Global Journal of Health Science; Vol. 16, No. 3; 2024
ISSN 1916-9736 E-ISSN 1916-9744
Published by Canadian Center of Science and Education

Low- and Middle-Income Country Perceptions of Global Health Engagements: A Scoping Review

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Received: January 10, 2024 Accepted: February 26, 2024 Online Published: February 29, 2024

doi:10.5539/gjhs.v16n3p35 URL: https://doi.org/10.5539/gjhs.v16n3p35

Abstract

More than one million Americans are estimated to participate in global health engagements (GHEs) in low- and middle-income countries (LMICs) each year. A growing number of studies document perceptions of GHEs from the perspective of American and other high-income country (HIC) visitors traveling to LMICs, particularly regarding motivations and satisfaction relative to their participation in these activities. Far fewer studies examine perceptions of GHEs from the perspective of LMIC hosts and other local constituent groups. The purpose of this study was to identify and analyze studies that examined local stakeholder perspectives of global health engagements in LMICs around the world. We conducted a scoping review of PubMed and Google Scholar using the Population-Concept-Context (PCC) framework. Assessment and analysis of articles was conducted by a team of three reviewers (EA, FS, SB). A total of 31 relevant papers published between 2009 and 2021 provided local perspectives of GHEs, with participants falling into three stakeholder categories: providers of care, recipients of care, and community members. Analysis revealed that stakeholder groups often held complex and highly nuanced perspectives of GHEs, perceiving these activities as having both positive and negative implications in the host communities. Synthesis of the eligible studies' findings resulted in three thematic categories: resources and perceived benefits derived from GHEs; perceived challenges associated with GHEs; and opportunities for improvement of GHEs. To our knowledge, this scoping review is among the first to identify and collectively analyze LMIC stakeholder perceptions of GHEs. Recommendations for future research are provided.

Keywords: LMICs, local perspectives, perceptions, global health engagements

1. Introduction

Participation in global health engagements in low- and middle-income countries (LMICs) has become well within reach for anyone with the interest and means to pursue it (Schnable, 2021). Organizations of diverse variety have offered opportunities for individuals from high-income countries (HICs) to travel to LMICs to take part in global health activities, including clinical service, health education, and other health-focused service activities (Chan, Sisk, Yun, & St Clair, 2020; Kerry et al., 2011; Lasker, 2016; Oliphant, 2018; Sullivan, 2018). Universities, nonprofits, religious institutions, and even for-profit volunteer placement companies have offered interested individuals the opportunity to "give back" and "do good" in countries perceived to be in need of such services (Lasker, 2016). Participation in GHEs increased exponentially in the early years of the new millennium, with more than 1,000,000 Americans estimated to have participated in international volunteer service trips annually from the early 2000s to 2014 (Hetherington & Hatfield, 2012; Lough, 2015). Annual expenditures in the United States have been estimated to exceed $3 billion annually when factoring in actual expenses, the dollar values of volunteer hours, and ancillary contributions associated with such activities (Caldron, Impens, Pavlova, & Groot, 2016).

Numerous studies detail GHE participation from the perspective of HIC visitors, particularly their motivations and satisfaction relative to their engagement with global health activities (Hetherington & Hatfield, 2012; Nelson, Kasper, Hibberd, Thea, & Herlihy, 2012). This is particularly true among medical trainees, a constituent group well-represented in the global health literature (Oliphant, 2018; Stagg et al., 2017). Motivations among this group included the cultivation of specific skill sets, such as seeing tropical diseases firsthand or developing cross-cultural communication skills (Melby et al., 2016). In addition to building resumes and marketing themselves as well-rounded job candidates, HIC participants reported that GHEs positively impacted their long-term career choice, overall job-satisfaction, and cultural and interpersonal competencies (Bazemore, Goldenhar, Lindsell, Diller, & Huntington, 2011; Jeffrey, Dumont, Kim, & Kuo, 2011; Lu et al., 2018). Conversely, one aspect of GHEs that garnered far less attention was the perspectives of various stakeholders in LMICs. Relatively few studies examined how global health engagements were perceived by those who regularly hosted these activities in LMICs. The aim of this scoping review was to identify and analyze studies that examined local stakeholder perspectives of global health engagements in LMICs. The objective of this study was to describe the diversity of viewpoints, attitudes, and beliefs held by local stakeholders in regard to the global health activities that impact their personal or professional lives. This scoping review provides a synthesis of existing research to identify current gaps and targets for future research.

2. Methods

2.1 Study Design

This study was guided by the scoping review methodological framework developed by Arksey and O'Malley (2005) and refined by Levac, Colquhoun, and O'Brien (2010). Scoping review methods were chosen for this study due to their utility in exploring emerging areas of inquiry and topics that have not been extensively studied (Pham et al., 2014). Results in this paper are presented using the Preferred Reporting Items for Systematic Reviews and Meta-analysis Protocols Extension for Scoping Reviews (PRISMA-ScR) guidelines (Tricco et al., 2018).

2.2 Identifying the Research Question

The research question guiding this scoping review was, "What evidence is available regarding the perceptions of global health engagements among local stakeholders (e.g., healthcare workers, patients, community members) who host these activities in LMICs?"

2.3 Identifying Relevant Studies

A comprehensive search strategy was devised in consultation with an experienced health sciences librarian. Boolean phrases and MeSH terms were used to increase the probability of locating eligible studies otherwise uncaptured under the primary keywords. Studies were selected as per inclusion and exclusion criteria based on the Population-Concept-Context (PCC) framework (Aromataris & Munn, 2020). Studies were selected if they: 1) focused on individuals living in LMICs according to World Bank classifications (population) and 2) described the viewpoints, attitudes, beliefs, and other subjective perspectives held by these individuals (concept) in relation to 3) their experiences with short-term global health activities and volunteers locally (context).

2.4 Eligibility Criteria

For the purpose of this scoping review, publications were considered eligible for inclusion if they successfully met a series of inclusion criteria. These included having a primary focus on perceptions of GHEs by LMIC individuals; focus on short-term activities (<6 months); focus on activities of HIC participants traveling to LMICs to engage in health-related programs; published in English; were available for full text review; and were peer-reviewed manuscripts published in academic journals. Gray literature and student theses/dissertations were not included in the study procedures due to data management and other limitations. Exclusion criteria included not having a primary focus on perceptions of GHEs by LMIC individuals; focus on long-term activities (>6 months); focus on activities of LMIC participants traveling to HICs to engage in health-related programs; were published in languages other than English; were not available for full text review; or were not peer-reviewed manuscripts published in academic journals. Studies with samples that included individuals from HICs (in addition to individuals from LMICs) were assessed for inclusion based on LMIC individuals having greater representation. Studies with HIC individuals were eligible for inclusion if individuals from LMICs comprised the majority of the sample as reported in the results section of each study. The decision to include these studies in this scoping review was based on the premise that their exclusion would otherwise equate to the unnecessary silencing the voices of LMIC individuals included in the studies' samples.

2.5 Study Selection

The scoping review search was conducted in iterative stages by the lead author (EA). The first stage focused on a search of the literature in the PubMed electronic database using a 30-year time frame from January 1990 to July 2020. The second stage consisted of a Google Scholar search. In the third stage, reference lists of eligible studies identified in the first two stages were reviewed to identify additional citations for potential review. Lastly, a confirmatory search was conducted in December 2021 using the same methods for the period of July 2020 to December 2021. All eligible studies were assessed for quality using the Mixed Methods Appraisal Tool (MMAT), a validated and well-established checklist designed for reviews that include studies across a range of methodological designs (i.e., qualitative, quantitative, or mixed methods) (Hong et al., 2018). Each of the studies included in this scoping review met all the basic MMAT criteria, therefore no articles were excluded following the quality assessment.

2.6 Charting Data

Using standard practice for scoping reviews, a data charting form was developed using Microsoft Excel to extract key information from each eligible study (Arksey & O'Malley, 2005; Levac et al., 2010). The data chart included essential information for each publication including lead author and publication year, World Bank region(s) and country/countries where the studies were conducted, participant demographics, and data collection methods. Coded themes outlining stakeholder perspectives (e.g., knowledge, attitudes, beliefs, perceived benefits, other viewpoints) were also charted in the data form.

2.7 Collation and Summarization of Results

Eligible studies were analyzed using a thematic analysis for qualitative data analysis. This multi-stage process consisted of conducting a line-by-line reading of each study's findings to explore the characteristics of each piece of data to develop codes, followed by a re-reading of the data to generate thematic categories and explore concepts and connections between codes, and lastly developing an overarching description of the phenomena observed in the data (Green & Thorogood, 2018). Thematic analysis of eligible studies was conducted by the research team (EA; FS; SB) using the following themes: *Resources and Perceived Benefits Derived from GHEs; Perceived Challenges Associated with GHEs;* and *Opportunities for Improvement of GHEs.*

3. Results

3.1 Screening Results

A total of 7,209 studies were identified in the database search. After screening for duplicates, and review of titles and abstracts according to inclusion and exclusion criteria, a total of 36 studies were eligible for an in-depth review of the full text. After full text review, five of these articles were determined to be ineligible because they did not satisfy minimum inclusion criteria. As a result, a total of 31 articles are included in this scoping review. Appendix A (Scoping Review Prisma Diagram) illustrates the eligibility results of the scoping review. All eligible articles were assessed for quality using the MMAT checklist, each of which met all basic quality criteria.

3.2 Characteristics of Included Studies

A total of 31 studies included in this scoping review were published between 2009 and 2021. Participant sample sizes ranged from 9 to 288 across diverse geographies, ranging from a single country of focus to 68 countries across multiple World Bank regions (*World Bank Country and Lending Groups*, n.d.). Appendix B provides an overview of the study populations of eligible studies. Eligible studies employed qualitative, quantitative, and mixed-methods approaches with the majority of studies having utilized qualitative methods. Of the 31 eligible studies, 22 (71.0%) relied on qualitative methods (i.e., semi-structured interviews and/or focus groups) as the primary research method. Eight (25.8%) employed quantitative methods (i.e., cross-sectional and semi-structured surveys). Only one of the studies (3.2%) used a mixed-methods approach to data collection. Studies that fell into the multi-region category relied more heavily on quantitative surveys than qualitative or mixed-methods approaches in their study designs.

3.2.1 Geographies Represented

The Sub-Saharan Africa and Latin America and Caribbean regions were well represented among eligible studies. A total of 12 studies (38.7%) focused on one or more countries in the Sub-Saharan Africa region. Ten studies (32.3%) focused on one or more countries in the Latin America and Caribbean region. Seven studies (22.6%) examined perceptions in countries across multiple regions. Publications that fell into this multi-region category focused on two or more countries across two or more distinct geographic regions. The least represented geographies among studies eligible for this scoping review were those of the East Asia and Pacific region and the

South Asia region. Only one study (3.2%) focused on a country in the East Asia and the Pacific region. Likewise, only one study (3.2%) focused on a country in the South Asia region.

Table 1. World Bank Regions Represented in Scoping Review

World Bank Regions Represented	Number of Studies	Percentage of Studies
Sub-Saharan Africa	12	38.7%
Latin America and Caribbean	10	32.3%
Multi-Region	7	22.6%
East Asia and Pacific	1	3.2%
South Asia	1	3.2%
Total	**31**	**100.00%**

3.2.2 Stakeholders Represented

Sixteen (51.6%) of 31 eligible studies exclusively focused on participants from LMICs, while 15 (48.4%) also included participants from HICs (e.g., expatriate care providers, other international staff). Study participants also included diverse groups of professional and lay individuals such as medical education supervisors, various healthcare workers, non-governmental organization (NGO) staff and administrators, patients and their families, community members, and government officials. Medical education supervisors were the most commonly occurring category of stakeholders in the literature, as one might expect given the high prevalence of publications of GHEs focused on medical pedagogy and medical missions involving HIC trainees. Participants were grouped into three overarching categories in relation to their involvement with GHEs or how those activities affected their community. These included *providers of care*, *recipients of care*, and *community members*. Providers of care were categorized as physicians, other healthcare workers, NGO staff and administrators, organizers of GHEs, and other individuals who played a role in executing GHEs in LMICs. Recipients of care were considered to be those who were often the intended beneficiaries of direct care provided through GHEs; this included both patients and families of patients. Community members were categorized as members of the general public, potential patients (i.e., those who did not receive direct care), and other stakeholders, including health authorities. Individuals in this category neither played a role in offering GHEs nor received direct care from them.

Table 2. Stakeholders Represented in Scoping Review

Stakeholder Category	Number of Studies	Percentage of Studies
Providers of Care	20	64.5%
Multiple Stakeholder Categories	9	29.0%
Recipients of Care	2	6.5%
Total	**31**	**100.00%**

3.3 Data Synthesis and Summary of Findings

Eligible articles were read and re-read to identify elements of potential interest and to generate an initial list of codes and definitions. The lead author (EA) developed the initial coding frame, which was then tested by two members of the research team (FS; SB) to determine if the coding frame was valid. A batch of eight randomly selected articles, representing more than a quarter of all eligible articles, was then tested by the research team to determine if codes suitably described the phenomena observed in the data. After determining the coding frame was valid, the remaining articles were coded using the validated coding frame. Thematic synthesis of eligible studies' findings resulted in 23 codes that were organized under descriptive themes. Themes were then organized into three analytical themes: 1) *Resources and Perceived Benefits Derived from GHEs*; 2) *Perceived Challenges Associated with GHEs*; and 3) *Opportunities for Improvement of GHEs*.

3.3.1 Theme 1: Resources and Perceived Benefits Derived from GHEs

A number of positive benefits were associated with hosting GHEs and included both tangible and intangible

resources. Financial resources, material supplies, and human resources were frequently referenced as tangible resources and benefits (Chaus, 2020; Elobu et al., 2014; Evans et al., 2017; Fotheringham, Craig, & Tor, 2018; Loiseau et al., 2016; Nouvet, Chan, & Schwartz, 2018; Russ et al., 2016). Intangible resources and benefits centered largely on intellectual and social capital derived from these activities, including elevated reputations of individuals and institutions, relationship-building, and knowledge and skills sharing (Chaus, 2020; Loiseau et al., 2016; Nouvet, Chan, & Schwartz, 2018; Renaud-Roy, Bernier, & Fournier, 2020).

Table 3. Theme 1: Resources and Perceived Benefits Derived from GHEs

Code	Quote	Study Location(s)	Author
Financial resources	"The hospital gets a ready source of income which is actually valuable in a state system where there's no money for projects, so it was often used as conference money or for rehabilitation of grounds, so it created a fund that the hospital could use for projects that benefited the hospital."—Physician participant	Eswatini, South Africa, Uganda	(Fotheringham et al., 2018)
Material resources	"Teams are important to health of community because they bring good medicine. Some of the teams bring food or medication which is less expensive than at the local hospital."—Community member participant	Dominican Republic	(Loiseau et al., 2016)
Human resources	"[the volunteers] help us, we are understaffed here...[they] really give us a helping hand...these volunteers are really doing work and helping."—Healthcare provider	Uganda	(Hayes et al., 2020)
Elevated reputation	"Most of our patients are appreciative, and some think 'My doctor has visitors from other countries. Okay. The doctor is so learned because he is teaching the foreign student"—Physician participant	Bolivia, India	(Kung et al., 2016)
Knowledge and skill sharing	"They bring developed experiences from the countries they're working [in] and the best practices there...Last year we had some students from...the US, and they were able to come up with a disclosure protocol for our pediatric patients infected with HIV. And we were able to adapt that at the hospital and use that, so that has become part of our standard operating procedures now."—Physician participant	Guyana, Kenya, Nepal, Uganda	(Roebbelen et al., 2018)

Financial resources centered on sources of monetary benefit or economic relief provided to individuals and organizations. Contributions of monetary donations, or participation fees paid to host facilities provided a revenue stream for clinical facilities, provided salary support, subsidized costs of patient care, and the procurement of supplies (Fotheringham et al., 2018; Sullivan, 2018). Material resources, such as consumable supplies, equipment, and other materials were a frequently stated benefit of hosting GHE volunteers (de Visser et al., 2020; Fotheringham et al., 2018; Hayes, Clark, & McCauley, 2020; Kung et al., 2016; Worden, Stephenson, & Senior, 2020). In particular, donated supplies and some specialty equipment were a valuable resource to supplement facility stockpiles or serve as a stopgap for periodic supply shortages (Evans et al., 2017; Nouvet et al., 2018).

Although financial and material resources are perceived as being significant inputs, human resources, perhaps unsurprisingly, were the most frequently cited benefits associated with hosting GHEs due to paucity of resources (Gathara et al., 2020; Ouma, Masai, & Nyadera, 2020). Human resources were among the most visible and impactful benefits associated with GHEs and were perceived to offer substantial benefit to hosting organizations. The primary benefits of human resources were associated with filling critical staffing gaps, complementing facilities' capacity levels, alleviating high patient need, and spurring organizational growth (Fotheringham et al., 2018; Loiseau et al., 2016; Renaud-Roy et al., 2020; Russ et al., 2016). Human resources were also associated with increasing access to care, particularly for specialty clinical services, as well as providing technical expertise to enhance clinical education and improve patient care (Loiseau et al., 2016; Lukolyo et al., 2016; Nouvet et al., 2018). Several studies described hosting GHEs as directly attributing to changes in patient care practices, such as improvements in diagnosing patients, increasing the overall quality of care, and integration of patient-centered

practices (Bozinoff et al., 2014; de Visser et al., 2020; Keating et al., 2019; Roebbelen et al., 2018). Similarly, patients and other community members perceived institutions that host global health volunteers to provide high quality healthcare. Multiple studies described individuals and institutions as garnering an elevated reputation among community members as a result of hosting HIC visitors (Chaus, 2020; McMahon, Shrestha, Karmacharya, Shrestha, & Koju, 2019; Roebbelen et al., 2018). Hosting foreign global health volunteers, such as North American or European medical students, was perceived to enhance the reputation of institutions in the local community, which sometimes enticed more patients to seek care in those facilities (McMahon et al., 2019; Renaud-Roy et al., 2020).

In addition to elevated reputations, other intangible benefits were derived from hosting GHEs. Perhaps most notable is the potential establishment of ties with foreign volunteers that would last beyond the short-term experience in-country. Local hosts hoped to cultivate and maintain friendly relations in the long-term to support knowledge sharing and future collaborations as well as to have visitors return in the future (Cherniak, Drain, & Brewer, 2013; de Visser et al., 2020; Evans et al., 2017; Green, Green, Scandlyn, & Kestler, 2009; Kumwenda, Dowell, Daniels, & Merryless, 2015; Kung et al., 2016; Roche & Hall-Clifford, 2015; Sullivan, 2018). Local host expectations in this regard were not always met. Participants in a study conducted in Peru and Argentina expressed frustration that some visitors taking part in GHEs were never heard from again, ultimately viewing this as a lost investment of time and effort (O'Donnell et al., 2014). Another study of 170 individuals, hosts, and partners in 38 countries reported that 90% of respondents indicated a desire to keep in touch with GHE volunteers, and 87% of those respondents reported that 25% or less of HIC visitors ever returned after their initial visit (Cherniak et al., 2017). Unkept promises to keep in touch or to return in the future were noted as a great disappointment for LMIC hosts who wished to establish lasting ties with HIC volunteers (Kung et al., 2016). Interest in building relationships was frequently framed in connection with the intangible benefits that could be derived from such relationships, namely the sharing of knowledge and skills (Kumwenda et al., 2015; Roche et al., 2018; Roche & Hall-Clifford, 2015; Russ et al., 2016). One study in Uganda reported that participants hoped long-lasting ties would facilitate ongoing knowledge and skills sharing between them, particularly with regard to developing and conducting research with North American collaborators (Elobu et al., 2014). Even in the absence of establishing long-term professional relationships, several studies reported that knowledge and skills sharing had a positive impact on hosts in LMICs, as well as local patients (Bae et al., 2020; Elobu et al., 2014; Keating et al., 2019; Roebbelen et al., 2018). Such changes were attributed to unstructured knowledge and skills sharing opportunities such as observations of visitor-patient interactions, or discussing different medical approaches. One study in Vietnam reported activities such as these to be among the highest valued aspects of the medical service trips they hosted (Worden et al., 2020).

3.3.2 Theme 2: Perceived Challenges Associated with GHEs

Hosting GHEs has been shown to come with seemingly substantial benefits. However, these activities also introduced notable challenges into the host environment. The majority of studies examining local perspectives of GHEs in LMICs generally focused on the benefits over challenges of global health activities. Similarly, many studies reporting local perceptions indicated that participants voiced concerns about appearing too critical of GHEs for fear of losing them (DeCamp, Enumah, O'Neill, & Sugarman, 2014; Nouvet et al., 2018; Roebbelen et al., 2018; Rozier, Lasker, & Compton, 2017). In spite of a documented fear of being overly critical, some GHE hosts in LMICs reported concerns and challenges associated with hosting global health activities. Common challenges often centered on the attributes and actions of the foreign volunteers, particularly with regard to professional behavior.

Table 4. Theme 2: Perceived Challenges Associated with GHEs

Code	Quote	Study Location(s)	Author
Beyond scope and skill	"One would always assume that medicine is medicine regardless of where you are in the world. If students are doing something that is beyond their abilities, then that is a major ethical issue." —Clinical host supervisor participant	Malawi, Tanzania, Zambia	(Kumwenda et al., 2015)
Arrogance	"…they come in as 'I know it all, you don't need to tell me anything'…but at the end of the day, we just manage it because we know their placement will come to an end." —Clinical host supervisor participant	Uganda	(Hayes et al., 2020)

Disrespect	"We often have problems with [volunteers] talking down to our national staff or disregarding their extensive knowledge in developing world pediatrics, primarily because they are clinical officers and not physicians."—Clinical host supervisor participant	Botswana, Eswatini, Lesotho, Malawi	(Lukolyo et al., 2016)
Unprepared for context of the local healthcare system	"Some of the things take time here, for example, the laboratory investigations. So they would really like to have everything very quick,...they demand for results, and we don't have them for quite some time, so that becomes a little conflict."—Clinical resident participant	Kenya, Tanzania, Uganda	(Russ et al., 2016)
Power differentials	"Of course, we wanted a particular thing but we are not . . . in a position to be very exacting in the kind of person we want. We may be inclined to accept someone who then turns out to be inappropriate."—Clinical faculty participant	Kenya, Tanzania, Uganda	(Russ et al., 2016)

Several studies examining local perceptions of GHEs reported that foreign volunteers presented numerous challenges to their local hosts related to unprofessional behavior and their lack of preparedness to live and work in the local environment. A common critique of these visitors centered on their negative attitudes toward local care providers, local standards of practice, and even the local community and culture (Chaus, 2020; Keating et al., 2019; Sullivan, 2018). HIC visitors acting with arrogance and disrespect was top of mind for many LMIC hosts who observed poor treatment of local nurses, support staff, and even supervisors (Bae et al., 2020; Berry, 2014; Chaus, 2020; de Visser et al., 2020; Hayes et al., 2020; Keating et al., 2019; Kumwenda et al., 2015; Roebbelen et al., 2018; Sullivan, 2018). However, more concerning than arrogant or disrespectful behavior were the myriad instances of HIC volunteers practicing beyond their scope or skills and disregarding local standards of care (Evans et al., 2017; Roche & Hall-Clifford, 2015; Russ et al., 2016). Foreign visitors reached beyond practical (and surely ethical, perhaps even legal) bounds to attain experiences they would never be permitted to explore in their home settings (Sullivan, 2018). In particular, one study described a scenario in which a high school student dispensed aspirin as antibiotics to patients (Berry, 2014). Although concerning, this event pales in comparison to other documented deceitful behaviors such as an undergraduate misrepresenting themselves as a medical student and delivering a breech birth, or a volunteer without clinical training or skills (a policeman by training) assisted in circumcisions and multiple births, including caesarian sections (Sullivan, 2018). Given these challenges, it should come as no surprise that hosts of GHEs in LMICs might view volunteers with apprehension when they seem eager to reach beyond their limits. Whether volunteer negligence or malpractice was fueled by ignorance of local context, blind confidence, or a self-centered desire to attain certain experiences, it underscores the need for additional training for volunteers in bioethics and cultural humility, their ability to recognize the limits of their skills and competencies, and respect the local authority of their host supervisors and established clinical guidelines.

This scoping review also revealed that HIC volunteers often received little to no specialized orientation or training to prepare them to work effectively in the host environment (Berry, 2014; Bozinoff et al., 2014; Kumwenda et al., 2015; Lasker, 2016; Rees et al., 2018). Additionally, several studies described volunteers as having an insufficient understanding of the capacities and constraints of the health system and a limited understanding of local populations (Cherniak et al., 2013; Fotheringham et al., 2018; Green et al., 2009; Kraeker & Chandler, 2013; Lukolyo et al., 2016). Other studies described volunteers as having a limited understanding of the sociocultural context of the environment, or lacked cultural sensitivity altogether (Berry, 2014; Cherniak et al., 2013; de Visser et al., 2020; Green et al., 2009; Hayes et al., 2020; Kung et al., 2016; Lough, 2015; Roche & Hall-Clifford, 2015; Roebbelen et al., 2018; Rozier et al., 2017).

Challenges associated with arrogance, disrespectful behaviors, and limited knowledge of the local context were further exacerbated by power differentials that undeniably favor HIC visitors and their sending organizations over their LMIC counterparts (Roche et al., 2018). Illustrations of power differentials in eligible studies were often subtle and not often named directly as uneven distributions of power or authority. However, power dynamics appeared to underpin many of the activities associated with GHEs. One study highlighted that novice individuals travel to low-resource environments with massive financial capital and short-term commitments, which "confers inappropriate amounts of influence to young travelers" and created a clear imbalance of power at baseline (Kung et al., 2016). This often gave HIC volunteers an inordinate amount of social influence and control in global health engagements (Bae et al., 2020). Similarly, a study conducted in Kenya, Tanzania, and Uganda suggested that

power differentials precluded the hosting organizations from inviting GHE participants with the desired or needed expertise (Russ et al., 2016). Power imbalances created an environment where the priorities of foreign volunteers and their sending organizations determined the parameters—the who, what, when, and where—of providing care in lieu of locally-identified need (Evans et al., 2017; Lasker, 2016; Nouvet et al., 2018; Schnable, 2021).

3.3.3 Theme 3: Opportunities for Improvement of GHEs

The third theme observed in studies examining local perceptions of global health activities focused on recommendations to improve planning and oversight of GHEs. Recommended improvements included the development and execution of activities themselves, preparation of individuals, achieving reciprocity, and increasing opportunities for LMIC individuals and organizations (Bae et al., 2020; Bozinoff et al., 2014; Loiseau et al., 2016; Lukolyo et al., 2016; Nouvet et al., 2018; Worden et al., 2020).

Table 5. Theme 3: Opportunities for Improvement of GHEs

Code	Quote	Study Location(s)	Author
Pre-departure orientation	"I think what makes them effective is...structure. We need to give them structure, so it's not like they have to make up what they want to give. We need to articulate our needs very clearly. Sometimes we do that by extracting from the curriculum and giving it to them beforehand, and thus communicating with them exactly what we want to achieve and then they are more likely to do the right kind of preparation or they have the right expectations."—Clinical faculty participant	Kenya, Tanzania, Uganda	(Russ et al., 2016)
Reciprocity	"I think the relationship has to be reciprocal…it's not ethical if it's not reciprocal…"—Physician participant	Tanzania, Uganda	(de Visser et al., 2020)
Clearer roles and objectives	"Personally, I did not receive their objectives. What do they want to do in the service? Do they want to learn? Do they want to see how things are going in the service? I did not get any paper saying that."—Clinical host supervisor participant	Benin	(Renaud-Roy et al., 2020)
Improved communications	"The other side of the coin is that maybe these students are doing things completely outside their curriculum. All I know is they apply saying they would like to come and we accept them. Maybe that as far as the faculty in their school is concerned, they don't really expect to hear from us–I don't know...But I have enough to do to run this place and I'm not going to be chasing medical schools to be telling them what their students are doing–if they are not interested[enough] to contact us, then why should we contact them?" —Clinical host supervisor participant	Malawi, Tanzania, Zambia	(Kumwenda et al., 2015)
Evaluations and feedback	"There should be somebody that we can talk to when we have feedback. We should be able to notify them of issues so that learners do not repeat the same mistakes. This way learners will know what is expected of them based on previous experiences." —Clinical host supervisor participant	Lesotho, Malawi	(Rees et al., 2018)
Longer stays	"It's most disappointing when students are all of a sudden oriented and comfortable and productive in their new environment and then that's usually about the one-month mark and then they go." —Clinical host supervisor participant	Eswatini, South Africa, Uganda	(Fotheringham et al., 2018)

Participant roles and objectives were frequently cited as being unclear, making it difficult to determine responsibilities and expectations for those involved (de Visser et al., 2020; Elobu et al., 2014; Kumwenda et al., 2015; Roebbelen et al., 2018). Findings suggested a greater need for improved communications from sending organizations, and that they should play a more collaborative role in organizing these activities (Kumwenda et al., 2015; Rees et al., 2018). Thus, several studies recommended that predeparture orientation for GHE participants be

rigorously improved, because individuals were frequently unprepared for the sociocultural context, or were not adequately prepared to work in the context of the local health system (Cherniak et al., 2013; de Visser et al., 2020; Green et al., 2009; Kumwenda et al., 2015). There was also strong preference for GHE participants to have the ability to communicate in the local language. This would position them to be more effective providers of care and also reduce the burden on local staff to provide translation services (Evans et al., 2017; Fotheringham et al., 2018; Kumwenda et al., 2015; Lough, 2015; O'Donnell et al., 2014). Longer stays were also cited as a potentially useful improvement of GHEs in many LMICs around the world. One study conducted across nearly 70 countries collectively found that GHE hosts and supervisors preferred HIC participants to remain in-country for longer periods of time, with most preferring stays of one month or longer (Bae et al., 2020; DeCamp et al., 2014; Green et al., 2009; Lough, 2015; Roche & Hall-Clifford, 2015; Russ et al., 2016). There was also a stated desire for reciprocity between sending and hosting organizations. Studies conducted in South Africa, Eswatini, Namibia, Bolivia, India, Lesotho, Malawi, and Uganda reported that bidirectional exchanges were strongly desired but opportunities for individuals from LMICs to travel to HICs were very limited or non-existent (Elobu et al., 2014; Fotheringham et al., 2018; Kraeker & Chandler, 2013; Kung et al., 2016; Rees et al., 2018). The unidirectionality of many global health activities goes against the principles of good partnership that have been promoted in recent global health research (Russ et al., 2016). It also raises ethical questions on how power and privilege is maintained in global health collaborations and suggests that stronger and more transparent relationships might empower partners in LMICs (de Visser et al., 2020; Evans et al., 2017). Recommendations to overcome these challenges included implementing mechanisms to support host organizations to have increased say in determining need and developing objectives, the selection and preparation of GHE participants, and improved opportunities for monitoring, evaluation, and feedback (Fotheringham et al., 2018; Green et al., 2009; Kumwenda et al., 2015; O'Donnell et al., 2014; Rozier et al., 2017).

4. Discussion

This study is among the first to collectively examine local perceptions of GHEs in LMICs, with a notable exception. Upon conclusion of the data collection and analysis phases, it became known that a similar study of perceptions of global health activities in LMICs had been conducted concurrently to the current study (Lu, Mansour, Qiu, Biraro, & Rabin, 2021). The study by Lu et al. had similar objectives, but was conducted using different methodology (Lu et al., 2021). Despite the different methodological approaches, these contemporaneously conducted scoping and systematic reviews achieved similar results. Lu and colleagues (2021) cited fewer studies. The primary reason was due to their narrower focus on perceptions of GHEs involving clinicians (i.e., medical trainees, physicians), whereas the current study more broadly examined perceptions of GHEs involving volunteers of any variety without a specific skillset or other distinguishing feature. Achieving similar results to Lu et al. confirms findings from the present investigation, and further validates scoping review methods as a suitable methodological tool.

This study revealed that local stakeholder perceptions of GHEs in LMICs centered around three core themes: resources and perceived benefits derived from GHEs, perceived challenges associated with GHEs, and opportunities for improvement of GHEs. Study participants identified several tangible and intangible resources and benefits associated with hosting GHEs. Tangible resources included financial resources for clinical operations and staff salaries, material resources such as consumable supplies and equipment, and human resources to fill critical staffing gaps, increase capacities, and spur growth. Tangible resources, by extension, provided LMIC hosts and facilities with intangible benefits, namely reputational and technical improvements. The presence of HIC volunteers brought notoriety to the host facility, which elevated the reputations of both the organization and its staff among community members. Community members perceived the healthcare in hosting facilities to be high-quality, and in some instances, viewed local physicians supervising HIC volunteers as experts having obtained international recognition. Host physicians also perceived improvements in care in their facilities and reported positive changes in patient care practices due to knowledge and skill sharing that resulted from hosting GHEs.

Study participants also noted several challenges associated with hosting GHEs in their facilities, some of which were alarming, from bioethical and patient safety perspectives. Challenges identified by study participants included volunteers practicing beyond their scope or skills, arrogant and disrespectful behavior, and being underprepared for living and working in the host environment. Power differentials were also identified as a challenge underlying GHEs. This was reported by participants of eligible studies in this review and has been well-documented elsewhere in the global health literature (Eichbaum et al., 2021).

Of particular interest for this research, this scoping review also identified certain elements of GHEs that local study

participants perceived to be areas for improvement of global health activities. Study participants frequently pointed to volunteers being underprepared to work in the local environment, both in terms of the context of under-resourced health systems, as well as the sociocultural context in which the work is situated. More comprehensive pre-departure orientation, including the development of language and cultural competencies, could better position volunteers to provide impactful services and disencumber hosts from needing to provide translation and other supports to HIC individuals. Study participants also reported a lack of mutuality between HIC and LMIC individuals and institutions which centered primarily on issues of reciprocity, unclear roles and objectives, and poor communication across the spectrum of planning and follow-up of GHEs.

GHEs were sometimes perceived to be more beneficial to HIC visitors than LMIC hosts, as evidenced by the relative lack of opportunity for those living in LMICs to travel to HICs for similar learning opportunities. There was a strong desire to establish bidirectional exchanges, thereby enabling LMIC and HIC partners to learn from one another in both environments. LMIC hosts also conveyed a need for roles and objectives to be more specifically delineated. Many studies in this review reported that HIC sending organizations did not adequately communicate goals and expectations, making it difficult for hosts to establish and achieve a specific purpose (e.g., learning objectives, program outcomes, etc.) for their participation in GHEs. Increasing the frequency and effectiveness of communication between sending and hosting organizations was frequently cited by LMIC stakeholders as a potential improvement that would better align activities with expectations to achieve intended outcomes. Similarly, participants expressed a need to create opportunities for evaluation and feedback for volunteers and the GHEs as a whole. Several studies indicated that assessments were often unidirectional, with LMIC hosts receiving feedback from HIC volunteers or sending institutions. Unintentionally, this might contribute to actual or perceived power imbalances within GHEs. To improve this deficit, structures for bidirectional evaluation and feedback should be implemented so that all parties have a voice in, and co-equally benefit from, assessments and constructive feedback. A critical suggestion and identified area of improvement from LMIC stakeholders on how to strengthen global health exchange partnerships was in regard to the length of HIC volunteer stay. LMIC study participants reported that stays of less than one month by HIC volunteers were ineffective and preferred that volunteers remain in-country for at least one month or longer. Finally, increased efforts by HIC partners to ensure language competency among volunteers, perhaps by yoking teams with local, remunerated bilingual translators, might improve communication among visitors, guests, and LMIC communities. Taken together, these recommendations represent significant yet achievable growth areas for GHEs and would go far in better aligning global health activities to more effectively meet LMIC hosts' stated needs and expectations.

The recommendations provided here suggest that LMIC hosts want greater investments from their HIC collaborators but not necessarily in the form of financial investment. Although financial benefits were derived from GHEs, requests for additional financial resources were not directly expressed. Rather, these findings suggest that study participants desired greater investment into the relationships associated with global health activities, particularly with regard to investments of time, communication, and mutuality necessary to cultivate and maintain productive and reciprocal bilateral relationships. Existing relationships were frequently described as one-sided, with the perception that LMIC hosts were often more invested, professionally and personally, than their HIC counterparts (de Visser et al., 2020; Fotheringham et al., 2018; Kraeker & Chandler, 2013; McMahon et al., 2019). In other words, the long-established model of drop-in-and-out short-term global health engagements failed to meet the needs and expectations of LMIC stakeholders. These findings point to a strong preference for co-equal partnerships in which power is balanced and equity is shared between HIC and LMIC partner organizations. This emphasizes the need for greater adherence to principles of ethical partnerships and the implementation of practices that serve to decolonize global health activities (Arora et al., 2017; Eichbaum et al., 2021; Monette et al., 2021).

4.1 Recommendations for Future Research

This scoping review reveals that relatively few studies have explored perceptions of GHEs among LMIC stakeholder groups despite growing interest in global health engagements over the past 30 years. This demonstrates a need for greater research on the topic. Further, many studies in this scoping review came from biomedical disciplines (e.g., surgery, pediatrics, gynecology), with a particular focus on medical education. Future research should also be directed to examine other global health engagements in disciplines such as public health, social work, and allied health among others. Many studies in this scoping review included study sites in multiple countries, sometimes across multiple World Bank regions, or involved multiple stakeholder groups. Such groupings may make it challenging to determine if the perceptions presented were universally representative or if experiences varied across contexts. Additional research focused on individual institutions and stakeholder groups is necessary to better understand how perceptions of GHEs might differ amongst different groups in various LMICs. Research conducted exclusively amongst participants from LMICs is necessary to bring into sharper focus

perspectives of GHEs without potential biases introduced with the inclusion of individuals from outside the context of interest. Lastly, eligible studies included in this scoping review were primarily focused on countries in the Sub-Saharan Africa and the Latin America and Caribbean regions. The dearth of research in other regions of the world represents an opportunity to examine perceptions of GHEs among populations in many other LMICs, particularly those in the South Asia, East Asia and Pacific regions. The importance of conducting research in countries of these regions is further elevated when considering the high prevalence of global health activities in countries such as India, Nepal, Cambodia, or Indonesia, to name a few (Schnable, 2021).

4.2 Strengths and Limitations

This scoping review was among one of few studies to identify and collectively analyze LMIC stakeholder perceptions of GHEs and represents an incremental step toward achieving a more nuanced understanding of how global health activities impact the lives of key constituencies in LMICs around the world. Strengths of this study include the use of a thematic analysis approach, which brings together multiple perspectives to highlight key strengths and challenges as they are collectively perceived by individuals living in LMICs. Further, this study provides insight into recommendations for improvements in the management of global health endeavors before, during, and after the in-country visit.

This study has several limitations. Primarily, its scope was designed to only investigate peer-reviewed published manuscripts from scientific journals. Gray literature, student theses/dissertations, and sources of local knowledge were not included in the study procedures due to data management and other limitations. These sources could potentially reveal additional data on this emerging topic and may well be considered in future research efforts. This study excluded studies published in languages other than English, potentially introducing bias toward studies conducted and reported by researchers with relative fluency in the English language, or limited to GHEs conducted in LMICs in which English is the national or official language. Finally, the perspectives reported in this study are not solely those of LMIC stakeholders. Many eligible studies include in their samples both individuals native to the LMICs of study as well as expatriates from HICs. This perhaps could impact findings of eligible studies given that vastly different lived experiences could influence the lenses in which HIC expatriates and individuals native to LMICs view the global health activities around them.

5. Conclusion

With an increased universal focus on diversity, equity, inclusion, and “decolonization” within public and global health, a nascent field of inquiry examining LMIC stakeholder perceptions has begun to develop (Garba, Stankey, Jayaram, & Hedt-Gauthier, 2021; Guzmán & Rowthorn, 2022). Short-term global health engagements have been on-going for approximately three decades, and within this 30-year history, the majority of past literature has focused on the benefit for high-income country individuals. The current study indicates that, in comparison to HIC volunteer perceptions of GHEs, local stakeholder perceptions are currently underrepresented in the literature on global health engagements in LMICs. This scoping review aimed to identify and describe the diversity of attitudes, opinions, beliefs, and other perceptions of GHEs among local stakeholders in low- and middle-income countries around the world. Findings from this study illustrate that LMIC hosts perceived GHEs to have several benefits and challenges, and offered recommendations for improvements in several key areas. Recommendations outlined in the discussion section are largely consistent with calls for greater equity in global health and have laid bare some challenging aspects associated with short-term GHEs (Demir, 2022; Guzmán & Rowthorn, 2022; Kwete et al., 2022). This study consolidates the body of literature on the subject and provides a foundation for future research in an understudied area of inquiry (Amick, Naanyu, Bucher, & Henry, 2023). Increased research on the subject can offer greater insight into how benefits might be bolstered and what challenges might be mitigated if GHEs are to fulfill stakeholder-identified priorities and achieve targeted outcomes.

Acknowledgments

The authors wish to thank Beth McGowan, Health Sciences Librarian at Northern Illinois University, for her consultative support in developing a comprehensive search strategy for this study.

Funding

None.

Provenance and Peer Review

Not commissioned; externally double-blind peer reviewed.

Competing Interests Statement

The authors declare that there are no competing or potential conflicts of interest.

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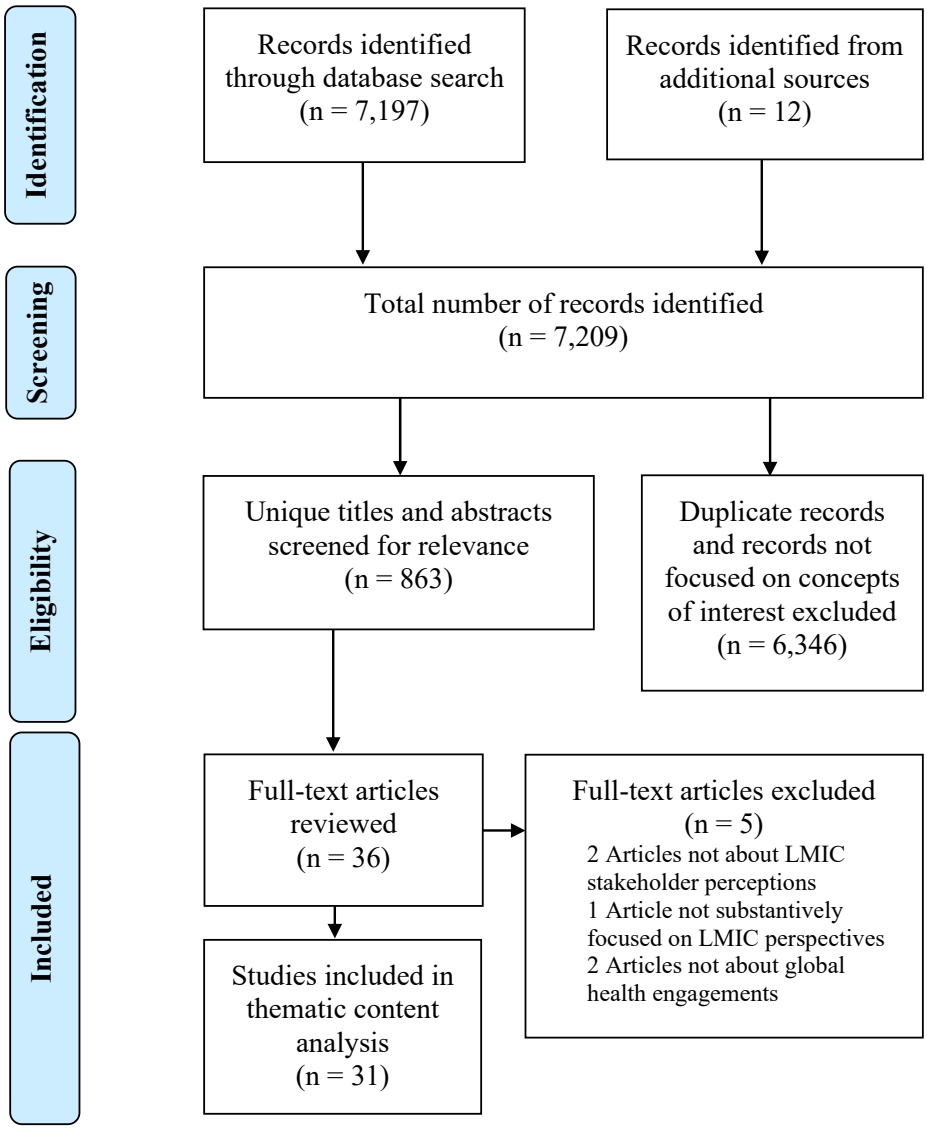
Appendixes

Appendix A. Scoping Review PRISMA Diagram



Appendix B. Population Overview of Eligible Study Populations

Lead Author and Publication Year	Stakeholder Category	LMIC Stakeholders Included in Sample *Portion of study sample includes individuals from HICs
Bae, 2020	Providers of care	Physicians in 51 countries*
Berry 2014	Providers of care, Community members	NGO staff, and a ministry of health official in Guatemala*
Bozinoff, 2014	Providers of care	Physicians supervising medical trainees in 22 countries*
Chaus, 2020	Providers of care	Clinical and non-clinical staff at host hospital in Haiti
Cherniak, 2017	Providers of care, Community members	Individuals who interact with global health participants in work or community settings in 38 countries*
De Visser, 2020	Providers of care, Recipients of care, Community members	Physicians, medical trainees, healthcare administrators, patients and their family members in Uganda and Tanzania
DeCamp, 2014	Recipients of care	Patients in Dominican Republic
Elobu, 2014	Providers of care	Medical trainees at host hospitals in Uganda
Evans, 2017	Providers of care, Recipients of care	Health profession students and community members in Dominican Republic*
Fotheringham, 2018	Providers of care	Physicians supervising medical trainees and healthcare administrators in Eswatini, South Africa, and Uganda
Green, 2009	Providers of care, Recipients of care, Community members	Local healthcare providers, health authorities, foreign medical providers, healthcare administrators, parents of pediatric patients in Guatemala*
Hayes, 2020	Providers of care	Clinical and non-clinical staff at host hospital in Uganda
Keating, 2019	Providers of care	Clinicians supervising medical trainees in Lesotho and Malawi
Kraeker, 2013	Providers of care	Healthcare professionals in Namibia
Kumwenda, 2015	Providers of care	Clinical and administrative staff in Malawi, Tanzania, and Zambia*
Kung, 2016	Providers of care, Community members	Physicians supervising medical trainees, NGO/healthcare administrators, and host-family members in Bolivia and India
Loiseau, 2016	Providers of care, Community members	NGO staff and host community members in Dominican Republic*
Lough, 2018	Providers of care	Individuals affiliated with volunteer placement organizations in 68 countries*
Lukolyo, 2016	Providers of care	Clinicians supervising medical trainees in Botswana, Eswatini, Lesotho, and Malawi*
McMahon, 2019	Providers of care, Recipients of care	Physicians and patients in hospital hosting medical students in Nepal
Nouvet, 2018	Providers of care, Recipients of care, Community members	Physicians, nurses, and patients and their families in Nicaragua
O'Donnell, 2014	Providers of care	Physicians supervising medical trainees in Argentina and Peru
Rees, 2018	Providers of care	Physicians supervising medical trainees in Lesotho and Malawi
Renaud-Roy, 2020	Providers of care	Clinicians supervising medical trainees in Benin
Roche, 2015	Providers of care	Clinical and administrative staff in Guatemala*
Roche, 2018	Recipients of care	Adult patients and parents of pediatric patients in Guatemala
Roebbelen, 2018	Providers of care	Clinicians supervising medical trainees in Ghana, Guyana, Kenya, Nepal, and Uganda*

Rozier, 2017	Providers of care	Individuals affiliated with volunteer placement organizations in 16 countries*
Russ, 2016	Providers of care	Physicians and medical trainees in host hospitals in Kenya, Tanzania, and Uganda
Sullivan, 2018	Providers of care	Healthcare professionals in Tanzania*
Worden, 2020	Providers of care	Clinicians and medical trainees at host hospitals in Vietnam*