (2015), and others (e.g. Charmaz, 2006) recommend researchers adopting GT spell out what GT is (including its various permeations) and provide a rationale for the chosen permeation from ontological and epistemological stance to preserve credibility. In what is to come, I discuss the different permeations of GT and provide rationale for considering 'constructivist GT' for this study.



### **3.7 Versions of Grounded Theory**

Several permutations of GT have evolved over time and as described in 3.3.1, they all exist on a methodological spiral that can be identified depending on researcher's ontological and epistemological positions (Mills et al., 2006). There are, however, a set of common features shared by the different versions of GT: theoretical sensitivity, theoretical sampling, treatment of the literature and identifying core categories for meaning. Others (e.g. diagramming, and measures of rigour) are 'model' specific and appear mainly in the work of Glaser (2001, 2002, 2004) and Strauss et al. (1990, 1994, 1998). As a starting point, I read seminal GT texts, some of which included the original work of Barney Glaser and Anselm Strauss (1967).

I understand that some of the original aims of developing GT included a need to challenge the dominance of the quantitative approaches which posited that qualitative research was less rigorous (Glaser et al., 1967). The rationale was therefore to offer an alternative approach to the prevailing positivist paradigm that emphasised on the gathering of verifiable 'facts' (Mills et al., 2006). One difficulty with this view of knowledge was that such approach to research and knowledge more generally limited the creative approach necessary to discover the theory (Glaser et al., 1967). Glaser is generally recognised as having retained much of the original work involved during the inception of the methodology, which constitutes the 'traditional' approach to GT (Glaser 2001, 2002; Glaser and Holton, 2004). In the following two sections, I will explore the 'traditional' and 'evolved' GT to refer to the work of Glaser and Strauss and Corbin respectively before moving on to 'constructivist' GT, the methodology informing this study.

#### **3.7.1 Traditional Grounded Theory**

Although Glaser's (1978, 1992) GT (or simply Glaserian) shares common characteristics with other versions of GT, it is often criticised for over sensitivity and rigidity in its application. The table below outlines some of the key premises of Glaserian and which have both ontological and epistemological implication for research process.

Table 2. Key premises of Glaserian (1978) grounded theory

Theoretical Sensitivity – remain open: <i>‘as few predetermined ideas as possible’</i> (p.3).
Process of open coding: <i>‘derive or induce logic from data then apply it to data after ideas emerge’</i> (p.11).
Identify a Basic Social Process (BSP) which: <i>‘explains a considerable portion of the action in an area (and) integrative of all the categories needed in a theory’</i> (p.5).

According to Glaser (1978), a researcher enters a setting without preconceived or a *priori* ideas of the topic or the context to be explored: *“the problem emerges, and questions regarding the problem emerge by which to guide the theoretical sampling”* (p.25).

For Glaser (1978), researchers should allow the phenomenon to emerge from the data in order to ensure ‘theoretical sensitivity’ (Glaser, 1978). Applying a Glaserian perspective to the current study would not initially identify ‘interactions’ as a phenomenon of importance; instead one would wait to see what emerges in the data once fieldwork has begun. The second key premise is open coding which Glaser (1978) describes as: *“coding the data in every possible way”* (p.56). The researcher codes different occurrences into categories which may ‘fit’ until theoretical saturation – this allows data to emerge and not force it into predefined categories. Finally, the ‘basic social process’ which explains the key constituents of the theory is identified. The emergent theory should ‘fit’ and ‘work’ providing a relevant account of area of interest (Glaser, 1978).

Although very descriptive and crude in so many ways, my observations of Glaserian GT based on its common characteristics with other version of GT, and also on the above three key premises in particular, I made the decision not to adopt this approach. This decision is made from philosophical and procedural stance. Philosophically, Glaser’s (1978, 1992) approach is arguably positivist in its underpinnings: the researcher adopts a ‘neutral’ stance using a set of procedures to render the data into identifiable knowledge (Charmaz 2000).

Procedurally, whilst Glaser (1978) presents insights into the methods of GT, due to their complexity, these are arguably not easily implemented particularly in cross-cultural contexts. Referring to the complexity relating to Glaser's traditional GT, Charmaz (2000, p.512) wrote: "*the abstract terms and dense writing Glaser employed rendered the book inaccessible to many readers*". Next, I present a consideration of Strauss and Corbin's (1990) version of GT with reference to my work.

### 3.7.2 Evolved Grounded Theory

Distinguishing themselves from Glaserian GT and making a case for what they described as 'evolved' GT, Straus and Corbin (1994) suggested that they had developed a revised and 'improved' version of the 'traditional' GT, (with pragmatist touch), arguing that there is no "*...pre-existing reality' out there to think otherwise is to take a positivistic position that...we reject...our position is that truth is enacted*" (p. 279). This version of GT takes a relativist outlook and diverges from traditional GT arguing that "*...the discovery of truth that emerges from data representative of a 'real reality'*" (Mills et al., 2006, p.27). However, the notion of 'real reality' suggested by Straus et al.'s (1994) work had come under scrutiny brought about in part because the paradigm of thought that underpins their version of GT is not clearly set out in their popular GT texts – Straus et al. (1990, 1998). Evidently, their work draws on a blend of terminologies that embodies aspects of postpositivism and constructivism demonstrated by the use of phrases such 'recognising bias' and 'maintaining objectivity' when referring to the relationships between the knower and the known. Nevertheless, the authors somewhat retracted this position stating, "*we emphasise that it is not possible to be completely free of bias*" (Strauss et. al., 1998, p. 97).

This apparent confusion led some researchers to remark that "*people can find support in it for any ontology that they wish*" (MacDonald and Schreiber, 2001, p. 44). Mills et al. (2006) lend support to Macdonald et al.'s (2001) critique of the evolved GT but nonetheless view its changing positions as evidence of a struggle to move alongside methodological spiral. Such struggle can be observed first, in Strauss and Corbin's recognition of 'multiple views' and in this way "*extended...the range of theoretically sensitising concepts that must be attended to in the analysis of human action/interaction*" (MacDonald, 2001, p. 137); and secondly and unlike traditional GT, their recognition that researchers cannot wholly divorce themselves "*from the*

*accumulations of knowledge and experience which temper understanding, observation, and interpretation”* (Jones and Alony, 2011, p.8).

In addition to the inconsistencies of evolved GT described above, two further features highlighted in Straus et al.'s (1994) evolved GT make it somewhat incompatible with my work. The first lies with the procedural rigour of their work, outlining step by step guide of coding (axial and selective coding in particular) and the complex use of matrices which, according some scholars, amounts to 'massaging' data (e.g. Charmaz, 2006). Glaser himself well known for his use of Constant Data Comparative Coding (CDCC) techniques criticised Straus et al.'s (1994) coding rigour (particularly regarding 'waving the red flag' and 'flip-flop' techniques saying, *'that's all there to it'* – implying that data is 'forced' rather being 'allowed' to emerge (Glaser, 2004, p.43).

The second concerns Strauss et al.'s (1990) ontological position which is not explicitly set out in their text and so moves along the methodological spiral, leaning towards positivism in some texts, and relativism in others (Charmaz 2000). For example, Annells (1996) locates evolved GT in 'neo-positivist' because the researcher must adopt a prescribed number of steps in order to analyse and judge the utility of the findings; Mills et al. (2006) see it as 'relativist pragmatist – pointing to their justification: *"theories are embedded 'in history' – historical epochs, eras and moments are to be taken into account in the creation, judgment, revision and reformulation of theories"* (Strauss et al.,1994, p. 280).

Having set out an overview of traditional and evolved versions of GT in 3.7.1, and 3.7.2 respectively, and after careful consideration of their underlying assumptions (from ontological and epistemological positions), and characteristics of GT, I began to understand not only the difference between the two authors, but also how their permeations differ from my work. In identifying my position, I considered Charmaz's (2006) 'constructivist' GT, and her claim to what she felt were limitations of the original approach and improvement on the traditional (Glaserian) approach to GT. In making such consideration, I intended to use constructivist GT in non-dogmatic manner and as a 'guide' rather than a 'prescription' to position my research methodology.

### 3.7.3 Constructivist Grounded Theory

As aforementioned, one has to be careful not to fall into terminological jungle, particularly when manoeuvring around the ‘constructionist’, ‘constructivist’ paradigms, and moving along the methodological spiral. While subtle differences exist between the two, the challenge arises when one is used in the place of the other. Kathy Charmaz herself, the author credited with this version of GT, to some extent, contributes to the confusions around –nist and vist use of ‘constructed realities’. She wrote “*my approach is constructionist in that I view action as a central focus and see it as arising within socially created situations and social structures*” (Charmaz, 2006, p.398). Yet, her work is presented as ‘constructivist’ rather than ‘constructionist’. Broadly speaking, however, the essence of Charmaz’s contribution to this methodological approach could be said to include recognition that no theory is objectively created without consultation of one’s own historical and social contexts.

From this end, Charmaz’s work seemed to be most fitting with a particular world view which allows for a more flexible methodological approach and brings questions to the research from the same school of thought as Berger et al.’s (1966) philosophy outlined in section 3.4 of this chapter. For this reason, Charmaz could be described as ‘constructionist’ and ‘relativist’ and this becomes apparent when she says, “*data do not provide a window of reality – rather the discovered reality arises from the interactive process and its temporal, cultural and structural contexts*” (Charmaz, 2000, p.524).

Charmaz’s (2006) version of GT is preferred in this study, and for the following reasons. Firstly, its philosophical approach fits my constructionist philosophical assumptions set out in 3.4; secondly, the need for flexible guidelines for methods and not ‘*methodological rules, recipes and requirements*’ (Charmaz, 2006, p.20) fits with my approach to preserving ‘wholeness’ of Ugandan voices and experiences, and thirdly; the central role of the researcher in the analysis process and theory which facilitates an emergent approach to the data. The key tenets of constructivist GT are set out below in Table 3.

Table 3. Key premises of constructivist grounded theory

<ul style="list-style-type: none"> <li>• Ontologically relativist (multiplicity of perspectives, realities not discovered but constructed).</li> </ul>
<ul style="list-style-type: none"> <li>• Epistemological subjectivist assumptions (include the researcher’s perspective).</li> </ul>
<ul style="list-style-type: none"> <li>• Theoretically interactionist demonstrated by the way “...<i>data and analysis are created through an interactive process whereby the researcher and participant construct a shared reality</i>” (Breckenridge et al., 2012).</li> </ul>
<ul style="list-style-type: none"> <li>• Methods are flexible and thus ‘emergent’.</li> </ul>
<ul style="list-style-type: none"> <li>• The end product of constructivist GT is not preordained “<i>the finished work is a construction, yours</i>” (Charmaz, 2006, p.11).</li> </ul>

As demonstrated in Table 3, constructivist GT allows but also emphasises the interaction between the knower and the known, and in doing so, brings to light the notion of the knower as ‘author’. This position presents GT as an emergent approach whose methods can be adopted flexibly; “...*a set of principles and practices, not ...prescriptions or packages*” (Charmaz, 2006, p.9).

In this study, the views and experiences of Ugandans were not ‘forced’ into pre – defined categories but rather they were allowed to emerge and I, the researcher, constructed the codes. Bryant and Charmaz (2007) argues that constructivist GT draws its emergent nature from the researcher in terms of the questions they pose, and the means employed to analyse the data as well as the choice of topic itself. I chose constructivist GT because it puts the views of the ‘known’ to the fore by arguing that there is no ‘pre – ordained’ end product of GT. Underpinning my choice and consistent with the study’s constructionist epistemology, is the assumption that *the “interaction between the ‘knower’ and the ‘known’ “produces the data, and therefore the meanings that the researcher observes and defines”* (Charmaz, 1995, p. 35). Further, embedding my choice is Charmaz’s (1995) view of the knower as the ‘co-producer’ adding “...*a description of the situation, the interaction, the person’s affect and [their] perception of how the interview went*” (p. 33). This is particularly important in constructionist – informed studies because the prime focus is achieving a co-constructed knowledge.

One important utility of constructivist GT to this study therefore is that not only does it accommodate co–constructions, it also provides guidance in constructing meanings from data and suggests researchers should code for ‘actions’ (what has happened, how, and why) and ‘themes’ (how actions should relate to each other) to identify potential meanings. In this way, researchers are able to diffuse the tension between preserving participants’ views and presence and developing a theory from emergent data (Charmaz, 2006).

A key distinguishing feature of Charmaz’s GT lies in its focus on data collection, which inherently is less complex, and procedural compared to traditional and evolved versions of GT. Flexibility here has two functions; firstly, it allows researchers to seek meanings in data, to identify potential temporal sequences about values, beliefs, and ideologies; and secondly, it allows researchers to make sense of data, to establish outcomes or directions. It may also be that some data demand further exploration or a different exploration technique in which case flexibility becomes a methodological issue. For Charmaz (2006), the question is not about the ‘number’ of methodologies researchers can use to better understand social relationships – rather the emphasis is on ‘best–fit’ and how ‘compatible’ research methodologies are ontologically and epistemologically.

My methodological journey was exploratory in the sense that I set out to explore a specific aspect of voluntarism experience (views of Ugandans hosting volunteers) where very little is known and where new perspectives (Ugandan voices) were required. Simply put, I adopted constructivist GT approach due to the interactive and dialectic nature of area of interest, as well as its compatibility with the study’s ontological and epistemological stance. Finally, reflexivity is a key principle of constructivist GT, and in the section that follows, I outline the different considerations made throughout the research process, and how I kept track of the decisions made.

### **3.8 Reflexivity in Grounded Theory Research**

Research designs following the traditions of constructivist GT are vulnerable to potential influences including those that may arise from researchers and their roles in the research setting (Cruz and Higginbottom 2013; Holloway and Wheeler 2010). Constructivist theorists are therefore required to acknowledge how their presence and actions may inform the research process. Schreiber, (2001, p. 60) explains:

*“What is needed is for the researcher to recognise her or his own assumptions and beliefs, make them explicit, and use grounded theory techniques to work beyond them throughout the analysis.”*

This recognition makes the use of such techniques defensible against claims of imposition of preconceived knowledge of the research topic (Mills et al., 2006). Finlay (2002, p.532) calls this ‘reflexivity’ and defines it as *“thoughtful, conscious self – awareness”* Despite its importance, it is widely acknowledged that reflexivity has received little attention in GT research (Hall and Callery, 2001). Much of this deficit reflects wider differences in worldviews but also a growing drive to conduct a ‘bias free’ research. Neill (2006) contends that reflexivity can be an important tool to account for such biases and demonstrates the potential effects of the self in the research process. In fact, Charmaz claims that no research design is neutral and points out that researchers *“...are not passive receptacles into which data are poured”* (Charmaz 2006, p.15). While reflexivity is not a magic cure for research bias, what matters for the consequences of research in the end is, as Michael Lynch has observed, *“who does it and how they go about doing it”* (2000, p.36). In this study, I demonstrated reflexivity in several ways.

By drawing on constructivist GT, I was aware from the outset, that my knowledge of the field and topic was crucial to how I generate, analyse and interpret data (Charmaz 2006). I was also aware my identity as black African, Somali, Muslim, and as an affiliate of the SVP were significant markers of my researcher identity and could potentially influence (for better or worse) the way Ugandan health workers perceive my presence in their health facilities.

The importance of such identity became apparent when I entered the field and began interacting with Ugandans. Some Ugandans referred to me a ‘brother’ to denote my black East African heritage; others were drawn to me by my Somali and Muslim heritage and were keen to discuss with me about issues relating to ‘terrorism’ and the role of Ugandan peace keepers in Somalia. Some thought I was a ‘spy’ (a common word used by Ugandans to refer to people whose roles in Ugandan public health facilities are not clearly defined, and whom they are suspicious of); others thought I was evaluating the SVP project and wanted to find out what exactly I was looking for before agreeing to be interviewed.



These pre – interview interactions were import reminders of the need for reflexivity, and an awareness of how these different researcher characteristics I embodied may influence data collection, analysis and interpretation. As will be highlighted in Chapter 4, I made my position as researcher clear and from the outset, was open and forthright about the overall aim and objectives of my study. I utilised reflexivity consistently throughout the research process, from pre–interviews encounters with Ugandans, and throughout the data collection and analysis processes. One way of ensuring reflexivity was through memo writing. I documented reflections of events, incidents, emerging data, and made personal assumptions explicit to minimise my own imposition on the data, and to progress the development of ideas and concepts. Where appropriate and ethically sound, some of these memos and reflections were shared with my PhD supervision team to record evidence of the research process and progress made. By actively going back and forth during the data collection and analysis processes, I was able to minimise making assumptions, and articulate how my past experiences and relationships with the data may influence data analysis. The issue of reflexivity is revisited in 4.5 where an example of a written reflexive account is provided.

### **3.9 Chapter Conclusion**

Chapter three has described the research design adopted for this study. It has outlined the complexities of researching the social world including a note on research terminologies and paradigms. The views and experiences of Ugandans were explored using the research framework suggested by Crotty (1998) outlining the philosophical perspective of this study. A particular emphasis was put on how an appropriate methodology for this study was sought, and how through exploration (including a scoping visit to Uganda), constructivist GT was discovered in line with study's constructionism epistemology. The chapter has concluded with the importance of reflexivity as a way of acknowledging my research position, and influence as researcher and to be transparent about the decisions made throughout the research design. The following chapter provides a discussion of the research methods used in this study along with a rationale for adopting them.

## **Chapter Four: Methods**

### **4.1 The Introduction**

This chapter builds on the research design outlined in chapter 3. It begins with a discussion of some of the research methods utilised in the field of international voluntarism which goes on to form the basis of a rationale for the research methods employed in this study. Following this, a detailed account of the recruitment methods along with sampling strategies employed in this study is outlined. The research conduct is then provided, leaving an audit trail of the data collection and analysis processes. Practical and ethical considerations are summarised including the different ways in which participants' welfare were observed and maintained. Reflexive accounts are woven into the discussion and research quality criteria outlined to increase transparency of the research conduct. By the end of this chapter, the reader should have an understanding of not only how the study was conducted, but also how existing literature was utilised to embed the different decisions made throughout the chapter.

### **4.2 International Voluntarism: Methods**

As suggested in 3.5.2, traditional approaches to researching international voluntarism draw on standardised surveys with a focus on a number of dimensions including intercultural competence (Hammer, Bennet, and Wiseman, 2003), cross-cultural adaptability (Kelley and Meyers, 1995), social capital (Grootaert, Narayan, Jones, and Woolcock, 2004; Onyx and Bullen, 2000), and civic engagement, (Sherraden et al., 2008). Broadly speaking, these tools are designed to generate large amount of measurable impacts on and experiences of volunteers to examine the scope of volunteering programmes, and to demonstrate the value of international volunteer placements (Akingbola, Duguid, and Vivero, 2013; Brundey and Glazley, 2006). More recently, however, attempts to understand how various volunteering stakeholders, processes, and contexts influence one another and the pathway to 'change' have led to numerous calls for 'participatory' methods of data collection. These calls (and many others) have inspired the increasing use of qualitative research methods. An increasing use of these methods is observed in volunteering styles that prioritise learning and sustainable change (Burns, 2012).

In particular, individual interviews (Tillson et al., 2016; Watt et al., 2016), and group discussions (e.g. Jones, 2011; Bjerneld, Lindmark, McSpadden, and Garrett, 2006; Kalila, Wilson, and Noyoo, 2006) tend to be utilised. Some volunteering studies adopt a combination of these two approaches (e.g. Madziva, and Chiouya, 2017; Hague et al., 2015; Brassard, Sherraden and Lough 2010), to triangulate data, or serve participants' wishes by providing a choice. Individual interviews, in particular, serve the purpose of flexible guides (May, 2001), which are either developed from the literature (Elnawawy, Lee, and Pohl, 2014; Watts, and Stenner, 2012), or from pilot studies and/or scoping surveys (Rozier et al., 2017; Lough et al., 2011). These guides are sometimes altered continuously throughout data collection; adding prompts and questions as new ideas and themes emerge. For example, Elnawawy, et al. (2014) reviewed their original interview schedule with British General Practitioners (GPs) volunteering in Nepal making minor changes to improve the clarity of the questions asked. Similarly, observational research, commonly cited as 'participant observation' is used as a standalone method in volunteering research (e.g. Charleston, 2008); in 'conjunction' with interviews (e.g. Kerrigan, 2012); or as a 'supplementary' method with interviews and focus groups (e.g. Zavitz, and Butz, (2011), to accommodate participants' needs and explore a range of volunteering experiences.

The methods used in this study align with some of the methods used in researching volunteering styles that emphasise learning and sustainable change not because they were proven right, but because they appear compatible with the traditions of constructionist research epistemology and are applied in similar contexts (i.e. LICs). Discussions on how the study aligns with those methods are provided throughout the subsequent sections of this chapter. The following section provides an overview of the recruitment methods along with the sampling strategies used in this study.

### **4.3 Recruitment Methods**

Participant recruitment is a crucial stage of any research process, but it can be challenging if the research participants are not easily accessible (Archibald and Munce, 2015). Previous studies highlighted challenges in the recruitment of research participants from hard to reach or under-researched groups (Sheldon et al., 2007). Researcher suspicion and mistrust have been identified as possible explanations for the challenges in recruiting from these groups (Strang and Mixer, 2015).

Also identified are the presence of multiple actors and gatekeepers with diverging interests (Amerson and Strang, 2015), and a culture of reimbursement for research participation particularly in ‘resource–constrained’ settings (Mduluzza, et al., 2013). It was therefore apparent that careful consideration was required to optimise the recruitment of Ugandans, whose voices and experiences were critical to this study. To achieve this, the recruitment process followed the suggestion of Richens and Smith (2011) that:

*“...researchers must understand the cultural and environmental needs of their target group and use this knowledge to constantly evaluate the success of their recruitment strategy and data collection method.”* (2011, p. 34).

Working with and supervised by professionals with extensive knowledge of volunteering and development in the context of Uganda was therefore critical at this stage of the recruitment process, as was the support of the University of Salford based Knowledge, Health and Place (KHP) research group. Throughout the recruitment stage, I received an on–going support on various recruitment strategies including suggestions on how to enhance the participation of Ugandan health workers in my research. Among other things, it was suggested that I:

- Familiarise and immerse myself in the Ugandan health system and understand volunteer host cultures including researcher expectations.
- Liaise with Ugandan health facility leaders and the [multiple] gatekeepers in Ugandan health facilities and share with them the rationale and the potential benefits of my research.<sup>23</sup>
- Conduct interviews in Ugandan health facilities and at time suitable to Ugandan health workers to avoid potential disruption to their duty of care.

In order to action the above suggestions and meet the research objectives outlined in section 1.7, a sampling strategy was needed. The following section provides an overview of sampling, followed by a discussion of the sampling strategies adopted for this study.

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<sup>23</sup> Operating in Ugandan health facilities are multiple local actors. Some, like health facility leaders (or in–charges), are more accessible than others (i.e. District Health Officers), but all have varying degrees of influence and control.

### 4.3.1 Sampling

Sampling has been subject to different interpretations. For some, sampling involves: “...*the techniques used to select groups from a wider population.*” (Jupp, 2006, p.270); for others, it involves just more than a selection of a research group. (Ploegg, 1999, p.36) defines sampling as:

*“...a randomisation technique to pick respondents from a larger population with the purpose of removing selection and other biases.”*

While these two definitions approach sampling from generic viewpoints, others argue sampling in inductive approaches should not be guided by a focus on ‘representativeness’ (e.g. Brady, 2006; Silverman, 1997). Instead, the authors suggest that the emphasis should be about the depth and richness of data rather than numbers. This emphasis, according to Brannen and Collard (1982), may explain why research participants in qualitative studies are broadly speaking significantly less compared to research participant in quantitative studies, and in some circumstances, may even consist of only one participant (Becker, 1996; 1998). Further, Brady (2006) suggests that sampling should be understood in conjunction with research epistemology, which in the case of this study, is the idea of knowledge is a social construct, and at the heart of it are the knower and the known (Schwandt, 2003; Burr, 1995; Berger et al., 1966). It was therefore important that the sampling techniques chosen for this study reflect the constructionist underpinnings of this study. In view of this, purposive sampling and snowballing were chosen for this study. An overview of each of these two sampling techniques is provided next.

#### 4.3.1.1 Purposive Sampling

Purposive sampling is often utilised in researching populations that often under-studied or hard to reach groups (Richens et al., 2011). It involves the selection of participants with the most knowledge, and experiences of the phenomenon under study (Redshaw and Heikkila, 2011; Schutt, 2006). According to Rubin and Rubin (1995), consideration of a purposive sample should reflect diverse experiences and variations of point of views. Schutt (2006) adds:

*“Each sample element is selected for a purpose, usually because of the unique position of the sample elements. Purposive sampling may involve studying the entire population of some neglected group (homeless adults) or a subset of a population (mid-level managers) with a reputation for efficiency.”* (2006, p.155).

Purposive sampling was used in previous studies exploring both volunteer and volunteer host experiences of voluntarism. For example, Elnawawy et al. (2014) employed this sampling strategy to ensure a breadth of views was obtained from both British and Nepalese health workers participating in knowledge exchange volunteering project. In this study, two research phases (or visits to Uganda) were considered, and purposive sampling was employed in both phases. The first, a scoping phase, was conducted across five Ugandan public health facilities with a sample of thirty–three Ugandan health workers (see Appendix 4); the second, a follow–up phase, was conducted across two Ugandan health facilities with a sample of thirteen Ugandan health workers as highlighted in Appendix 5<sup>24</sup>. The following inclusion criteria was used in both phases of this study:

#### *Ugandan Health Workers*

- a. Ugandans meeting the broad definition of ‘health workers’ provided in section 1.4.3.
- b. Ugandans with past, present (or both) experiences of engaging with volunteers.

The rationale for using the broad definition of Ugandans was to enable me to draw on experiences of engaging with volunteers from multiple perspectives or viewpoints. Emphasis was put on ‘expert’ Ugandans (those with good knowledge) of volunteers to gain deeper insights of the topic under investigation (Polit and Beck, 2006).

#### *Ugandan Public Health facilities (Research Sites)*

- a. Smaller and less complex public health facilities.
- b. Public health facilities with past, present (or both) volunteer activities.

The rationale was to avoid bigger and more complex public health facilities with the presence of multiple players or actors including NGOs. While this was successful in six of the seven health facilities considered in this study, it is important to note one bigger and more complex health facility, namely Mbarara Regional Referral Hospital (MRRH) was included, but only in the maternity ward where volunteers and more ‘junior’ Ugandan health workers participated in planned and on–going obstetric

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<sup>24</sup> A focus group consisting of four Ugandan health workers was also conducted at the University of Salford as part of the follow–up phase of this study.

training exercises. All the seven health facilities followed the MoH referral system, existing at different levels of Ugandan health care as demonstrated in Appendix 1.

During both phases of the study, purposive sampling strategy provided a direct approach to talking to Ugandans who were most likely to provide 'relevant information' (Strauss et al., 1998). In order to gain insights into Ugandans' experiences of engaging with volunteers, it was essential to talk to Ugandans at their own convenience to allow them to share their experiences as freely as possible. Once a few Ugandans were recruited through purposive sampling, attempts were made to utilise the snowball sampling strategy to recruit Ugandans with similar past or present (or both) experiences of engaging with volunteers.

#### 4.3.1.2 Snowball Sampling

Snowball sampling (or simply snowballing) refers to a technique where researchers use 'knowledgeable' participants to recommend others with similar views and experiences of the topic studied (Harper Bulman and McCourt 2002). Researchers begin this approach through gatekeepers; individuals with good knowledge of the setting, and who can offer useful insights into participants' characteristics (Essén, Binder, and Johndotter, 2011). These participants or 'brokers' are used not only to identify knowledgeable others, but also to set up initial contacts, and assist in future snowballing (Essén et al., 2011). While this sampling technique is both practical and suitable in busy settings (such as Ugandan public health facilities) where 'eligible' participants are hard to identify and recruit, some researchers contend that it increases the likelihood of homogeneity bias as participants are likely to recommend others with similar opinions or characteristics (Twamley et al., 2009). Further, some researchers contest that snowball sampling can filter out other potential participants with knowledge of the topic investigated (Twamley et al., 2009). These researchers also contest the use of health professionals to recommend other health professionals for research participation. They point out to potential risks and unintended consequences as the demand of recruitment for research may disrupt health professionals' duties of care. Snowballing, in this study, was only employed to recruit Ugandans meeting the inclusion criteria outlined in 4.3.1.1, and at their convenience.

The snowball technique was more appropriate to junior cadres partly due to the nature of their split site training (i.e. between University and health facility), and constant mobility between departments and wards which made them difficult to interview. After sharing their experiences of engaging with volunteers, many junior cadres passed my contacts to their counterparts and helped set up initial contacts and subsequent interviews.

Having outlined the recruitment methods and the sample characteristics utilised in this study, the following sections discuss data collection and analysis processes.

#### **4.4 Data Collection**

Based on the methodological approach outlined in 3.7.3, along with the temporal considerations, the following data collection schedule was developed:

- i. The Scoping Phase (5 weeks): familiarising with the research context:
  - Getting to know Ugandans, volunteers, and health facilities (attending meetings, training, informal conversations with Ugandans and the SVP volunteers, and working closely with health facility leaders.
  - Recruiting Ugandans utilising sampling strategies described in 4.3.1.1 and 4.3.1.2.
  - Conducting interviews with Ugandans meeting the inclusion criteria described in 4.3.1.1.
  - Observing Ugandan–volunteer interactions in 4.4.1.3.
  - Collating and analysing data to gain initial findings.
  - Recording lessons learned.
  - Informing the follow–up phase of the study, updating and refining the research methodology and tools.
- ii. The Follow–up Phase (4 weeks): gaining in–depth experiences, perceptions and reflections:
  - Facilitating a focus group discussion in Salford with four Ugandan health workers hosted by the University of Salford to set the scene for this phase of the study as outlined in 4.4.2.1.
  - Visiting health facilities, meeting Ugandans and volunteers.
  - Initiating an informal discussion with facility leaders.
  - Identifying ‘eligible’ Ugandans for the study.



- Conducting semi-structured interviews and observational research simultaneously.
- Transcribing and analysing first sets of interviews to inform subsequent interviews.
- Going back and forth data collection and analysis in line with the study's methodology outlined in 3.7.3.

Actual data collection differed slightly from the data collection schedule outlined above particularly during the follow-up phase of the study. A focus group discussion (described in detail in 4.4.2.1) preceded the follow-up phase of the study, and had served two main benefits; firstly, it provided me with the opportunity to interview Ugandans in a different context (the University of Salford), allowing me to spend some more time with them; getting to know their worlds, their experiences and journeys. Such interactions allowed me to uncover broader information relating to Ugandan-volunteer engagement in Ugandan public health facilities; secondly, it had refined my research focus, and shed some light on important themes to pursue in the follow-up phase, potentially reducing the amount of time needed for completing the follow-up phase of the study. This possibility was particularly important given my family commitment in the UK, including the arrival of our second baby girl. The details of this research conduct are presented below in line with the two phases of the study.

#### 4.4.1 The Scoping Phase – Familiarising with the Context

In line with the exploratory approach, and as outlined in 4.4 above, the scoping phase involved getting to know the research context. The aim was to pilot research tools and lay the groundworks which formed the basis of the follow-up phase of the study. Thirty-three Ugandans were recruited in five health facilities across Uganda (Appendix 4). Two steps were taken in gaining access to potential (eligible or expert) Ugandans. Firstly, a formal discussion with the management of the volunteer deploying agency, the SVP was initiated. I had meetings with the SVP coordinators, and subsequently travelled with them to Uganda to gain some understanding of the context and to get to know past and present volunteers who engaged with Ugandans. Secondly, and upon arriving in Uganda, I contacted several Ugandan health facility leaders to discuss my intentions and gain their approval to talk about my study. I spent some time with them to familiarise myself with the setting and identified some eligible Ugandans to contribute to this study beforehand.

I anticipated that through these efforts, access to Ugandans could be improved as the health facility leaders could be informed in advance to provide advice, guidance, as well as permission to talk to Ugandans willing to participate in this study.

#### 4.4.1.2 Interviews

Interviews are increasingly becoming preferred tools to researching voluntarism (Elnawawy et al., 2014), mainly because they encompass 'conversations with a purpose' (Eyles and Smith, 1988). Arksey and Knight (1999, p. 32) define an interview as a:

*“... powerful tool of helping people to make explicit things that have hitherto been implicit – to articulate their tacit perceptions, feelings and understandings.”*

Interviews are effective ways of tapping into how people feel and make sense of their experiences of the social world (Mack et. al., 2005). The purpose of interviews is to add knowledge and understanding of the meanings that life experiences hold for particular groups of people (DiCicco–Bloom and Crabtree 2006). Interviews vary according to the research objective, stage, and the disciplinary viewpoint of the researcher. In the field of voluntarism, and in the 'piloting' stages of qualitative studies, 'structured' tools such interviews are utilised to set the scene and inform future, more interactive data collection tools (see Rozier et al., 2017; Lough et al., 2011). Consistently, an interview schedule with open and closed ended questions was utilised in this phase of the study for exploration, contextualisation, and learning purposes. The interview process began with two 'practice' interviews with colleagues at the University of Salford to test the interview questions and responses to them. The practice interviews were followed by a scoping visit to five health facilities in Uganda in November 2014 where I conducted thirty–three short interviews. The interviews (digitally recorded with Ugandans' consents and transcribed by the researcher) were conducted within Ugandan public health facilities and lasted between 20 – 30 minutes. During the interview process, I regarded myself an 'interviewer' whose role was to uncover Ugandan experiences of engaging with volunteers. I did not interact much with the setting and focused more on speaking to as many Ugandans as possible. This was partly because of limited time factors, but also due my limited experience of undertaking qualitative research at the time, and particularly in the context of Uganda or Africa more generally.

In fact, this phase of the study occurred during a transition period when I journeyed from deductive to inductive research, and when I still had inclinations towards quantitative research, and the need to be an 'outsider' researcher. Upon reflection, and with the support of my PhD supervisors, I gradually realised that I needed to immerse myself in the research process, and this recognition allowed me to spend longer periods of time with Ugandans towards the end of this phase of the study. This helped not only establish rapport with Ugandans but also gain some useful insights into their experiences of engaging with volunteers.

In line with the exploratory nature of this scoping phase, the short interviews consisted of both open and close ended questions. The interview began with demographic questions such as 'What is your job title?', 'How long have you worked here [Ugandan public health facility]?' which helped set the scene. These questions evolved into open – ended questions that sought to tap into the processes involved in host–volunteer engagements, (i.e. periods of engagements, activities undertaken, and the role (s) played by both Ugandans and volunteers). Starting the interviews with demographic questions served as an icebreaker, allowing me to gradually build rapport and access Ugandans' memories and experiences of engaging with volunteers. Specific questions relating to perceived benefits of engaging with volunteers included: 'What are your experiences of engaging with volunteers?' 'What specific skill (s) did you gain while working with volunteers?' 'How much of this skill (s) did you know before engaging with volunteers?' These questions were impact–oriented and formed a simplistic way of 'quantifying' complex phenomena such as 'learning' (or skill gains). These were nonetheless supported by open ended questions. More specifically, the flow of the interview was enhanced by the responses of Ugandans who were encouraged by open ended questions such as '*How did they [the volunteers] do that?*' to develop issues raised. This approach was reflective of 'research as exploration for discovery' in which a new phenomenon is uncovered, and existing ones expanded. However, upon reflection, I felt the interviewing technique I adopted for this phase was not flexible enough, although it satisfied the learning (i.e. tool refining) aim of this phase of the study. The lack of flexibility may have resulted in "*loss of meaning from asking questions in a standard way*" (Fielding and Thomas, 2008, p.247). A reflection on this helped shape the adoption of more flexible and in–depth type of interviews for the follow–up phase of this study.

#### 4.4.1.3 Observational Research

Participant observation (observational research in some texts) allows researchers to immerse themselves in a context, learn, and document how people interact among themselves and the world around them more generally (LeCompte, and Schensul, 1999). Participant observations in this phase of the study was conceived at a later stage of this phase of the study and was not an original part of the data collection schedule. In fact, it was borne out of my own experience, in the field, of conducting multiple short interviews with Ugandans without spending much time with them to gain better understanding of the meanings they attach to engaging with volunteers.

Observation was conducted only at Kisenyi Health Centre (HCIV), a public health facility located in impoverished area in the nation's capital, Kampala that serves a population of over 20,000 including refugees and migrants (MoH, 2010). In order to build rapport with Ugandans, I introduced myself as doctoral researcher, and took part in a variety of activities including attending staff meeting, training, updating admission and referral books as well as working with health facility leader on staff attendances and registers.

My visit to KHCIV coincided with a time when the health facility faced serious staffing issues brought about, in part, by delayed salary and subsequent health worker absenteeism. This situation rather unexpectedly made my newly acquired role in the health facility all but relevant if not useful. The Ugandan team I interacted with appreciated my role and thanked me for 'stepping in', carrying out some useful administrative tasks under the supervision of the health facility leader. From a practicality point of view, this newly acquired role gave me the opportunity to interact more freely with Ugandans and observe them in their daily routines while at the same actively taking field notes. For example, on several occasions, I was able to probe Ugandans to explain some of their behaviours and interactions with volunteers during observation periods. Such interactions generated informal discussions, and some, subsequently led to interviews. Data emerging from these informal interactions were recorded as field notes during observations, providing context for analysis of observation data. Some of the observed health workers agreed to take part in follow-up interviews. All observations took place outside health facility 'wards' in line with the study's ethical approval (see Appendix 9).

#### 4.4.2 The Follow-up Phase – Gaining a Deeper Understanding of the Context

The follow-up phase extends the scoping phase, and operationalises lessons learned including a reflection on research tools. A major distinction between the scoping and the follow-up phases of this study is that the former sought to familiarise with the research context, refine the research tools, and learn lessons about how to better approach the context and uncover diverse Ugandan voices and experiences. The latter, the follow-up phase, built on the lessons learned, and sought to gain an 'in-depth' understanding of Ugandan experiences of engaging with volunteers. As mentioned earlier, the first stage of this phase of the study began with a focus group discussion followed by a visit to two active volunteer hosting public health facilities in Western Uganda. Access to Ugandans in these health facilities was gained through the processes described in the scoping phase outlined in 4.4.1.

##### 4.4.2.1 Focus Group

In this phase of the study, the focus group was conducted at the University of Salford with four Ugandan health workers hosted by the University of Salford through the Common Wealth Fellowship Scheme. The University of Salford's School of Health and Society (SHS) hosts Ugandan health workers<sup>25</sup>, and deploys UK students to Ugandan public health facilities as a part of the wider move towards student exposure to health systems in LICs (Ackers and Ackers-Johnson, 2016). Focus group is "*an interview style designed for small groups*" (Berg, 1998, p.100). It also allows researchers to clarify and challenge participants' views, while at the same time presenting participants the opportunity for self-interpretation, adding more insights to the research (Kitzinger, 1994). Focus groups have been found to be particularly useful for engaging with participants who are reluctant to participate in individual interviews (Richens et al., 2011; Patton, 1990). Morgan (1998) provides four criteria for focus group discussion:

1. As a standalone method for research relating to group norms, meanings and processes.
2. In a multi-method design to explore a topic or collect group language or narratives to be used in later stages.
3. To clarify, extend, qualify or challenge data collected through other methods.

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<sup>25</sup> See broader definition of 'Ugandan health workers' in 1.4.3.

4. To feedback results to research participants.

The two key factors that led to the focus group in this study were:

1. Proximity: I interacted with this Ugandan group through KHP, and despite being placed in various settings across the university, the group had plenty of time to meet, discuss and share ideas among themselves, with me, and with other members of KHP research team. Some of the discussion I had with this group inspired me to interview them formally.
2. Group dynamics: This group consisted of diverse Ugandans from a broad range of disciplines, experiences, professions, all with the potential to generate past, present (or both) views and experiences of engaging with volunteers.

As a departure point of the follow-up phase of the study, the focus group provided an opportunity to experiment not only with group interviews, but also interviews outside the Ugandan context. Prior to the focus group at the University of Salford, all data collection in the scoping phase took place in Uganda. Also, the potential impact of interview venues (spaces and environment) on participants' responses has been a major consideration in this study. A recent study sheds some light on this phenomenon. Hämäläinen, and Rautio (2013) found participants interviewed in health settings were less open in their answers as compared to those interviewed in university settings or private residence. It appeared that Ugandans who participated in the focus group at the University of Salford were able to build on each other's answers and therefore provide more detailed accounts on sensitive issues such as health worker absenteeism, a chronic problem in Ugandan public health facilities discussed in 7.3 and 7.4. While interview outside Ugandan health facilities may have influenced some of the Ugandans' responses in the focus group, it is important to acknowledge that such responses could have also resulted from the discursive nature inherent in focus groups as the *"process of sharing and comparing provides the rare opportunity to collect direct evidence on how the participants themselves understand their similarities and differences"* (Morgan, 1997, p. 21). Despite the usefulness of focus group interviews outlined above, two limitations inherent in focus groups meant that individual interviews were more appropriate in Ugandan public health settings.

The first related to the 'busy' nature of Ugandan health spaces and the difficulty associated with recruiting and pulling together a group of Ugandan health workers in the same space and time. The second related to the ethical implication of taking health workers off wards for research participation purposes (Twamley et al., 2009). This was particularly relevant in all the public health facilities I visited where health worker shortage was very common and where removing a group of health workers from the wards may have put patients' lives at risk.

#### 4.4.2.2 Interviews

Increasingly, studies on global health volunteering draw on interviews with flexible topic guide (Elnawawy et al., 2014; Watts et al., 2012). As described in 4.2, some studies design semi-structured interviews from readings gained in the literature (Elnawawy et al., 2014; Watts et al., 2012); others utilise 'pilot' tools to inform the development of more conversational semi-structured interviews (Rozier et al., 2017; Lough et al., 2011). May (1997) suggests that semi-structured interviews allow the researcher to gain deeper insights into a topic and are particularly useful in identifying new areas that were not initially covered in the topic guide. Further, such interviews provide opportunities to ask participants to elaborate important issues in the discussion. These characteristics of semi-structured interviews make them attractive particularly to constructionist informed studies because the primary goal is understanding the meanings people attach to their experiences in the social world (Saunders et al., 2003). The interview guide used in the scoping phase highlighted in Appendix 6 was redrafted and modified (see Appendix 7) to comply with the methodological requirement (constructivist GT) of the follow-up phase of this study outlined in 3.7.3.

In keeping with the traditions of constructivist GT, and expanding on the scoping phase, I used semi-structured interviews during the follow-up phase of this study to allow flexibility and provide adequate background information about Ugandans, processes and settings. Such method of data collection has the potential to "*reveal what lies beneath the surface*" and provide "*multiple views of the participants' range of actions*" (Charmaz, 2006, p. 19). The flexibility provided by semi-structured interviews assists participants to construct accounts of their experiences in their own words (Flowerdew and Martin, 2005), allowing an in-depth knowledge to be elicited (Sin, 2003).

The semi-structured interviews adopted during the follow-up phase of this study allowed for this, providing flexibility for interviewees – an option not feasible with other individual based interview techniques (Bryman, 2004). As previously mentioned, however, the potential of semi-structured interviews to reveal rich data depends on several factors primarily but not exclusively relating to space and time. Although all interviews were conducted in Ugandan public health facilities, my experience suggest ‘time’ and ‘immersion’ rather than interview venues proved crucial to gaining insights. As previously stated in this chapter, the busy nature of Ugandan health facilities required patience and immersion, to better understand the context in which Ugandans and volunteers interact. Working closely with Ugandans allowed me to work around their busy schedule and identify ‘appropriate’ time for longer interviews. This is evident in the fact that all interviews lasted between 60 – 90 minutes.

The interview questions explored perceptions, attitudes, beliefs, experiences and actions (Charmaz 2006). More specifically, the interview questions focused on Ugandans’ experiences of engaging with volunteers. Each interview began with Ugandans answering demographic questions to build a rapport and to put them at ease (Minichiello, Aroni, and Hays, 2008). This was then followed by flexible, conversational, and explorative interview questions, aimed at uncovering new insights as well as building on issues raised in the focus group that preceded the follow-up phase and the semi-structured interviews. There were some variations within the interview questions, necessitated partly by information gained from the observational research, and data from first sets of interviews. Subsequent interview questions including those utilised during the middle stages of the interview process were ‘modified’ or even ‘redrafted’ to reflect emerging data and to progress the emerging theory (Charmaz, 2006). For example, prompts relating to the benefits of engaging with volunteers for Ugandans were broad and less specific, and were later modified to progress the emerging story. Prompts added to the interview questions during the middle interview stages of the interview process included asking whether the benefits of engaging with volunteers mentioned by the Ugandans during at the initial stages of the interview process reflected ‘gaining’ new skills or ‘validation’ of existing skills. Examples of these constructions or modifications are highlighted in italics in Appendix 7. All interviews were digitally recorded with Ugandans’ consents, and transcribed by the researcher.



Consistent with the traditions of constructivist GT, questions were posed in no particular order, and in some scenarios not all the questions captured in the interview guide were posed. In a similar vein, the interview prompts were used only where appropriate, and to develop further emerging concepts, ideas and categories (Charmaz, 2006). While the process or the 'art' of redrafting aspects of the initial interview questions is data driven, and necessary for meaning construction, I understood the risk of bringing my assumptions into the interview questions.

I addressed this by documenting aspects of the interview questions redrafted, providing reasons in the form of memos<sup>26</sup>. I also understood that putting too much emphasis on minimising my preconception or biases, I risked losing close touch with the data, or what Charmaz referred to as "*taken for granted meanings*." (2006, p.35). This was particularly relevant in researching a setting or culture different to that of the researcher. Such was the case interviewing a Ugandan midwife when I asked what she thought of health worker absenteeism; she replied, "*I have to work twice as hard and clear the line*." Due to my scoping visit to Uganda, I knew the meaning of the phrase 'clear the line', but I was careful not to rush to my own interpretation, and prompted the midwife to gain an understanding of what she said as documented in the following conversation:

Researcher: *Can you please elaborate on this [clear the line]?*

Ann, a senior midwife: *You mean clear the line?*

Researcher: *Yes, I do, please*

Ann: *It is a local term used here in Uganda. It means seeing as many patients as possible without necessarily attending to all their needs...I would say it is a short cut and very risky practice to patients because you are not paying attention to their concerns but just seeing them with the least time possible...."*

Where appropriate, interview questions were tailored to specific cadres based on observation data and the uniqueness of their experiences.

#### 4.4.2.3 Observational Research

As previously mentioned, the decision to embark on participant observation during the scoping phase of this study was borne out of the experiences of conducting multiple short interviews with little emphasis on gaining better understanding of the meanings Ugandans attach to hosting volunteers.

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<sup>26</sup> Discussion on memos are provided further on in this chapter.

However, this decision came during the final stages of the scoping phase, and at time when nearly all the interviews were already conducted, leaving very little time for contextualisation. A lesson learned therefore was to blend observation with interviews, and embrace the relational dimensions of both methods (Charmaz, 2006). In the follow-up phase of this study, observation preceded semi-structured interviews, although some post interview observation was conducted to develop some emerging ideas, and concepts further. Observation for this phase was conducted at Bukuuku HCIV, a public health facility located in the outskirts of Fort Portal, Western Uganda (see Appendix 1) serving predominately a rural population. The aim of the observation was to document interactions between Ugandans and volunteers and follow this up with semi-structured interviews. I spent the first three weeks of this phase of the study at this health facility observing and recording informal conversations; probing Ugandans and asking questions about specific comments. Furthermore, the observation allowed for important and context-specific knowledge that would not have been captured in an interview setting as my observation below suggests:

During the first week of the observation, and particularly when it rained, I noticed very few patients and Ugandan staff on site. On one occasion, it rained till midday, and it was only after the rain cleared when the first wave of patients and staff arrived. I did not observe this behaviour during the scoping phase of the study and did not know what to make of it. I asked a volunteer who simply remarked “*Ugandans do not like rain!*” The following day, the weather was not any better – it rained on my way to the health facility. Upon arrival however, I noticed many patients and staff already on site. I looked at my watch – it was 8:45 am. I looked round and saw a neatly polished bench under a small tree with the sign ‘coughing area’. I knew there was more to this, but I could not quite make out what exactly this was all about. I asked a Ugandan nurse what was happening. She smiled and replied, “...*the big guys [referring to American donors] are coming here this morning.*” I knew I witnessed something interesting and wanted to gain further insights. In order to achieve this, I had a conversation with two Ugandans whom I already established a rapport with through taking on an administrative role in the health facility.

While the details of this conversation were not recorded mainly due to the request of the two Ugandans, the conversation had allowed me to appreciate the importance of observational research in unpicking such highly complex relationships between Ugandans and development NGOs. In particular, it enabled me to better understand the complexities of the spaces in which Ugandans and volunteers interact and the ‘adjustments’ Ugandan health workers make in order to comply with the expectations of development NGOs. However, I realised that achieving such important insights in health settings is particularly challenging for non–health professionals, and as highlighted in the reflexive account below, it was not a straightforward matter.

#### **4.5 A Reflexive Account – Non-clinical Identity**

As discussed in 3.2, and locating myself in this study, it is important to acknowledge the identities I bring to the research process. Particularly worth considering is how my non–clinical identity may have shaped the research process. From the outset, I was aware of the potential challenges that may arise from conducting this study without clinical training particularly given the limited non–clinical workforce employed in Ugandan public health facilities. This awareness coupled with the importance of ‘identity’ in Ugandan public health system demanded that I construct my own identity or rather identities<sup>27</sup>. As mentioned in 4.4.2.3, I adopted a ‘colleague’ identity by taking on an administrative role with the supervision and support of two Ugandan health workers. In this way, I was able to familiarise myself with some medical terminologies, practices, and also build useful rapport with individual Ugandan health workers. However, I was soon reminded of the potential conflict that may arise from working in clinical settings as a researcher. Having spent some time with Ugandans, I was aware that I could be mistaken for a medical professional and surely, I was, on several occasions by both patients and Ugandan health workers. To avoid such misunderstanding and to make my presence clearer, I emphasised that I was a doctoral student; and that I arrived at their settings to explore their views and experiences of hosting volunteers.

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<sup>27</sup> Ugandan health system is very hierarchical – identities and titles (i.e. seniority) matter. While my primary identity upon entering Ugandan public health facilities was that of a researcher, I realised during the data collection process that such identity was largely redundant particularly in relation to gaining trust and building rapport with Ugandans hence the need for the adoption of a ‘colleague’ identity.

From a data collection point of view and while my colleague identity provided some useful insights as reflected in 4.4.2.3, I felt my experience particularly at the initial stages of the study may have been more fluid with clinical experience (and perhaps title) in the context of Uganda or Africa more generally. My limited familiarity of the Uganda health system and medical terminologies more generally meant that I relied on Ugandans to clarify certain words or phrases during interviews. The problem with this was that at this stage, many Ugandans would have forgotten about my non-clinical identity and would employ highly complicated medical terms I did not understand. However, having senior supportive Ugandans and sometimes volunteers accounted for this knowledge deficit as clinical phrases and jargons were explained to me at ease.

Overall, my awareness of the different identities I bring to Ugandan health spaces, and the adjustment I needed to make to build rapport with Ugandans minimised potential shortcomings particularly in relation to researching hierarchical clinical settings where identities (mainly clinical) play significant role not only in gaining entry, but also producing meaningful feedback. This position allowed me to approach the context with both curiosity and caution, and therefore produce analytical lens through which to view data.

The following section discusses the data analysis processes.

#### **4.6 Data Analysis**

As discussed in 4.4, data collection was achieved through a blend of methods including recorded interviews, written observation notes and general field notes in both phases of the study. During and after each interview, I wrote down my reflections of Ugandans, and the conversations I had with them. These reflections were very short (and limited to main points) and followed no formal structure. The aim was to help bring myself back to the interview settings, and use these notes to compliment interview transcripts, and field notes. Further to this, literature reviewed over the course of the PhD was brought into the data analysis to provide contextual background to the findings, demonstrating the cyclical nature of the research strategy outlined in 1.8. The analysis also observed the exploratory and the more in-depth nature of the scoping and the follow-up phases of the study respectively.

A common denominator of both phases of the study was the need to search across data sets to locate repeated patterns of meanings and allow a storyline to emerge. Although there are various ways of locating repeated patterns in data, it is important that I provide clear explanations of the approaches and stages I embarked on to provide transparency to the reader (Braun and Clarke 2006).

#### 4.6.1 Stage One – Data Familiarisation

Most of the interviews were transcribed in research sites in Uganda; others were transcribed upon returning to the UK. Transcribing the interviews helped to relive the moments of conversations and piece views and experiences with individual Ugandan health workers together thus ‘humanising’ the transcripts. All transcripts were read and reread line by line, and in their entirety to ensure accuracy. This approach was particularly useful as repeatedly listening to interviews allowed me to ‘hear’ Ugandan voices, taking me back to the interview settings, therefore providing context and improving credibility of meanings (Charmaz, 2006).

#### 4.6.2 Stage Two – Data Organisation

Contemporary ways of data organisation include the use of computer software. Some researchers have expressed concerns that computers will impose ‘rigidity’ to the analytical process given their statistical disposition (Seale, 2005). Others stressed the usefulness of computer packages highlighting their utility particularly in relation to data management, organisation, and comparison (Zamawe, 2015; Corbin and Strauss, 2008). Creswell (2013) wrote:

*“The process used for qualitative data analysis is the same for hand coding or using a computer: the inquirer identifies a text segment or image segment, assigns a code label, searches through the database for all text segments that have the same code label, and develops a printout of these text segments for the code. In this process the researcher, not the computer program, does the coding and categorizing.”* (p. 201).

In this study, QSR NVIVO 10, a qualitative data package was used for data organisation and management purposes. All transcripts in the form Microsoft Word documents were imported onto QSR NVIVO 10, to organise and make sense of the data. I utilised NVIVO 10 in non-exhaustive manner, to code data, and identify themes and their relationships.

#### 4.6.3 Stage Three – Coding Generation

Coding involves grouping or organisation data into meaningful subsets (Tuckett, 2005). It entails “*labelling a line, sentence or paragraph of interview transcripts or any other piece of data...with a short and precise name*” (Charmaz, 2006, p.43). Three strategies of coding were adopted: open coding, in vivo coding, and focused coding:

- i. Open coding: the first step towards the discovery of categories and involves ‘fracturing’ data into codes.
- ii. In vivo coding (utilising Ugandans’ own words as a code or codes), and my own construction to reflect the data.
- iii. Focused coding: initial codes were identified and then tested against extensive data.

##### 4.6.3.1 Open Coding – Identification of Initial Codes

As the first stage of coding, open coding had two distinct advantages; firstly, due to its surface–level iterative nature, it minimised the risk of thinking theoretically at this initial stage; and secondly, it presented me the opportunity to reflect on my relationship with the data while remaining open to what could emerge from the data. During open coding, the interviews, and focus group transcripts were introduced to the coding process for themes and categories to emerge. During this stage of the coding, I began the coding process by allocating a short label (gerund)<sup>28</sup> to each line or fragment of the data. This allowed me to remain open and recognise subtle differences in the data (Charmaz 2006). Applying initial codes allowed me to ask questions in order to continually remind myself of the original research intentions and to keep track of the data being accrued (Alemu et al., 2015). One way of staying with the data during the initial phase of coding was to code data spontaneously, and to treat emerging themes as provisional and comparative (Charmaz, 2006). This way of coding provided insights into the kind of data that needed to be collected next in the research and continued until codes emerged that required further exploration. At a practical level, all the texts that represent the same or similar Ugandan experience were linked and given a code. During this coding stage, twenty such codes were generated which then progressed to more in–depth coding – focused coding.

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<sup>28</sup> Charmaz (2006) describes ‘gerunds’ as short and “*compelling codes that capture the phenomenon and grab the attention of the reader*” (p.49).

It is worth reiterating here that each open code in NVIVO represent a segment of text (i.e. sentences or short excerpts) of the raw data. Appendix 8 illustrates an extract of interview transcript during the open coding stage of the data analysis process

#### 4.6.3.2 In Vivo Coding

First used by Glaser and Strauss (1967), *in vivo* codes entail the exact expressions or words employed by research participants (participants' own words). *In vivo* codes are used to preserve Ugandans' own responses, expressions or categorisations (Charmaz 2006). Several *in vivo* codes were used in this study. For example, many Ugandans described engaging with volunteers led them to *learning new skills* or *developing existing skills*. This action was initially coded as *acquiring new skills* and *increasing existing skills* respectively. However, during the later stages of the open coding, I noticed two Ugandans used the phrase *gaining new skills* and *validating existing skills* while describing how engaging with volunteers benefited them. Following this find, I adopted *gaining new skills* and *validating existing skills* as *in vivo* codes. I replaced earlier coded data describing similar Ugandans' experiences with these *in vivo* codes and utilised them for future codes. Another *in vivo* code utilised in this study was '*responsibility without authority*', a phrase used by senior Ugandans to describe their largely powerless leadership roles in Ugandan public health facilities (see 7.2). One important utility of *in vivo* coding to the methodology adopted in this study is that it represents and accounts for Ugandan voices rather than existing evidence (Charmaz, 2006).

#### 4.6.3.3 Focused Coding

Focused coding adds rigour to the coding process and aims to develop the initial codes further (Alemu et al., 2015). It is more specific, and directed than open coding, but coding is not meticulously assigned to every word, phrase or sentence. Instead, using the most common codes to examine large amounts of data, I was able to assign codes to more meaningful conceptual categories. Some codes and themes were noted to be emerging over and over again. But more importantly, very few new properties were emerging at this stage of coding. I continued to code new interviews and re-code earlier interviews, employing the constant comparative method to help raise my analysis to a more conceptual and abstract level. Charmaz (2006) states:

*"...the process of going back and forth between collecting and analysing data raises the emergent levels of analysis"* (2006, p.161).

In focused coding, there is a potential risk of being dragged into the realm of *priori* knowledge rather than what is actually emerging from the data (Charmaz, 2006). In my experience and while exploring the relationships between the different codes I generated, I found myself reviewing existing literature on coding generation, risking cross pollination or ‘interference’ (Alemu et al., 2015). Writing memos allowed me to identify the conditions under which a process arose, persisted or changed. It also enabled me to achieve a balance between *priori* knowledge and keeping an open mind throughout the focused coding process for data to emerge. Focused codes were initially developed by comparing data with data. During these comparisons, “*the analysis moves from mere description to conceptualisation.*” (Alemu et al., 2015, p.534). Overall, the data analysis resulted in the emergence of four core categories, which represented common Ugandan experiences of engaging with volunteers. The terms associated with each of the four categories were not exact match to those expressed by all Ugandans, but iterative conceptualisation highlighted these categories incorporate the experiences of Ugandans engaging with volunteers. Table 4 below highlights the 4 emergent themes, and sub–themes.

Table 4. Emergent themes and sub–themes

<b>Themes</b>	<b>Sub themes</b>
<b>1. Perceptions</b> (Ugandans’ perceptions of volunteers entering their health facilities)	<i>‘helping’, and/or ‘personal and/or professional development’</i>
<b>2. Motivations</b> (Ugandans’ motivations of engaging with volunteers)	<i>‘validating existing skills’; ‘improving curriculum vitae (CV); ‘supporting community development’ (improving health provision, promoting health education); ‘gaining new skills’; gaining intercultural exposure and learning’; and ‘accessing further training’.</i>
<b>3. Perceived Benefits</b> (mutual benefits associated with volunteering)	<i>Benefits for volunteers: ‘context–specific knowledge’. Benefits for Ugandans:</i>



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	<i>'professional networking'; 'securing resources'; 'gaining recognition and credibility'; 'good practice'; 'health worker supervision'; and 'local empowerment and participation'.</i>
<b>4. Barriers</b> (to engaging with volunteers)	<i>'responsibility without authority'; 'health worker absenteeism' (causes and impact - inadequate pay and moonlighting); 'heavy workload'; 'prevailing volunteering styles'; and 'volunteer avoidance'.</i>

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#### **4.7 Ethical Considerations**

Ethical approval for this study was sought and approved by the University of Salford's Research, Innovation and Academic Engagement Ethical Approval Panel in November 2014 (Appendix 9). As part of the University's Research Ethics Approval Requirements, there were several ethical considerations made when designing and conducting this study. Underpinning these considerations is the paramount need to ensure participants' welfare is maintained at all times. For example, ethical dilemmas reflected in this study related to interviewing health workers while on duty and the potential affects their absence from the bedside may have on patient safety. In the scope of this study, this ethical issue was addressed by working closely with Ugandans and negotiating with them appropriate times, and spaces for interviewing. Similarly, managing cultural expectations particularly in relation to remunerations for research participation was also considered. An awareness of such expectations enabled me to make my research objectives clearer and include participant information booklet which clearly outlined the nature of the study and the voluntary participation it sought (see Appendix 10). This, to some extent, reduced the monetary expectations for contributing to this study. Further, a number of temporal factors were considered. These centred on the busy nature of Ugandan health facilities which required more immersion, and more time to better understand the context. Achieving this was particularly challenging for me given my family commitments back in the UK.

Coincidentally, both phases of the study occurred at a time when my wife experienced some health issues, and when my stays in Uganda were limited.

An awareness of these challenges helped refine my research schedule. Ethical considerations in this study followed recommendations described by Kvale, (1996) which included informed consent, confidentiality, benefits, or harm, lone researching, and others such as data management outlined in research ethics literature (e.g. Burns, and Grove, 2005).

#### 4.7.1 Informed Consent

In order to gain informed consent, I gave all Ugandans meeting the study's inclusion criteria a brief verbal overview of what the study involved, and then provided them with information booklet outlining the study. Depending on time and space, Ugandans who expressed interest in the study were asked to provide their contact details (including phone numbers and email addresses) as well as their availability slots.

I then contacted them and answered any questions they posed prior to arrivals for interviews including questions on informed consent. This process was repeated in the interview room and before the start of the interviews to accommodate final thoughts or questions regarding the study. At this stage, Ugandans were reminded that participation was solicited on strictly voluntary basis, and their rights to withdraw at any time, without providing any justifications. Ugandans agreeing to continue with the study at this point were given consent forms (Appendix 11) to sign, and verbal consent was sought at the beginning of the interviews and the focus group discussion.

#### 4.7.2 Confidentiality

At all levels of interaction with Ugandans, I emphasised the importance of confidentiality, and how this should be met before, during and after the research process. The following steps were taken to maintain and ensure confidentiality.

- All interviews were recorded and stored in secure dropbox immediately after every interview. All the interview recordings were deleted from the digital recorder immediately after transferring the audio files to a secure dropbox.
- All interviews were anonymised and allocated unique identification numbers which could not be associated with individual Ugandan health worker.

- Important data that can be traced back to individual Ugandan health worker such as audio recordings and consent forms were, and still are, kept in accordance with the University of Salford guidelines.
- All interviews were conducted at participants own convenience and choice. All participants were interviewed in their own workplace but away from patients and colleagues.
- All personal contact details (including names and contact details) collected in the recruitment process were destroyed after interviews.

#### 4.7.3 Benefits or Harm

Participation was solicited on strictly voluntary basis. I offered no reward, financial or otherwise, as an enticement for participation in the study. Similarly, there was no suggestion of any direct benefit to participants, other than sharing their perspectives and experiences of hosting volunteers – thus extending volunteering research. Due to the conversational nature of the study, I anticipated no risks or harm to Ugandans, but understood some Ugandans may find some of the interview questions sensitive. However, I did not detect any concerns at any point during the interviews or observations, and no Ugandan raised any concerns with me before, during and after the study.

#### 4.7.4 Lone Researching

I lived and commuted with volunteers and spent most of my stays with Ugandans and therefore did not engage in lone researching. Health facilities' leaders were aware of my visits and allocated individuals to guide and assist me should I required any assistance. Additionally, I utilised the following steps to prevent myself from lone working and from harm:

- I avoided engaging in any work or activities within health facilities on my own and researching over nights and weekends.
- I kept regular communications with Ugandan health facility leaders, volunteers, SVP management, and my PhD supervisors.
- I travelled to health facilities with volunteers and their management and returned with them to a shared accommodation.

#### 4.7.5 Data Management

In line with the University of Salford's ethical approval requirement, and Data Protection Act (1998), I adhered to the following data collection and storage principles:

- All interviews and observation data were anonymised using a coding system described in 4.6.3, so that individual participants could not be associated with the data.
- As mentioned in 4.7.2, audio files, interview transcripts, written field notes, and consent forms were stored in secure dropbox.
- During the data analysis process, all research related data saved on my university laptop was password protected and deleted after the completion of the data analysis process.
- Stored data was only accessible to my PhD supervisors for guidance and monitoring purposes only. In line with the guidance from the University of Salford's Research Ethics Requirements, all research related data will be archived for a minimum period of three years after graduate award has been agreed.

#### 4.8 Research Quality Criteria

It is widely acknowledged that research findings should be rich and robust enough to inform knowledge and practice (Noble and Smith, 2015; Charmaz, 2006). Accounting for quality in research projects requires assessments and verifications, and there are different ways of scrutinising the quality of research (Ely et al., 1991). Unlike quantitative approaches, the quality of research in qualitative approaches cannot be verified using probability or statistical measures. Instead, researchers are required to make sound judgements about their research in relation to methods, presentation, and integrity of findings (Noble and Smith, 2015). As such, several criteria for assessing the rigour of qualitative research are proposed (Charmaz, 2014). Credibility, transferability, and dependability tend to be the commonly used ones although this depends on the philosophical underpinnings of the research (Lincoln et al., 1985). The ultimate goal of qualitative research is to ensure participants' views and experiences are accurately reflected in research projects (Bryman, 2001). This includes establishing a match between the views and experiences expressed by participants and those presented by researchers (Guba et al., 1989).

By achieving this match, research findings are judged credible (Nakkeeran and Zodpey, 2012). The strategy recommended to increase the likelihood of this and adopted in this study include multiple research site visits and 'data triangulation' (Guba et al., 1989). Easterby-Smith, Thorpe and Lowe (1991) referred to data triangulation as the process of collecting data over different times or by using multiple methods. Decrop (1999, p.159) asserted that "*using multiple methods pave the way for more credible and dependable information*". These measures were incorporated in this study by adopting a two-phase approach to the study: a scoping and a follow-up phases, the former informing the later (or vice versa). Further, data triangulation was achieved through the collection of data from different sources (i.e. diverse cadres of Ugandan health workers), and drawing on multiple methods, including: interviews, observational research, focus group and field notes. Using such complimentary data sources allowed the generation of not only rich information, but also helped overcome some of the shortcomings of individual methods used (Gray, 2004; Eisner, 1991). Other strategies for ensuring quality in qualitative research (particularly those aligning with the traditions of constructivist GT) include, originality, resonance, and usefulness. Originality refers to the ability of a project to contribute to knowledge of a field, topic, or practice, and how such contribution extends or challenges current understanding; resonance, denotes the extent to which research findings reflect the voices and experiences of participants. In other words, the participants should not only locate themselves in the final text, but also understand the underlying message of the study (Charmaz, 2014). Finally, 'Usefulness' concerns the important message of the study, and how it should inform the focus of the study and contribute to knowledge more generally (Charmaz, 2006). Appendix 12 demonstrates how credibility, originality, resonance, and usefulness were embedded in this study.

#### **4.9 Chapter Conclusion**

This chapter provided a comprehensive account of the methods used to explore Ugandan experiences of engaging with volunteers. A brief overview of methods of data collection used in the field of voluntarism was provided to contextualise the methods of data collection considered for this study. The strategies adopted to collect, and document Ugandan voices and experiences were outlined, and a reflection of the decisions made provided. This included an overview of the two phases of the study, and the usefulness of scoping the research, testing the research tools, and most importantly, learning lessons. A detailed discussion on the procedure for identifying and recruiting Ugandans, and the cyclical process of data collection and analysis was also provided.

The chapter concluded with a discussion on the ethical considerations made and how quality was maintained throughout the study. The next three chapters present the findings of this study. Chapter 5, the first of those chapters, discusses Ugandans' perceptions of volunteers and their motivations to engage with them.

## **Chapter Five: Ugandans' Perceptions of Volunteers and their Motivations to Engage with them**

### **5.1 The Introduction**

Chapter five is the first of three findings chapters. It answers objectives one and two, and is divided into two distinct sections. The first section discusses what Ugandans think motivates volunteers to come to Uganda and engage with them. An awareness that volunteers come to Uganda to support local capacity and learn from their volunteering experiences emerged. This awareness is explored in two main themes; (i) helping; and (ii) personal and/or professional development. The second section answers objective two and discusses Ugandans' motivations to engage with volunteers. A wide range of Ugandan motivations are explored including a desire to derive personal and/or professional development. Six main themes representing these motivations are discussed in this section: (i) validating existing skills; (ii) improving curriculum vitae (CV); (iii) supporting community development; (iv) gaining new skills, (v) gaining intercultural exposure and learning, and (vi) accessing further training. The first three motivations were primarily but not exclusively expressed by senior Ugandans (i.e. doctors, leaders or in-charges) while the remaining three by more junior Ugandan health workers (i.e. students and interns). These emergent themes are discussed in the light of existing literature.

### **5.2 Section One: Volunteer motivations for coming to Uganda – Ugandan perspectives**

The world has, in recent years, changed significantly. People are now more mobile and interconnected than ever before: facing the same risks from pandemics worldwide (Crisp et al., 2013). This interdependence means that the UK and the NHS develop relationships and engage with partners across the world. Volunteers can play a significant role not only in building such relationships but also improving awareness and learning between various stakeholders including the NHS, NGOs and communities in LICs (Crisp et al., 2013). Yet, very little is known about what communities in LICs think of volunteering and what motivates foreign volunteers to enter their spaces or lives more generally. As discussed in 2.3, the perceptions communities in LICs hold of volunteers and their mobility have either been neglected or at best understood through the lenses of volunteers (Wearing et al., 2013; Conran, 2011; Ackerman, 2010).

The first objective of this study therefore is to bring forth these untapped perceptions. Interviews with Ugandan health workers hosting volunteers provided unique insights and revealed two common themes associated with volunteers' mobility and arrival in Uganda: 'helping' and 'personal and/or professional development'. Discussions on these two themes are provided in the following two sections.

### 5.2.1 Helping

The notion of 'helping' is synonymous with many versions of voluntarism, both in local and overseas settings (Mati, 2016). Yet, it holds different meanings for different people in different settings. In many African cultures and traditional communities, helping is deeply ingrained in community activities and traditions of sharing and reciprocal exchanges (Mati, and Perold, 2012; Wilkinson–Maposa and Fowler, 2009). Voluntarism is spurred to action by visions of 'togetherness', and as a vehicle for 'giving' or 'receiving' help, either 'horizontally' (i.e. poor-poor) or 'vertically' (rich–poor; Wilkinson–Maposa et al., 2009). While Ugandans did not use the word 'poor' or 'rich' in their discussion about volunteers, they used words such as “*colleagues*”, “*privileged*” and “*normal*” people to refer to volunteers and their relationships with them. Hillary, a junior nurse, describes volunteers:

*“Volunteers are privileged but normal people like us who have come to help us overcome some of the health problems we have in Uganda. They [volunteers] work with us and offer us support for the greater good of our people.”*

Similar to Hillary's representations of volunteers, most Ugandans saw [SVP] volunteers as health workers who came to work alongside them to jointly address local (Ugandan) health challenges. The phrase the “*...greater good of our people*” implies a conception of CoP and understanding by Ugandans that some volunteers align their work with Ugandans' agency and priorities on the ground. Such conception is also shared by Jane, a senior nurse. She explains:

*“Volunteers come to give us a hand in tackling the various health challenges our community faces. They [SVP volunteers] are our colleagues; we have a shared vision, and from their arrival to their departure, they are determined to improve situations for staff and patients alike.”*

The view of volunteers as 'normal' or 'health workers' expressed by many Ugandans suggests a recognition by Ugandans of the role volunteers play in their settings.



References to ‘shared’ learning or ‘vision’, and ‘professionalism’ by some Ugandans reflect a sense of togetherness, and the presence of CoP. This finding is particularly interesting because it counters dominant imaginaries in development circles where volunteers are viewed as part of the AID package, and their inputs conceptualised as giver–receiver (vertical) relationship (e.g. Raymond and Hall, 2008; Simpson, 2004). Charity, who identified herself as a junior midwife, illustrates this point further:

*“...Unlike people from the Ministry of Health (MoH) and foreign AID, volunteers are normal people we come into contact with...people we see every day...caring professionals who left behind their families, friends and jobs to support our work and help provide effective health care for local communities.”*

Charity saw the Ugandan MoH and foreign AID as distant entities that have limited connection with her life and her setting. She described the relational nature of volunteering and suggested that volunteers ‘humanise’ international AID and actively participate in care delivery in local communities. Charity, in the excerpt above, and throughout the interview, shared a perception of voluntarism that is ‘current’, participatory, and inclusive (Devereux, 2008). What is interesting about Charity’s distinction between government bodies, foreign AID, and volunteers is the fact that she spent limited time with [SVP] volunteers prior to the interview. However, like other Ugandans I interviewed, Charity had in the past engaged with Ugandan volunteers in remote areas to participate various activities such as home births and family planning aimed at improving health indicators, especially, but not exclusively, in the field of maternal health. These Ugandan volunteers, collectively known as Community Health Workers (CHWs)<sup>29</sup>, or Village Health Teams (VHTs), comprise largely unpaid, and untrained Ugandan men and women (Namazzi et al., 2017). Charity describes CHWs as “*ordinary*” people helping patients and communities.

*“Community Health Workers are ordinary people in the community who realise that they can offer help to mothers and babies by simply being with them and giving them basic health care. I think there is an awareness among Ugandans to collectively improve the wellbeing of our people.”*

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<sup>29</sup> CHWs are mostly recruited by the Ugandan Ministry of Health (MoH) and NGOs partly to counter the potential effects of health worker shortage in Ugandan public health system, and to broaden health coverage particularly in remote areas.

Charity also describes SVP volunteers in similar light, suggesting that her description of SVP volunteers might have been influenced by her understanding of volunteers in the Ugandan context, and more specifically, her experiences of engaging with CHWs. She says:

*“...the SVP volunteers are ordinary health workers with a mission to understand the challenges of our health system and to provide help for mothers and babies. I have not read much about their policy but their goals of working together and learning together makes us want to work with them...it looks to me we [Ugandan health workers and SVP volunteers] have similar goals...”*

These parallels in conceptualising Ugandan and SVP volunteers were also confirmed by more senior Ugandans with past experiences of engaging with both Ugandan and SVP volunteers. More specifically, Beauty, a senior nurse, notes that SVP volunteers remind her of CHWs she worked with as a junior nurse in that both volunteers:

*“...sacrificed their time and had strong desires to help mothers and babies without judgement and without expectations of rewards of any kind.”*

Unlike Charity and Beauty who described help at a micro-level (i.e. community level), other Ugandans discuss help at a macro-level (i.e. global level). Betty, a junior nurse, states that SVP volunteers come to Uganda following a “*global*” drive to address global health challenges such as maternal and newborn health. She describes Uganda as “*third world*” and the UK as “*developed world*” and suggested that the SVP volunteers, as global citizens, should help “*Ugandan mothers and babies who are really poor, and in need of health care.*” Leslie, a health facility leader, describes help in similar tone. He explains:

*“... volunteers come to Uganda to help and support our work. We [Ugandan health workers] see this as a great gesture because we feel part of a bigger world...the health of our people [Uganda] is the health of the people of the world. I believe there is similar recognition in the UK and the SVP volunteers’ arrival in our health centres is testimony to this shared vision...”*

Aside from such interconnectedness (whether perceived or otherwise), conceptualising help at a macro level is very common in ‘collectivist’ culture, defined as an individual’s obligation to pursue the interest of the group as a whole (Finkelstein, 2010). In some volunteering literature, collectivism is often contrasted with ‘individualism’, an ideology, or social outlook that emphasises independence, autonomy, and personal achievement (Skillman, 2000).

Consistent with the collectivist definition, and as highlighted by Beauty above, it appears that Ugandans view SVP volunteers, and the UK, as part of their collective endeavor to tackle Ugandan health challenges. Such perceived interconnectedness is testimony to a vision of working towards a common goal, and of CoP espoused by Ugandans and volunteers. Further, the view that Ugandans see themselves as ‘partners’ in practice is positive and presents an opportunity to promote more productive volunteering relationships. That said, it is important to state here that the notion of help is not innocent or without problems. Reflecting on help more broadly, Leslie, explains:

*“...help from outside [development AID] is better than no help. I say this because our help to our people is unconditional, it’s informal, help from outside is very formal and owned by those who bring it—we simply go along with it.”*

Leslie raises several important points. Firstly, he poignantly describes how help is understood in the Ugandan context and contrasts that with what he called help from the ‘outside’ which he feels is not ‘owned’ by the people [Ugandans] it is meant to benefit. This way of making sense of help from outside is commonly cited in the literature where AID is described as a top down, ‘expert’ led process that undermines local agency (e.g. Uvin, 2004; Ferguson, 1990). It appears that some Ugandans held perceptions of volunteers that are, to some extent, informed by their past experiences of AID. In particular, senior Ugandans, who, broadly speaking, appeared more familiar with how AID manifests more than their junior counterparts, describe volunteers as “*highly skilled*” people from a “*superior culture*”. For example, Beauty, refers to volunteers as “*experts*” and touches on a range of issues including the need for “*outside help*” or “*volunteers’ help*” to “*eradicate maternal mortalities*” in Uganda. She declares:

*“...the UK is a rich country and volunteers have had good training. They [SVP volunteers] are experts and very skilled in diverse clinical practices. We [Ugandans rely on them [volunteers] and outside assistance to help our people and eradicate maternal mortalities.”*

Interestingly, Beauty’s point above echoes those found in a study by Perold et al. (2013) which showed volunteer hosts in Tanzania and Mozambique perceived volunteers as members of a ‘superior race’ with specialist skills that members of host organisations did not possess.

The authors argued these perceptions are, to varying degrees, shaped by both the past (colonial history) and the present (the default helper tag of the volunteer). Brown and Hall (2008) illustrates this point:

*“The use of volunteers, who often have little knowledge or experience of work they are undertaking, also calls into question their ineffectiveness and raises the specter of neo-colonialism in the tacit assumption that even ignorant Westerners can improve the lot of the people in the South.”* (p.845).

Broadly speaking, this assumption can be observed in the ‘positive’ slogans (such as ‘make a difference’) volunteering programmes use to promote their work and recruit volunteers. Such slogans while commodifying voluntarism, masks the genuine motivations behind volunteering. Cook’s (2007) study of youth volunteers in Pakistan revealed that volunteers subscribed to the default helper tag and distanced themselves from ‘touring’ Pakistan, stressing that they had come *“to work for a Western-funded NGO with a goal of improving local living conditions”* (Cook, 2007, p. 87). This, according to Cook (2007), was the ‘official’ motivation most of the participants in her study expressed when asked why they had come to Pakistan. This language was, in this study, reflected by many Ugandans, who, on the whole, held the view that volunteers came to Uganda solely to alleviate local health challenges. Joyce, a senior midwife, shares such a view:

*“...we know [SVP] volunteers come here [Ugandan public health facility] to do their bit and help deliver mothers...they don’t get paid...they do this for the benefit of Ugandan babies and mothers whom we cannot help on our own.”*

Further to this, Baaz (2005) argued that the help narrative has a ‘gendered’ construction. The recipients of help are often perceived to be ‘helpless Third World women’ and this reinforces the *“dominant discourse of the victimised African woman”* (Baaz, 2005, p. 119). While most female Ugandan health workers discussed ‘help’ from the point of view of ‘helpless’ mothers’ and babies, it is not clear how much (or if at all) such expression is influenced by their gender. What is clear, however, is that, the need to ‘help’ appears to be a popular narrative used to reflect a desire to make a difference but only in so far as it reflects positively on those who wish to provide the help (Heron, 2007). Further building on the narrative of help, Gronemeyer (2010, p. 55) argues that the notion of help (in development discourses) has long lost its innocence and became a disempowering instrument which is *“unrecognisable, concealed, supremely inconspicuous”*.

For Gronemeyer (2010), the need for ‘help’ expressed by many Ugandans represents a disempowering view and makes assumptions about their capabilities, agency and aspirations. Among other things, the notion reinforces stereotypes and actively promotes an image of a ‘third world other’, incapable of leading his or her change. Further, researchers such as Kate Simpson (2004) and Raymond et al. (2008) expressed concerns about the casual use of help and stressed that volunteers (and to some extents their hosts) do not necessarily understand the inequalities and the romantic view of poverty the notion embodies. The authors argued volunteers imagine visiting a world in which ‘luck’ explained inequality, and in which solutions come through volunteering, and foreign intervention more generally. Simpson, in particular, calls for a ‘pedagogy of social justice’ and an understanding of inequalities and injustices inherent in the volunteer experience and development more generally. Simpson’s concern is indeed reflected in the programmes and strategic goals of many NGOs reviewed in this study, which, broadly speaking, present volunteers as change agents, and their destination hosts as inactive helpless others. Further echoing Simpson’s pedagogy of social justice and referring to what she termed as “*transformative intervention*”, Gronemeyer (2010, p.70) calls for radical shift of viewing help as an act of restoration (where local people decide what help is needed) as opposed to it being a diagnosis made by foreigners with very little understanding of the context in which the help is applied. Further, Kowalski (2010) argues help is no longer helping but a manifestation of paternalism, and a catch–up development. While much of what Ugandans derive from engaging with volunteers is considered ‘helpful’ as will be highlighted in chapter 6, it is worth considering that the very notion of help in this context is highly contestable. In addition to being driven by altruism (i.e. helping Ugandans), there was also a recognition among Ugandans that volunteers come to their settings to gain from their placements and derive some personal and/or professional development.

### 5.2.2 Personal and Professional Development

There are subtle differences between personal and professional development, and in some career development literature, there are several overlaps between the two (e.g. Evans, 2008). The aim here is not to present a definition for both or provide comparisons for that matter. Rather, I seek to describe what each entails, and how they should be understood in the context of this study.

Personal development involves improving one's talent and potential to accomplish the results required, both in work and life in general. Professional development, on the other hand, relates to developing one's self in work to understand the job and seek a new job or career progression (Cordingley et al., 2003). The idea that volunteers sacrifice their time for the benefit of others does not incorporate the possibility that people may volunteer to accrue personal benefits (Heron, 2007). The understanding that different individuals can engage in the same volunteer behaviour while having entirely different drives adds to the complexity of the current discussion (Clary et al., 1999). In a rapidly globalising world, with extensive changes in communication and mobility, voluntarism is thriving (Lyons and Wearing, 2008). Volunteers are driven, at least in part, by their personal needs for learning and 'mobility /career capital' (Ackers et al., 2017). As highlighted in section 1.3, volunteer motives tend to fluctuate between helping the poor and helping the self (Mustonen, 2011), and have been described as an altruism–self–interest mixture (Yeung, 2004; Clary et al., 1999). While most Ugandans I interviewed identified volunteers' desire to 'help the poor' as a primary reason for entering Ugandan public health facilities as described in the foregoing section, some suggested volunteers had more individualistic reasons for coming to Ugandan health settings – to derive personal development.

#### 5.2.2.1 Personal Development

An awareness of volunteers' motivations emerged with some Ugandans referring to volunteers as "*tourists*". In these instances, Ugandans cited that some volunteers are driven by greater interest in tourism and social activities. For example, when asked why volunteers come to Uganda, Mary, a senior anaesthetist, states that volunteers are driven by greater interest in tourism activities. She says:

*"Some of the SVP volunteers have been to all over Ugandan, Africa, and the world. They seem to be enjoying themselves travelling. They do very little work and not work nights and weekends..."*

The idea of linking SVP volunteers with tourists is understandable given the explosion of what has been termed 'voluntourism', or simply having 'fun' while 'helping' communities largely in LICs (Sin 2009; Simpson 2004; Telfer and Sharpley, 2008).

Particularly relevant here is the notion of taking a “*holiday with a difference*” (Wright, 2013, p. 241), or wanting to achieve a feeling of ‘heroism’ (e.g. Tomazos and Butler, 2010), through multiple short trips to LICs. It is possible that some Ugandans may have previously encountered voluntourists in their settings, and that the mobility of SVP volunteers both within Uganda and elsewhere may have reminded them of voluntourists. It is, however, important to note that SVP volunteers and Ugandans jointly participate in development exercises, and efforts on the ground are channelled towards identified local priority areas. While this is the view shared by most Ugandans, references to volunteers doing “*very little*” as shared by Mary above is a suggestion of SVP volunteers deviating from the traditional service delivery volunteering roles (i.e. volunteers working on rota and covering shifts for Ugandan health workers). Such perceived deviation becomes a source of conflict between volunteers and Ugandans and is a matter of discussion in 7.5 and 7.6. Ann, a senior midwife, who works in the same health facility as Mary, and who had past experiences of engaging with two SVP volunteer midwives, provides a more balanced perception of volunteers’ motivations of coming to Uganda:

*“... I think they [SVP volunteers] come to Uganda to experience our culture and wildlife...some volunteers also come to find out for themselves the stories about Ugandan and Africa they hear or watch in the media. Others of course come to experience how we do things clinically here [Uganda] and to learn from being with us...”*

Ann’s comment touches on both ‘pleasure’ and ‘business’ dimensions of volunteer motivations. These dimensions are widely reflected in volunteering programmes and existing literature. Scheyvens (2011, p.98) suggested that volunteer experience in the global South represents an outlet for the self-centred interests and desires of volunteers to improve their skills and/or “*to have an adventurous experience*”. Consistent with adventurous experience, Brian, a junior Ugandan doctor, stated that volunteers seek what he described as “*life changing*” experiences in Uganda health settings. He reflects how international volunteering agencies promote volunteering in poor countries such as Uganda as “*rewarding*”, and how development workers such as volunteers seek this “*life changing*” experience. Brian explains:

*“I read an article a few weeks ago suggesting volunteering in poor countries in Africa can be rewarding and life changing for people of Europe. I think some volunteers join us [Ugandan health facility] to gain such experience.”*

Brian's comment above is indeed not an isolated observation. In fact, the use of attractive terms such as those used by Brian are increasingly becoming common strategies in recruiting volunteers both in short-term and long-term. Volunteers are often spurred to action by such terms along with images, advertisements, and personal accounts of volunteer work done by returning volunteers (Freidus, 2016). Beyond motivating individuals to action, images can propagate misrepresentations of the people of the South, including their aspirations and needs. Van Engan (2000) argued there is a culture of 'romanticising' enduring challenges in the global South and voluntarism has done very little to empower volunteers challenge inequalities, and to understand the ways that the historical legacies impacted on local culture. However, more recent studies in the context of Africa demonstrate that many returned volunteers with first-hand experiences of the challenges that exist within volunteer hosting countries have begun to pay a closer attention to the impacts inequalities may have on local people, suggesting a paradigm shift is gradually taking place (Graham et al., 2011).

#### 5.2.2.2 Professional Development

Ugandan health workers suggest the potential of volunteer programmes to provide learning experience for volunteers is a primary attraction (Potter, 2004). There was a shared view among Ugandans that volunteers enter their health facilities to learn and gain experiences in Ugandan contexts. Three areas of learning were identified. Firstly, "*limited*" knowledge of tropical medicine was cited as a primary motivation. For example, having previously worked with several volunteers, Josephine, a junior nurse, recognises that some volunteer doctors prioritise knowledge of tropical medicine, including diagnosis and treatment. She notes:

*"...I understand that some [SVP] volunteer doctors lack hands on skills in some tropical conditions... gaining such knowledge is a target if not a priority for many volunteers including the volunteer doctor I worked with."*

Ann, a junior doctor, was more specific in her views about volunteers' attraction to Uganda. She suggests that volunteers are driven to gain knowledge of diagnosis and treatment of common tropical diseases such as malaria and Tuberculosis. Josephine, a senior midwife, supports Ann's claim with a conversation she had with a volunteer midwife who since returned to the UK. She reflects:



*“...I worked alongside [name of female SVP midwife removed] for nearly a year. She [midwife] used to say I always wanted to work in an African health system to learn more about malaria and tuberculosis. I do not know but for some reason, she put a lot of energy in learning the diagnosis and treatment of these two conditions.”*

Despite the increased mobility of people globally, tropical diseases are not very common in the UK where volunteers have their initial training. As such, and broadly speaking, many UK trained health professionals have limited on-the-job experiences of such conditions. Volunteering in tropical countries such as Uganda provides the opportunity to apply theoretical learning (Gedde, et al., 2011). It also provides an experience of a country and culture for fulfilling course or work-related requirements as reasons for volunteer motivations. Mary, shares her experience of the latter volunteer motivation:

*“...when they [SVP volunteers] first came here, they said they needed to spend some time with us [Ugandans] to gain experience of third world country as part of their training and to show evidence of their work in Uganda to their supervisors in the UK.”*

I asked whether Mary noticed any differences between volunteers fulfilling clinically oriented requirements and those on capacity development placements such as the SVP volunteers. She replied:

*“There is a clear difference. Volunteers with work related motivations focus more on the activities that give them the experience they are looking for, and spend much time recording all their activities in their own laptops...volunteers with other motivations are reliable, flexible, and contribute to our daily tasks...”*

It is clear from the above excerpt that some Ugandans value “flexible” volunteers who can actively participate in various activities in their settings more than those with a predetermined goal such as fulfilling individual objectives. While this is understandable given the human resource challenges Ugandans experience in their settings, it is also an indication of wider expectations shaped by dependency relationships that continues to exist between people of the global South and NGOs from the global North. For example, a study conducted by Perold et al. (2011) found that, volunteer host organisations and members of host communities in Southern Africa represent international volunteers as mobile, ‘hard working’ and ‘skilled’ helpers with the ability to solve their problems.

Volunteers who do not conform to these volunteer expectations and stereotypes were viewed as untypical of the dominant understanding of global North volunteers, and therefore perceived ‘unreliable’, and less valuable (Perold et al., 2011). From a learning point of view, knowledge in the context of LICs was identified as a major motivation of volunteers. Ugandans showed a strong awareness of volunteers’ motivations to gain “*unique*” health solutions from their settings to transfer to the NHS. Timothy, a health facility co–leader explains:

*“...some volunteers have in the past discussed with us how we operate with very limited budget and survive at the same time...for many [SVP volunteers], working with what we had at the time was an impossible task, and some even suggested they would rather quit their jobs than work in such environment! Later, however, they [SVP volunteers] began to understand our unique ways of surviving and appreciated very much...I am sure some volunteers come to Ugandan for this purpose.”*

Timothy’s observation of volunteers and their motivation to experience health care provision in LICs is widely acknowledged. In fact, in the UK, emphasis on learning from LICs promoted by the emerging idea of ‘reverse’ or ‘frugal’ innovation (see Ackers et al., 2017; Crisp, 2014; Syed et al., 2013; Govindarajan, and Trimble, 2012), is gradually being embedded in global health volunteering programmes. The view that services based in HICs could create opportunities from innovative services emerging from LICs was first highlighted by Brown and Hagel (2005) using the reference ‘innovation blowback’. Jeffrey Immelt and colleagues (2009) advanced the concept of ‘reverse innovation’ to refer to any innovation likely to be adopted first in LICs before spreading to HICs. Related to this, are the much–emphasised notions of health worker ‘resilience’ and ‘resourcefulness’, and some Ugandans expressed awareness that volunteers come to Ugandan to experience work in resource limited settings. Jane explains:

*“...as a first–time volunteer, my friend [SVP volunteer midwife] said she read about the poor conditions of Ugandan health facilities, and the resilience of Ugandan health workers...she wanted to find out and learn with us and see if she can cope working in such environment [laughs].”*

The volunteer motivation of “*finding out*” what it is like working in tough conditions particularly intrigued me. I asked Jane to describe what the experience was like for the volunteer midwife. Jane replies:

*“...At first, she [SVP volunteer midwife] occasional became emotional and upset particularly when tragedy hit. She said she recognised how lucky she was being born in the UK and growing up with good health facilities around her. Later, she learned how to control her emotions and stay focused...she developed her own routine and coped in her own ways...”*

Finally, public health facilities in Uganda are exciting places particularly for first time volunteers because many things happen simultaneously: delayed births, preventable deaths, to name but a few. Such experiences are believed to draw volunteers to Ugandan health facilities. Maria, a senior Midwife, explains:

*“...health care provision in Uganda is complex and challenging. Health workers encounter so many challenges; some preventable; other not; ...all are exciting things for first time volunteers with little knowledge of medicine outside the UK. They [SVP volunteers] make it clear to us they come to Uganda with the purpose of learning and they see our health centres as places for learning and sharing ideas...”*

Consistent with Maria’s observation, volunteering in LICs such as Uganda is regarded as a form of professional learning. Also, highly regarded by employers are candidates with some understanding of cultural diversity (e.g. Crossman and Clarke, 2010; Brook et al., 2007; Cook and Jackson, 2006). It is therefore no surprise that international learning has become a ‘rite of passage’ in careers such as medicine (Ackers et al., 2017; Beames, 2004). It is among other things incorporated into curricula and offered with a focus on learning opportunities (Gedde et al., 2011; Button et al., 2005). Understandably therefore such placements are very popular among health professionals with a particularly keen interest in surgical residencies (Butler et al., 2010; Powel et al., 2007). In fact, it is now acknowledged that non-clinical placements are of little interest to professional volunteers, mainly because knowledge gained from clinical placements in LICs are increasingly being recognised as adding value to the NHS (Chatwin, and Ackers, 2016; Gedde et al., 2011). While international exposure and learning underpin much of international placement in medicine, questions about how mobility shapes knowledge and expertise is being asked. This is particularly relevant given the inequalities in mobility that exist between volunteers and Ugandan health workers which is also reflective of socio-economic injustice (or maldistribution), and cultural injustice (misrecognition) in the sense that host spaces become training grounds for highly privileged volunteers from the global North.

In addition to these inequalities, there is also potential risk of shifting towards instrumentally–motivated volunteering which, if not carefully managed, risks the deployment of career track volunteers with less insights on host capacity, agency and aspirations (Ackers et al. 2017; Dean, 2015).

### **5.3 Section Two: Ugandans' Motivations to Engage with Volunteers**

For too long now, the reasons why volunteer hosts in the global South welcome and engage with volunteers remained largely unknown (Sin, 2010). And, in relation to this gap in our understanding is the call for researchers and development practitioners to explore host motivations for better engagement, and outcomes. Responding to this call, and in attempt to answer objective two of this study, this section of the study explores why Ugandans are motivated to engage with volunteers. The findings suggest parallels between Ugandans' perception of volunteers' arrivals in their settings, and their own motivations of wanting to engage with them. More specifically, the findings suggest that Ugandans are motivated to engage with volunteers for personal reasons aimed at personal growth, including a desire to have a personal and/or professional experience. The following six themes are discussed in this section: (i) validating existing skills; (ii) improving CV; (iii) supporting community development; (iv) gaining new skills, (v) gaining intercultural exposure and learning, and (vi) accessing further training. As mentioned in the chapter introduction in 5.1, the first three motivations were primarily but not exclusively expressed by senior Ugandans, while the last three by more junior Ugandans. A discussion of each of these motivation themes is provided next.

#### **5.3.1 Validating Existing Skills**

The desire to validate existing skills was mentioned by senior Ugandans who described themselves as 'experts' in their roles. Some of these Ugandans stated using volunteers' perceived knowledge as a marker from which they can self–validate own levels of expertise. Prossy, a senior midwife, illustrates this point:

*“...after so many years of clinical practice, I think there is no much to learn but with very little contact with health professionals from the rest of the world such as the volunteers, I wanted to find out my competency level through engaging with volunteers...”*

Prossy works in the same health facility and held the same role for nearly twenty years.

She describes herself as a “*very experienced*” midwife but with little contact with non-Ugandan health professionals. Her motivations for engaging with volunteers was to ascertain how far she had come in her career through engaging with volunteers. Priscilla, a senior nurse, is more evaluative in her desire to engage with volunteers. She is not concerned so much with learning with volunteers, but rather comparing and contrasting her clinical competencies with those of volunteers, and in the process, assessing her ‘strengths’ and ‘weaknesses’. She explains:

*“It is not a question of learning from volunteers for me...it is rather finding out how similar or different volunteers’ clinical competencies are to mine, and what my strengths and weaknesses are moving forward...I have been practising for a long time...”*

It emerged that many senior Ugandans use volunteers as ‘external’ validators to inform their clinical practice. Validation, as a motivation mechanism, has not yet been explored in volunteering discourses. However, as a practice, it is sometimes used informally by small scale volunteer sending agencies. In this context, volunteers’ work is assessed against pre-set goals to assess progress. A practical guide entitled ‘Volunteering Validation Highway’, an international benchmarking framework sponsored by the European Commission (EC), defines validation as process where demonstrated and/or documented evidence of competencies or achievements is assessed against a commonly agreed set of criteria to assure their quality matches these criteria. It appears that most senior Ugandans initially engage with volunteers primarily to observe and mentally encode volunteers’ competencies and assess them against their own. If volunteers are found to be offering something new or different, senior Ugandans are likely to continue engaging with them. By contrast, if through the first few encounters, volunteers are found incapable of offering something new or different, then disengagement by senior Ugandans almost always follows. Validation, in this regard, therefore, may explain the disparity in volunteer engagements between senior and junior Ugandans, with the latter more likely to ‘actively’ engage with volunteers than the former<sup>30</sup>.

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<sup>30</sup> The disparity in volunteer engagement highlighted here is based on my observation in two health facilities where I spent four weeks observing Ugandan–volunteer interactions. It is also explained by high rates of absenteeism and dualism rampant among senior Ugandans such as doctors (see Ackers et al., 2017; Ackers, Ioannou and Ackers–Johnson, 2016). This phenomenon is explored further in 7.3.

### 5.3.2 Improving Curriculum Vitae (CV)

The practice of enhancing one's CV through volunteering is a growing phenomenon (Simpson, 2004). Much of existing literature on this topic highlight trends towards volunteering to better compete in the job market rather than to fulfil a social need (Dean, 2015; Rothwell et al., 2008). However, very little research (if any) explored whether volunteer hosts in the global South engage with volunteers to improve their CVs and future job prospects or not. Interviews conducted during both phases of the study revealed inherent tensions between the 'good for others' and the 'good for the self' in health spaces. More specifically, the findings showed reporting individual accruals was quite problematic for Ugandans not least because they do not happen, but because they contradict with their collectivist culture where the good for others is emphasised over the good for the self (Mati, 2016; Caprara et al., 2011; Finkelstein, 2010). As consequence, most senior Ugandans mentioned the desire to improve their CVs indirectly while answering related questions, indicating that they did not want to appear selfish or insensitive to the plight of their patients. Sensitivity to both culture and to the ill was particularly important because some of these senior Ugandans held leadership roles and were therefore expected, at least in theory, to be role models. One way in which most senior Ugandans overcame this sensitivity was to stress the desire to improve their CVs was 'not' a major factor of wanting to engage with volunteers.

*“...for me, learning with volunteers and improving my skills was the main reason for engaging with them. As you know, volunteers came from a country that has more advanced health system than ours [Uganda], so there is a scope for learning...also working with volunteers offers a useful experience to put in my CV to help me find a better paid job in the future [laughs].” [Rose, a senior nurse].*

It must be stated here that the less emphasis on CV by senior Ugandans can also be an indication of their seniority compared to their volunteer counterparts. This was particularly the case in at least one Ugandan I interviewed who was in practice for nearly thirty years, and who has worked in several Sub-Saharan African countries including neighbouring Kenya. By contrast, most SVP volunteers tend to be early career health professionals with limited exposure to medicine outside the UK or global North contexts.

Timothy was perhaps more forthcoming with his CV enhancing motivation to engage with volunteers. He cites perceived volunteer motivation for coming to Uganda and uses this to contextualise his own motivation. He explains:

*“Look it is not secret volunteers come here [Uganda] to give and take. I personally want to engage with volunteers to improve my CV and chances of landing a better job...it is difficult working in the public sector these days and it is important that I update my skills and take them where I think it will be more productive for me and for my family.”*

References to a “*better job*” throughout most interviews and the almost light-hearted manner in which senior Ugandans expressed them were indicative of not only dissatisfactions of their public sector roles, but also their intentions to leave for “*greener pastures*” in the future. Jane is more persuasive about her motivation of wanting to improve her skills whether through working with volunteers or otherwise. She explains:

*“In my experience a lot of what we do involve learning. Whether it is through working with local or international professionals. People are always interested in keeping up with their area of expertise, and when better opportunities come up, you have to take them to progress and improve. Working with volunteers may make this possible whether it is here [referring to a health facility] or in greener pastures elsewhere [laughs].”*

In line with the ‘development’ language used in Ugandan health system, phrases such as “*better job*”, and “*greener pastures*” often mean working in the private health sector, most probably with Northern NGOs where remuneration is disproportionately higher than in public health sector (Matsiko, 2011). Ann, puts this in a better light:

*“...most experienced people [Ugandan health workers] try to find other ways of sustaining themselves. Things are getting tougher in Uganda [public health], and people are constantly looking for alternative jobs with NGOs or in the private health sector. Volunteers and other people coming from the outside sometimes present job opportunities and senior people especially pay much attention to them.”*

The practice of using volunteers as a rite of passage by some senior Ugandans sheds some light onto two critical issues. Firstly, it provides an interesting perspective on employability, defined loosely as “...*the perceived ability to attain one's desired level and type of employment in the future*” (Rothwell and Charleston, 2013, p. 163). Hillage and Pollard (1998) stress that employability denotes the capability to access or move into work, but also to stay in work.

Employability also relates to the capability to move within labour or a field to realise potential through honing skills and contacts. Rose, explains this succinctly:

*“...part of my reasons for working with the volunteers is to gain on-the-job experience, have first-hand information about better jobs around and secure future jobs with organisations that value the importance of health workers and pay them well.”*

Secondly, using volunteers as a proxy for mobility capital provides a platform from which to scrutinise potential ‘knowledge displacement’ – the mobility of knowledge from public to private health sectors. Health professionals operate within CoP, and regardless of whether practising at public or private setting, there is an underlying recognition that they benefit people who rely on their expertise. However, questions arise when health professionals employed at public settings transfer knowledge and social networks gained in the public health sector through engaging with volunteers to the private health sector. It is argued that such practice has four significant detrimental effects in Uganda; firstly, it exacerbates the already unfolding dilemma of brain drain, reducing the resilience of the public health systems (Ackers et al., 2017); secondly, it further depletes human resources in a setting identified by WHO as in ‘crisis’ (WHO, 2006); thirdly, it undermines the realisation of SDG 3 relating to improving maternal and newborn health, a top priority for Ugandan Ministry of Health, and its international partners (Nabyonga-Orem, 2008); fourthly, it puts volunteers’ mission on the back foot in terms of contributing to public health capacity, a key mission of the SVP. Concerns about knowledge or networks leaving the public for the private health sectors is valid given the fact that the public health sector appears to be the primary source of health care for many Ugandans particularly those in rural or impoverished dwellings (MOH, 2010). From a social justice point of view, this raises important questions about distribution of health resources between the economic classes. It calls for a closer look at potential triggers of the displacement such as wages – push factors prevalent in Ugandan public health sector which need to be remedied for knowledge retention and for greater access to health for all Ugandans.

### 5.3.3 Supporting Community Development

Ugandans holding senior positions (i.e. health facility leaderships) expressed motivations of wanting to work with volunteers for the greater good of their community. Some made references to volunteers’ ‘potential’ to ‘strengthen’ their capacity and deliver ‘good’ health services.



Two such potential areas of community development were identified: improving health provision; and promoting health education. Discussion on each of these motivations is presented next.

#### 5.3.3.1 Improving Health Provision

It is widely acknowledged that international volunteering, if properly managed, has the potential to improve health provision for local communities (e.g. Hague et al., 2015; Laleman et al., 2007). In this regard, volunteers play a crucial role in strengthening local capacity to provide improved health care to wider populations. There was a recognition among some Ugandans that volunteers come with ideas and “plans” not only to facilitate knowledge exchange with Ugandan health professionals, but also to improve health provision for “local communities”. Jane states:

*“...of course, volunteers do work with us [Ugandan health workers] to share with us their clinical and life experiences; but they [volunteers] also come with practical plans to minimise risks and improve our provision to the local community...nothing makes them happier than seeing people go back to their villages and homes better and healthier.”*

The ‘practical’ plans to minimise risks in this instance means volunteers bring much needed human resources to Ugandan health facilities, adding more choice and expertise for the greater good of their community. Mary commends the ability of volunteers to contribute to human resources and take an “active lead” in improving health provision in the community.

*“...the volunteers increase our staff numbers and do an excellent job. They [volunteers] take active lead to create safe environment for us [Ugandan health workers], themselves, and patients.”*

It appears that volunteers assume contrasting roles within Ugandan health spaces ranging from service delivery, and leadership to health education and promotion. These roles are possibly in line with their career goals, and some inevitably conflict with their core mission – supporting local capacity through shared learning. As evident in the above excerpt, Ugandans make complex range of assumptions about volunteers in their spaces, and some (perhaps knowingly) extend volunteer roles to include ‘leading’ local projects. While at face value volunteers taking on such higher order roles may come across as benign, such practice may underscore local agency and may reinforce Eurocentric attitudes and cultural domination (Palacios, 2010).

Further, 'consistency' in operations and 'clarity' in the roles of development actors are identified as key components of development projects by UNDP and the SDGs particularly in North–South relationships that focus on goals 3 and 17, 'Good Health and Well-being', and 'Partnerships for the Goals' (Lopes and Theisohn, 2003).

### 5.3.3.2 Promoting Health Education

In recent years, health education has become a key feature in global health volunteering (Nyamwaya, 2003). This development has now acquired a steady pace and the use of health education as a means of increasing societal responsibility for health now exists in many LICs (WHO, 2013). Some Ugandans stated that volunteers have a 'keen' interest in health education, a topic that is very important to them, and to the local community. Particularly importance to them is the emphasis on prevention over cure:

*"...most of the cases we encounter can be avoided if we take the time to educate our patients on a thing or two about their health and that of their families...the volunteers show interests in promoting and raising health awareness to prevent preventable health problems."* [Ann].

And the need to embed this message in the care they give to the local community to reduce congestion in health facilities:

*"...volunteers come with practical ways of feeding patients with useful information during consultations that can help them stay on top of their health and their families...this will reduce the demand for our services in the long term, I think."* [Maria].

Health education is particularly important in LICs where access to preventative public health can be scarce or even lacking (Uganda Health System Assessment, 2011). Ugandans observe that volunteers' emphasis on encouraging members of local community to take responsibilities for their own health is positively received by the local community: Mary explains:

*"...The volunteers spend much time with patients and explain to them the do's and the don'ts and patients listen with curiosity...this empowers the patients and the wider community they [volunteers] engage with and equip them with useful information to keep themselves and their babies healthy."*

During both my research visits to Uganda, I noted Ugandans and volunteers conducting outreach work in rural communities, raising health awareness ranging from family planning, and safe use of contraception to the prevention of communicable diseases.

I observed how the presence of volunteers attracted the attention of members of the local community, and how senior Ugandans use this to their advantage to draw out crowds and promote a sense of togetherness, and CoP. I also observed how engaging with volunteers allows primarily but not exclusively more junior Ugandans to gain new skills critical to their professional development.

#### 5.3.4 Gaining New Skills

The desire to gain new clinical skills was noted mostly by more junior Ugandans and was informed by a general assumption that volunteers possess clinical competencies that are useful to junior Ugandans. Betty, a junior midwife, explains:

*“...I think volunteers are interested in sharing what they know with us [Ugandans]...People [Ugandan health workers] who worked with them before said they take health worker development seriously and want to train junior people like me. I hope to understand how they practice so we can work and learn with them.”*

Betty’s desire to gain new skills through engaging with volunteers, which itself is an indication of her limited clinical skills, was also shared by other junior Ugandans, who on the whole, saw volunteers and the UK as sources of knowledge. Lucy, a junior nurse, adds:

*“...the volunteers are professional people who bring many skills we lack here in Uganda...they [volunteers] come from the UK which is a world leader in medicine...this is actually the main reason why I wanted to work with them...”*

Lucy’s desire to gain new skills through engaging with volunteers was also a reflection of her past experiences of AID which distinguishes knowledge as ‘local’ and ‘expert’, with the latter almost always coming from the global North (Pastran, 2014; Guttentag, 2009). Her reference to the UK as “*a world leader in medicine*” is a testimony of her construction of knowledge coming from the global North. Lucy’s construction was also informed by her characterisations of volunteers as “*professionals*”, which itself has two important implications in Ugandan health systems and cultures: firstly, the badge ‘professional’ denotes hierarchy (positionality) and values and is often used as a marker of respect as evident in the following excerpt.

*“...we [Ugandan health workers] were told [by health facility leader] volunteers are very professional people with knowledge of different fields. As a junior nurse, I value learning and the volunteers have what I need to be good at my role.” [Charity].*

The phrase “*very professional people*” was often used by Ugandans to refer to volunteers both as an acknowledgement of their competencies and as a marker of integrity and accountability. Secondly, and in line with colonial legacy, the word ‘professional’ is often associated with elevated perceptions of (predominantly) white volunteers (Muzungu)<sup>31</sup> from the global North with ‘superior’ skills adding ‘efficiency’ to local communities (Roberts, 2004; Simpson, 2004). For most parts of the interviews, junior Ugandans such as Lucy expressed a desire to engage with volunteers in a manner consistent with the second implication of volunteers’ professional categorisation. The use of phrases such as “*capable people*” were common responses given by junior Ugandans expressing their desire to engage with volunteers. Such observations are often too common in many global South settings. For example, an ethnographic study by Palacios (2010) found members of host community in Fiji, Mexico and Vietnam believed that volunteers “*were representatives of a superior Western knowledge*” (p. 869). Volunteers, then, are perceived as being “*in a better position of power to judge and comment on the aid-recipients*” (Sin, 2009, p. 496).

In this study, volunteers organised and delivered training mostly to junior Ugandans, who on the whole, attached particular importance to training more than their senior counterparts. The content of the training was however designed with Ugandan priorities and needs on the ground. Unlike the ‘seniority’ implication the word ‘professional’ has in Ugandan public health system, and as expressed by junior Ugandans above, the SVP coined the term professional [volunteers] to serve two main functions; firstly, the characterisation of volunteers as ‘professionals’ sought to overcome the ‘safari-style’ concepts of volunteering such as voluntourism (see Wright, 2013; Wearing, 2001), and bring forth a notion of volunteering by “highly skilled and mobile professionals” (Ackers et al., 2017, p.12); secondly, it represents an attempt to distinguish the volunteering model Ugandans and volunteers participate from the traditional donor–recipient narrative imbued in AID and situate the relationships between Ugandans and volunteers within the framework of international knowledge mobilisation and human resource management.

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<sup>31</sup> The word ‘Muzungu’ [s] takes on several meanings; from simple ‘white man/woman depiction to the wider reflection of Africans’ experiences of European travellers, explorers and missionaries. In fact, Muzungu literally translates ‘*mtu anayezunguka*’ in Swahili, meaning ‘*someone who travels and moves about*’ and is sometimes applied across races, ethnicity and cultures.

The word 'professional' also reflects concepts and languages of the 'development edifice' and implies that knowledge and technical skills along with the mechanism to harness them are brought about by volunteers (who are predominately white), and emerge from the global North. And from a social justice point of view, 'professional' in this regard has undertones of both racial and geographical injustices along with the imposition of alien intervention. An awareness of the implication these constructions may have on relationships and sustainability is needed for meaningful intervention in global South spaces.

### 5.3.5 Gaining Intercultural Exposure and Learning

Some junior Ugandans acknowledged actively seeking to work alongside volunteers simply because they had limited exposure to working with 'white' volunteers. Charles, a junior doctor, explains:

*"I never worked with white people before until about a year ago. I did not know what to expect and to be honest I had my concerns. People [Ugandan health workers] who worked with volunteers at the time said they [volunteers] bring their own cultures to Uganda, and preferred working among themselves...later I found out volunteers were fun, caring and responsible."*

From Charles' experience above, and many similar others, exposure to the professional lives of different geographies and cultures can contribute to change in their perspectives on life, work, attitudes and cultural stereotypes. Increasingly, such exposure is encouraged, and in fact viewed as 'core' competency for health professionals (Kodjo, 2009). The ability, and awareness to perform effectively and appropriately when *"interacting with others who are linguistically and culturally different from oneself"* is often referred to as 'cultural learning [competency]' (Fantini and Tirmizi, 2006, p.12). Such ability and awareness do not only apply in transnational interactions (i.e. Northern volunteers engaging with host community in the global South), but also in local interactions. This is true in the context of Uganda, a nation of stark contrast, diverse lands and peoples (Thompson and Cechanowicz, 2007). There are many traditions, cultures, and health practices that impact on how people interact and relate to each other. To think of Uganda as a country with one or similar cultures would do no justice to the diversity that exists in the country. Leslie puts into perspective the diversity of cultures Uganda embodies, and the importance awareness of such diversity has for care delivery. He says:

*“...Here [Uganda] people have different beliefs, tradition and cultures...people from other African countries living with us also come with their own cultures. As clinicians, we are expected to have an awareness of such diversity and to respect all people at all times in order to provide care.”*

For that reason, intercultural exposure and learning in the context of Ugandan health systems refers to consideration on the part of health workers and health systems more generally, the importance of culture, the assessment and the adaptation of services to meet cultural needs. An awareness of cultural differences and the ability to embed cultural knowledge in practice is viewed as crucial to inclusive health care delivery. The importance of cultural awareness is increasingly being emphasised in Ugandan public health (Thompson et al., 2007). A strong desire to engage with volunteers to gain knowledge and exposure to intercultural learning emerged particularly from junior Ugandans such as interns and students. Betty, one such Ugandan, reflects:

*“...we are taught the importance of understanding patients’ traditions and cultures to provide effective care...engaging with volunteers will enable me to understand cultures that exist in Europe and how it may differ from ours [Ugandan cultures].”*

As evident above, volunteering presents opportunities for people of diverse cultures and experiences to engage and learn together. A great deal of the learning that occurs through volunteering is borne out of immersion and exposure to a different culture (or practice). The importance of this type of learning is that it requires participation and encourages individuals to step outside of their own worldview and consider how it may relate or differ another worldview (Comhlámh’, 2013). An understanding of culturally sensitive or situated knowledge has been identified as an essential skill for volunteers working in the global South. Limited cultural understanding has been cited among student health workers in the US (Bond, Kardong-Edgren, and Jones, 2001), and cultural ‘immersion’ has been used to inform cultural understanding (Hunter and McKenry, 2001). For example, Thompson, et al. (2007) examined the impact of nursing practice on two American University nursing staff who participated in a cultural immersion experience in two Ugandan hospitals. The authors identified patterns of cultural variations among the nursing and health care practices which they said were consistent with the diversity that exist within the Ugandan public health and Uganda more generally.

In similar light, junior Ugandans expressed a desire to engage with volunteers to experience cultural immersion in order to incorporate cultural sensitivity in their clinical practice. Lucy explains:

*“...I think volunteers and their culture bring real challenges to us...their presence tests our ability to effectively communicate with them while at the same respecting each other’s cultures, and practices.”*

Working with people from different cultures can be a daunting prospect but Lucy recognises it has the potential to inform her clinical practice. This view is also echoed by Betty who suggests that volunteers act as a bridge between the two ‘cultures’ and a conduit to *“promote understanding and shared values”*. These suggestions are particularly important given the cultural insensitivity imbued in AID, and often the distant and the unequal relationships between volunteers and their hosts in global South contexts (Simpson, 2004). Therefore, intercultural learning as expressed by some junior Ugandans has the potential to inform culture sensitive clinical practice, but also provide an opportunity to dispel inherent myths about culture superiority often associated with global North volunteers (see Perold et al., 2013). Similar to Thompson et al.’s (2007) observation above, it is possible that UK volunteers destined for Uganda were themselves seeking, among other things, an experience of cultural immersion in order to gain intercultural competency. The fact that knowledge of intercultural competency is looked upon favourably in the NHS if demonstrated at junior level by returning volunteers (see Gedde et al., 2011) adds weight to this proposition.

#### 5.3.6 Accessing Further Training

Many Junior Ugandans noted that their motivation to engage with volunteers was inspired by the desire to gain further training or undertake additional training. When I asked why they needed to gain further qualifications, different motivations arose. Junior female nurses stated they experienced poor working conditions and poor salary, and one respondent hoped volunteers’ presence may change her ‘luck’:

*“...as a junior nurse, you are expected to attend all shifts and work very hard...working conditions are very bad, and the salary is even worse...I needed to get out of this by gaining more qualifications. Some NGOs and volunteers sponsor Ugandans to do advanced courses both in Uganda and the UK...I thought I might be lucky so I keep trying...”* [Irene, a junior nurse].

Furthermore, the existence of fellowship programmes facilitated by the SVP is also a major attraction for some Ugandans. Knowledge of past and/or present recipients fed this belief. Lucy explains:

*“...my friend [Ugandan health worker] whom we have known since childhood has secured the Commonwealth Fellowship in the UK. She [referring to her friend] was hardworking and very committed. The SVP management team took note of her and helped with the application and trip to the UK. I did not know the [SVP] volunteers offered such fantastic opportunity...I am working towards securing the scholarship now...”*

It is argued that much of Ugandan’s drive towards seeking further training is informed by traditional styles of capacity development programmes in LICs with emphasis on Continuing Professional Development (CPD). In HICs, CPD is generally viewed as a framework with opportunities for review and progression. However, this is not the case in Uganda. Reflecting on ethnographic field work, Ackers et al. (2016, p.63) described CPD in the context of Ugandan public health as:

*“...a view that all training is good...and the received wisdom that attendance at training provides a legitimate reason for absenting oneself from work with personal financial gain results in a high demand for training.”*

In practice, there has been difficulties associated with formal training within the Ugandan public health system. Traditionally, it is expected that training delivered by NGOs take place outside public health facilities. Ackers et al. (2016) identified that such practice has the potential to take health workers off wards in a setting already chronically under-staffed. Further exacerbating what was already identified as a setting in ‘crisis’ (see WHO, 2006) is the lack of arrangements in place for staff cover. It is common to find no staff in Ugandan wards and to be told that they are ‘on a course’ *“...as if training can ever be a justification for leaving neonates unattended.”* (Ackers et al., 2016, p.57). The authors concluded that the SVP emphasises onsite training and mentoring to improve learning and confidence in embedding new knowledge, as well as minimising the potential of encountering the problems stated above. Other than engaging with volunteers, the drive towards seeking further training is linked to health worker migration. A study by Poppe et al. (2014) exploring motivations of African health workers studying in Europe identified education as the principal reasons for emigration.



More specifically, respondents in this study cited limited access to specialist training in Sub-Saharan Africa as well perceived inequality between European and Sub-Saharan African education. Education obtained in Europe was associated with better opportunities both in Africa, and globally compared to a Sub-Saharan African education.

#### **5.4 Chapter Conclusion**

As the first of three finding chapters of this study, chapter 5 has set the scene and brought to light two overarching themes reflecting Ugandan voices. The first theme examined Ugandan perceptions of volunteers entering their settings. Volunteers' desires to help Ugandans were mentioned, and the notion of *help* scrutinised in the light of the existing literature. Also mentioned was the recognition among some Ugandans of the uniqueness of their settings and its importance to volunteers to apply learning and gain new insights into Ugandan health system more generally. The second theme has explored Ugandans' motivations for engaging with volunteers. Several motivations varying across cadres and career levels were identified and discussed. It appeared that more senior Ugandans were motivated to validate existing skills, enhance CVs, and improve community development; while more junior Ugandans expressed motivations to gain new skills, intercultural exposure and learning as well as accessing further training to potentially move up in what is a very hierarchical employment system. The following chapter discusses perceived benefits of voluntarism for volunteers and Ugandans.

## **Chapter Six: Perceived Benefits of Voluntarism for Volunteers and Ugandans**

### **6.1 The Introduction**

Chapter six is the second of three finding chapters. It responds to objectives three and four and explores perceived benefits of volunteering for volunteers and Ugandans. The chapter proceeds in two distinct sections. Section one examines perceived benefits for volunteers; while section two discusses perceived benefits for Ugandans. Under each section, an introduction to the corresponding themes is presented and discussion provided in the light of existing literature.

### **6.2 Section One: Perceived Benefits for Volunteers**

As highlighted in 1.1, much of the research on the benefits of voluntarism for individual volunteers is based on volunteer or volunteer sending organisation perspectives (Lough and Carter–Black, 2015; Lyons et al., 2008). The findings presented in this section provide Ugandan perspectives of the benefits engaging with them have for volunteers. Several volunteer benefits consisting of a broad range of skills (or knowledge) thought to be ‘unique’ to Uganda and LICs more generally emerged. These benefits are collectively themed as ‘context–specific’ skills and are discussed next.

#### **6.2.1 Context–specific Skills**

Much of what Ugandans said volunteers gained in their settings consists of knowledge, skills, and awareness including creativity, innovation, and resilience, or what Laker and Powell (2011) broadly referred to as ‘soft skills’. Annette, a senior midwife, summarises these soft skills:

*“...We [Ugandan health workers] have not got much but we make things unique to our health system...volunteers start making sense of us slowly but with our help they adjust and learn...I saw them [SVP] volunteers transform in front of my eyes; from not knowing where to start and what to do, to using latex glove as a urine bag...over time, volunteers become Ugandans! [laughs].”*

Working in a resource limited setting requires flexibility, imagination and ingenuity. Excelling in such settings requires the expertise of locals, and the determination of volunteers to accommodate new insights and perspectives. It appears that the plethora of health conditions and needs in Ugandan public health facilities provide some volunteers the opportunities to practice learning and others to acquire new insights. Leslie explains:

*“...almost everything about us [Ugandans and their health facilities] is new, interesting and sometimes shock to the volunteers. They are so many patients to see, so many health complications developing at any given time, and so many needs to be met on the ground every hour, everyday...skilled volunteers get the opportunity to practice their skills, and the not so skilled ones get to learn new skills from the moment they set foot in our health centres.”*

A common example provided by Ugandans which was also briefly mentioned in 5.2.2.2 relates to knowledge of tropical conditions. There was a wider recognition that such conditions are not emphasised in most medical training in the NHS partly because tropical conditions are not very common in the UK. Uganda, according to Timothy, therefore, presents volunteers with:

*“...a unique and an exciting environment for first time volunteers (and even repeat volunteers) because of the diversity of clinical conditions and needs patients present... volunteers gain diagnosis and treatment knowhow of wide range of conditions such as malaria and typhoid.”*

Further supporting Timothy’s point above, ‘Engaging in Global Health, the framework for voluntary engagement in global health by UK health sector’, identified knowledge of tropical conditions as one of many areas UK health services can gain from LICs:

*“...UK health services can benefit enormously from the knowledge and experience gained from work in low and middle–income countries. For example, health organisations and individuals can gain from the awareness of tropical diseases and global health challenges that affect us all.”* (Cochrane et al; 2014, p.7).

Alice, a senior midwife, echoes Timothy’s notion of “*unique*” Uganda both in terms of its complexities and offerings. She says:

*“...in [Ugandan] health facilities, many things happen at the same time: comorbid conditions, delayed births, preventable deaths...such challenging problems provide education experiences for volunteers.”*

Alice provides a practical example of the complex challenges Ugandan health facilities present to volunteers, and how, with the support of Ugandans like her, some volunteers get the opportunity to gain on–the–job experience to contextualise and apply learning.

*“...as a first – time volunteer, she [volunteer midwife] could not cope working with us [Ugandan health workers]...everything seemed misplaced to her and understandably so...it was strange for her to see midwives taking blood and treating patients, and on several occasions, she thought we were taking things into our hands ...slowly, she began to understand the need to be adaptable and make things happen in Uganda...later, she became flexible and learned how to test for malaria and tuberculosis...and enjoyed very much!”*

In addition to applying learning, Susan, a senior midwife, suggests that the context (Uganda) itself is a “huge” attraction to volunteers with a view of experiencing “third world” health experience. She explains:

*“...volunteers enjoy their placements in Uganda. Everything including working conditions seems to draw their attention and interest them... [name of SVP volunteer midwife withheld] once told me, being in Uganda itself is educational to her...she [volunteer midwife] said it felt like walking through her training in real life...”*

Susan’s account is supported by a 2014 survey carried out by ‘Go Overseas’ which placed Uganda as the second most searched volunteer destination in Africa, and the tenth most popular volunteer destination in the world (see Appendix 2). Although Ugandans such as Susan did not elaborate why Uganda attracts volunteers other than it being “unique”, current literature on global health voluntarism point to several factors. Firstly, and perhaps most importantly, it is widely acknowledged that learning requires more than traditional classroom teaching (Crisp et al., 2013). Gedde et al. (2011) noted there is a growing realisation in the NHS and elsewhere to compliment classroom teaching and theory–driven knowledge acquisition with ‘on the–job–training to contextualise and apply learning. Equally, the focus on ‘lifelong’ learning in the UK requires Continuing Professional Development (CPD) to inform and underpin learning (Ackers et al., 2017).

Recognising the growing need in the global North to contextualise learning, Timothy suggests that the “friendly” and “sociable” atmosphere of Ugandan health facilities is key to realising both volunteers’ on the–job–training and lifelong learning drives. He first notes how volunteers’ work in Ugandan health settings is “totally” different from that of the NHS, which, he describes as “highly structured” and “competitive”<sup>32</sup>.

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<sup>32</sup> Timothy has been to the UK and appeared to have a good understanding of the structure of the NHS.

Timothy then adds that working in a relatively relaxed but highly demanding context enables volunteers to try “new” knowledge, coordinate care delivery, and among other things, gain clinical leadership skills<sup>33</sup>. He reflects his observation of a volunteer doctor and says:

*“...she [volunteer doctor] was keen to promote some clinical procedures to improve quality of care in [name of health facility removed]. With our support, she offered consultations to our staff and co-lead most of our work particularly in theatre. In some cases, she developed clinical guidelines which are very useful to our staff and to our development.”*

In the global health literature, clinical leadership skills include the ability to train, mentor, and empower diverse health workforce and coordinate care delivery (WHO, 2007). They also include designing and delivering intervention programmes that have positive effects on both health workers and members of local communities. Explaining this point, Timothy revisits his observation of the volunteer doctor:

*“...she [volunteer doctor] trains, and mentors UK student volunteers hosted by us and some Ugandan student midwives. She personally led the development of infection control training and was a consultant on several areas including health education promotion in the community.”*

The process of acquiring and/or applying knowledge in a different context (i.e. Uganda) requires various antecedents to happen successfully. In addition to the importance of a supportive environment (Metzler and Metz, 2010), and as Timothy suggested, it also requires ‘opportunities’ to access and embed learning. Upon closer observation, however, it became evident that such opportunity presented itself in two district ways. Firstly, it appeared that the noticeable absence of more senior Ugandans such as doctors in the health facilities provided highly skilled volunteers opportunities to fill this critical gap and coordinate some aspect of the health workforce and care delivery. There appears to be very little attempt (if any) on the part of the volunteers to gain insights into the root causes of doctors’ absence, which could have possibly brought to light some underlying socio-economic injustices along with an avenue from which to seek social justice.

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<sup>33</sup> The World Health Organisation (WHO) states that clinical leadership involves: “...providing direction to, and gaining commitment from, partners and staff, facilitating change and achieving better health services through efficient, creative and responsible deployment of people and other health resources.” (WHO, 2007, p.1).

Instead, volunteers launch a gentle takeover and simply assume the roles of their senior Ugandan counterparts. I observed how some junior Ugandans felt uncomfortable with the domination of volunteers in some aspects of their care coordination and delivery and how powerless they appeared to voice their concerns in what is very hierarchical health system. Taken together, these Ugandan experiences confirm the need to combat economic injustice through the promotion of cultural justice to ensure volunteers do not knowingly or otherwise disparage and 'other' Ugandan hosts.

Secondly, the practice by some Ugandans of delegating 'hard' jobs to volunteers may have inadvertently provided volunteers opportunities to hone their skills and apply learning. In reality, however, such practice underlines racial stereotypes – the assumption that volunteers have better skill sets simply because they are white and from the UK. This stereotype itself is captured in 5.2.1 and reflected in studies on host communities in Southern Africa (e.g. Graham et al., 2011). The practice, also a recurring theme in the empirical chapters of this thesis, may also reflect an attempt by some Ugandans to entice and/or encourage volunteers to actively take part in service delivery and share the workload with them.

Whether planned or incidental, it appeared that Ugandan public health facilities provide volunteers opportunities to gain skills that are rarely accessible to junior staff within the NHS. In particular, more specialised skills such as clinical leadership gained in the context of LICs are looked upon favourably (within the NHS) if demonstrated by non-consultant returning volunteers (Gedde et al., 2011).

The following section explores benefits engaging with volunteers have for Ugandans as identified by Ugandans themselves.

### **6.3 Section Two: Perceived Benefits for Ugandans**

Section two of this study brings forth Ugandans' perceptions of the benefits hosting volunteers have for them. There was a wider awareness among Ugandans of a range of benefits associated with engaging with volunteers. These benefits varied across professional cadres and career stages, and are explored in six main themes; (i) professional networking; (ii) securing resources; (iii) gaining recognition and credibility; (iv) good practice; (v) health worker supervision; and (vi) local empowerment and participation.

The first three benefits were primarily but not exclusively expressed by senior Ugandans; while the remaining three by more junior Ugandan health workers. These emergent themes are discussed in the light of existing literature.

### 6.3.1 Professional Networking

A great deal of global health voluntarism involves a recognition that health professionals are interconnected through shared humanity, advocacy and solidarity (Crisp et al., 2013). These shared values and interconnectedness present opportunities for co-working and mutual learning. Professional networking emerges as one of these opportunities, and Ugandans identified the roles volunteers play in building and maintaining professional networking. Jonah, a biomedical engineer, sees volunteers as “*networks*” of people channelling ideas, and contacts between professionals in different geographies and contexts. He explains:

*“I think of volunteers as knowledge transfer networks, professionals, and people capable of moving ideas and linkages between communities, groups and institutions across the world.”*

Mariam, a senior nurse, sees volunteers as embodying both ‘professional’ and ‘mobility’ networks’. She suggests that these networks are spurred into action through face-to-face interactions and co-working, and facilitate the cross pollination of ideas and knowledge, important markers for health system learning. Mariam notes:

*“Volunteers bring with them ideas, knowledge, and connections...these are expressed within their professions, and also through their movements between health systems both here [Uganda] and the UK. What this does for us [Ugandan health workers and Ugandan health system] and maybe for the UK is that ideas and knowledge from both contexts get fused and this is very critical for health resilience and learning.”*

In addition to the recognition of the networks that accompany volunteers as highlighted in the two accounts above, there was a wider recognition particularly among senior Ugandans of increased international networks following periods of engagements with volunteers. It appeared that working alongside volunteers and learning with them, expanded Ugandans’ horizons and reach by becoming more aware of the existence of global networks they could draw on to address some of the more common issues they experience. Benedict, a junior nurse, reflects:

*“...through working with volunteers, I began to see people, contacts, and opportunities that I never thought were available to us in Uganda. For example, I never knew through simple contacts, you can access professionals interested in our work who happen to know other professionals with both ideas and resources. It has indeed been an eye-opening experience working with [name of the volunteer withheld].”*

Senior Ugandans viewed these networks as critical for the utilisation of professional and organisational ties or connections with NGOs locally and globally:

*“...volunteers have many links with NGOs in Uganda and the UK. Having first-hand accounts of Uganda, our work, and our people, allows them to seek opportunities on our behalf...in many ways, it feels like they are still with us even though most of the volunteers I previously worked with and keep in touch with have long returned to the UK.” [Angel, a senior midwife].*

Taken together, these reflections of ‘networks’ can be best be conceptualised as ‘social capital’, which describe professional relationships that can give access to crucial resources not otherwise readily available to Ugandans. Such networks include ‘bridging capital’, which concerns linking people or professionals from different cultural and geographical backgrounds such as SVP volunteers working with Ugandans (see Putnam, 2000). This capital was particularly emphasised by health facility leaders, and senior Ugandans, with transnational experience for having worked, or trained in different countries in Africa, and the global North – and have established networks that can be tapped to draw material and human resources. Alice, one such Ugandan, explains:

*“...through working with volunteers, we [Ugandan health workers] could engage with many partners who, over time, came to know our work through volunteers who returned to the UK ...most of our international networks began this way. For example, we started working with the University of Salford, and other institutions through the SVP and its volunteers.”*

Some positive outcomes of engaging with volunteers such as advocacy were also mentioned. Returning volunteers who spent some time with Ugandans were thought to highlight the challenges the Ugandan public health system faces and gather support in the UK and beyond. Some Ugandans used phrases such as “*spreading the word*” and “*raising awareness*” to describe how returned volunteers promoted their work. Rose explains:



*“...Working with the volunteers and their projects helped our health facilities and patients because volunteer promoted our work in their home countries and advocate for change in Ugandan health facilities and system...some volunteers returned home and shared their stories with their colleagues and managers... for example, following volunteers’ return, we received various support over the years including equipment and new volunteers thanks to the work of returning volunteers. This would not have happened without their experiences in our settings and their dedications to promote our work in their countries and beyond.”*

In the above excerpt, it can be argued that international voluntarism acts as ‘development education’ and promotes global awareness, solidarity, and linkages between peoples and places (Lewis, 2005; Jones, 2004; Randal et al., 2004). Research by Civicus et al. (2008) suggests that volunteering is often a first step in a person’s further involvement in social activism and development. Similarly, Smith and Yanaculous (2004) highlight the potential impact of returned global North volunteers and how their experience of life in the global South can provide a ‘public face’ of development. The authors, in particular, point to how returned volunteers often take on ‘advocacy’ roles and engage in information dissemination to highlight pressing challenges faced by professionals and their people in the global South and call on stakeholders and development bodies to act.

Another networking benefit that volunteers bring along manifest in the form of Continuous Professional Development (CPD). Some Ugandans cited professional development such as fellowship programmes that were borne out of engaging with the volunteers. These Ugandans indicated that the volunteers’ vision extended to creating for them opportunities for professional development at home and abroad such as scholarships in the UK:

*“...some of colleagues [referring to Ugandan health workers] are currently in the UK through the Commonwealth Scholarship facilitated by the volunteers and their management team both in Uganda and the UK.” [Violet, a senior nurse].*

Others described professional networks in terms of ‘bonding capital’, described by Putman (2000) as social networks that link people of the same nationality, race, and ethnicity together to utilise resources and opportunities. Rose sees professional networks as a way of “*linking*” up local (Ugandan) health professionals, and “*establishing*” local connections to:

*“...facilitate links with local Ugandan professionals or ‘influential’ people that I never came across. Volunteers and their management are good at making people [Ugandan health care professionals, and government bodies] talk to each other and share experiences and work as one big team...”*

Jane supports Rose’s point above and provides a practical example of such networks, drawing mainly on a Uganda experience:

*“...with the help of the volunteers, we developed good relationships with the District Health Officer, and some local members of the Ugandan Ministry of Health...it feels like a team...people [Ugandan health professionals] from different health facilities are now communicating better, talking more often and sharing things better...”*

It appeared that volunteers play a significant ‘advocacy’ role in Ugandan public health facilities, and the relationships they build during their placements can create cross–local linkages and establish a platform for local [Ugandan] cooperation. Jane’s observation above is interesting in the sense that in addition to being viewed as knowledge ‘source’ (see 5.3.4), volunteers are also viewed as essential ‘intermediary bodies’ bridging Ugandans and the institutions of their government. There is an underlying assumption among Ugandans such as Jane that volunteers are more ‘impartial’ than local in–charges (health facility leaders), which suggests claims of ‘fairness’ on the part of volunteers. It is, however, important to note here that volunteers do not actively seek to promote or bring about these attributes. Rather, it is the set–up of the volunteering programme and the engagement styles underpinning volunteers’ work in these Ugandan health facilities that allow cross–local engagement, cultivate trust, and bring to light existing but dormant local links – a relationship that extends beyond the intermediate local boundaries (Wilson and Musick 2000). Bonding capital in this context therefore relates to locally generated networks bringing together Ugandan health workforce (who appear largely uncoordinated), reinforcing ‘shared identities’ and commonalities (Putnam, 2000). In some development literature, bridging and bonding capital are interchanged with vertical and horizontal capital respectively (e.g. Gilbertson and Manning, 2006). Vertical [social] capital relates to ‘exclusive networks’ that generate broader links with people outside one’s immediate circles. It has the potential to broaden horizons, but too much emphasis on vertical capital can diminish local important networks, and agency, and can create dependency on more distant global North networks.

This was particularly evident in some senior Ugandans I interviewed who showed disproportionate emphasis on vertical capital and discussed professional networks predominately from global North–South dimension and imaginaries.

*“...we [Ugandan health workers] try our best to generate as much international links as possible with the support of volunteers so we can bring fresh ideas and innovation into our practice. Volunteers bring such ideas in abundance and we seek to host and bring them to our health centres.” [Leslie].*

Some senior Ugandans such as Leslie, perhaps through his own international mobility, spoke in detail about the need to bring some (if not all) of their existing international networks to Ugandan health spaces. These included attempts to establish border–spanning professional networks and attract “*fresh*” perspectives in the form of NGOs including foreign global health volunteers. Field studies by Ackers et al. (2017) suggested that ‘disproportionate’ emphasis on accessing and securing international links, in part, reflects an ‘exit’ strategy and an attempt by senior Ugandans such as doctors to leave public health practice. From a Ugandan point of view, however, such attempts reflect a desire to maximise opportunities, growth, and innovation for themselves and communities within and outside their spaces. Further, in a setting with a few opportunities, it is incumbent on Ugandans both economically and professionally to adopt both local and international approaches to practice to meet growing demands on the ground. Meanwhile international exposure (both in terms of gaining innovation and resources) among senior health practitioners is encouraged and is viewed critical to the functioning of health systems in HICs including the NHS (Forrington, Grady, and Wilson, 2014).

Horizontal capital on the other hand, relate to ‘inclusive networks’ which takes place within and cements homogeneous groups (Putnam, 2000). It has the potential to revitalise local networks but can also lead to the exclusion of networks (i.e. volunteers) across a range of group settings, producing hegemonic structures within which bad practice [clinical] may flourish. Therefore, a trade–off between vertical and horizontal capital is needed to generate international networks while at the same time preserving local networks and agency. As Timothy shared, volunteers occupy important spaces in these international and local networks, and act as useful intermediaries between Ugandan health workers, Ugandan health system, and global North partners.

### 6.3.2 Securing Resources

There was a wider consensus among Ugandans that public health facilities lack basic physical resources to support clinical interventions. The inherent problems with resource management in Ugandan public health facilities supports this claim. According to the MoH's Health Sector Strategic Plan (2010/2011–2014/2015, most Ugandan Health Centre IVs (HCIVs) do not have fully functional operation theatres. Some of the Ugandans I interviewed, commended volunteers for providing basic physical resources such as infrastructure, equipment and consumables to support the functionality of their health facilities. Joy, a health facility leader, explains her *"journey through a transformed health facility"*. First, she takes us back to the beginning of the journey:

*"...before the [SVP] volunteers arrived, there were no sinks in the wards, curtains separating patients...we had operation theatre that never delivered mothers. We had huge demand for our services, but we never really took off as planned due to many unforeseen problems."*

Later, Joy recalls how the introduction of minor but nevertheless useful interventions such as sinks in the delivery suite, and curtains in the maternity wards by volunteers and their management, helped not only fight the spread of infection, but also *"functionalised"* the operation theatre. Joy reflects:

*"...people tell me, you cannot transform overnight with few sinks, curtains, and gloves...it is hard to believe...this is the story of [name of health facility withheld] ...one thing led to another, and today our success is attributed to those small but very important interventions..."*

An interesting point that Joy raises is that while the lack of equipment, infrastructure, and consumables were major impediments to the functionality of her health facility, and particularly the operation theatre, she acknowledges that a lack of willingness of *"people at the top"* contributed to her health facility's under-utilisation.

*"...I had to convince people at the top to change a few things...I became stubborn and perhaps risked my job [laughter]...but the hard work is finally paying off...I am glad we are now delivering many mothers and functioning much better...we feel we can do more but we have a lot to thank the volunteers and their management for."<sup>34</sup>*

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<sup>34</sup> Since I interviewed Joy, I heard she has been moved to a different health facility. Perhaps true to her fears, it is possible that she has upset 'people' at the top prompting her exit from the health facility.

Ugandan health system is very hierarchical. Challenging the hierarchy known locally as “*the system*” can have detrimental effects on less senior leaders such as Joy. However, with some persistence, and perhaps luck as lived through by Joy, it is possible to ‘shake’ up the system and foster change. Cautiously however, Joy’s words “*we can do more*” reflects the enduring challenges the health facility faces which remains largely under-utilised due to staffing and workload issues which are unravelled in section 7.4. In addition to bringing physical resources to Ugandan health systems such as those discussed above, volunteers, who throughout the interviews, were casually referred to as ‘muzungus’ were also assumed to bring in money. Some Ugandans expressed that volunteers ‘pay’ to get into Uganda, and more specifically into their health settings. Flavia, a senior nurse explains:

*“...Ugandan in-charges like money...I think volunteers pay them to come here [health facility name withheld]. If you do not pay them, they won’t let volunteers set a foot here. This is how it has been all the years I have worked here but nobody talks about these things because they are hidden...”*

Flavia’s comment above, also shared by two other Ugandans, is significant in two ways. Firstly, it sheds some light onto the inherent mistrust between health facility leaders and other senior Ugandans in non-leadership roles. This, to some extent, is exacerbated by the noticeable absence of senior staff particularly doctors who are hardly onsite with any degree of regularity to train or mentor ‘clinically active’ cadres (primarily but not exclusively junior cadres). Mistrust also occurs between more junior Ugandans themselves. Those who frequently engage with volunteers, casually referred to as “*the ones who like Muzungus*” are often suspected of receiving “*backhand payments*” from volunteers as Amanda, a senior nurse, contends:

*“...you can tell, they [Ugandan health workers] are always with the [SVP] volunteers; they follow the volunteers to their homes, weekend trips, and look after them. I think the volunteers are good to them [laughs]. Nobody else does that much work with volunteers or have that much time for them.”*

The casually used phrase “*good to them*” often implies suspicions of salary top-ups and in my observation, it is used as a reference to Ugandans with close working relationships with volunteers. Secondly, and closely linked is the notion of “*pay to get in*” which implies the existence of top-down corruption and backhand payment within Ugandan public health sector. Most Ugandans (and patients) are acutely aware of its existence, and the profound risks associated with challenging it as reflected by Joy above.

The SVP, which deploys volunteers to Ugandan public health sector is also aware of this and put in place a non-remuneration policy as part of its work in Uganda (Ackers, 2014). This is not to say volunteers and their management do not encounter “*highly entrepreneurial*” corruption designed to extract personal gains from them (Ackers et al., 2017, p.62). Broadly speaking, however, Flavia’s assertions of volunteers’ paying to get in is not far-fetched given the proliferation of the AID industry and the existence of Northern NGOs, willing to get in, and whichever means (Ridde, 2010; Pfeiffer, 2003). In fact, many NGO development programmes utilise remuneration to win over local communities, boost project participation and staff morale (Willis-Shattuck, 2008; Mathauer and Imhoff (2006). The long-term implications of remuneration, however, is debated and it is unclear whether remuneration leads to positive outcomes (Mbindyo et al., 2009; Stringhini et al., 2009; Mangham and Hanson, 2008).

### 6.3.3 Gaining Recognition and Credibility

Ugandan public health systems attract global attention and interventions (Matsiko, 2010). Much of this attention comes from development NGOs and their volunteers seeking to make a ‘difference’ locally while at the same time deriving personal and/or professional benefits for their staff. Domestically, volunteers are seen as something of a growing trend within the Ugandan public health sector, and a vehicle for opening up new opportunities, a global recognition and credibility. Many Ugandans reported that hosting volunteers, to varying extents, led to greater recognition and credibility within their local community, and among international donors including NGOs.

Brenda, a senior midwife, describes how the image of her local health facility “*improved*”, and how she gained local “*recognition*” which she said made her “*feel acknowledged and respected*.” She explains how after the arrival of SVP volunteers, some members of her local community, particularly expectant mothers “*suddenly*” began attending more visits than they would normally do. Brenda relates this “*elevated*” interests expressed by Ugandan expectant mothers to “*local cultural beliefs*” about volunteers. She explains:

*“... Ugandan mothers and even most people in the community think white people [SVP volunteers and white people more generally] bring better skills, resources...some people would just visit us just to have the chance to be seen by a white person...I cannot explain or understand why they do feel that way but you can find out for yourself – it happens all the time.”*

What Brenda refers to as local “*cultural beliefs*” is indicative of racialised relationships between black hosts and white volunteers (particularly in African and UK contexts), and what Lough (2014, p.6) described as ‘disempowered’ identities among intended beneficiaries. Some observers have long attributed such relationships to colonial legacy, and the succeeding AID which itself is, to date, largely Northern ‘expert’ led (Ellis, 2011; Perold et al., 2011). Brenda’s comment is unfortunately not an isolated observation. In particular, it resonates, with a study in Tanzania and Mozambique where members of volunteer host organisations expressed perceptions of white volunteers from highly skilled world, adding credibility, and efficiency to their organisations (Graham et al., 2011). Volunteers engaging in countries with colonial history, are often confronted with a ‘colonisation of the mind’ which reinforces inequalities and stereotypes (Perold et. al., 2012). Since identities are constructed through interaction, donor–recipient relationships often shape how volunteers and their hosts (including members of local community) see themselves and their roles (Baaz, 2005). In a manner consistent with such racialised relationships, some Ugandans acknowledged using these local “*cultural beliefs*” to their advantage. Barbara, a senior nurse, notes that Ugandan mothers like to have white health workers in the health centre because of common belief that white people emphasise on ‘prevention’ rather on ‘cure’ more than Ugandans do. Barbara suggests that working alongside white volunteers offers an opportunity to mobilise mothers and to embed health education in the wider health provision. She explains:

*“...based on my work experience, I knew that many Ugandan mothers including myself [laughter] have this belief that white health workers talk more about prevention than we Ugandans do. I used the presence of [white SVP volunteer midwife] to promote health education, and with very good response from local people...”*

Upon careful observation, it becomes clearer what Barbara is referring to above is essentially how volunteers intervene clinically and how they communicate with patients, which makes them more popular than most Ugandan health workers. Part of volunteers’ popularity among patients also relates to the amount of time they spend with patients which is not always possible for Ugandans who often do not have the luxury of spending much time with patients as they are expected to attend to queues of patients at any given shift.

More broadly, however, Barbara's reflection highlights a recognition by Ugandans to exploit what works best for them and for their patients. On the one hand, using [white] volunteers' presence to promote and embed health education among patients reflects creativity and resourcefulness on the part of Ugandan health workers, key health workforce characteristics identified as crucial to the functioning of health systems in LICs such as Uganda (e.g. Hague et al., 2015; Syed et al., 2013). On the other hand, the idea that white volunteers or white people in general have 'specific' attributes and qualities that black Africans do not have nurtures dependency and inflated expectations if not met, may pose serious implication on more positive and sustainable change in LICs (Perold et al., 2012). In addition to gaining credibility at community level, senior Ugandans stated using the presence of volunteers as an instrument to attract 'other' volunteers and NGO funding. Harry, a health facility leader, puts this point to light:

*"...it is difficult for health centres to attract Western partners for the first time...most volunteers and NGOs stick with one health facility where they build relationships and establish friendships with local people...volunteers help us bring other volunteers and funding which we cannot secure on our own..."*

What Harry is implying here is the commonly held belief among senior Ugandans that "*Mzungus follow Mzungus*" [Pauline, an anaesthetist]. In other words, Northern NGOs are more likely to support health facilities with presence of their counterparts, or as Harry put it:

*"...you secure one group of volunteers, and their friends and those with similar interests will follow sooner rather than later."*

Based on my previous NGO experience, I share Harry's expression relating to the "difficulties" experienced by 'virgin' health facilities in attracting NGOs and their volunteers, and the importance hosting volunteers for the first time has for Ugandans. From an NGO's perspective, however, part of the reason for not entering 'unknown' Southern spaces relates to expectations (from funding bodies) on the part of NGOs to develop existing links and relationships instead of reinventing the 'development wheel'. It also relates to perceived risk associated with working in 'untamed' or virgin Southern settings where 'concepts', 'languages', and 'institutions' built up around the "*development edifice*" is not yet imprinted (Uvin, 2004, p.32). Both of the rationale stated above carry racist undertones.



There is an underlying assumption made here that only African spaces and populations with previous encounters with white development practitioners can be trusted. This diverts attention to reaching out to vulnerable populations with minimal platform to express themselves. Such practice amount to denial of access to health provisions and raises ethical as well as social justice questions. Nevertheless, for Harry, it appeared that hosting Northern volunteers had a “*sanitising*” effect on his health facility and brought what he described as “*access*” to the worlds of NGOs, and perhaps to interventionist and disempowering bureaucracy. Harry explains:

*“...in the beginning, we struggled hosting volunteers and funding, but once we managed to host a few volunteers, more followed...in the space of a few years, we received interests from people from different NGOs...we currently have people from at least four Western countries in our facility.”*

The “*Muzungus follow Muzungus*” caricature, and its perceived credibility may, in passing statement, come across as innocuous<sup>35</sup>. However, in Ugandan health systems, it has strong monetary underpinnings. In simple terms, the more Muzungus Ugandan hosts attract, the more money they generate, and the more credibility they receive both at local and international levels. Similar to the concepts of AID, Ugandans, particularly those with a great deal of international exposure (who also happen to hold senior roles) learned to situate their priorities and to some extent, their existence, in line with the ‘helpless’ expectations some development NGOs hold of them. Leslie, more than any other Ugandan I interviewed typifies such a learned behaviour:

*“...people in the West are very kind and want to help us [Ugandans]. They understand very well that here in Uganda, people are suffering; some die because we do not the money and the skills; others die because there are no clinicians by their side when they need them the most...we cannot help ourselves so that’s why they come to us.”*

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<sup>35</sup> While Mzungu can best be conceptualised as a reference word, I found that it also has much deeper meaning (imbued in AID) and often expressed in the much-emphasised notion of ‘expert knowledge’. These deeper conceptions of Mzungu sometimes emerge in the form of inflated expectations in which Mzungu [s] (SVP leaders, volunteers and researchers in the context of this study) are viewed not only as colleagues (or co-workers), but also as sources of income and solutions to local challenges.

Surprisingly, however, development literature does not adequately explore what role (if any) some individuals and organisations in the global South play in ‘fuelling’ the development industry or in ‘othering’ themselves and their settings. While there is no denying that the Ugandan health system like many other Sub-Saharan African countries face growing challenges of varying degrees and intensities, the notion that Ugandans (highly skilled and innovative professionals) cannot help themselves as implied by Leslie is very interesting and worth exploring further. Unfortunately, existing research emphasises on how development NGOs misrepresent the aspirations and agency of people of the South (i.e. othering people of the South), and how they use their conditions to their advantages. For example, a review of ethnographic evidence of AID industry in Lesotho (AID-dependent country) showed how people in Lesotho were portrayed as a “*peasant society*” to justify the development agencies’ own existence (Ferguson, 1990). Further to this, researchers such as Lewis and Mosse (2006) and Ferguson (1990) suggested the development discourse is a Western “*project*” promoting interventionist and disempowering bureaucracy. There is clearly an interplay between economic and cultural injustices demonstrated by the economic dominance of NGOs, the misrecognition of local priorities, and imposition of outside intervention. Such misrepresentations pose serious implications on human development in the global South and limits the potential for the kinds of achievements likely to be valorised.

#### 6.3.4 Good Practice

*“...nobody [Ugandan health workers and leadership] cares. People [health workers] do not carry out clinical duties as it should be...it is very difficult to train in such environment if you are a junior nurse because you pick wrong practice and think it is right...at least with the presence of volunteers, we can see for ourselves how people from the rest of the world practice medicine...”*  
[Beatrice, a junior nurse].

The MoH is facing serious long-term challenges in delivering effective and good quality health for a rapidly growing population (Nbyonga-Orem et al., 2011). Among the challenges are human resource management and structural constraints such as poor health care infrastructures. These developments along with the growing human population, are gradually being recognised in the wider frameworks of ‘good practice’. Perleth, Jakubowski and Buse (2000) referred to good practice as a process-oriented concept aimed at fostering improvements within individuals, organisations, or settings over time.

The Ugandan Clinical Guidelines (2016) provides guidelines and recommendations about what amounts to good practice, and how it ought to improve health outcomes, and quality of care.

These among others include appropriate steps to follow during patient consultation and how critical issues such as compassion, privacy and dignity should be upheld at all times and costs. However, the application of these guidelines is seriously hindered by underpinning challenges including disproportionate health worker patient ratios, lack of effective health worker supervision, accountability as well as poor monitoring and evaluation systems (Matsiko, 2011). Ugandans shared some of these challenges. Lola, a junior midwife, sums up her experience of some of these challenges:

*“...the queues are always long; the pressure is always too much...it is non-stop; it is relentless...you can only do what you can.”*

Working in what they described as “relentless” health setting with too many challenges and constraints, some Ugandans are confronted with the dilemma of remaining professionally conscious at all times. Josephine, explains:

*“...I sometimes feel tired, overwhelmed, and hopeless...I try my best to do what I can, but it is difficult. Many times, I thought of just walking away from patients...unfortunately, some of us just do that—walk away and leave patients all by themselves.”*

Josephine does not ‘walk away’ as some of her colleagues do but she describes how she is often faced with attending to “long queues” of patients mostly by herself, and how as a coping mechanism, she sometimes resorts to “clearing the line”. The phrase clearing the line loosely refers to a common practice in Ugandan public health facilities of attending to as many patients as possible and with the shortest duration of time possible. While describing how clearing the line unfolds, Josephine, states:

*“...in they [patients] come, off they go...most of the time we ‘guess’ what patients are complaining about and give medication based on that. It is not right but everybody does that to ensure we see all patients ...”*

Without any prompts, Josephine, recognises the implication of her actions. She describes clearing the line as “unethical” and “very dangerous” practice but continues to justify it nonetheless. She explains:

*“...I do think about it [clearing the line] and it is not very nice or safe thing to do. However, my choices are very clear...I have to do it or not come to work at all...sometimes patients go to other health centres because none of the staff turns up to attend to them...clearing the line is sometimes the best we have, and you may disagree, but it works...”*

One of the issues Josephine is alluding to above, is health worker absenteeism<sup>36</sup>, an endemic problem amongst all cadres in Uganda. Absenteeism is a major contributor to what Josephine refers to as “*short cuts*” meaning not following clinical guidelines correctly. Josephine views short cuts as a “*learned*” behaviour expressed out of desperation. She gives an example of a short cut in action:

*“...sometimes, out of desperation, we raise our voices and shout at patients...we tell them to do most things for themselves even if they are weak and in pain...we sometimes do not mix medication properly and give wrong medication.”*

As heart breaking as it may sound, Josephine’s story is not an isolated occurrence. All the issues she described are common practice in Ugandan health facilities I visited. An underlying commonality in all the responses to this theme is the ‘justification’ of bad practice by junior Ugandans and its ‘normalisation’ by the health system. Janice, a junior midwife explains:

*“...every health worker does what he or she wants...I see people [Ugandans] doing wrong things, and I walk by...it is not my job to tell people what to do...in fact nobody tells nobody what to do...this is our health system...”*

Janice above neatly pieces together two major constraints of good practice in Ugandan health systems; lack of accountability, and leadership. She describes how the combined detrimental effect of these two “*powerful forces*” make Ugandan health facilities “*difficult*” places to work for non-Ugandan health workers such as volunteers. While acknowledging Janice’s accounts of the challenges that exist in Ugandan health facilities, Sophia, a junior midwife, ends the interview on a positive note. Speaking of her experience, she suggests that the arrival of volunteers unfamiliar with Ugandan practice was particularly invaluable.

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<sup>36</sup> Section 7.3 unpicks the phenomenon of absenteeism alongside a whole host of ‘barriers’ to host-volunteer engagements, and shared learning.

She recognises that the presence of volunteers shed some light onto professional consciousness and 'reminded' Ugandans of the principles of "good practice" and "professionalism", key dimensions of CoP. Sophia concludes:

*"...some volunteers do not like people [Ugandan health workers] taking short cuts; they challenge people like it or not. They do it in a nice way reminding people how to do their work responsibly...they [SVP volunteers] demonstrate to you a better procedure of conducting the same clinical procedure...a safer way for us and for patients..."*

An awareness of what health professionals bring into a CoP is not only necessary for effective relationship building, but also for productivity and outcomes. As evident above, Sophia attributes volunteers with three key main roles – advice, guidance and recommendation. These roles are an important component of 'mentoring', a process described by Clutterbuck (1991) as a form of assistance by one person to another in making significant transitions in knowledge, work or thinking. As a junior midwife, Sophia, fits in this definition of mentoring. Anderson et al. (2012) sees mentoring not as binary distinction between 'expert' and 'novice', but rather as a boundaryless process that occurs within and between professionals, and across contexts. Janet, an intern doctor sees volunteers as 'mentors' providing emotional and practical support, including encouragement, affirmation and opportunities to co-engage and learn. She reflects her experience of engaging with a volunteer midwife:

*"I still have her [SVP volunteer midwife] in my mind [laughter], I still have her voice on my phone...Her advice was always good. I knew if I did what [she] told me, I'd be okay."*

Janice echoes Janet's point, and from a practical point of view, adds that volunteers brought a "fresh pairs of eyes" into the Ugandan public health system, allowing Ugandans to carry out much of their activities 'slower' but more 'effectively'. She explains:

*"We [Ugandans] found that working with volunteers allowed us to do first things first and not rush patients...they [SVP volunteers] like to slow down things, and explain the process so you can do it on your own...it works for me and for the patients too..."*

Discussing further issues relating to the role volunteers play in promoting good practice in Ugandan public health facilities, two Ugandans touched on what they described as ‘institutional blindness’ or ‘industrial blindness’. Mary, an anaesthetist, provides her own definition. She says:

*“...in my view, institutional blindness occurs when health workers or professionals spend a great deal of time in the same system and setting with the same people...people gradually become blind to what they do, when and how...most of the time, professionals would not notice these unless they have effective systems in place designed to monitor and inform clinical practice.”*

Further, Mary approaches institutional blindness from a system learning point of view and provides a practical example of how volunteers’ presence helped not only identify a clinical oversight, but also put in place intervention measures:

*“...a good example of what I mean by institutional blindness relates to our work with the volunteers. Not long ago, one of the volunteers pointed to us that we did not have surgical checklist in theatre. Somehow, we ceased using surgical checklist altogether. We quickly realised the seriousness of this and put one in place straightaway. We now have an effective surgical checklist and it is my responsibility that all surgical tools are counted before and after operations.”*

Sometimes it is in the simplest of things where the greatest effects of institutional blindness can be felt. Justice, a junior nurse, explains a situation involving theatre keys, and the story of the elusive theatre key holder who “is never there”. He explains:

*“...we had an unpaid person who kept the keys of the operation theatre. I do not know who assigned that role to him [referring to the person who holds the keys] and it did not bother me to be honest. It happened in more than one occasion that we could not get hold of this person in emergency where a patient needed an urgent operation...afterwards, the volunteer suggested that we keep the keys in a safe place in the health centre, so to avoid unnecessary delays. We now have solutions for the keys...”*

Justice provides a rationale as to why health workers including himself sometimes do not spot what he loosely described as “avoidable” and potentially “costly” mistakes. He says:

*“...I think we [Ugandans] switch off sometimes to cope with the ever-increasing workload on the ground [health facilities] ...this makes us become unaware of what is going on round us including making good decisions at the right time.”*

Increasing workload as justice referred to above was commonly used by junior Ugandans to justify bad practice, and this appeared to be shared by more senior ones including health facility leaders. This phenomenon is discussed in detail in section 7.4, under the broader theme of ‘barriers associated with hosting volunteers’.

The following section discusses health worker supervision and the importance it has for more junior cadres who, on the whole, appear to actively engage with volunteers.

#### 6.3.5 Health Worker Supervision

*“...as a junior person [health worker], you are likely to be working alone...you would need someone more experienced to turn to and learn on-the-job and to be a safe health worker...”* [Eunice, a junior Nurse]

On-the-job supervision was cited as one of the benefits associated with engaging with volunteers. Supervision involves guiding, and monitoring, but also the promotion of compliance with standards of practice (Grigler, Bergen and Perry, 2013). The concept of supervision in the context of health has evolved from a primarily administrative exercise (Crowe, et al., 2011), to a facilitative and relational interaction (Hill, Crowe, and Gonsalvez, 2013). The Ugandan MoH developed an integrated health package to guide essential health service delivery. A supportive supervision programme was included as a way of improving health worker performance but also achieving the health indicators enshrined in the SDGs. The Ugandan Health Sector Development Plan 2015/16–2019/20 identified health worker supervision in the public sector as “erratic” due to budget and staff availability challenges. It added that supervision guidelines and tools were under review. My observation in Ugandan health facilities revealed that health worker supervision was not only a major problem but also a rarely spoken one for two main reasons. Firstly, supervision was viewed as superficial concept rarely practiced in Ugandan health systems. In fact, it was largely raised as an issue worthy of discussion by more junior Ugandans who saw supervision as critical to their learning, transition, practice and progression. Secondly, supervision signified seniority, power and influence within Ugandan health systems. It was conceptualised as the designated role of the powerful, and the invincible such as doctors (who, in most cases, are also the health facility leaders).

Understandably, due to the seniority and power the word ‘supervision’ denotes as described above, most junior Ugandans although acknowledging the importance of supervision to their career development, showed sensitivity to answering prompts on supervision, often replying: “...*supervision of who, and for whom...*” This was an attempt to clarify that I was not examining their experiences of supervision by Ugandan supervisors such as doctors. I constantly reminded Ugandans that the aim of the study was to explore their perspectives of engaging with volunteers, and not their seniors. This affirmation put some at ease, but others remained tense throughout the interviews as Janet highlights:

*“...I do not know who supervises who but all I can tell you is that junior health workers work without supervision most of the time. You cannot ask for a supervision if you are a junior health worker because that is how the system works and everybody goes with it.”*

Janet’s evasion of my questions relating to supervision was perfectly understandable given her ‘intern’ or ‘junior’ health worker badge. Due to the hierarchy of Ugandan health system, junior Ugandans avoid being ridiculed for “*talking too much*” as Victoria, a junior nurse, reminds us:

*“...in Uganda, you do what you can and what you are asked to do...people [senior Ugandan cadres] do not like people [junior Ugandan cadres] who talk too much. At this level, you are better off doing what you can for yourself.”*

Fortunately, I met a few junior Ugandans who wanted to talk more freely about their experiences of supervision, and how important it is to their career development. Hope, an intern nurse, for example, shared her experiences of being “*abandoned*” by senior Ugandans in a high–risk ward without supervision, and how, through sheer luck, a volunteer midwife came to her rescue. She explains:

*“...we [intern nurses] were put in a ward full of very sick mothers and babies. We were not confident in our practice and did what we could...later [name of SVP volunteer midwife withheld] found us and began to talk to us and offered support...it was just a relief...since then, I worked with volunteers and received supervision and mentoring in the wards.”*

It is not uncommon for interns and students to be thrown in the deep end and left all by themselves without supervision. There are many highly skilled and very experienced Ugandan clinicians, but it is very rare to find them in the wards let alone providing support to interns such as Hope.



In fact, as reflected in Ackers et al.'s (2017) field work in Ugandan public health facilities, lone working is normalised in Ugandan health system, and health workers are expected to work on their own [independently]. While the practice of lone working, to some extent, is necessitated by huge human resource shortage in Ugandan public health spaces (see WHO, 2006), it raises serious ethical questions specifically “*where the lack of senior staff or their failure to be present on the wards*” puts interns and junior cadres in “*situations where they have to work on their own and outwit the bounds of their competency*” (Ackers et al., 2017, p.50).

While Hope was very lucky to have volunteers by her side, it is not uncommon to see interns taking things into their hands out of necessity. Ackers et al. (2017) report the experience of SVP volunteer doctor on a short placement in a busy obstetric theatre in Mulago Hospital referring to the sheer ‘butchery’ he observed at the hands of junior interns with little experiences or supervision. Add this to the chronic staff shortage in public health settings, it is not surprising that volunteers and more junior Ugandans highlight the need for supervision. More specifically, junior Ugandans recognise the risks of lone working to themselves and patients, and some stated turning to volunteers in desperation and to cope. Doris, a junior midwife explains:

*“...it is risky working alone when you are not confident enough...I tried, tried and finally made friendship with her [volunteer midwife] ...I followed her through the wards... she noticed I was not too skilled...she let me observe her do certain procedures; and she made me try some...this was very good...”*

Doris’s experience is typical of many interns and students pressed by the Ugandan health system, and who somehow found volunteers’ presence not only reassuring but also nurturing. The key to understanding the experiences of interns like Doris lies in volunteer operations in Ugandan health systems. A strong emphasis on knowledge mobilisation led to the adoption of ‘co–presence’ as placement and learning strategy informing volunteers’ work in Uganda. In practical terms, co–presence has two significant implications for Ugandans. Firstly, it minimises the chances of volunteers being used as labour substitutes. Secondly, it increases the chances of interns and students coming into contact with volunteers and therefore being supported and supervised. The former implication of co–presence is discussed in several related sections in chapter 7; the latter implication of co–presence is recognised by health facility leaders. Mark, observes:

*“...volunteers make themselves available at all times to all health workers...I cannot explain but junior people [health workers] like to work with volunteers and volunteers seem to like them. Based on my own observation, the junior people receive mentoring and training from the volunteers which helps them increase their knowledge and awareness of various clinical practice.”*

Although acknowledging and to some extent commending volunteers' contributions in relation to supervising 'junior people' as he liked to refer to more junior Ugandans, Mark avoids answering questions on the supervisory role of senior Ugandans and fell short of explaining why they do not often supervise more junior health workers.

He tentatively cites 'limited resources', a phrase I came to know to be used more commonly by Ugandan health facility leaders to 'legitimise' the limited or lack of on-the-job supervision and support for junior Ugandans by senior ones.

In addition to supporting and supervising junior health workers, volunteers' supervision role was also highlighted by task-shifting health workers. Task-shifting relates to a process of delegating tasks or practices to less specialised health workers to optimise health worker roles, and to increase health provision and coverage (Nabudere, Asiimwe, and Mijumbi, 2011). It is world-wide phenomenon, and is in part, a reflection of the changes in the roles and responsibilities of health professionals (Maier et al., 2018). In many HICs, ageing population along with increasing rates of chronic conditions have put enormous pressure on health systems. In direct response to some of these challenges, some HICs have expanded the roles of traditional medical cadres and have introduced new specialised roles. In LICs, task-shifting serves to optimise health worker roles to counter shortage of human resources for health and is increasingly gaining both popularity and momentum. Most health systems in LICs adopt 'we are where we are' approach and make the most of available human resources (Chang, 2009). This includes rational distributions of tasks and responsibilities among the different cadres, and where possible and safe, moving specific tasks and responsibilities from highly qualified cadres to junior cadres (WHO, 2008a).

Uganda is one many countries in Sub-Saharan Africa implementing this practice primarily as a pragmatic response to the health workforce shortage at an informal level particularly in obstetric care (Nabudere et al., 2011).

A common phenomenon I encountered at the outset of this study relates to the number of midwives identifying themselves as nurses, and nurses as midwives (i.e. dual qualified health workers). The statements “...I am a midwife, and a nurse” and vice versa was common theme in the introductory part of the interviews I conducted in Uganda. Task–shifting is extremely laborious undertaking and health workers task–shift not by choice but by necessity. Sylvia, a senior nurse, explains:

*“...it [task–shifting] is quite tiring and demotivating way of working...I understand we [Ugandans] have to try all possible means to ensure people [patients] are attended to and seen regardless of staff shortage...we have no choice other than to stretch ourselves and capabilities, so as to accommodate the growing needs on the ground.”*

Sylvia’s comment above highlights that task–shifting demands more than what health workers can actually offer, and in some cases even beyond the bounds of their competencies. In my observation, much of the task–shifting occurred without a clear policy, planning, or supervision. Consequently, some task–shifting practices conflict with quality of care and professionalism (Dlamini–Simelane and Moyer, 2011). However, it appeared that although some task–shifting Ugandans take comfort in the widely held assumption that task–shifting concerns more about “*efficiency*” rather than “*effectiveness*”, others recognise the importance of acquiring task–specific skill sets to provide quality care. Gloria, a senior nurse, shares:

*“...to be honest, I am more of a nurse than a midwife, but I do more midwifery work because there are very few midwives around most of the time...I still need to grasp some midwifery techniques and procedures [laughter] and this is key to carrying out my midwifery role right.”*

The need for task–specific skills during task–shifting processes takes Ugandans to the realm of volunteers who seem to occupy important spaces in bridging skill gaps during transitions. Task–shifting health workers require on–going supervision and mentoring to help them cope with their personal challenges. However, such support is not always available to these cadres, but some Ugandans found volunteers’ roles useful during their transition from one role to another. Evelyn provides an example of the usefulness of volunteers in her roles. She outlines her transition from midwifery to anaesthesia, and the “*crucial*” role volunteers play in “*keeping*” an eye on her during her practice as a midwife:

*“...I am a midwife and feel competent in my role...I received some midwifery training but never felt confident at it. I moved to the wards when there is less work in theatre but I sometimes found the transition very difficult...I do not receive supervision from Ugandan people and they do not care if I work alone or make mistakes...during the week, I turn to volunteers and they let you work under their supervision which I found reassuring.”*

Although Evelyn identifies herself as a senior health worker in her midwifery role, the concerns she raises about her anaesthesia competence are similar to those raised by more junior Ugandans discussed earlier on in this section. In addition to the lack of supervision during transition, Evelyn raises the underpinning crippling issues of lone working and the unavoidable prospect of making clinical mistakes. She also raises the supervisory role of volunteers and its importance to the transition in her anaesthesia role.

However, relying too much on volunteers to assume the role of experienced Ugandans is not feasible let alone sustainable. Although an on-going endeavour, SVP volunteers follow a model of volunteering that promotes capacity building and discourages local labour substitution which reinforces dependency culture inherent in Ugandan health system. Providing an on-going support for extended period may create dependency and risk volunteers being used as local labour substitutes. While such observation is valid, it is important to acknowledge that task-shifting health workers occupy important spaces in Ugandan health systems and offer a lifeline to many people in need of urgent medical intervention. Given the right support and supervision, they can counter some of the effects of human resource shortage. Recent evidence on task-shifting from Mozambique and Tanzania adds weight to its indispensability, particularly in obstetric care. A study endorsed at the Karolinska Institute in Stockholm in 2010 reviewed task-shifting of major surgery to more junior health workers such as clinical officers; and found no clinically significant differences of caesarean sections outcomes when postoperative assessment is carried out by non-physicians or specialists in obstetrics and gynaecology. Interestingly, non-physician clinicians had high retention rates (90% after seven years compared with 0% for physicians) in rural health facilities, further supporting the growing recognition that task-shifting among junior cadres can positively contribute to care in both obstetrics and gynaecology.

Given the similarities between these two countries (Mozambique and Tanzania) with Uganda particularly in relation to human resource shortage, and the growing practice of task–shifting, these findings echo a great deal of Ugandan experiences about task–shifting highlighted in this section. As highlighted by Mark, more junior Ugandans can successfully undertake roles that are traditionally reserved for senior health workers such as doctors. This intervention allows more junior Ugandans not only to cope well with their roles, but also continue to work in the same settings (including rural settings) for considerably longer periods of time than senior health workers such as doctors, who, on the whole, appear ever absent from the wards.

#### 6.3.6 Local Empowerment and Participation

The concept of empowerment is associated with an increased sense of self–determination and self–esteem (Marks and MacDermid, 1996).

It is often interchanged with related community–based concepts such as ‘community participation’, ‘community capacity building’ and ‘community development’ (Yeung, 2004). Bearing this complexity in mind, empowerment broadly defines the process by which relatively like–minded people strive to gain control over the events that determine their lives and health (Marks et al., 1996). Some Ugandans regard volunteers as important players in their endeavour to overcome health care challenges. Janet passionately describes how volunteers brought critical clinical ideas and practice to her settings, and how, over time, these ideas became embedded in her practice, lifting her morale and those of colleagues. She explains:

*“...volunteers make us [Ugandans] realise we are working together towards achieving one shared goal – saving lives where we can...they [volunteers] are very positive and have very strong work ethics...they focus on one challenge at a time and work through this...we [Ugandans and volunteers] are now working on ‘eclampsia’ and how to prevent it as much as we can. We could not have done this without them and this makes us stronger, more determined, and better prepared.”*

Janet further identifies a number of contributory factors. In the first instance, she recognises important attributes such as participation and belonging as epitomised by her use of the phrase “*we are in this together*”. Participation means having a share in something, and benefiting from that share, or taking part in a group and thus collaborating with that group. Other Ugandans discuss empowerment from a linguistic (and psychological) point of view.

In particular, they stress that volunteers' use of words such as “*colleagues*” and “*fellows*” made them feel respected and acknowledged. Robert, an anaesthetist, reflects:

*“Volunteers make you feel you are a part of them, a part of a team, a resilient and strong health professional who is doing a fantastic job saving lives...team work is very important for coordinating care and even resources... volunteers stress ‘we’ and not ‘I’ and this makes me come to work every day.”*

Robert's account is very powerful in the sense that it makes the link between participation and empowerment. A model of volunteering based on these attributes (i.e. empowerment and participation) is gradually embedded in many global health volunteering programmes using terminologies such as “*involvement*”, “*collaboration*” and “*partnership*” as described in 2.6.1. The volunteering programme Ugandans participate in is a living example of this. However, the links between participation and empowerment appear complex and gendered to some extent.

Some junior female Ugandans, nurses in particular, feel volunteers did little to improve her health facility and describes this feeling in terms of disempowerment, leaving responsibility for change in the hands of more senior Ugandans: Doris, explains:

*“...I think they [SVP volunteers] give too much attention to [Ugandan] doctors and male colleagues who do not care about us [female junior Ugandans], and patients...even the female volunteers seem to like male [Ugandan] colleagues...”*

By contrast, some junior male Ugandans, express a sense of empowerment and commitment, of having a personal stake in volunteering spaces. They appear more enthusiastic of engaging with volunteers and show greater appreciation of volunteers' presence regardless of their genders. Perhaps key to understanding Doris's dissatisfaction with the work of both male and female volunteers lies in the notion of gendered spaces (see Sixsmith and Boneham, 2003). For junior midwives such as Doris, health spaces – especially maternity wards – were perceived as situated in the feminine domain. Being overlooked in such a context by volunteers may have constituted a threat to her feminine identity.

By contrast, junior male Ugandans view working in such gendered spaces, and with volunteers as part of their professional roles. Thus, voluntarism, in its different styles, may have a gendered spatial dimension, which, has not yet been fully explored in existing research<sup>37</sup>.

#### **6.4 Chapter Conclusion**

In line with the research aim, and in an attempt to explore Ugandan voices, the chapter has brought forth the experiences of a diverse groups of Ugandans engaging with volunteers. It has set the scene with a brief introduction of the benefits of voluntarism and brought to light how existing evidence is geared towards uncovering benefits for volunteers, and from their own perspectives. By contrast, section one of the chapter has explored benefits of volunteering for volunteers from the point of view of Ugandans engaging with them. A wide range of 'context-specific' skills including knowledge of tropical medicine and more specialised clinical leadership skills were identified. Such knowledge and skills were recognised as important to the volunteers and to the NHS more generally. Section two of the chapter has explored benefits of voluntarism for Ugandans. It has outlined differentiated benefits for Ugandans varied across cadres and career levels. More senior Ugandans have attached particular importance to securing international networks, resources, recognition and credibility for themselves and for their health facilities; whereas more junior ones have emphasised learning about good practice, on-the-job supervision, and local participation more broadly. The following chapter presents barriers to hosting volunteers expressed by Ugandan health workers.

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<sup>37</sup> Recent introduction of midwifery focused programmes in Uganda by the Knowledge for Change (K4C), a sister charity of the SVP, reflects an attempt to better understand midwifery practices in the Ugandan context as part of a broader commitment to improving maternal and newborn health in Uganda.

## **Chapter Seven: The Barriers Associated with hosting Volunteers – Ugandan Perspectives**

### **7.1 The Introduction**

The third final findings chapter builds on the preceding chapters five and six. Chapter five explored Ugandans' perception of volunteers and their motivations to engage with them; chapter six looked at Ugandans' perceptions of the benefits engaging with them have for volunteers and for themselves. This chapter responds directly to objective five and explores barriers associated with hosting volunteers identified by Ugandan health workers. The chapter is structured thematically and begins with a detailed discussion of the challenges of health worker mobilisation and the perceived limited 'power' in public health spaces epitomised by the much-emphasised phrase 'responsibility without authority'. This is followed by a discussion on absenteeism, its definition, prevalence, and aetiology. A particular emphasis is placed on 'inadequate pay' mainly due to its perceived association with absenteeism and moonlighting. The chapter continues to heavy workload, a chronic problem related to human resource crisis in Ugandan public health spaces, and a discussion of its impact on host-volunteer relationships and learning. Finally, the chapter discusses how prevailing volunteering styles and cultures shape local expectations of volunteers and examines the notion of 'volunteer avoidance' – a form of resistance to how volunteers intervene clinically – brokering learning through co-presence and shared learning.

### **7.2 Responsibility without Authority**

A strong and resilient health system is essential for effective individual and population health (Uganda Health System Assessment, 2011). The Ministry of Health recognises that health worker mobilisation is key to a strong and responsive public health system. Attempts to achieve this included among other things, relinquishing a substantial amount of power and decision making to district level government (Bossert, Beauvais, and Bowser, 2002). The aim was to improve transparency, accountability, and service delivery through coordinated health workforce. In reality, however, health worker coordination remains a key challenge in Ugandan public health facilities. Part of the problem relates to questions around leadership, power, influence and decision making. At a health facility level, health facility leaders are assigned to coordinate and mobilise health workers.



Often, however, foreign partners entering Ugandan public health facilities are confronted with multiple leaders with contrasting roles, although some appear 'active' and 'present' more than others. How much power is available to each of these leaders, and what they do (or can do) with it, is beyond the scope of this study. However, senior Ugandans highlight limited powers and authority vested in them by the district government to manage their health workforce as well as “*complex*” health personnel issues. Timothy describes this phenomenon as a “*responsibility without authority*.” He explains:

*“...as an in-charge [health facility leader], I am expected to do all the things a leader should do which is fine...however, I am seriously restricted in what I can do...I have a title that is powerless...to be honest, I simply do what I can, when I can, and with whom I can. This may sound irresponsible thing to say but I am being very honest with you...”*

One of the challenges of being a “*powerless*” leader as Timothy points out can be observed in the decision-making processes particularly in relation to mobilising the health workforce or coordinating care delivery more generally. Senior Ugandans observe that health worker mobilisation becomes particularly problematic when foreign volunteers arrive at their health facilities and when the emphasis is placed on health worker ‘participation’ and ‘learning’. Timothy, reflects:

*“...we [Ugandan health workers] have areas of health care that we need to address urgently with the support of [SVP] volunteers...these areas are identified in advance with the volunteers’ management. When they [volunteers] arrive, they seek our guidance and get to work straightaway...they are always on site [Ugandan health facility] but somehow, somewhere, we cannot put in place people [Ugandan health workers] to work with them...”*

What Timothy poignantly described above is his limited influence on Ugandans, and his inability to channel volunteers’ presence and offerings to locally identified priority areas within the health facility. The phrase “*somehow somewhere*” denotes a mismatch between policy and practice particularly in relation to identified areas for improvement, and the mechanisms (in terms of health workforce) put in place to address them. Later in the interview, Timothy points to the constraints inherent in what he referred to simply as the “*system*” (the Ugandan Health System to be precise) for the apparent mismatch identified above. He explains:

*“The system is very top down...I am like any other health worker here [name of health facility withheld]. There is somebody somewhere responsible for managing the health workforce including people like me [health facility leaders]. I cannot make decisions entirely on my own or even with the local District Health Officer...in front of the eyes of the central government, no health worker can discipline or dismiss another, this fact makes my ability to manage and coordinate health workers very difficult if not impossible.”*

An interesting point to note here is how the term ‘system’ is used casually to indicate a distant mechanism; one that belongs to no one but affects everyone. Interestingly, Timothy, a senior health professional, did not see himself as a part of the system but rather the “*victim*” of it. He particularly cites his ‘delicate’ position as a health facility leader and the continuous attempts by his workforce to “*block*” his efforts to making Ugandans more engaging and responsive when it comes to engaging with volunteers and learning with them. Timothy, like other senior Ugandans, see himself deserted at the mercy of what he described as a “*stubborn*” health workforce which in his own words, operates on its “*own accord*.” He explains:

*“You may not know this but health workers here [health facility] understand the system, and work around it very well. Some [Ugandan health workers] even work on their own accord and you cannot do much about it. They always come with excuses but I do not have the mechanisms or power to challenge them and put my message across...all I can do is simply work around their own schedule and be very patient with them.”*

Working around health workers’ ‘schedule’, and as a coping mechanism, Timothy shares some of the strategies he employs to “*devise his own plans and make things happen*” despite the limits of his power and influence. Among others, Timothy uses volunteers’ presence as a mechanism to “*reach*” out to Ugandans, who, on the whole, seem intractably disengaged. The phrase ‘reaching out’ in the Ugandan public health context has several meanings. On the one hand, it may simply mean volunteers having conversations with Ugandans and reminding them of the reasons for their visit and the importance working together has for health care provision and shared learning. On the other hand, it may mean volunteers ‘covering’ shifts for Ugandans thereby assuming some of Ugandans’ care roles (i.e. attending to patients on their own). The latter meaning of the phrase ‘reach out’, a feature of complex lexicon of adapted English used in Ugandan health facilities, is certainly not an isolated proposition.

There are widely held expectations of development partners in Ugandan public health facilities (including volunteers) not only to muck in, but also lead some aspects of the health provision locally (Ackers et al., 2017). These expectations although in many ways linked to [development] AID, are in fact salient in Ugandan public health facilities, and pose greater risks to building sustainable relationships and leading positive change. Reflecting on ethnographic work in the Ugandan health system, Ackers et al. (2017) attribute such Ugandan expectations of volunteers to the existence of missionary-style volunteering programmes which are thought to encourage implicit or explicit gap-filling, and labour substitution cultures in many global South settings. The authors contrast such styles of volunteering with those that emphasise capacity development, co-learning through consultation and knowledge dissemination. As highlighted in Chapters 1 and 2, the SVP aligns with the latter style of voluntarism, and operationalises its work in Ugandan public health through the principle of 'co-presence'<sup>38</sup>. The capacity development roles of international partners in Ugandan public health is highlighted in various government policies and reports. For example, the Uganda Health System Assessment (2011) acknowledges the role of development partners such as volunteers to “*Jump-start*” the nascent structure of Ugandan public health system, and leverage knowledge and expertise (p.111). In order to do this, the plan recognises the critical role of forward-thinking Ugandan leaders, and the presence of 'nurturing' public health spaces to absorb ideas and innovations.

Throughout my visits to Ugandan health facilities, I observed the dedication and passion shown by Ugandan health facility leaders to pull together their health workforce to maximise impact and streamline health provision working collaboratively with volunteers. I also observed how the hierarchical nature of the public health system disempowered their endeavour and left very little room for them to have a say in the management of their health workforce. Margaret, a junior midwife, recognises the disempowering effects the health system has on health facility leaders:

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<sup>38</sup> The co-presence principle demands Ugandans and volunteers participate in face-to-face interactions to facilitate shared learning and knowledge exchange (Ackers, 2014).

*“I do not know much about the UK but the in–charges in health centres are just like us [junior health workers]. We are all managed by other people [laughs] whom we do not see or hear from most of the time. It is easy for people like you [foreigners] to miss out the context in which we work; a health system that does not empower those who are meant to lead health workers and care.”*

Margaret lends support to Timothy’s reference to the health system as a distant mechanism that health workers rarely engage or interact with. She, however, is rather cautious of how health facility leaders approach their workforce. Margaret recognises the potential risks associated with mobilising a haemorrhaging health workforce without the support of the ‘system’. She explains:

*“...for quite some time now, the number of health workers in this health facility remained very low. There are very few of us [Ugandan health workers] working at any given time...the health facility leaders are aware of staff shortage but without the support of people at the top [central government], they cannot afford to push or fire health workers. The consequences of making people [Ugandan health workers] do what they do not want may be very severe. Some health workers may decide not to come to work if they feel they are ‘pushed’...everybody knows where they stand, and people respect each other in that way.”*

As Margaret explains, all that health facilities leaders have at their disposal is negotiation, and for good reason<sup>39</sup>. The Ugandan Ministry of Health’s Health Sector Strategic Plan III (MOH 2010) asserts that “*Uganda, like many developing countries, is experiencing a serious human resource crisis*” (p. 20) restricting the country’s ability to respond to its health needs. It goes on to state that around 40% of its health workers are working in private sector. This is further compounded by a high proportion of unfilled positions in the public health sector. For example, in 2011, only 58% of advertised positions in health facilities were filled by trained health workers (MoH, 2011/2012, p.7). Rural areas are particularly hit because health workers prefer to work in urban dwellings. Further, it is reported that up to 64% of all nurses and midwives work in urban regions, where only 27% of the population live, suggesting that the rural areas where Timothy works are severely under–staffed.

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<sup>39</sup> Health facility leaders often deploy negotiation tactics to avoid falling out with their workforce because the process for replacing them is problematic and painfully slow (see Vujcic 2010).

The challenges of mobilising an inadequate health workforce are compounded by health worker absenteeism and rampant moonlighting, two major challenges identified by Ugandans as barriers to engaging with volunteers and learning with them. The following discussion explores health worker absenteeism in detail, bringing forth its definitions, prevalence, aetiology and impact on relationships and learning.

### 7.3 Health Worker Absenteeism

*“You cannot work with the wards...there is no one [Ugandan health worker] out there for volunteers to work with...my worry is that volunteers do not understand why Ugandans do not attend work...they [volunteers] are simply obsessed with a Ugandan being with them all the time...I think they do not grasp the magnitude of the challenges we face...everyday...” [Rose].*

In order to gain deeper understanding of how health worker absenteeism can become a barrier to Ugandan–volunteer relationships and learning, it is important to first consider the different ways absenteeism manifests in Ugandan public health systems. In this section, therefore, I provide definition and prevalence of absenteeism, and more detailed discussion of how it unfolds in Ugandan public health facilities.

#### 7.3.1 Definition and Prevalence

There are several diverse definitions of health worker absenteeism in the literature. Some definitions are narrow and characterise absence by specific health conditions, such as knee and back pain (e.g. Alexopoulos, 2011); others are broad and include absence due to illness and other causes (e.g. Manzi, 2012). The definitions of health worker absenteeism provided by Ugandans were similarly diverse. Lucy, describes absenteeism simply as:

*“...not attending work when one should...sometimes disappearing without telling others [Ugandans].”*

Other Ugandans provided extended definitions to include excused absences such as scheduled leave which can result in the interruption of health service delivery:

*“...absenteeism involves people [Ugandan health workers] dodging work when they want...it [absenteeism] should not happen but it does, always...actually it normal and nobody bothers with it [laughter]” [Rose].*

Rose says absenteeism has no place in Ugandan public health spaces but acknowledges that it is a daily reality and something of a huge concern to her as a “*health worker*” and a “*mother*”. Her reference to ...”*people* [Ugandan health workers] *dodging work when they want*” is partly, an indication of the lack of effective accountability and leadership mechanisms embedded in Ugandan public health system. It is also a reflection of a growing disinterest of Ugandans to work in public health facilities where the pay is pitifully low and working conditions are typically poor. Equally detrimental is her reference to “*nobody bothers with it*”, a suggestion of the inability (and to some extent, disinterest) of health facility leaders themselves to effectively address chronic absenteeism. Surprisingly, however, Ugandans in non–leadership roles did not blame health facility leaders for health worker absenteeism, but rather the ‘system’. Phrases such as “*they can do very little*” in reference to the limited powers of health facility leaders were very common. Susan, puts this point in a better light:

*“...it is easy to blame people [health facility leaders] but you know as a health worker, you have a responsibility and you should take responsibility for your actions...some of us [Ugandan health workers] abuse our responsibility and our actions make in–charges look bad...they [in–charges] can do very little to hold us responsible. It is the government that is not doing enough to strengthen the rules and hold people accountable.”*

Susan’s account echoes a study by IntraHealth International with a rather fitting title – ‘who is there?’ The study revealed that 67% of Ugandans blamed government policies for health worker absenteeism; whereas 33% did not. The extent to which health facility leaders can make a difference in relation to the chronic absenteeism in a health system that “*disempowers*” them as suggested by Timothy, and his colleagues is a matter of contention. However, as will be shown further on in this chapter, health facility leaders are in fact the worst offenders of absenteeism in Ugandan public health spaces, “*setting a very poor example to their staff, and failing to observe and enforce contractual terms*” (Ackers et al., 2017). A fitting analogy by IntraHealth International goes ...when the senior [in–charges] are not there, chances are that no health worker is there, and no patient is there (2011).

Absenteeism and “*dodging work*” were interchangeably used, and in most of the interviews conducted, references to them were made using subtle phrases such as “*skipping work*” and “*hiding from work*”.

These phrases were used rather casually and often without any inhibition or concern. In some extreme examples, the phrase dodging work was followed by a laughter as expressed by Josephine, “...*he* [a Ugandan doctor] *is a big time dodger [laughter]...*” meaning the Ugandan doctor hardly attends work. In reality, however, this is not a laughing matter, in fact far from it. Figures from the MoH paint a worrying picture. The MoH report released in September 2013 suggest as many as 40% of Ugandans countrywide rarely report for duty. Furthermore, the Health Sector Performance Report (HSPR) 2012/2013 identified district hospitals and health centres where this study was conducted as the most affected. The reality however is far worse. A senior Ugandan health leader cited by Ackers et al. (2017) reported much higher “*genuine*” rates of absenteeism, suggesting that as many as 65 % of his staff were absent at any point in time. In my observation, health worker attendance in the health facilities I visited was sporadic, and at best hit and miss. Some of the health facilities I visited had attendance records misplaced, unaccounted for or rarely used; others had attendance records that lacked the required data or detail. Where attendance records were frequently used, they were left at the entrance of the wards where staff signed in their names. Unsupervised self-reported attendance although better than no records of attendance at all, is often susceptible to abuse. Determining the actual attendance figure is thus challenging. While conducting observational research in a health facility in Kampala in November 2014, I witnessed how one health facility leader found out some shift attending health workers were in fact signing in for their friends and seniors who, in some cases, never attended work for months.

Putting the health worker attendance book in her lap and going through some pages, Joy, noted:

*“...some people [Ugandan health workers] are only present in this book [pointing to staff attendance register] ...their colleagues signed for them...look! I have not seen him [a doctor] for three days!”*

Joy is an inspiring and transactional leader. Some of her staff described her as a “*clever*” but “*difficult*” women [Rose]. During my stay in Joy’s health facility, I learned how Ugandans and indeed Ugandan people adapt the meanings of some English words. The word ‘difficult’ in this context is used in reference to ‘someone who does not always conform to the expectation of others’.

In other words, Joy was exceptionally good at her work. Part of Joy's success was credited to the nurturing role of the SVP and its volunteers, and also, an intermediary body that brought much needed power closer to the health facility, and most importantly, to Joy. Even so, Joy acknowledged that decision making is a lengthy and tedious process. She explains:

*"...when I raise an issue with the authority, it goes through different people...by the time they [authority] get back to me, people and things have already moved on..."<sup>40</sup>*

Elsewhere however, the picture is different. IntraHealth International researchers such as Matsiko and colleagues found that 14% of Ugandan health facility leaders either did not use a reporting book; while 11% reported not monitoring staff attendance (2011). The authors remind us that a great deal of reported figures is based on estimates and should be treated with caution. Often missing from these figures is the chronic problems of serial absenteeism, late arrivals, and early departures. These three are observed amongst all cadres in Uganda, the situation however is most acute in doctors. Jane observes:

*"...I hardly see them [referring to Ugandan doctors]. They come to see a few patients and leave when they are still more patients waiting for them. They have more freedom than us."*

Furthermore, a survey by Chaudhury and colleagues (2006) on five global South countries: Bangladesh, Ecuador, India, Indonesia, Peru and Uganda support Jane's observation. The survey found health worker absenteeism was more widespread. Senior and more powerful cadres such doctors were absent more often than junior cadres. Across the six countries, the survey found, 39% of doctors were absent, while only 31% of other health workers were absent. In the context of this study, absenteeism by doctors was worse during night shifts. Brenda, shares her experience of working in a busy HCIV without a doctor. She recalled that two doctors were on rota on one of many 'fateful' nights in November 2014 but none turned up for work. She describes how she called one doctor after another using her own mobile phone but to no avail. She had a serious case to address, and a decision to make. Brenda reflects:

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<sup>40</sup> Since this interview in 2014, I heard through Ugandan contacts that Joy too has moved on. She was apparently transferred to another health facility but the circumstance that led to her departure remains largely unclear.



*“... The patient was a bit dizzy; she has bled but did not lose too much blood. I thought she would have been fine here [health facility] but I did not want to take chances. I thought of referring the patient to Mulago National Hospital (MNH) but her conditions were not life-threatening. I called doctor [name removed] who was meant to be on duty, but he did not pick up the phone; I called doctor [name removed] who also did not answer her phone. In the end, I had to make the right decision and refer the patient to MNH for her own safety.”*

In addition to the chronic problem of absenteeism, Brenda’s dramatic (but sadly routine) experience also pointed to the underutilisation of HCIVs. The MoH (2010) identified the restoration of HCIVs as central to its strategy to reduce congestion at the national hospital (Mulago), and to reduce delays in treatment caused by travel (MoH, 2010). However, as apparent in Brenda’s experience, attempts to use HCIVs to reduce congestion at regional referral or national hospitals are curtailed by health worker absenteeism particularly among doctors.

Having outlined health worker absenteeism, its prevalence, and the different ways it manifests in Ugandan public health facilities, the next sections discuss its causes and impacts on Ugandan–volunteer relationships and learning more generally.

### 7.3.2 Causes and Impacts

*“...some health workers just leave work when they want...patients and volunteers are left stranded. There is very little interaction between us [Ugandan health workers and volunteers]...and even less opportunity to learn...” [Jane].*

As demonstrated in 7.3.1, and Jane’s experience above, health worker absenteeism is a wide spread phenomenon, well documented in the ‘human resources for health’ (HRH) literature (e.g. Belita et al., 2016; Isah et al., 2008). The reasons for absenteeism are multiple, and vary from one cadre to another, and from one health setting to another. Absenteeism relating to doctors attracts the most attention, mainly because of the widely held notion that staff are more absent when doctors are not around (Matsiko, 2011). Common causes of absenteeism identified across all cadres include lack of accommodation on site; poor remuneration; and general dissatisfaction of the public health system (UHSA, 2011; Matsiko, 2005). Ugandans who participated in this study including those who took part in the focus group identified ‘inadequate pay and moonlighting as key contributing factors.

In the following sections, I provide discussion on each factor along with their impacts on Ugandan–volunteer engagement and shared learning.

### 7.3.2.1 Inadequate Pay

The issue permeating this section is health workers' strong emphasis on the financial returns of their work. This is understandable given the fact that access to formal employment is very limited and work in the agriculture sector is the most common type of work for adult Ugandans (Ugandan Bureau of Statistics, UBSOS 2013). Although still a dominant sector in Ugandan economy, agricultural productivity growth has stagnated in the last few years despite the rising trend of national population. Income streams from salaried work therefore appear to make formal employment desirable over the increasingly unreliable income from farming (UBSOS, 2013). However, the inadequacy of health worker pay in Ugandan public health spaces brings little comfort to the Ugandan health workforce who, among other things, seek the security a formal salaried work brings to their lives. Throughout the interviews, Ugandans made repeated references to phrases such as *“hardly enough”* or *“under-paid”* to describe their experiences of the financial returns for their roles. Annette, states:

*“...I am happy that I have a job that I like but I cannot survive on my salary alone. It is hardly enough for my household's expenses let alone supporting my extended family...”*

Annette's experience of inadequate salary is well supported by existing evidence. For example, Ugandans are approximately thirteen times underpaid compared to NHS staff (McCoy et al., 2008), and approximately four times underpaid compared to Kenyan health workers (WHO, 2009). The average monthly salary for a senior Nurse/Midwife is \$341 in Uganda compared to \$630 in Tanzania and \$1,384 in Kenya. Clearly salary is a problem and as Annette suggests, Ugandans are acutely aware of it. Anne's reference to *‘I cannot survive on my salary alone’* is indicative of not only her dissatisfaction with her salary, but also a recognition that she had to do something in order to make ends meet. Most often than not, this would mean seeking a supplementary source of income both inside and outside Ugandan public health spaces. For long, NGOs and AID projects have been a steady source of income for Ugandan health workers, and expectations of remuneration has become embedded in local cultures and practices. Mariam, explains:

*“There is a culture in Ugandan that if you bring a project and want people [Ugandan health workers] to work with you, then you need to consider paying them...”*

Clearly, pay matters, and for foreign projects that do not pay its Ugandan host, the consequences can be severe. Brenda explains:

*“You may struggle to find [Ugandan] staff to work with because there is plenty of opportunities out there for health workers to earn more money to support themselves and their families...”*

While Brenda’s observation sheds some light on the context in which Ugandans and volunteers interact, it is important to note that such expectations of ‘pay’ is not a Ugandan problem. Underpinning this is a global drive to boost health worker ‘participation’ and ‘improve’ health outcomes in LICs. For example, WHO (2006) recognises that ‘proper’ pay is vital for responsive health systems. And in this light, evidence highlighting the usefulness of health worker remuneration emerges. Public health sector reforms such as increasing health workers’ salary, has, in the past, been associated with improved attendance in countries such as Bangladesh (Ssengooba et al., 2007). It has also been attributed to improved organisational relationships in Kazakhstan (Abzalova et al., 1998). Further to this, a number of quantitative studies across Sub-Saharan Africa confirmed the importance of pay for health worker mobilisation. For example, motivations to work in rural settings was strongly influenced by pay among prospective doctors and nurses in Ethiopia and in Malawi (Serneels, 2014; Mangham 2007).

More specifically, the Ethiopia study found that doubling wages increased the proportion of doctors willing to work in rural areas from 7% to over 50%; while for nurses, the increase was from 4% to 27% (Hanson and Jack 2010). Analysis for Tanzania confirmed similar strong effects of salary increase and allowances although this analysis found that female health workers were less responsive to salary increase more than their male counterparts (Kolstad, 2011). Broadly speaking, similar evidence is hard to come by in Uganda. However, it is suggested that some private health clinics and NGOs offer a package of compensation that includes salary, housing allowance, meals at work, transportation allowance, and family health care benefits (Hagopian et al., 2009).

Expectations of at least some of these packages are in fact very strong within Ugandan public health spaces, and the existence of some Muzungus (i.e. SVP volunteers) oblivious to or unwilling to meet these expectations baffles some Ugandans. Moses, a clinical officer is mystified:

*“The volunteers do not understand how we work in Uganda, and what we earn... to work well together [Ugandan health workers and SVP volunteers], volunteers need to realise we need compensation for our time...we have commitments and we need to make ends meet...”*

Moses makes the point that success at the health facilities depends on adequate compensation by volunteers. However, the SVP does not compensate Ugandans for project participation (Ackers et al., 2014), and yet it pays its volunteers a monthly ‘stipend’ three times higher than the average Ugandan salary<sup>41</sup>. To exacerbate the situation further, the SVP implements a non-numeration policy in Ugandan public health facilities, which, unsurprisingly, draws criticisms from some Ugandans who believe volunteers bring with them what they described as “*dry knowledge*” – meaning volunteers are concerned more with ‘leveraging knowledge’ and ‘expertise’ without providing any ‘financial’ support for their Ugandan hosts. Moses explains this point nicely:

*“...they [SVP] volunteers bring along dry knowledge...they talk about working, learning, improving things...but you know it is very difficult to achieve many of these things if you are not earning enough...”*

The significance of seeing volunteers’ work simply as ‘dry knowledge’ can be understood better from the lenses of socio-economic and cultural injustices. The former is accounted for by the privileged mobility of predominately white volunteers from the UK, and racial and geography injustices are embedded in the economic order of a capitalist society. The latter is evidenced by the SVP’s apparent imposition of alien intervention (i.e. co-presence), its unappreciation of local Ugandans’ agency and aspirations (i.e. need to make ends meet), and disrespect – seeing Ugandans as mere project participants.

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<sup>41</sup> The SVP pays its volunteers a monthly stipend of over £1,000 excluding flights and other expenses.  
[https://www.aagbi.org/sites/default/files/Advert\\_Ugandan%20maternal%20and%20newborn%20hub.pdf](https://www.aagbi.org/sites/default/files/Advert_Ugandan%20maternal%20and%20newborn%20hub.pdf).

The concept of dry knowledge and the pursuit for remuneration observed among many professionals and communities in the global South can also be viewed as a consequence of the disempowering ways in which prevailing volunteering styles and cultures intervene locally. As captured in my observation below:

*On the morning of November, the 28<sup>th</sup> 2014, I was invited to attend neonatal training at the maternity ward in MRRH by volunteers, and the head of the maternity ward. I arrived early to help with the set up, and meet the trainers; two volunteer doctors, and one Ugandan nurse. The trainers told me that 35 Ugandans expressed interest in the training, but due to previous experiences of conducting similar training, they were expecting much less. Soon, we put the last few paper works together and sat down in anticipation for Ugandans' arrival. Time went by, and after nearly half an hour late, only 7 Ugandans showed up. As the training was about to begin, one of the trainees broke the news that most of the Ugandans who initially expressed interest in attending the neonatal resuscitation training, were in fact attending similar training delivered by an American NGO in the same vicinity! The trainers did not show any signs of frustrations—they simply got on with the training. At first, I did not understand what was at stake; after all, training was a good thing regardless of who delivered, or attended it. I was however, later told by the trainees that this American NGO pays [training] or attendance allowances, and that some Ugandans simply 'follow' the money and prefer to engage with Muzungus that pay.*

While such observation is quite sad but real, evidence suggests that such practice undermines the public health system. Ridde calls this practice acute “*perdiemitis*”, and suggests that “...it is decidedly one of the most prevalent illnesses in African public health projects.” (2010, p.1). My observation suggests that most Ugandans view NGO allowances as a means to maximise their income. Moses typifies such Ugandans. He declares:

*“...I like attending training, it is a good opportunity to learn and gain new ideas. Sometimes, there is money too which is good enough to see you through the week...I think more training is good for all of us [Ugandans] because we can make some money and gain some knowledge at the same time.”*

However, the practice of ‘chasing’ training allowances has a negative impact not only on the quality of health services, but also on relationships between Ugandans and between Ugandans and volunteers largely due to the high levels of absenteeism they create in public health facilities. Timothy claims:

*“...I do not know if you have noticed it but people [Ugandan health workers] like to participate in training mainly to escape work and also get some transport allowances...people forget however that when they all leave for training, volunteers and patients are left behind alone...”*

As Timothy acknowledges, there is no culture or system in place for providing staff cover in the absence of health workers. Ackers et al. (2017, p.57) field work in Ugandan public health suggested that it is “...not unusual to find no staff present to be told that they are ‘on a course’ as if training can ever be a justification for leaving neonates unattended.” In addition to inadequate pay, the irregularity of pay adds further difficulties in keeping Ugandans in the wards. The lack of reliable prompt payment of salaries was also cited as contributing to absenteeism. Philomena, a junior nurse, observes:

*“...actually, it is not all about the salary not being enough; it is to do with how often it is paid. In most cases, we get paid months in arrears. It’s a miracle that some of us still come to work.”*

Rose supports Philomena’s observation but adds that irregular salary payments was used by Ugandans as an “excuse” to justify chronic absenteeism, and not to commit to working with volunteers. Rose argues:

*“...staff [Ugandans] use all sorts of excuses not to attend work...some use salary delays to skip work, or come to work but avoid doing much...like working with volunteers on a shift...they [Ugandan health workers] sit outside most of the time and disappear when they hear volunteers are looking for them...they like to do very little or nothing at all when they are not paid.”*

Rose’s comment touches on two important issues. The first relates to volunteer avoidance, a resistance to co–presence, and a phenomenon discussed in detail in 7.6. The second concerns the link between absenteeism, morale, and delayed salaries, issues I noted during my two–week long observation at KHCIV, where Rose worked. It was brought to my attention an email circulated by the MoH and an intermediary authority informing staff of potential further delays in salary payments. This was the third consecutive month health workers were not paid, and there was a tense feeling, and so many unhappy faces around.

One senior health worker was convinced that delayed salaries triggered absenteeism, and low morale among health workers. Similar correlation was observed in public health facilities in Bushenyi District in Uganda where more than two-thirds of Ugandans interviewed identified poor remuneration as one of the contributing factors to staff absenteeism and low morale (Nyamweya et al., 2017). The low morale among health workers was particularly more pronounced when engaging with volunteers. I observed that volunteers rushing from one ward to another looking for a Ugandan health worker to work and shadow them. And when they find one, I observed how dejected and unwilling Ugandans looked. I managed to interview two Ugandans following such observations. I asked one, Annette, specifically what she thought about working with volunteers without referring to my observation to avoid leading her to answer directly from a specific interaction she had with a volunteer. She responds:

*“...they [volunteers] are ok but [name of health facility leader withheld] told us we cannot leave volunteers working alone so at least one of us should work with them...I do not understand why...sometimes there is nothing to do in the wards but they insist we go in and speak to patients...they don't understand...”*

Annette sees the relationship between Ugandans and volunteers purely from motivation point of view. She claims that volunteers are “*prepared*” and motivated to talk to patients and learn from their placement in Uganda. She says:

*“...if you come to work in place happy and motivated, you are likely to have good relationships with people and learn. Volunteers come prepared and they are supported by their people...we are not.”*

Demotivation clearly plays a key role in Ugandan–volunteer engagement and potentially learning. Questions about what happen to such demotivated workforce remains largely unclear. The response by many Ugandans in the context of this study provided some answers to these questions, but also generated more questions in the hindsight. Without hesitation, most Ugandans acknowledged that they and their colleagues hold their public–sector jobs while at the same time pursuing “*other means of survival elsewhere*” [Moses]. What Moses is eluding to here is the practice of ‘moonlighting’. Husain (2014) defines moonlighting as “*having a second job, part time or full time, in addition to a primary full-time job*” (p. 6). Moonlighting is a global phenomenon and is observed in various fields of practice including medicine (Saxon, 2015), and politics (Campbell and Cowley, 2015).

Several theoretical frameworks have been used to explain moonlighting. Betts (2006) proposes economical approaches and dispositional approaches. The former considers moonlighting mainly as a source of [additional] income. Dispositional approaches consider societal factors and suggest that moonlighters tend to be members of communities who are economically and socially deprived. For example, Amuedo–Dorantes and Kimmel (2009) found that African–Americans moonlight more than their White American counterparts, suggesting the role of socio–economic factors in moonlighting trends or dispositions.

Moonlighting, as a practice, is discouraged in Ugandan public health settings (Ackers, et. al., 2016). It is nonetheless endemic, and to some extent, presented as a logical response to inadequate pay. Moses describes a case of rampant moonlighting and provides a rationale for it. He claims:

*“...in trying to make ends meet, some of us [Ugandan health workers] have a second or even a third job elsewhere...this can be a private business such as a pharmacy or a job with companies and NGOs...”*

Moses account above reflects those held by other Ugandans that moonlighting is primarily financial – to supplement inadequate wages and to improve household income. The 2013 report of the Global Health Workforce Alliance (GHWA) suggests that moonlighting is driven by the nature of the health worker labour market. Evidence elsewhere supports the financial underpinnings of moonlighting (Van Lerberghe et al., 2002). Studies conducted in Rwanda and Ghana, in particular, highlight the critical role additional income from dual practice plays in health worker retention (Lievens et al., 2011). While such argument holds as evidenced by the studies described above, the potential conflict of interest when combining jobs in public health settings is immense. Ugandans such as John, for example, recognises the economic push factors, but cites the moral dilemma that arises from leaving “*poor*” patients in public wards to help “*richer*” patients in private health settings. Similarly, Timothy suggests that the practice trumps clinical ethics, and “*encourages malpractice*”. Both John and Timothy agree that moonlighting leads to disruptions and unsafe practice within the public wards. Among other things, Jane suggests, moonlighting exacerbates scarce human resources, and increases the workload of “*shift attending*” health workers.



Further, there is the view that moonlighting undermines Ugandan–volunteer engagement, and learning. Such view appears to be largely propagated by volunteers who seem not to understand reasons for moonlighting. Jane explains this point:

*“...the volunteers do not like to see people [Ugandans] working here and there and see this as a problem...they [volunteers] do not ask questions about why people moonlight.... they just want people to be there with them all the time.”*

From Jane’s observation, it is evident volunteers do not pay much attention to the complexities that exist in the spaces in which they are placed. More specifically, emphasis by volunteers on “...people to be there with them all the time” suggests that volunteers prioritise gaining experience at the expense of local people. Instead of sympathising with Ugandans and working towards building CoP, such actions by volunteers may in fact lead to misrecognition and disempowerment, raising important social justice questions. It is therefore important to view moonlighting not as a Ugandan problem, but in the light of prevailing inequalities both economically and culturally, and some of which are propagated by institutions and peoples from the North. A disproportionate emphasis on the impact of (and not the causes of) moonlighting can be counterproductive and may lead to the misrecognition of Ugandans’ agency. An acknowledgement of the underlying social structures that contribute to moonlighting, and collective actions to redress them are needed for more sustainable outcomes that work for Ugandans and volunteers.

Experiences of heavy workload by Ugandans, along with their preferred ‘interventions’ to overcome it, present another barrier to Ugandans engaging with volunteers which is discussed next.

#### **7.4 Heavy Workload**

*“...the demand for our work is increasing daily because people [Ugandan population] are having more babies than ever before...but the same number of people [Ugandan health workers] work here for the past seven years as far as I can remember...somethings needs to be done but I do know who should do and how...” [Joy].*

The above comment represents a typical response to the heavy workload experienced by Ugandans in public health facilities. Joy, here, raises two important issues inherent in Ugandan health system.

The first relates to the rapidly growing population aided by high fertility rates, the highest in Sub-Saharan Africa (see World Bank 2013c; UHSA 2011); and the second relates to the shortage of health workforce in Ugandan public health spaces, which is identified as in 'crisis' (WHO, 2006). Putting the magnitude of the problem to light, the Budget Monitoring and Accountability Unit (BMAU) in the Ministry of Health stated that doctor to patient ratio in 2010 was estimated at 1:24,725; and nurse to patient ratio at 1:11,000. Both ratios were far below the WHO recommendation of 2.3 health worker per 1,000 people. This means Ugandan health workers currently in the system take the brunt of the health worker shortage, leading to heavy loads with dire consequences. Rose, succinctly explains:

*"...we [Ugandan health workers] have to double and treble our work to cope up with the growing demand for our services...more and more are coming for all types of problems...this is physically and mentally draining...we are struggling..."*

An interesting finding in 7.3.2.1 was how Ugandans readily associated inadequate pay with absenteeism; and how this, to some extent, has been contributed to 'frictions' between Ugandans and volunteers. The same observation was redundant when it came to discussions on heavy workload and absenteeism. In fact, Ugandans problematised the suggestion that heavy workload leads to absenteeism, and this was consistent across genders, cadres and geographical locations<sup>42</sup>. Instead, heavy workload was associated with health worker shortage which Ugandans discussed in greater details. One possible explanation for this finding could be that heavy workload formed a part of health workers' initial expectations when taking on their roles in Ugandan public health facilities. It could also be that abandoning work (i.e. patients) was perceived as a weakness and unprofessional act. In my observation, Ugandans like to be seen to outsiders as resilient, innovative professionals, and surely many are. On several occasions, I observed how clinical officers, nurses and midwives working almost entirely on their own, attended to streams of patients throughout their respective shifts, and without any complaints or incidents. Rose typifies such distinctively Ugandan resilience:

*"Sometimes the workload is crazy, I struggle with it, it affects my family, my life...when I see people who came with pain and distress go home much better, it makes me want to work here for the rest of my life...I know it is unreal."*

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<sup>42</sup> Evidence elsewhere in Uganda suggests a strong link between workload and absenteeism in public health spaces (see Hagopian et al., 2005).

Heavy workload in the context of this study was identified as exerting serious strain on the health workforce, but also on the relationships with development partners such as volunteers. At the centre of this, are the prevailing volunteering styles and cultures utilised by different development actors in Ugandan public health settings. In the following section, I explore the underpinnings of such styles of volunteering (i.e. ‘working for’ versus ‘working with’); and discuss how the preference of the working ‘for’ model over the working ‘with’ model in Ugandan public health spaces puts volunteers at loggerheads with ‘conditioned’ Ugandans. In the section that follows, I present how volunteers’ adherence to working with through coordinated face-to-face interactions (i.e. co-presence) gives rise to volunteer ‘othering’ or ‘avoidance’ in Ugandan public health facilities.

### **7.5 Prevailing Volunteering Styles and their impacts**

As briefly described in 1.3, and in the latter stages of the preceding section, two broad styles of volunteering tend to be cited, and both are applied in Ugandan public health settings<sup>43</sup>. Short-term styles are often supply driven in nature and emphasise on ‘helping’ local people in order to lead them to a short-term development (Lough, 2013). The emphasis here is often on responding to human and material resources to boost local projects or services for a short period of time. A distinctive characteristic of this style of volunteering concerns the sheer number of largely young and often unskilled volunteers (i.e. voluntourists) looking to atone for global injustices by escaping the vacuity of the global North. These volunteers undertake a range of activities in global South spaces sometimes working unsupervised and entirely on their own. While such activities may provide some short-term respite for local projects or people, the long-term effects can be devastating. In the case of global health and in short-term medical missions, evidence suggests significant potential for medical negligence, and for health system damage. This is particularly more problematic when diagnosis is made without much focus on the causes that often stem from an unjust global economic order, and without the awareness of local needs, priorities, aspirations, or broadly speaking, ‘context’ (Ackers et al., 2017; Bauer, 2017).

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<sup>43</sup> These categories denote generalisations distinguished by variations in ‘length of stays’ and ‘reciprocity’ (see Lough, 2013) in 1.3.

By contrast, long-term volunteering styles often follows a practice of volunteering where volunteers and their hosts engage through 'established' links to strengthen local capacity through joint ventures or exercises (Crisp, 2007). The SVP has a long-established relationships in Uganda, and places long-term British volunteers in several Ugandan public health facilities. The emphasis is on knowledge brokerage through coordinated face-to-face contacts (i.e. co-presence) between British volunteers and Ugandan health workers. A strong awareness of the latter style of volunteering exist in Ugandan public health facilities, and some Ugandans expressed reservations towards it. Jane, reflects:

*"...they [SVP] volunteers can see we need help in attending to patients. They have plenty of time, and the knowledge to attend to patients, but they do not want to work independently on their own...they demand people [Ugandan health workers] to work with them all the time...we have a problem with this because it does not suit us."*

Jane's comment above also highlights her dissatisfaction with how volunteers intervene clinically, and the disproportionate emphasis they put on co-presence. With its origin in studying knowledge mobilisation in Europe, co-presence is concerned with workplace co-learning and knowledge creation/transfer (Williams and Baláž, 2008; Williams, 2006). It relies on one's understanding of local discourse and other aspects of an organisational culture, and these are often acquired over a significant period of time. Managing co-presence and knowledge transfer in a socially diverse workforce can therefore be problematic. Co-learning depends, fundamentally, on the willingness of individual workers and the organisation *"to embrace external reference standards and methods"* (Earl, 1990, p.742). Clearly, some Ugandans appear unwilling to integrate co-presence in their practice. One of the obvious reasons for this is that many Ugandans do not simply have the time or even the scope to be with volunteers at all times. Others see co-presence as a rather misplaced idea that does not resonate with local realities or constructions. In particular, they cite the strain co-presence puts on scarce resources in the form of leveraging knowledge and expertise<sup>44</sup>.

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<sup>44</sup> The SVP recognises the 'unintentional' strain co-presence has on scarce Ugandan resources, but has not yet announced interventions to address this shortcoming.

Further, The phrase “...*they demand people* [Ugandan health workers] *to work with them all the time*” implies an imposition of an outside intervention, and unappreciation of local agency and aspirations – important dimensions from which misrecognition may be contested.

In equal measures, co–presence is also problematised by some SVP volunteers who would prefer to work alone and sometimes unsupervised. Although this tendency breaches SVP placement guidance and in particular its lone working policy, some career track volunteers seek to optimise their clinical skills through boundless clinical practice and service delivery (Ackers, 2014). Moses appears to have a preference for these types of volunteers. He purposefully calls for lone working at the expense of co–presence. He argues:

*“Volunteers can learn on their own. There are plenty of mothers and babies, some with serious problems that need urgent care. I give them [SVP volunteers] the chance to do whatever they want but some insist on my presence, our presence, and everybody’s presence... [Laughs].”*

The practice of providing foreign professionals including volunteers direct access to patients, and ‘the all clear’ to do whatever they want with them (as implied by Moses above) is increasingly observed in the ‘so called medical missions’ (Bauer, 2017). It is possibly that Moses may have engaged with such missions before although diverse numbers of volunteering styles (some claiming to be sustainable) allow volunteers to treat patients alone and sometimes work outside their scope of practice. Concerns about such practice have been raised particularly in relation to using voluntarism along with its ‘professionalised’ guise as ‘opportunities’ for experimental practice and for skills enhancement (Benson and Wearing, 2012; Bishop and Litch, 2000). Despite such concerns, the presence of on–site and highly–skilled volunteers entices Ugandans to utilise them as gap–fillers and labour substitutes, but the volunteers’ ‘resistance’ of such attempts creates tensions and conflicts. Josephine is left confused:

*“...we asked her [SVP volunteer midwife] to help for the day because we needed one person to attend to the antenatal ward, but she refused...I do not know why some volunteers behave this way...maybe they do not understand their role properly...it is not good to be there just doing nothing.”*

Josephine’s reflection suggests a mismatch between volunteers’ ‘expected’ roles and their ‘actual’ roles in Ugandan public health settings.

This mismatch becomes more apparent when some Ugandans openly suggest volunteers go on staff rota to “*maximise service delivery capacity*” [Moses]. Helen, a junior nurse, echoes Moses’s suggestion. She complains:

*“...the volunteers only work briefly during the weekdays...they do very little and disappear over nights and weekends...it would be better if they are put on rotas alongside Ugandan staff so we can improve health care delivery together and help more people this way...”*

Such mismatch also fuels suspicion and leads some Ugandans to believe that volunteers are driven by greater interests in tourism and social activities than giving Ugandans a helping hand in overcoming what they described as a “chronic” understaffing. Alice contends:

*“...some volunteers do not see what we see; there are lots of problems and we are under-staffed to address them all by ourselves... the volunteers prefer meeting new people and travelling than spending some more time in the wards. Sometimes it feels we have different needs and goals...”*

As highlighted in chapter 5, Ugandans are exposed to contrasting styles of volunteers, some perhaps geared towards tourism more than capacity development (see Sin, 2009). While most Ugandans can readily make this distinction, some nonetheless attempt to shift the goal posts and expect volunteer to assume service delivery roles. Where such attempt fails, disengagement and volunteer avoidance almost always follow.

## **7.6 Volunteer Avoidance**

Following my observations in the two health facilities described in 4.4.1.3 and 4.4.2.3, I noticed how some Ugandans deliberately avoid engaging with volunteers. This was particularly apparent at peak times and when fewer Ugandans were on duty. Following this phenomenon up with individual interviews, I discovered that volunteer avoidance occurred due to a combination of several related factors. The first concerned misconceptions about volunteer roles in Ugandan public health spaces. In line with the muzungu caricatures, Ugandans expected volunteers to come with the money and improve conditions on the ground without putting much pressure on what is already perceived, and in reality is, a ‘stretched’ health workforce. Linda, a senior nurse, typifies such expectations:

*“...volunteers I know are nice people with good hearts...they want to improve things but sometimes they slow down things...they do not provide salaries or give hand when we need more people on the ground...most staff prefer to keep away from them [SVP volunteers]...the volunteers do not seem to mind the problems we face...”*

These expectations are understandable given the existence of NGOs that pay entry into Ugandan public health spaces and provide per diems for health worker participation (Hagopian et al., 2005). However, as discussed above, the SVP policy of non-remuneration deviates from local conceptions of Muzungus, and this practice has led volunteers become known locally as bearers of “dry knowledge”. Jargons such as dry knowledge (previously mentioned in 7.3.2.1) is utilised by Ugandans to express their needs in line with the interventionist development language [see the adapted use of the word ‘project’ in 6.3.3]. Violet, outlines how Ugandans welcome volunteers and nurture them as they settle in their new environment. She goes on to explain how in return, volunteers and the MoH do not pay them back for inducting volunteers and “looking after them”. Violet pulls these points together and contextualises dry knowledge in the following excerpt:

*“...when [SVP] volunteers first come to Uganda, they face many challenges such as language, and our culture. We [Ugandan health workers] help them settle and make them feel free to help our people. But, after months and months of being with us, they still want us to be near them, work with them and look after them...but volunteers do not pay us to do that, the Ministry of Health does not pay us too...nobody like a dry knowledge [laughter]...so [Ugandan] health workers avoid them as much as possible...”*

Moses supports Violet’s view of volunteers and suggests that as hosts, he and his colleagues have a ‘duty of care’ and responsibility to “look after” volunteers, and that they should be compensated accordingly. Moses acknowledges that lack of recognition of and compensation for their roles as hosts may have led to volunteer avoidance behaviours among Ugandans. He states:

*“We as Ugandan health workers have a duty of care and a duty to look after [SVP] volunteers who come to work with us...we are expected to show volunteers around and make them settle into our health facilities. Some people [foreigners] know what we do for them and compensate; others do not...I do not have a problem with anyone, but I understand those who see volunteers and their presence as a problem...”*

Other Ugandans, however, had a different take on this. There was a wider consensus that volunteer avoidance goes deeper than the simple and binary mismatch between the expectations Ugandans hold of volunteers and what volunteers can actually offer. More specifically, Ugandans identified volunteers' missions and roles as key to understanding reasons why some health workers avoid working with them. Three such key volunteer missions were identified:

1) *Volunteers 'interrupt' the pace of service delivery* – depleted by absenteeism and heavy workload to overcome, some Ugandans, as a coping strategy, developed the habit of 'clearing the line', an ethically contested process described briefly in 6.3.4. Often oblivious to the workload Ugandans face, and with clinical ethics in mind, volunteers challenge the practice of clearing the line much to the frustrations of some Ugandans who see it as a way of "*keeping things moving*": Rose expresses her frustrations:

*"...sometimes [SVP] volunteers would just observe us and interrupt our work, and yet we have so many patients to see...it is not like we do not get it...we have to work this way [clearing the line] in order to keep things moving...sometimes it is better to work without them [volunteers] because all they do is say this is not how to do it well...this is how to do it [laughs]..."*

As evident in the above excerpt, volunteers are seen as disrupting a practice many Ugandans see as a coping strategy, and the only practical option of attending to masses of patients. Moreover, volunteers' advice in relation to 'good practice' is viewed by some Ugandans as an attempt by volunteers to assume the unqualified roles of quality assurers. Certainly, the notion of 'shared' goals espoused in the concept of CoP is redundant here, and so are important dimensions such as 'engagement' and 'alignment' as means to overcoming differences and working towards common goals. Bringing innovation and new ideas to the community is central to CoP, and problematising host practices without offering alternative clinical interventions not only has potential for disempowerment, but also for embarrassment on the part of Ugandans. Mina, a senior midwife, puts this point to a better light:

*"[SVP] volunteers sit back and watch as if they are assessing you...they only speak to when you think you are doing something wrong...this can be very rude and disruptive...sometimes patients and staff are there and you feel very bad..."*



It is therefore not surprising that some Ugandans view volunteers' style of working as a burden, putting more demand on their shoulders and further exacerbating what is already perceived as 'unmanageable' workload. Such concern is also acknowledged by the SVP. A policy report by the SVP in 2014 entitled 'Understanding Co–presence in the Sustainable Volunteering Project' highlighted the 'unintended' consequence of co–presence posing potential risks to reducing staff presence in the wards and putting pressure on already haemorrhaging human resources (Ackers, 2014). This acknowledgement by the SVP raises important questions about volunteer deployments in settings with chronic human and material resources. It further raises questions about 'learning' and how it can be achieved without putting mechanisms in place for learning to be acted upon and for knowledge to be applied successfully.

The second volunteers' role key to understanding volunteer avoidance behaviours among Ugandans is outlined next.

2) *Volunteers 'streamline' service delivery*: while most Ugandans appreciated the volunteers' commitment and enthusiasm to mobilise their resources, some felt volunteers were trying to create an action plan to streamline workflows. This was met with resistance particularly by senior Ugandans who think the volunteers were assuming the role of management that does not actually exist in Ugandan public health settings. Timothy explains:

*"...although it is a pleasure working with volunteers, sometimes they think they can bring health workers together using their own initiatives...there is nothing in place in terms of power and influence to achieve this...even I cannot achieve this with all the support I can get...some Ugandans laugh off when they see volunteers trying too hard to do the impossible..."*

While Timothy's disempowering view of the Ugandan health system described above is understandable given its many challenges, mobilising Ugandans from the disadvantaged position of offering 'dry knowledge', and through the much problematised practice of co–presence is equally difficult (if not impossible) feat to achieve as far as volunteers are concerned. Nonetheless volunteers fuelled by a mixture of altruism and career goals march on and seek strategic ways of improving the efficiency of health delivery.

Even so, this attempt is almost always met with unwillingness by some Ugandans to commit to set work schedule and is followed almost always by an abrupt disengagement. The enormity of such challenges as well as potential consequences are highlighted by Rose who contends:

*“...when you [referring to outsiders such as volunteers] tell a Ugandan health worker to work this number of days and this number of hours and you do not pay them, you risk losing them for ever...you will be lucky if you find one or two willing to put in a commitment for the good of the people [patients]...”*

The situation that Rose described above is particularly relevant among senior cadres such as doctors. In one health facility, I observed how one female volunteer doctor with the support of the SVP management attempted to institute an elective caesarean section lists not only to prevent emergencies arising in the first place, but also to make sure Ugandan doctors work alongside her to leverage knowledge exchange and learning. I also observed the different strategies the volunteer doctor employed in ‘operationalising’ Ugandan doctors including offering them free rides to the health facility. To the volunteer doctor’s disappointment, I saw the extent to which Ugandan doctors went to avoid engaging with her including not sharing their rotas and work schedule. For example, on one occasion, the volunteer doctor rang a Ugandan doctor who said he was in nearby town for a ‘business’ trip. Minutes later, a senior nurse at the same health facility rang the volunteer doctor and informed her that this Ugandan doctor was actually at the health facility at the time of her call performing two emergency caesarean sections alongside another Ugandan doctor. While such behaviour could be viewed as a resistance by some Ugandan doctors to work alongside volunteers, it is important to understand that Ugandan doctors work under incredibly difficult circumstances and are sometimes moved between public health facilities in a short notice to cover shifts. It appears that volunteers are steadfast in their pursuit for career development, and erroneously discount the life and work experiences of Ugandans. Such misrecognition on the part of the volunteers risks cultural imposition, and unappreciation of local cultures or perspectives. Misrecognition could also be the source of resistance by Ugandan doctors to utilise volunteers’ presence for more impactful service delivery.

To achieve parity of participation and social justice, volunteers need to recognise the difficult circumstances in which Ugandans operate both economically and culturally, and actively participate in addressing the underlying social structures that shape them (Fraser and Honneth, 2003).

The third and final volunteers' role key to understanding volunteer avoidance behaviours among Ugandans is outlined next.

3) Volunteers want to change things: the word 'change' like in any other context involves switching from one stage to another, and this is almost always followed by a break down (or a modification) of existing structures and the creation of new ones (Chonko, 2004). Transitioning from a 'known' to a largely 'unknown' position can lead to uncertainties, anxiety and ambiguities. In this context, there was a general belief that volunteers want to change things, and this created tensions and fear among Ugandans. Joy puts this point to a better light:

*"...the volunteers want to shake up things and change things...this is problematic for some of us [Ugandan health workers] who want to keep things the way they are because nobody seems prepared enough to take on new challenges...volunteers are therefore ignored..."*

My observation suggests that the perceived fear of change expressed by some Ugandans partly emerges from volunteers' ambiguous roles within Ugandan spaces. An operation strategy centred on 'knowledge exchange' and 'capacity' or health system strengthening is often replaced with a focus on 'knowledge transfer', and 'health system change'. The latter, an increasingly common tenet in THET-funded programmes is extended to both resource limited settings and to the NHS (Ackers et al. 2017). The notion of 'change' cultivates uncertainty, and for many Ugandans whose health system has not evolved a great deal in recent years, "holding onto" what they know and have seem rather logical. Helen explains:

*"...I think some [Ugandan] staff are afraid of change. In our experience, changing things has always led to more challenges and problems...we [Ugandan health workers] know what we have, it may not be perfect but at least we know what to do and how to live with what we have...somehow we hold onto what we know..."*

For others, however, volunteers' persistence on doing things certain ways was viewed as a way of not fostering change but rather imposing foreign practices and cultures. This, according to Nancy, a junior nurse, is evident in volunteers' "inflexibilities" in some of their approaches and practices. She claims:

*"...We [Ugandan health workers] faced a situation where local nurses had disagreement with a volunteer midwife over delivery positions. We prefer certain positions because it works for us, and the majority of mothers like it this way. However, the volunteer midwife insisted doing things her own way...she [volunteer midwife] became less popular and Ugandan midwives avoided working with her..."*

Nancy's example above demonstrates the limited knowledge and expertise some volunteers bring to the table. It also demonstrates the arrogance of some volunteers to import their practices to Ugandan public health facilities which has its own unique and localised health practices. This, understandably, leads to suspicions about volunteers' presence and roles in Ugandan public health spaces. Such experience unfortunately leaves some Ugandans adopt avoidance behaviour and dissociate themselves from some volunteers. The experience also leads some volunteers create parallel spaces within Ugandan health facilities in which they practice, sometimes on their own. Taken together, avoidance along with its consequences raise important questions about the role of SVP volunteers in Ugandan public health spaces. In particular, and from social justice point of view, it brings to light issues of imposition of British practices and unappreciation of local Ugandan practices – a recipe for disempowerment. For meaningful engagement and learning, such conflict needs to be remedied and priority given to Ugandans' needs and practices. Similarly, avoidance is not limited to engaging with volunteers. It is extended to the application of ideas, knowledge and skills harnessed through engaging with volunteers. Embedding ideas is critical to strengthening health capacity in public health settings (UHSA, 2011), and is also one of the key components of volunteers' mission in Uganda (Ackers, 2014). However, there is a "culture" of resistance to the application of 'new' ideas, knowledge or skills. Sarah, a junior Midwife, explains this culture:

*"...We gained so many things from volunteers, and most, if not all can be implemented if we [Ugandan health workers] really try and if our leaders want to make this a priority. The reality, however, is that we are not motivated enough to move things forward to apply the things we learned in real life situation and not to throw them away...there is a culture to keep things the way they are now, and this is a big problem we are all aware of."*

Sarah's view was supported by Timothy. While acknowledging volunteers' contributions, and highlighting problems in relation to the public health capacity to embed ideas, knowledge or skills gained while working alongside volunteers, Timothy acknowledges:

*"...there's no denying the [SVP] volunteers bring useful and needed skills, but I think we do not have champions to ensure effective applications of what volunteers leave behind."*

I asked Ugandans who raised issue regarding resistance to knowledge application to elaborate their views further. The following conversations were constructed from follow-up interview prompts that focused on the challenges to knowledge and skills application.

Researcher: Do some Ugandans have concerns incorporating new knowledge into the health system?

Janice, a junior midwife: *Some health workers think bringing in new ideas would upset the system; others think it would increase their workload.*

Moses: *It is mainly because some staff are afraid of new ideas, particularly those that do not 'rhyme' with organisation's and staff culture; those that tend to challenge staff behaviours. You are better off not pushing things and upsetting people [senior Ugandan health workers].*

Evidently, it is not simply the case that Ugandans do not want to embed innovation resulting from contacts with volunteers. Rather it appears structural challenges inherent in the Ugandan health system limit the potential for the kinds of innovation likely to be transferred and embedded. For one thing, bringing ideas and innovation to the table for the greater good of practitioners (volunteers and their Ugandan counterparts) is a good thing, and so is putting in place the mechanism to embed and inform wider practices. As stated in several parts in the empirical chapters of this thesis, volunteers appear to pay little attention to the wider social and economic structures that exist in the spaces they work. From a social justice perspective, a recognition of such inherent structures offers an opportunity to seek appropriate remedy from which knowledge retention within Ugandan spaces and communities maybe realised.

## 7.7 Chapter Conclusion

Chapter seven has built on some of the constraints to the benefits of voluntarism highlighted in various parts of the preceding chapter 6. The chapter has uncovered several inherent barriers to engaging with volunteers expressed by Ugandans. Among other things, the voices of Ugandans (senior ones in particular) revealed how the absence of effective authority in the public health domain made mobilising Ugandans a problematic undertaking, and shared learning a difficult prospect. A further barrier discussed in the chapter related to the chronic problem of absenteeism. Definitions, prevalence and aetiology were provided in the light of existing literature. A strong argument linking 'inadequate pay' with absenteeism and moonlighting was provided. Further, the issue of workload was explored, and discussions has centred largely on the expectations some Ugandans hold of volunteers (i.e. Muzungu caricatures) to gap-fill and substitute local labour; and the resistance of volunteers to comply with and reinforce such expectations. Related to this, the roles of prevailing volunteering styles and cultures was scrutinised and discussion provided in the light of working '*with*' and working '*for*' styles of volunteering. The impact of these styles of volunteering was explored, and implications for relationship building and learning examined. The chapter concluded with a discussion on volunteer avoidance, a form of resistance to co-presence informed interactions viewed by some Ugandans as an attempt by volunteers to increase their workload, impose their own practices, and lead system change that not many Ugandans were prepared to embrace. Chapter 8 presents the conclusion of the study.

## Chapter Eight: The Conclusion

*“...there is no such thing as a single correct view of any subject under study but that there are many correct views, each requiring its own style of interpretation.”*

(White, 1978, p.47).

### 8.1 The Introduction

This final chapter reflects on the overall study. The chapter first recaps the overall research aim and reviews findings. It then discusses the contribution of the study to existing knowledge and implications for future research. Following this, the chapter discusses strength and weakness of the study, and outlines a set of recommendations before drawing some final conclusions.

### 8.2 Recap of Research Aim

This study forms a part of a wider research project exploring the placement of British volunteers (primarily but not exclusively employed in the NHS) to public health facilities in Uganda. Specifically, the study explores the views and experiences of Ugandan health workers who host these volunteers. The study proposed to use empirical data gathered in Uganda and the UK to give voice to Ugandans, and to contribute to research on host perspectives of international voluntarism more generally. The following six broad sets of objectives were articulated to achieve the aim of the study:

- 1. To explore how Ugandan health workers perceive volunteers' presence in their health facilities.*
- 2. To examine factors that influence Ugandan health workers to engage with volunteers.*
- 3. To investigate how important Ugandan health workers perceive volunteer presence in their development or practice.*
- 4. To investigate how important Ugandan health workers perceive their presence in volunteers' development or practice.*
- 5. To identify whether there are challenges that may be associated with hosting volunteers.*
- 6. To propose new ideas as to how to better engage with Ugandan health workers.*

The study set out to answer these objectives in two distinct phases: the first through a scoping phase conducted in five Ugandan public health facilities with a sample of thirty-three Ugandan health workers; and the second through a follow-up phase conducted in two Ugandan public health facilities with a sample of thirteen Ugandan health workers<sup>45</sup>. The following section reviews the findings of this study.

### **8.3 Review of Findings**

Due to the uniqueness of the findings of the study along with the wide palette of related themes and sub-themes, chapters 5, 6, and 7 were designed to address the core objectives of this study set out in 1.7 and 8.2. These findings were articulated using themes and concepts emerging from the data analysis, which are themselves informed by an iterative methodology – constructivist GT. The findings reflect four major themes: perceptions, motivations, benefits, and barriers. An overview of these findings is provided next in the light of existing literature.

Firstly, Uganda perceptions of volunteer arrivals reveal two contrasting narratives – charitable help and learning. The former is conceptualised primarily as an ‘intervention’ package delivered by highly skilled help ‘agents’ – volunteers from a ‘superior’ culture with a mission to saving lives. This finding is consistent with host perceptions observed in Southern Africa (Perold et al., 2011), South America (Loiseau, et al., 2016), and across several countries in the global South (Palacios, 2010). The study uncovers help as a local social construct, and contrasts this with the widely held claim that it also underpins much of volunteer recruitment, volunteer placement, and the commodification of volunteering more generally (Cooke, 2006; Baaz, 2005; Simpson, 2004).

Further, the perception of ‘charitable’ help is contrasted with a ‘learning’ narrative, and a recognition by Ugandans of the ‘uniqueness’ and importance of their settings for volunteers’ personal and professional development, as well as health system learning more generally. The study finds that a growing body of development literature highlights the importance of global South health spaces for gaining and applying learning (e.g. Crisp et al., 2013; Gedde et al., 2011).

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<sup>45</sup> A focus group consisting of four Ugandan health workers hosted by the University of Salford was also conducted as part of the follow-up phase of this study.



The fact that such observation emerges from discussions with Ugandans, although novel, speaks volumes about the agency and aspirations that exist in Ugandan health spaces – important dimensions to challenging charitable help and working towards building more sustainable relationships.

Secondly, and broadly speaking, host motivations exist largely as anecdote and appear ‘assumed’ rather researched (Pastran, 2014; Guttentag, 2009). Bringing this to light, and drawing on Ugandan voices, the study finds that Uganda motivations parallel those of volunteers, and encompass both personal and professional development dimensions. Importantly, however, the study reveals Ugandan motivations are multiple and varied, challenging the notion of homogenous ‘others’ – a widely held depiction of volunteer hosts in the global South (Simpson, 2004); hierarchical – bringing to light much discounted structural and systemic factors that shape relationships within Ugandan public health spaces, and learning between Ugandans and volunteers; and reflective of prevailing NGO cultures – highlighting the rampant practice of remuneration, and per diems in Ugandan public health spaces. The study further calls into question the implications such practices have on ‘health worker’ and ‘knowledge’ flows within Ugandan public health system – important health indicators and key priority areas for The Ugandan Ministry of Health, the SVP and development partners more generally (Ackers et al., 2017; Crisp et al., 2013; WHO, 2006).

Thirdly, the study highlights the reciprocal dimensions of volunteering, and uncovers a whole host of benefits for Ugandans and volunteers. More specifically, the study uncovers parallels between benefits for volunteers identified by Ugandans, and those identified by volunteers themselves reflected in primarily but not exclusively in Western perspectives (e.g. Tillson et al., 2016; Jones, et., 2013), and more specifically in the context of Ugandan public health sector (Ahmed et., 2017; Ackers et al; 2017; Hague et al., 2015; Tate, 2015). The fact that such observation was made by non – Westerners supports the growing recognition of LICs as ‘learning spaces’ – providing volunteers opportunities to gain and apply learning (Crisp et al., 2013; Gedde et al., 2011). It also lends weight to the growing emphasis on ‘reverse innovation’ – the concept of translating learning and innovation in the global South to the global North (Ackers, Ackers-Johnson, Chatwin, and Tyler, 2017; Syed et al., 2013).

Perhaps more importantly, the study reveals that benefits identified by Ugandans appear targeted and relative to priorities on the ground. In particular, these benefits point to the important spaces volunteers occupy in bridging knowledge gaps and supervision primarily but not exclusively for junior and task–shifting cadres through on–the–job training and mentoring. Although this role of volunteers is covered in volunteering guides (Gedde et al., 2011), and policy reports (Ackers, 2014), it has not yet been explored in both depth and detail or as a ‘learning’ outcome particularly from a Ugandan perspective. Also emerging as a novel finding in this study is the role of volunteers as local ‘advocates’ and ‘intermediaries’ bridging connections and networks within and between Ugandan groups, health spaces, and officials – reinforcing commonalities, and leading to more collaborative approach to health system learning. The emphasis, to date, has been exploring ‘international’ connections and networks generated for volunteer hosts by returning volunteers, and their placement agencies (Lough, 2014; Lewis 2005; Randal et al., 2004; Jones, 2004).

Fourthly, the study finds the relationship between Ugandans and volunteers (and to some extent, between Ugandans) is not always frictionless. Among other things, it uncovers a whole host of contextual factors which impact upon not only on relationship building, but also learning outcomes for both volunteers and Ugandans. These factors are extensively covered by research on health worker motivation (Mbindyo et al., 2009; Stringhini et al., 2009; Mangham and Hanson, 2008), but less so in voluntarism research. Even more redundant is the emerging practice of ‘volunteer avoidance’ observed among some Ugandans borne out of the ‘dry knowledge’<sup>46</sup> approach to the clinical intervention adopted by the SVP and its volunteers. This practice has not yet been observed in volunteering texts largely because of the preference of remuneration and per diems by NGOs as means to boost project participation in global South spaces (Hagopian et al., 2005; Ridde, 2011).

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<sup>46</sup> An informal phrase used by Ugandan health workers to refer to SVP’s practice of brokering knowledge without remunerating Ugandans for participation (see 7.3.2.1).

Further the study sheds some light on underlying reluctance by Ugandans to translate learning harnessed through engaging with volunteers partly because of perceived lack of receptivity (and responsivity) within the health system. Little research, has, to date, explored this phenomenon, but nonetheless these findings raise critical questions about health system learning and knowledge application, and draw our attention to the need for health system support to translate learning and realise more sustainable outcomes. Meanwhile, questions about knowledge translation in the NHS by returning volunteers are also being asked, and discussions on this topic are gradually beginning to emerge (see Ackers et al., 2017).

Collectively, the findings of this study bring to light host perceptions of volunteers, and volunteering more generally, and reiterate the reciprocal dimension of volunteering. The findings also highlight the importance, in a hierarchical health system, of differentiation, and draw attention to the impact which contextual factors along with prevailing volunteering styles may have on Ugandan and volunteer learning, sustainability, and relationship building more generally. Interestingly, none of the studies reviewed has paid explicit attention to the interplay between these highly complex dynamics. It is often the presumed lack of 'knowledge' on the part of volunteer hosts rather than the complexities of their settings (institutionally, culturally, and historically) that attracts much of the current discourse on this topic (see Kulasabanathan et al., 2017). In this regard, therefore, some aspects of these findings are unique to this study, and shed some light on the importance of host voices for relationship building and learning; others mirror existing studies and contribute to research on host perspectives of volunteering more generally (Palacios, 2010; Sen, 2010; Laleman et al., 2007).

#### **8.4 Contributions to Knowledge**

This study makes significant contributions to existing research on international voluntarism and development more generally. It is one of only a handful of studies exploring the views and experiences of people in the global South who host volunteers predominately from the global North.

As such, it constitutes a timely response to the growing call for greater engagement with volunteer hosts in the global South (Lasker 2016; Lasker et al., 2014; Taplin et al., 2014; Martiniuk et al., 2012; Palacios, 2010; Maki et al., 2008).

Furthermore, the study represents one of only very few studies venturing beyond the much emphasised theme (i.e. perceived 'benefits' volunteers bring to hosts) and presents a whole host of life perspectives; including host perceptions of volunteers and their offerings, as well as contextual factors shaping host–volunteer relationships. Due to the increasing proliferation of international voluntarism in global South spaces along with the growing absence of host voices, such research is both timely and highly relevant.

In relation to the theoretical framework, the study highlights the value of social justice approach to understanding voluntarism, and as means to bringing to light beneath the surface and highly complex issues prevalent in Ugandan public health spaces. Much of the existing studies in the field draw on knowledge exchange frameworks of 'reciprocity' and 'mutuality', where the emphasis is on relationship building and learning at the level of individuals (surface level interaction). The adoption of the social justice approach in this study therefore, sheds some light onto the role structural and historical factors play in shaping volunteering relationships and learning. Evidently, imported interventions focusing on reciprocal learning is viewed less beneficial by Ugandans, and this warrants a need to expand our understanding of 'capacity development' from a narrow focus on unilateral skills and knowledge exchange to incorporate host agency and priorities. An important utility of social justice approach to this study has been bringing Ugandan voices and experiences to the fore including the complexities that exists in the spaces in which they interact with volunteers. In doing so, this approach shed some light onto the interplay between economic and cultural injustices, including the extent to which misrecognition (deliberately or otherwise) of Ugandan agency or voices is shored up by economic inequalities between Ugandans and volunteers. Moreover, it confirms the need to promote cultural justice, and give Ugandans a greater voice not only in determining a 'development' that works for them, but also supporting them in destabilising the social structures which may inhibit such development. An awareness of the need to remedy these injustices has inspired a set of recommendations outlined in 8.7.

Methodologically speaking, the study underlines the value of qualitative inquiry for exploring host perspectives (i.e. Ugandans' voices and experiences), a relatively under-researched group in the field of voluntarism. In particular, the study highlights the usefulness of constructivist GT as exploratory and yet rigorous qualitative design which draws out concepts grounded in raw data while at the same time seeking to understand how these concepts relate to existing theoretical frameworks.

The importance of this methodology is reflected in the presentation of the research findings, where Ugandans' own words have been used to embed the presentation of themes throughout the study. For example, instead of imposing strict *a priori* assumptions on Ugandans' perceptions of volunteers, the study encouraged Ugandans to articulate what they thought of volunteers, and what brought them to Uganda. This approach produced rich original findings and identified perceptions of both 'altruism' (i.e. volunteers come to help Ugandans), and self-interest (i.e. volunteers come to help themselves) dimensions of voluntarism. Furthermore, by asking Ugandans to discuss their experiences of engaging with volunteers specifically, in their day-to-day roles, the research approach illustrated how prevailing practices of foreign projects and actors (including volunteers) shape local people's expectations, motivations, and to some extent, priorities. Further 'strengths' of this methodology is outlined in 8.6.

In terms of the specific research findings, the study establishes clear links between hierarchies (positionalities), motivations and learning. In particular, it identifies an apparent motivation by junior cadres to prioritise learning (partly to move up the hierarchy) more than their senior counterparts. Interestingly, much of the learning reported in this study was reported by junior cadres. Importantly, such learning addresses critical gaps in Ugandan health system identified by the Ugandan Ministry of Health, and international partners such as the SVP (Ackers et al., 2017; UHSA, 2011). This finding, therefore points to the need to refine host engagement and focus, and highlights the role hierarchies play in shaping relationships and learning.

Equally emerging from this study is the relationships between volunteering styles, (dis) engagement, and learning. Underpinning this relationship is volunteers' 'dry knowledge' approach to intervening locally, a source of tensions between Ugandans themselves and between Ugandans and volunteers.

An important contribution of this finding, therefore, is to view volunteering from the context in which it unfolds, but importantly also, in relation to wider determinants such as prevailing volunteering styles, NGO cultures, and development AID more generally.

A further contribution to knowledge stemming from this study lies in its implications for future research underpinned by the identification of numerous areas and ideas which warrant further research.

### **8.5 Implications for Future Research**

The study uncovered diverse but contrasting Ugandan experiences some of which could be explored further. Finding a match between volunteer goals and Ugandans' 'needs' should take a high priority for volunteer sending agencies. The much emphasised need for highly skilled volunteers to assist with capacity development in LICs may overshadow local agency, priorities and needs. The findings of this study, while pointing to a preference by Ugandans for 'paying volunteers', do not offer a comparative analysis of the different volunteering styles unfolding in Ugandan public health settings. An important next step for future research would be to look at concrete learning outcomes associated with different volunteering styles. This would help assess whether subjective preferences for certain types of volunteering on the part of Ugandans correlate with clinical outcomes, and learning more generally.

As stated, this study has focused primarily on Ugandans' perspectives, opinions, and experiences of volunteers using a qualitative design. Among the research findings, Ugandans have attributed certain characteristics, and values to volunteers identified as culturally different, which are also reflected in existing research on this topic. Therefore, further research which engages with members of the local community (i.e. Ugandan patients) is highly advisable. This would add a non-professional perspective of volunteers and help gain a broader understanding of how volunteers operating in Ugandan public health system are perceived than those articulated in this study.

Furthermore, given that one of the limitations of this study reflected in section 8.6 relates to the shorter duration of the research, a longer stay with Ugandans would allow better understanding of local AID and development organisations, their scope, relationships with local communities, and some of the indicators used to make sense of development outcomes. Similarly, a larger sample involving health facility leaders would allow for greater variance in viewpoints and experiences, as would the voices of district level health officials.

Finally, and given that remuneration has emerged as a major source of tensions between Ugandans and volunteers, further research into remuneration and how it affects Ugandans' lives beyond the spaces in which they work or interact with volunteers is recommended. Similarly, research into the practice of per diems is also needed, particularly given its preference and use by foreign NGOs as both 'carrot' and 'stick' in global South spaces. In addition to this and given the apparent need to create protocols to regulate these practices so that training (and interventions) reach intended beneficiaries, research into the development, implementation, and assessment of per diems is advisable.

### **8.6 Strengths and Weaknesses of the Study**

There are several strengths and weaknesses of this study based on several dimensions including knowledge, theory, methodology and methods. The first strength relates to the contribution of the study to existing knowledge about international development and voluntarism. Reviewing existing literature of this field in chapter 2, the study contributes to a very limited knowledge repertoire about host experiences of voluntarism in the global South, and puts forth a palette of potential future research avenues, and a set of recommendation which are outlined in 8.5, and 8.7 respectively. Since the study draws on constructionism philosophy, the extent of the theoretical perspectives linking voluntarism and development perspectives is rather immense. This is evidenced by Ugandan constructions, of previously undiscovered way of making sense of the concept and language built up around the 'development edifice'. The value of this knowledge emerges from the fact that there is a relative lack of critical pedagogies of development from global South perspectives (Diprosé 2012).

Previous studies either did not explore local constructions of development or have not paid adequate attention to the significance of these constructions in relation to host volunteer engagements in global South spaces.

A further strength of this study emerges from the consistent application of co-construction: the interaction between the researcher and Ugandans, and the back and forth movement between the different stages of data collection and analysis. Consequently, the back and forth movement that was developed in this study is a novel approach to resolving the tension that exists between developing a conceptual analysis of Ugandan stories while at the same time ensuring their presence in the final presentation.

Further, an important parameter of bringing forth the viewpoints of research populations is the recognition of “...*whose voices are included in the text, however they are given weight, interpreted, prioritised, and juxtaposed*” (Sparkes, 2002, p.19). Gergen and Gergen (2000) argue that all voices matter and discourages the elimination or the sanitisation of some to achieve ‘singularity’; whereas Sparkes (2000) calls for ‘selection’ of voices as capturing all voices could lead to what has been referred to as “*commodified cacophony*” – the inclusion of too many quotes overriding the individual story, its meanings, interpretations, and place in the world (Smith, 1993, p.395). In view of the challenge of presenting the experiences of Ugandans engaging with volunteers in the final text, this study accomplished a best-fit not only between the voices of Ugandans and my authorship over the research findings in the light of the literature, but also between the different accounts, and interpretations provided by Ugandans themselves.

In view of data analysis and interpretation, going back and forth between the data allowed a much deeper investigation of the spoken word, and that which is immediately before the researcher. This argument seems valid as having chosen the experiences of Ugandans engaging with volunteers indeed generated new perspectives of international voluntarism, and potential future research focus outlined in 8.5. Whilst the constructionist approach was appropriate to provide direction and guidance to the study, the fact that I had limited immersion in the field may have resulted in drawing ‘partial’ Ugandan experiences.



In hindsight and drawing on the suggestions provided by Holloway, Brown, and Shipway, (2010) who adopted longer immersion in exploring event participants' experiences, this could have provided a broader understanding of the lives and experiences of Ugandans engaging with volunteers. Further, an important acknowledgement of this study, also reflected in most qualitative studies, is that the findings of this study are not a complete representation of the volunteer experiences of Ugandans interviewed. As observed by Holroyd (2007) in cross cultural study, some experiences will remain "*undiscovered*" (p.1), and this recognition, highlights another limitation of this study.

### **8.7 Recommendations**

Evidence suggests the persistence of some forms of 'development' programmes that emphasise 'serving' locals in isolation from their surrounding environments, therefore inadequately addressing their priorities and needs (Simpson, 2004). It is safe to assume that at this current juncture, the same can be said for some volunteer programmes in diverse settings, especially those in LICs (Pastran, 2014). Following this critical analysis, which included listening to Ugandans' voices and experiences, the study proposes a call for action to realise a meaningful outcome that works for all stakeholders. In particular, consideration should be given to 'listening' to Ugandans in relation to what matters to them the most – including existing opportunities and barriers in their settings. In view of this study which has explored Ugandans' experiences of engaging with volunteers, several barriers were uncovered, and their wider effects examined. Integrating these contextual issues into volunteering programme models along with more 'flexible' and 'differentiated' approaches to volunteer roles in Ugandan public health settings, could allow the SVP (and potentially other international partners) to greatly strengthen their efforts to promote global health – facilitating more localised, strategic, and sustainable health solutions in the global South. Further, given that co-presence along with its 'dry knowledge' guise proved problematic in Ugandan public spaces, the SVP should revisit its operational goals in Uganda, and consider a more socially just approach to intervening locally – to ensure Ugandans realise their full potential and take positive steps towards achieving their development goals.

Introducing a 'salary scheme' or 'performance-based incentives' could help boost morale, and counter the effects chronic issues such 'absenteeism' have on patient safety, relationship building and learning more specifically.

Similarly, there is an urgent need for a coordinated approach to volunteering programmes to curtail exploitation and disempowerment practices in global South spaces. And while, 'standardisation' of overseas volunteering programmes is almost impossible given the proliferation of different types of volunteering some in the 'for-profit' sector, stakeholders should consider a bottom-up approach to volunteering and facilitate dialogue that encourage direct, open, and honest communication. This will bring to light some of the complexities and challenges volunteer hosts experience – an avenue from which to address the mismatch that continues to exist between local priorities and volunteers' offerings and lead more positive change.

A final way forward relates to the need for innovative ways to improve participation and co-working between Ugandan hosts and volunteers. Creating 'model' health spaces with multiple stakeholders including the Ugandan MoH, and Northern development partners (such as the NHS and its volunteers) could improve participation and reinforce professionalism and accountability within Ugandan public health spaces. It could also lead to more strategic mobilisation and management of the health workforce and provide avenues to not only improve contacts between Ugandan hosts and volunteers in Ugandan public health spaces, but also introduce similar model health spaces that can be replicated across Ugandan public health spaces.

### **8.8 An Exploration for Discovery - PhD Journey**

Looking back at my PhD journey, I went through a plethora of learning experiences that were shaped by the integration of my work experience with development NGOs and academic life, which together, led to my development as a person and as a researcher. Reflecting on the commencement stage of my PhD in the autumn of 2014, I remember how I imagined the process of undertaking a PhD to be illuminating, and straightforward. Instead, undertaking the PhD turned out to be a journey of discovery. I started off with an exploratory visit to Uganda, with no fixed methodology in mind other than to enter the field and explore the experiences of diverse Ugandan professionals hosting volunteers in multiple Ugandan public health spaces.

I remember vividly my PhD supervisors advising me to immerse myself in the context, to better understand Ugandan public health spaces, Ugandans, and their relationships with volunteers. I also remember how, guided by a crudely assembled interview schedule, I could not resist hitting the field, and before long, I was moving from one health space to another interacting with many Ugandans and interviewing them in the process. While such exploration enabled me to meet the initial research objectives, it did little to allow me to build enough rapport with Ugandans, with the health facilities, and this has been an important lesson learned. Such lesson along with subsequent reflections brought a greater focus to the follow-up phase of the study. It has, in particular, shed some light onto a range of useful markers including the need to embrace the construction of knowledge and the multiple views and interpretations of Ugandan experiences. For one thing, [human] constructions embody historical, cultural and linguistic configurations. Unpicking these constructions from interview transcripts can be daunting to say the least, but the iterative 'beneath the surface' approach to research added particular utility to the follow-up phase. In particular, it helped bring forth several emergent themes and interrelating sub-themes which sparked new ideas and concepts. Whilst this way of making sense of research guided me to novel findings which are now incorporated in chapters 5–7, it has caused much delays resulting from time spent trying to situate the study's findings in a range of literature without departing from the study's core objectives altogether.

By the same token, recruiting Ugandans meeting the study's inclusion criteria outlined in 4.3.1.1 proved challenging. This was partly because of the need to recruit Ugandans with first-hand experiences of engaging with volunteers in line with the study's underpinning methodology. Due to the 'tight' schedule of Ugandans along with the broader emphasis to recruit them in 'suitable' venues in line with the study's ethical approval, the process of recruiting was not straightforward. Nevertheless, the challenges of recruiting Ugandans led to a number of lessons learned. This included the need to 'spread' the word and highlight the importance of my study and the participation of Ugandans for better understanding of their experiences.

Another lesson learned occurred during the course of the data collection. From conducting largely structured interviews in the scoping phase to in-depth semi-structured interviews in the follow-up phase of the study, I began to appreciate the importance of listening, and understanding the 'deeper' meanings of Ugandans' experiences. In contrast to the scoping phase, and rather than viewing interviews as a question and answer exercise, the follow-up phase adopted conversational in-depth interviews, and discussion flowed largely unprompted. Having journeyed from deductive to inductive approach prior to commencing the PhD, I was very careful not to fill in the moments of silence and impose my own sanitisation of the dynamics of the interviews. Conducting a dummy interview before embarking on the follow-up phase, and shadowing my PhD supervisors conducting a real-life interview sharpened my focus. An awareness of my influence as a researcher on the direction, and flow of the interview as well as the overall flow of discussion was an important part of this process.

Reflecting now, it appears to me that my initial imagination of a PhD as a straightforward matter turned out not to be the case. In fact, if anything, it has been a messy experience which demanded absolute immersion, determination and continuous reflection. Such dedication was not always possible for me mainly for two reasons; firstly, my wife experienced an untimely series of health problems, and the birth of our second daughter amidst all these did very little to help; and secondly, my attempts to 'sanitise' my research and to claim for my qualitative work the kind of rigor valorised in quantitative works significantly disrupted my progress. This propensity developed from my past experiences of deductive research particularly in relation to working as a research assistant and quantitative research methods lecturer. In many ways, this experience has been a source of frustration for myself and my supervisors particularly in my second year PhD journey. In respect to all the experiences therefore, I arrived at the conclusion that the process of undertaking a PhD is not a linear process. Rather, it is a circular process, one that demands continuous consultations, and flexibility including allowing adjustments and revising parameters in line with the research direction. In view of the findings, undertaking this study exploring the experiences of Ugandans hosting volunteers advanced my personal perspectives of international voluntarism.

Having previously worked in international development arena, and after being exposed to 'voluntourism', and 'gap-year' volunteering in the past, I had the impression that global South spaces were magnet for adventure seeking, and to some extent, disempowering Western mavericks. While such argument stood the test of time, and as concluded in many recent volunteering genres (e.g. Pastran, 2014), I did not have much understanding of other styles of voluntarism in global South spaces. Although I knew early on in my PhD application process that the volunteering style underpinning the work of the SVP was based on the health partnership model, I was not familiar with how this style of volunteering operated, and indeed how different it was compared to my previous volunteering encounters. Although later, and after being offered the PhD scholarship, the characteristics of this style of volunteering slowly began to infuse with my existing reservations and thoughts. Even so and given the limited representation of Ugandan voices in the SVP reports and volunteer accounts, I still could not make out how this volunteering style could be different from those outlined above. The findings of this study however brought much clarity and some useful insights. It did not only demonstrate the relational nature of the volunteering style, but also contextualised how its configurations provided opportunities for leveraging knowledge and expertise. Crucially, the findings highlighted, from Ugandan perspectives, reasons volunteers and Ugandans work together, and the different ways such experience inform their careers. The findings also demonstrated a range of barriers with strong financial underpinnings and which pose greater constraints on relationship building and learning in Ugandan public health spaces.

Having been under the impression that all volunteering styles in global South spaces are largely the same, such perception has changed within the course of my PhD journey. It has been replaced by a differentiated view of volunteering, and a recognition of the positive roles carefully planned volunteering programmes can play in global South spaces. What has never changed, however, is my respect for Ugandan health workers, and their resilience in the face of adversity. Their ingenuity, resourcefulness, smiles and generosity, had a profound impact on me personally, and for that I will forever be grateful. Adding the voices of Ugandans to existing literature of the field has been the aim of this study.

The wholeness of Ugandan voices along with their distinctiveness in terms of phrases and jargons have been maintained to allow Ugandans to see themselves in my writings about them, and in a non-judgemental manner.

### **8.9 Chapter Conclusion**

The aim of this study was to explore the experiences of Ugandans engaging with British volunteers on placement in Ugandan public health facilities. Implicit in this study is the need for a body of evidence to better inform host perspectives of voluntarism, and voluntarism more generally. The findings of this study provided valuable new experiential insights into Ugandan voices and delivered analytical contributions to the existing body of knowledge with both academic and policy implications. Further, the study identified a palette of potential research avenues that can be pursued in the future. Finally, the study provided a set of recommendations that can be applied to address some of the complexities that exist in the spaces Ugandans and volunteers interact before drawing a reflective account of my PhD journey.

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## Appendices

Appendix One: Health facilities and their functions (Source: The Ugandan Ministry of Health)

Health facility types	Health facility Purpose
National Hospital	<ul style="list-style-type: none"> <li>○ Located in Kampala city</li> <li>○ Provide comprehensive specialist services and is involved in health research and teaching in addition to providing services offered by regional hospitals</li> </ul>
Regional Referral Hospital (RRH)	<ul style="list-style-type: none"> <li>○ Regional level care</li> <li>○ Provides specialist clinical services such as psychiatry, Ear, Nose, and Throat (ENT), ophthalmology, surgical and medical services, and clinical support services</li> <li>○ Teaching and research</li> </ul>
Mission Hospital (MH)	<ul style="list-style-type: none"> <li>○ Typically private, not-for-profit hospitals</li> <li>○ Provide preventive, promotive, curative maternity, in-patient health services, surgery, blood transfusion, laboratory and medical imaging services</li> <li>○ Some are involved in teaching and research.</li> </ul>
Health Centre Four (s) (HCIVs)	<ul style="list-style-type: none"> <li>○ County level care</li> <li>○ Provide curative and preventive services, emergency surgery and blood transfusion services</li> </ul>
Health Centre Three (s) (HCIIIs)	<ul style="list-style-type: none"> <li>○ Sub-county level care</li> <li>○ Provides basic preventative, promotive and curative care</li> <li>○ Provides laboratory services for diagnosis, maternity care and first referral cover for the sub-county</li> </ul>
Health Centre Two (s) (HCIs)	<ul style="list-style-type: none"> <li>○ Parish level care</li> </ul>

- 
- First level of interaction between the formal health sector and the communities
  - Provides only outpatient care and community outreach services

Health Centre One (HCI)

- Village level care
- Coordinating centre for Village Health Teams (VHTs)
- Has no physical structure but uses the VHT as a link between health facilities and the community

Appendix Two: The ten most searched volunteer destinations in the world

Rank	Country	Searches (Relative)
<b>1</b>	The Philippines	3.45
<b>2</b>	India	3.12
<b>3</b>	Thailand	2.96
<b>4</b>	Nepal	2.72
<b>5</b>	Cambodia	2.37
<b>6</b>	South Africa	2.36
<b>7</b>	Costa Rica	2.08
<b>8</b>	Vietnam/Peru	1.36
<b>9</b>	Australia	1.35
<b>10</b>	<b>Uganda</b>	<b>1.27</b>
<b>11</b>	Kenya	1.22
<b>12</b>	Ireland	1.13
<b>13</b>	Brazil	1.07
<b>14</b>	Haiti	1.02
<b>15</b>	Japan	1.00

Source: Go overseas 2014.

Appendix Three: Tools for evaluating qualitative enquiry. Adapted from Long and Godfrey (2004)'s tool for evaluating qualitative research.

#### Search strategy

- Information (contacts/links) gained through research seminars (in particular Knowledge, Health and Place (KH&P) to identify other potential studies (published and unpublished).
- Reference lists of both published and unpublished literature to identify potential studies and sources.
- Google Scholar search engine to screen citations for relevance – analysis of the words contained in the title, abstract and index terms.

#### Inclusion criteria

- Published and unpublished literature (mainly due to the scarcity of literature on host perspectives of international voluntarism).
- English Language (or translated to English).

Tool used to facilitate the evaluation of existing literature Adapted from Long and Godfrey (2004)'s tool for evaluating qualitative research.

The tool provides a template of key questions to assist in the critical appraisal of qualitative studies.

#### **Study Overview**

#### **Key questions**

*Purpose*

*Findings*

*Summary*

***Phenomena under study***

*Context*

*Theory*

*Setting*

1. What is and/are the aims of the study?

2. Is the study part of on-going research?

3. What are the key findings?

4. What are the strengths/weaknesses or implication for knowledge

5. What is being studied?

6. What is/are the underpinning theoretical framework?

*Outcomes*

7. How do the authors locate the study within the existing knowledge base?
8. What setting (s) is the study being conducted? Why?
9. How is the sample (events, persons, times and settings) selected?
10. What are the key characteristics of the sample (events, persons, times and settings)?
11. Whose perspectives are addressed (professional, service, user, carer)?

**Ethics**

12. Was Ethical Committee approval obtained?
13. Was informed consent obtained from participants of the study?

**Data Collection**

*Data analysis*

14. What data collection methods are used to obtain and record the data?
15. Is the process of fieldwork adequately described?
16. Was the role of the researched adequately described?
17. How were the data analysed?
18. How adequate is the description of the data analysis?
19. Was researcher's position made clear?
20. What are the implications for policy?
21. What are the implications for service practice?

**Other Comments**

22. What were the total number of references used in the study?
23. Are there any other noteworthy features of the study?



Appendix Four: Sample for the scoping phase (N=33)

<i>Health facility</i>	Professional Cadre	Gender	Career Level	N
<i>Kisenye HCIV</i>	Nurse	Female	Junior	1
	Nurse		Senior	1
	Midwife		Senior	1
<i>Mbarara Regional Referral Hospital (MRRH)</i>	Leader	Female	Senior	2
		Male		
	Nurse		Junior	1
	Nurse	Female	Junior	1
		Female		
	Midwife		Junior	2
	Midwife	Female	Senior	1
		Male		
	Doctor	Male	Junior	1
Doctor		Junior	1	
Doctor	Female	Senior	1	
<i>Kabubbu HCIII</i>	Anaesthetist	Male	Senior	1
	Biomedical Engineer		N/A	1
		Female		
<i>Kisiizi Mission Hospital (KMH)</i>		Male		
	Nurse		Senior	2
	Nurse	Female	Senior	1
	Midwife	Male	Senior	2
<i>Hoima Regional Referral Hospital (HRFH)</i>	Biomedical Engineer		N/A	1
		Female		
	Nurse	Female	Junior	1

Nurse	Female	Senior	2
Midwife	Male	Senior	2
Biomedical Engineer		N/A	1
	Female		
	Male		
Nurse		Junior	1
Nurse	Female	Senior	1
	Female		
Midwife		Junior	1
Midwife	Male	Senior	1
Doctor	Male	Senior	1
Biomedical Engineer		N/A	1

Appendix Five: Sample of the follow-up phase (N=13)

<b>Health facility</b>	<b>Professional Cadre</b>	<b>Gender</b>	<b>Career Level</b>	<b>N</b>
<b>Bukuuku HCIV</b>	Nurse	Female	Junior	2
	Nurse		Senior	1
		Female		
	Midwife	Female	Senior	2
	Midwife		Senior	1
<b>Kagote HCII</b>		Male		
	Leader		Senior	1
		Female		
		Female		
	Nurse		Junior	1
	Nurse	Female	Senior	1
		Female		
	Midwife		Junior	1
	Midwife	Male	Senior	1
	Clinical Officer		Senior	2

*Note: The professional cadres stated in both Appendix 4 and 5 reflect the ‘main’ roles Ugandan health workers held at the time of the interviews. In reality, however, most of these Ugandans held at least one other role. Midwives doubling up as nurses were the most common professional cadre in both phases of this study.*

## Appendix Six: Interview guide - the scoping phase of the study

- Please tell me about yourself? [gender, cadre, roles, job title]
- How long have you worked here?
- What are your experiences of engaging with volunteer [name removed] [prompts: period of engagement, one-off or recurring engagement, cadre]?
- Why do you think SVP volunteers come to Uganda to work alongside you? [sharing knowledge, personal development, humanitarian]
- What do volunteers do in your settings? [How do they do that?]
- Why do you engage with them?
- How does working with volunteers benefit you? [specific skills ideas, competencies]
- Reflecting on your engagement with SVP volunteers, what specific skill (s) did you gain while working with volunteers?
  - How much of this skill (s) did you know before engaging with volunteers?
  - 'Are you able to use this/these skill (s) in your setting, and why?
- How is learning achieved? [Prompts: training, meetings, workshops, observations, teaching, other]
- What do you think SVP volunteers gain from working alongside you?
- What (if any) makes it difficult engaging with volunteers?
- Is there anything that you would like to add?

## Appendix Seven: Interview guide – the follow-up phase of the study

The flow of the interview and the contents of the questions varied from one interviewee to another. Because Ugandan health workers engage with volunteers at different levels, the interview questions varied slightly to capture such dimensions. As such, the following questions functioned as an interview guide.

- Tell me about yourself. Prompt – gender, job title, career level?
- When you first met [name of volunteer (s)], what were your initial reactions?
- How do you feel about volunteers coming to your health facility? Prompt – given enough information about their arrivals? Felt comfortable hosting them?
- Why do think volunteers come your health facility?
- Tell me why you engage with volunteers? Prompts – learning, gaining experience
- What role do you play in hosting volunteers? Prompts - welcoming, co-working, guiding, mentoring?
- Tell me how you interact with volunteers? Prompts – wards, off-wards, training?
- Describe what it is like engaging with volunteers? Prompts – enjoyable, difficult, time consuming?
- Tell me about your relationships with [name of volunteer (s)]? How would you describe them? Prompt - would you describe these as positive relationships – why/why not?
- Tell me how engaging with [name of volunteer] impact on your development? Prompts – learning, improving practice.... *gain new skills, validate existing skills?*
- Describe how engaging with you impact on the volunteer (s) development? Prompts – awareness of local cultures, *clinical practice?*
- Are there any barriers to engaging with volunteers? Prompt – time, workload, culture, *professional practice?*
- How have you responded when there have been barriers?
- How has the volunteer (s) responded when there have been barriers?
- Have you experienced any differences between SVP volunteers, and other Western volunteers? Prompts – priorities, engagement styles?  
If so, how do these differences inform relationships?

## Appendix Eight: The interplay between codes and data segments during the open coding stage

The screenshot displays an open coding software interface. On the left, a list of codes is shown under the heading "Open coding". The codes are: Absenteeism, Advocacy, Culture, CV building, Expectation, Family planning, Good practice, Health education, Improving health provision, Improving knowledge, Improving practice, Improvisation, Inadequate pay, Moonlighting, Networking, Outreach work, Partnership, Qualification, Skill share, and Tropical medicine. The codes "Improving health provision" and "Skill share" are highlighted in blue. On the right, a text window shows interview transcripts. The window title bar includes tabs for "Anaesthetist R1", "Midwife P1", "Midwife P2", "Midwife R4", and "Nurse R7". The transcript content is as follows:

Researcher: Please tell me about your own experiences of working with volunteers at BHCIV.

Anaesthetist R1: Fortunately, I worked with and still do work with volunteer professionals who have a sense of purpose and lots to share and learn. They are very useful sources of knowledge and guidance for us. Of course our staff is different; some have lots of clinical experience, others haven't. Volunteers benefit all of us. For example, an experienced clinical officer working with volunteers can pick up different ideas or clinical procedures which are not practised in Uganda. This is not to say they are learning new skills but rather they are being kept refreshed and this is good for good practice. Junior staff and those with limited clinical experience can learn whole new skills through engaging with volunteers. So, it is all good.

Researcher: How has working with volunteers benefited you or your colleagues?

Anaesthetist R1: A great deal really. I work in theatre with (name removed) and watch how Ugandan doctors learn from her. For example, Ugandan doctors are discouraged from and are not taught how to deliver babies by forceps because of associated risks including brain damage. It has also been shown that babies delivered through forceps develop seizures later in life although the cause of this is disputed. As a result, many babies are delivered through sections. However, the volunteers brought forceps technique that can be used to deliver babies without damaging their brains. Through this procedure, we have managed to bring down section rates and Ugandan doctors now carry this procedure without any complications for mother and baby.

Appendix Nine: Research Ethics Approval Letter from the University of Salford'  
Research, Innovation and Academic Engagement Ethical Approval Panel



Research, Innovation and Academic  
Engagement Ethical Approval Panel

College of Health & Social Care  
AD 101 Allerton Building  
University of Salford  
M6 6PU

T +44(0)161 295 7016  
r.shuttleworth@salford.ac.uk

[www.salford.ac.uk/](http://www.salford.ac.uk/)

3 November 2014

Dear Hassan,

**RE: ETHICS APPLICATION HSCR14/99 – Examining the outcomes of engaging UK volunteers for Ugandan healthcare workers**

Based on the information you provided, I am pleased to inform you that application HSCR14/99 has been approved.

If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible.

Yours sincerely,



Rachel Shuttleworth  
College Support Officer (R&I)

## Participant Booklet



Please read this information carefully before completing the consent form

**Project title:** Voices from the Global South: Exploring the Lived Experiences of Ugandan Health Workers Hosting British Volunteers

**Researcher:** Hassan Osman

**Reference number:** HSCR14/99

You are invited to take part in this study. Before you decide whether you would like to participate, it is important to read the following information carefully. This explains what will happen if you take part, and that you are free to withdraw at any time. You should only participate if you want to; choosing not to take part will not disadvantage you in any way, shape, or form.

Please feel free to talk to other people about the study. If there is anything you do not understand, or if you would like any further information, please contact the PhD researcher, Hassan Osman:

Address:

University of Salford  
Allerton Building  
Frederick Road Campus  
Salford  
M6 6PU  
Email: [h.osman@edu.salford.ac.uk](mailto:h.osman@edu.salford.ac.uk)  
Supervisor: Professor Louise Ackers  
Email: [h.l.ackers@salford.ac.uk](mailto:h.l.ackers@salford.ac.uk)



### **What is the purpose of this study?**

This study explores the experiences of Ugandan health workers engaging with British volunteers. The objective is to bring forth Ugandan voices, and in doing so, contribute to host perspectives of voluntarism in the global South. We would love to hear your past, and present (or both) experiences of engaging with British volunteers. Your responses will help identify your perceptions of SVP volunteers (including why they come to your health facility); why you engage with them; what happens while you interact with them; and what barriers (if any) exist in engaging with SVP volunteers.

Your responses will be made anonymous and no-one will be able to identify you, where you work, or the views you have expressed. The findings of this study will be shared with people and organisations that support or are interested in understanding host perspectives of international voluntarism. The findings will contribute to research in the field and bring to light the lived experiences of people who host volunteers, and from distinctively Ugandan perspectives.

### **Why have I been asked to participate?**

You have been asked to take part in this study because you like many other Ugandan health workers have recently or previously engaged with SVP volunteers to share knowledge and skills regarding maternal and infant well-being. If you agree to take part, all data that is collected will be made anonymous. This means that it will not be possible to identify you from what you have said.

### **What does participation involve?**

Participating in this study involves a recorded interview with the researcher regarding your experiences of engaging with SVP volunteers. There are no right or wrong answers to the interview questions, and you can choose not to answer questions if you feel to do so. The interview will take place in the health facility and at a time of your convenience and will last no longer than 90 minutes.

Taking part in this research may also include being observed outside the wards and only with your permission or consent. This observation will be as unobtrusive as possible and will be limited to a general observation of your interaction with volunteers.

**What are the possible benefits of taking part in this study?**

There will be no financial rewards or direct benefits to taking part in this study. However, the findings of this study will be used to provide volunteer practitioners and stakeholders (including in-charges) with valuable information about the views and experiences of Ugandan health workers hosting SVP volunteers.

**What are the possible risks of taking part in this study?**

It is unlikely that there will be any risks from taking part. However, some people may find it difficult to answer specific questions or emotionally distressing to reflect about a specific experience. If you feel uncomfortable with any question during the interview, you can ask the researcher to skip to the next question or stop the interview altogether without any reasons.

**Can I withdraw at any time?**

You do not have to take part in this study if you don't want to. If you decide to take part, you can still withdraw from taking part without explanation. You can also ask to withdraw specific comments made during the interview, but this will need to be requested before the interview transcripts are anonymised in which case it will very difficult to identify individual responses.

**What will happen to the findings of this study?**

The findings will be stored safely, and all your personal details will be kept in a safe and secure environment. A summary of this study will be available, and you can request a copy when it becomes available.

The researcher will also be presenting a summary of the findings of this study at conferences and research seminars, but this will not include your identity of personal details.

**How will confidentiality be maintained?**

All data will be collected and stored in accordance with the United Kingdom Data Protection Act (1998). This means that all of the data collected throughout the course of this study will be stored securely and anonymously.

Only the principal researcher and supervisors will have access to data. On completion of the study, data will be retained for a minimum period of three years after graduate award has been agreed in line with the University's research ethics requirements.

**Who should concern about this study be addressed to?**

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will try to answer your questions. If you remain unhappy and wish to complain formally, you can do this by contacting the Research, Innovation and Academic Engagement Ethical Approval Panel. College of Health and Social Care AD 101 Allerton Building University of Salford M6 6PU.

**Who has reviewed this study?**

The study has been examined and approved by Salford University College of Health and Social Care Research, Innovation and Academic Engagement Ethical Approval. Ugandan Health facility leaders working in partnership with SVP volunteers and their management team have also examined this study and provided verbal approval. Professors Louise Ackers and Anya Ahmed are supervising the study. This study is funded by Health Education England (HEE) through the Measuring Outcomes of Volunteering for Education (MOVE) project.

**Giving informed consent to take part**

We would now like you to think about whether you would like to take part in this study. If you think you might like to take part, please fill your contact details below and give it to your in-charge. The researcher will contact you to see if you would still like to take part in this study.

Thank you for taking the time to read this participant information booklet.

Appendix Eleven: Participant consent form

**Consent Form**



**Project title:** Voices from the Global South: Exploring the Lived Experiences of Ugandan Health Workers Hosting Volunteers

**Researcher:** Hassan Osman

**Reference number:** HSCR14/99

Please read the study information sheet below. If you agree to participate in this Study please complete and sign the form below.

I confirm that I have read and understood the information sheet for the above study and had the chance to ask questions and had them answered appropriately.

I understand that my participation in this study is on voluntary basis and have the right to withdraw from the study at any time without any reason and detriment to my job.

I agree to take part in an audio-taped interview and that the recordings will be kept in password-protected software.

I understand the researcher will use my responses for this current study and that my identity will be kept for a minimum period of three years after graduate award has been agreed

I understand that the information I have submitted will be published as a report and that I can be sent a copy on request.

**I agree to take part in the above study**

For further information and advice regarding this study please contact [Name deleted]

Appendix Twelve: Criteria for establishing rigour in grounded theory (adapted from (Charmaz, 2014)

Criteria	Evidence
<p><b>Credibility</b></p> <p>Familiarity with the topic achieved.</p>	<p>Past experience of the field, extensive literature review (Chapter, 2). The scoping phase and the lessons learned helped refine the topic, and the methodology.</p>
<p>Sufficient data.</p>	<p>Data triangulation in the form extensive interviews (46), observational research, focus group, and field notes.</p>
<p>Systematic comparisons made between incidents and categories.</p>	<p>Data comparisons aided by memo writing to compare incident with incident, data with data, themes with themes.</p>
<p>Strong logical links between the gathered data and argument and analysis.</p>	<p>Data collection and analysis followed a process with an audit trail, and data comparisons between categories, concepts and themes were presented.</p>
<p>Evidence to allow the reader to form an independent assessment – and agree with claims made.</p>	<p>Chapter 4 provided step by step guide to data collection and analysis and reflexivity to guide the reader to follow the logics behind the research process, and to independently reassess credibility to the research to draw informed conclusions.</p>

Criteria	Evidence
<p><b>Originality</b></p> <p>Categories offered new insights.</p>	<p>Emergent themes and concepts offered insights (under-researched) populations to compliment and advance current body of knowledge on international voluntarism and development.</p>
<p>Analysis provided a new conceptual rendering of the data.</p>	<p>Clear and transparent process was followed, and practical examples of data collection and analysis provided.</p>
<p>Social and theoretical significance of this work.</p>	<p>Snapshots of social and theoretical implications of this work was provided in 8.4.</p>
<p>The theory challenged, extended or refined current ideas, concepts, and practices.</p>	<p>The theory offered insights that challenged the representation of volunteer hosts in the global South as mere recipients of volunteer knowledge, and thus extended the current body of knowledge (see 8.4).</p>
<p><b>Resonance</b></p> <p>Categories portrayed the fullness of the studied experience.</p>	<p>Multiple data collection methods were utilised, and Ugandans' views from a diverse range of professional cadres (e.g. midwives, nurses, clinical officers, educators and leaders) were explored. This provided a 360-degree representation of Ugandans' experiences of engaging with the volunteers.</p>

Criteria	Evidence
Revealed both liminal and unstable taken-for-granted meanings.	Meanings of all references including those I came across previously in Uganda and elsewhere were cross-checked with the participants to establish Ugandans' actual interpretations. An example of this is provided in chapter 4.
Links made between larger collectives or institutions and individual lives, when the data so indicated.	Consistent with the study's constructionist epistemology, both individual and collective constructions were taken into account.
The theory made sense to participants or people who shared their circumstances.	<p><i>"...I see the value of this research, and I can relate to the questions you are asking me. You are trying to know my experiences of engaging with [name removed], and I am happy to share them with you."</i> [Charity, Midwife].</p> <p>This excerpt clearly highlighted the GT interview questions posed were relevant and thought-provoking.</p>
Analysis offered participants' deeper insights about their lives and worlds.	While interviewing and where appropriate, I developed ideas and concepts further and asked Ugandans to elaborate meanings they attached to specific social phenomenon.

Criteria	Evidence
<p><b>Usefulness</b></p> <p>Analysis offered interpretations that people can use in their everyday worlds.</p>	<p>The theory focused the analysis on the Ugandans' accounts, and on eliciting their perspectives rather than that of the existing literature.</p>
<p>Analytic categories suggested generic processes.</p>	<p>The key constructs were largely generic and allowed cross-data comparisons and analysis.</p>
<p>The analysis sparked further research in other substantive areas.</p>	<p>The theory was rigorous and had uncovered related topics further exploration as highlighted in 8.5.</p>
<p>Research contributed to knowledge, and to making a better world.</p>	<p>The theory helped contextualise the field, added Ugandan voices to the current body of literature on host perspectives of volunteering, and offered insights into the benefits of North– South engagements in improving health system learning in both Uganda, and the UK. The emergent findings contribute to both knowledge and practice (8.4).</p>