



Ethical challenges in global short-term health volunteering in low- and middle-income countries: A narrative review

Betelehem Ketema¹ · Heuiwon Han¹ · Yodith Tekabe²

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Abstract

Short-term medical missions have become a common response to global health needs in resource-limited countries, yet concerns persist about their ethical implications and sustainability. This study aimed to explore the ethical challenges of short-term medical missions and volunteer health initiatives in low- and middle-income countries, with a particular focus on their impact on local health professionals and systems, using Ethiopia as a contextual example. The study adopted a narrative review of literature published between 2010 and 2024. A comprehensive search of MEDLINE, CINAHL Complete, Dentistry & Oral Sciences Source, and Scopus, supplemented by Google Scholar, was undertaken. After screening titles, abstracts, and full texts, along with reference lists of included sources, 61 sources were included. Findings were narratively synthesised to identify major ethical themes and structural contributors. Three recurring themes emerged: violations of clinical scope of practice and inconsistent regulatory oversight; structural power imbalances between foreign volunteers and local professionals; and psychological strain and moral distress among local health professionals. Weak credential verification, dependency on external funding, and limited institutional accountability were identified as contributing factors. Ethical reform in global health volunteering requires a shift from episodic charity to partnership-centred practice that prioritises local leadership, accountability, and sustainability. Key strategies include transparent credential verification, pre-departure ethics and cultural competency training, equitable supervision frameworks, and alignment with international guidelines. By implementing these measures, global health volunteering can strengthen local health services and professionals, build more resilient systems and ensure the benefits endure beyond the mission period.

Keywords Bioethics · Ethiopia · Health ethics · Scope-of-practice violation · Short-term medical mission · Voluntourism

Extended author information available on the last page of the article

1 Introduction

Global health volunteering is widely perceived as altruistic, yet its ethical foundations are increasingly questioned (DeCamp 2011; Crump et al. 2010). Short-term medical missions (STMMs) offer international health professionals opportunities to deliver care abroad, particularly in low- and middle-income countries (LMICs), where health system gaps persist. These missions may help address urgent workforce shortages, introduce new techniques, and foster cross-cultural exchange (Martiniuk et al. 2012). In Ethiopia and similar contexts, temporary care is often positioned as a critical response to urgent health needs, which is essential to the system. However, evidence shows that some STMMs prioritise volunteer experience over sustainable health outcomes, operate in parallel with local health systems, and risk disrupting continuity of care or reinforcing inequitable power dynamics (Abimbola and Pai 2020; Larson and Vaughan 2022).

Ethiopia exemplifies these tensions. A high disease burden, workforce shortages, and limited regulatory oversight can attract foreign volunteers, while also creating accountability gaps (Teka et al. 2024). Practices that would be unacceptable or considered unprofessional in high-income countries, such as students performing procedures without close supervision or general practitioners acting as specialists, may be tolerated under the banner of humanitarianism (Pinto and Upshur 2009; Wintrup 2021). Similar patterns have been reported in Tanzania, Uganda, Nepal, and Guatemala, where funding and resource pressures on local health services, combined with institutional expectations for foreign health volunteers, can enable questionable practices (DeCamp et al. 2018; Sykes 2014; Patti L Tracey 2015).

These dynamics are also evident across multiple health disciplines, including dentistry. Short-term dental missions have been credited with providing urgent pain relief, introducing preventive strategies, and sharing new techniques with local dental professionals, sometimes contributing to reductions in untreated dental caries and improved oral health awareness in underserved communities (Holmgren and Benzian 2011). However, evidence also shows that poorly integrated dental volunteering can disrupt continuity of care, create dependency on foreign resources, and inadvertently undermine local dental professionals, reflecting broader ethical concerns associated with STMMs (Friedman et al. 2014). This highlights both the positive and negative impacts of STMMs on local communities and reinforces calls for sustainable, locally led approaches that adhere to ethical frameworks specific to health volunteering.

Postcolonial and decolonial perspectives help clarify these dynamics by situating STMMs within historical patterns of colonial power and knowledge transfer (Abimbola and Pai 2020). Postcolonial analysis highlights how foreign-trained professionals are often privileged over local expertise, perpetuating epistemological hierarchies and “saviour” narratives that can unintentionally replicate colonial relationships (Abimbola and Pai 2020; Larson and Vaughan 2022). Non-governmental organisations, universities, and institutions therefore play a pivotal role in shaping the ethical standards, sustainability, and local relevance of short-term medical and dental missions. Beyond individual volunteers, systemic oversight, including robust credentialing, ethics training, and co-designed programmes involving local and foreign volunteering institutions, is essential to ensure short-term missions align with com-

munity priorities and support sustainable workforce development (DeCamp 2011; Koplan et al. 2009).

While the challenges associated with STMMs in LMICs have been increasingly documented (Patti Tracey et al. 2022), there remains a need for deeper analysis of their impact on the local health professionals and services (Lasker 2016). This narrative review aims to explore the ethical challenges and impacts on local health professionals arising from STMMs and volunteer health initiatives in LMICs, with a particular focus on Ethiopia.

2 Methods

2.1 Search process

Given the limited research in this area, an international literature search was conducted across multiple databases, followed by a narrative analysis of the included sources. A systematic approach guided the identification of relevant literature (Popay et al. 2006). An initial search strategy was developed using key terms derived from the review aim, which was subsequently refined by the research team to ensure that all essential terms were included (Table 1). To maximise coverage, broad search terms were used, and the strategy was adapted for different databases (MEDLINE, CINAHL Complete, Dentistry & Oral Sciences Source via EBSCO, and Scopus) (Moher et al. 2009). The search was limited to studies published between 2010 and 2024 to ensure a contemporary reflection of issues related to the topic. Additional searches were undertaken in Google Scholar to capture both published and unpublished sources, with the first 100 results included for screening.

Table 1 Search strategy for MEDLINE, CINAHL Complete, Dentistry & Oral Health Sciences Source via EBSCO

Number	Query
1	medic* OR health* OR clinic* OR hospital* OR dent* OR nurs* OR physic* OR doctor* OR operat* OR surg*
2	unethic* OR misconduct* OR violat* OR breach* OR neglect* OR negligenc* OR malprac* OR wrongdoing* OR harm* OR disciplinar* OR trauma* OR damag* OR distress* OR mortalit* OR morbid*
3	Ethiopia* OR glob* OR LMIC* OR “developing countr*” OR “underdeveloped countr*” OR “low-income countr*” OR “middle-income countr*” OR africa*
4	“short term*” OR short-term* OR one-off OR one off OR casual* OR Season* OR project*
5	volunteer* OR aid* OR relief* OR reliev* OR humanitarian* OR mission*
6	1 AND 2 AND 3 AND 4 AND 5 (Limit Year=January 2010 to December 2024)

Table 2 Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
<ul style="list-style-type: none"> • Sources discussing ethical issues in short-term global health volunteering • Research addressing psychological, emotional, or systemic impacts of foreign volunteers on local healthcare professionals • Studies documenting instances of scope-of-practice violations or professional misconduct by foreign volunteers • Sources providing frameworks, guidelines, or recommendations for ethical engagement • Primary and secondary sources, including qualitative and quantitative studies, commentaries, policy briefs, and reviews 	<ul style="list-style-type: none"> • Studies conducted outside of low- or middle-income country contexts • Legal judgments, local jurisdictional documents, books, and book chapters • Non-English language sources

2.2 Source screening

All identified sources were imported into EndNote™, and duplicates were removed. Screening was conducted using the inclusion and exclusion criteria outlined in Table 2 to ensure that included sources were relevant to the research aim. A two-stage screening process was used; first by reviewing titles and abstracts, followed by full-text assessment (Moher et al. 2009). To refine the process, two reviewers piloted the screening using 30 randomly selected sources, which led to further refinement of the inclusion and exclusion criteria. Once consensus was reached, one reviewer completed the full screening process. Finally, the reference lists of all included sources were screened by title to identify any additional relevant sources.

2.3 Analysis and finding synthesis

All included sources were narratively analysed independently by two reviewers to identify key concepts and findings from each source. All observations were then compared and consolidated, after which one reviewer synthesised the results into overarching themes with input from the other reviewers. These themes were subsequently presented in a narrative format.

2.4 Researchers' positionality

While the synthesis was conducted to ensure an accurate reflection of the included sources, the authors acknowledge the potential influence of their own experiences and perspectives. Two authors are originally from Ethiopia and now practise as health professionals in Australia and New Zealand, which may have shaped their interpretations. Both have faced the challenges of navigating cross-cultural health systems as migrants and health professionals, which could offer valuable insights but also introduce certain biases. By recognising these positionalities, the authors aim to ensure transparency and reflexivity in presenting their findings (Berger 2015).

2.5 Findings

The comprehensive search initially identified 2,383 sources. After removing duplicates ($n=291$), 2,092 sources remained for screening. Title and abstract screening, followed by full-text assessment, resulted in 42 sources being included. Reference list screening yielded an additional 19 sources, bringing the final total to 61 sources. From the analysis, three themes were identified: (1) ethical failure and scope of practice violations, (2) power imbalances between foreign volunteers and local health professionals, and (3) psychological impacts on local health professionals.

2.6 Ethical failures and scope of practice violations

Violations of clinical scope of practice are a recurrent concern in global health volunteering. In high-income countries, strict legal regulations and professional frameworks govern clinical activities for health professionals and students (DeCamp 2011; Green et al. 2009; Sykes 2014). In LMICs, including Ethiopia, volunteers have been documented performing procedures beyond their qualifications or training, often with limited direct supervision (DeCamp 2011; Green et al. 2009; Sykes 2014). Although staffing shortages and urgent patient needs are frequently cited to justify these practices, such reasoning risks prioritising volunteer participation over patient safety and may inadvertently weaken local health systems over time (Lasker 2016). A survey of international medical volunteers working with Voluntary Service Overseas (a long-standing international development organisation that places skilled volunteers in LMICs to strengthen local services and health systems) found that while most participants perceived their contributions as positive, many also highlighted gaps in placement monitoring and clinical support (McCauley et al. 2018). These findings suggest a need for stronger oversight. Similar findings from Addis Ababa University's Tikur Anbessa Specialised Hospital, Ethiopia, highlighted that some volunteers' experiences appeared to focus on personal and professional development rather than the systematic evaluation of clinical safety or capacity building (Busse et al. 2014).

Inadequate local regulatory frameworks, which include the policies, licensing requirements, and oversight mechanisms for foreign health volunteers, can create a two-tiered system, one in which foreign volunteers are exempt from the level of scrutiny or compliance required of local health professionals (DeCamp 2011; Crane 2010; Makita 2016). This dynamic allows foreign volunteers to deliver care beyond their scope of practice or without proper oversight, as documented in Ethiopia and other LMICs (DeCamp et al. 2018; Swanson et al. 2015; Girma et al. 2021; Teka et al. 2024). Reports of inconsistent infection control practices in volunteer-run clinics, such as inadequate sterilisation protocols, further emphasise risks to patient safety and community trust in volunteers (Bauer 2017; Martiniuk et al. 2012).

2.7 White coat privilege and power imbalances

The power imbalance between foreign volunteers and local health professionals is a persistent ethical challenge in global health volunteering. This dynamic described as "white coat privilege" (Lokugamage et al. 2020, p. 244) reflects the unearned author-

ity and status associated with Western medical professionals, thereby reinforcing colonial hierarchies and inequities in healthcare. The term refers to the social power granted to (frequently white or foreign) health professionals because of their credentials, symbolic attire, and affiliations with high-income countries (Lokugamage et al. 2020; Romano 2018; Crane 2010). These dynamics illustrate how colonial legacies and racial hierarchies continue to privilege foreign expertise over local knowledge and autonomy (Büyüm et al. 2020; Romano 2018; Blum and Schäfer 2017).

Foreign volunteers often lack sufficient understanding of local culture, health systems, and community expectations, which can result in care that is misaligned with both professional norms and patient needs, ultimately compromising acceptability and quality (Lasker et al. 2018). This disconnect reinforces existing inequities and limits opportunities for sustainable, contextually appropriate collaboration.

This dynamic reflects the enduring legacies of medical colonialism, in which foreign expertise has historically been privileged over local knowledge and autonomy (Baillie Smith and Laurie 2011; Pinto and Upshur 2009). In Ethiopia and similar LMIC contexts, foreign volunteers, regardless of seniority or expertise, may be afforded greater authority than experienced local professionals (Pinto and Upshur 2009). Documented manifestations include junior foreign health volunteers or student volunteers performing procedures beyond their scope, even when skilled local staff are present (Lasker 2016). Local health professionals are sometimes discouraged from questioning decisions made by foreign volunteers, even when patient outcomes are at stake (DeCamp 2011). Additionally, local clinical reasoning may be systematically sidelined in favour of perceived foreign expertise (Pinto and Upshur 2009). These dynamics can undermine local accountability structures, erode morale, and perpetuate inequities. Institutional reliance on international funding may exacerbate this imbalance, discouraging local health professionals from raising ethical concerns for fear of jeopardising support (Crane 2010; Lasker 2016).

2.8 Psychological impacts on local health professionals

These power differentials shape not only clinical decision-making but also the emotional well-being of local professionals. The psychological impact of STMMs on local health professionals remains underexplored yet significant. These effects build on the structural power imbalances and scope-of-practice issues described above, creating additional pressures for local teams (DeCamp 2011; Crane 2010; Swanson et al. 2015; Maes et al. 2019). Ethical analyses suggest that health professionals in LMICs, including Ethiopia, may experience moral distress (DeCamp 2011; Maes et al. 2019; Crane 2010). This can occur when they witness volunteers providing care outside their scope or without adequate oversight. However, they often feel unable to intervene because of institutional hierarchies or funding dependencies (Pinto and Upshur 2009; Stokes 2020).

This moral distress is compounded by existing workforce challenges. Occupational stress among Ethiopian healthcare professionals is consistently high, with estimates ranging from 52.5% to 68% and elevated rates of job-related anxiety and depression (Girma et al. 2021; Jemal et al. 2021). When local expertise is overridden

by foreign volunteers or excluded from decision-making, a sense of disempowerment can intensify emotional exhaustion, frustration, and disengagement (Lasker 2016).

Additional burdens further strain morale. Local professionals may have to correct clinical errors, bridge communication gaps between patients and volunteers, or manage logistics without adequate recognition or institutional support, tasks that increase cumulative emotional labour and risk professional burnout (Pinto and Upshur 2009; Stokes 2020). Unspoken expectations to remain grateful for international assistance can discourage open critique, reinforcing hierarchical imbalances and psychological strain (Baillie Smith and Laurie 2011). Poorly coordinated or unaccountable volunteer interventions may therefore exacerbate existing stressors, with implications for morale, retention, and the quality of collaborative care.

3 Discussion

This narrative review explored the ethical challenges and impacts of STMMs and volunteer health initiatives on local health systems and professionals in LMICs, with a particular focus on Ethiopia, and synthesised evidence-based recommendations for more responsible engagement. Three interconnected themes emerged: scope-of-practice violations, psychological strain on local health professionals, and power imbalances between foreign volunteers and local health professionals. While these findings underscore significant risks, it is equally important to highlight the potential benefits of STMMs, including critical short-term relief in resource-constrained settings, the introduction of innovative practices, strengthened cross-cultural understanding, and relationships that may evolve into long-term collaborations (Friedman et al. 2014; Patti Tracey et al. 2022; Holmgren and Benzian 2011).

When well-planned and ethically managed, STMMs can complement local services, enhance skills exchange between foreign and local health providers, and raise awareness of global health inequities in volunteering countries and institutions, benefits cited by both volunteers and local communities (Friedman et al. 2014; Lasker 2016). Acknowledging these dual perspectives emphasises the need for balanced approaches that maximise benefits while mitigating documented harms. Existing literature indicates that poorly planned or inadequately supervised volunteer programmes may inadvertently compromise patient safety, undermine local expertise, and weaken health system integrity (DeCamp 2011; Lasker 2016; Martiniuk et al. 2012). The high prevalence of occupational stress, anxiety, and depression among Ethiopian health professionals suggests that poorly coordinated volunteer interventions may exacerbate existing workforce pressures (Girma et al. 2021; Jemal et al. 2021). Moral distress, arising from recognising unethical practices while feeling unable to intervene due to hierarchical or funding constraints, appears to be a particularly underexplored yet critical issue in LMIC contexts (Pinto and Upshur 2009; Stokes 2020).

The three themes identified in this review, ethical failures and scope-of-practice violations, power imbalances between foreign and local professionals, and the psychological impacts on local health professionals, are consistent with prior critiques of charity-based approaches that operate parallel to, rather than within, local health

systems (Bauer 2017; Pinto and Upshur 2009; Crane 2010; DeCamp 2011). Ethiopia-specific studies echo similar global patterns: while international volunteers often report personal and professional growth, monitoring and support mechanisms are insufficient, and local perspectives are underrepresented (Busse et al. 2014; McCauley et al. 2018). Postcolonial and decolonial analyses frame these dynamics within broader structural inequities, where developed-country credentials are frequently privileged over local knowledge and authority.(Pinto and Upshur 2009; DeCamp 2011).

Addressing white coat privilege requires systemic reform that moves beyond episodic volunteerism toward sustainable, long-term partnerships. This entails fostering collaboration grounded in mutual respect, shared authority, and alignment with local health institutions' priorities (Pinto and Upshur 2009; DeCamp 2011). Ethical reform in this context means understanding and integrating local cultural values, professional norms, and community structures into programme design and implementation. Partnerships with local health professionals and community stakeholders should be prioritised to ensure that initiatives strengthen, rather than substitute, existing systems (Lasker et al. 2018; DeCamp 2011; Crane 2010). Recent Ethiopia-focused oral health research reinforces the importance of locally targeted and culturally appropriate approaches (Ketema et al. 2026). Recognising international frameworks, such as the Global Code of Practice on the International Recruitment of Health Personnel (Taylor and Dhillon 2011) and the Guidance on Ethics and Governance of Global Health Partnerships (Ward et al. 2018) published by the World Health Organisation, provides an important foundation for promoting fairness, accountability, and reciprocity across global collaborations (Organization 2022, 2024; DeCamp 2011; Koplan et al. 2009). Strengthening ethical integrity, therefore, requires transparent credential verification, adherence to local regulations, and supervision structures that reinforce equity and local ownership (DeCamp 2011; Lasker et al. 2018; Lasker 2016; Crane 2010).

3.1 Implications for policy and practice

A key policy priority is to strengthen and consistently enforce credential verification and supervision mechanisms to ensure accountability and patient safety (Maki et al. 2008; Martiniuk et al. 2012). Strengthening existing regulatory processes, which are already in place but unevenly applied in Ethiopia, would reduce the risks associated with unqualified or unsupervised care (Girma et al. 2021; DeCamp et al. 2018). Embedding pre-departure ethics and cultural competency training, together with structured accountability mechanisms and opportunities for joint planning between foreign and local teams, can help mitigate power imbalances and improve preparedness (DeCamp 2011; Crane 2010). Transparent monitoring systems, such as ethical performance dashboards or accreditation frameworks, could further incentivise responsible practice while empowering communities to hold organisations accountable (Coombe and Malik 2018; Lemeilleur and Allaire 2019). These recommendations provide practical guidance for policymakers seeking to enhance oversight and for health professionals aiming to adopt ethical, collaborative, and sustainable approaches to volunteering.

3.2 Strengths and limitations

A major strength of this review is its integration of broader LMIC literature with Ethiopia-specific evidence, providing both contextual depth and practically relevant recommendations. The narrative synthesis approach enabled the flexible integration of diverse qualitative, quantitative, and grey literature sources. However, reliance predominantly on published literature may underrepresent local or informal knowledge, and the limited number of empirical studies constrains country-specific generalisations. Furthermore, the authors' professional backgrounds and personal experiences, as outlined in the positionality statement, may have shaped their interpretation. While this positionality adds contextual insight and reflexive rigour, the absence of extended stakeholder engagement and community consultation may limit the review's contextual validity.

3.3 Future research

Further research is needed to evaluate the long-term effects of STMMs on patient outcomes, workforce retention, and health system resilience. Comparative analyses of credentialing frameworks, ethics training effectiveness, and accountability mechanisms would help inform evidence-based policy reforms. Participatory research involving local health professionals and communities is fundamental to ensure that proposed ethical frameworks reflect local priorities rather than external assumptions. Additionally, exploring the perspectives of diaspora health professionals who volunteer in their countries of origin could provide valuable insights into culturally informed approaches, power dynamics, and strategies for fostering equitable and sustainable partnerships.

4 Conclusion

In resource-limited settings, STMMs and volunteer health initiatives can offer critical short-term relief during periods of acute service need. However, the literature consistently identifies three interrelated ethical concerns: (1) scope-of-practice violations, (2) power imbalances between foreign volunteers and local health professionals, and (3) moral distress among local health professionals. These problems are sustained by weak oversight and inconsistent credentialing. The central implication is the need to re-centre local leadership and accountability within genuine partnerships so that programmes are co-designed with local institutions, supervised appropriately, and aligned with international standards. Reframing STMMs from episodic charity to equitable partnership is essential if global health volunteering is to strengthen, rather than substitute, local systems, and to enable local health services and professionals to build resilience, enhance patient safety, and ensure benefits that endure beyond the mission period.

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Data availability No datasets were generated or analysed during the current study.

Declarations

Competing interests The authors declare no competing interests.

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Authors and Affiliations

Betelehem Ketema¹  · Heuiwon Han¹  · Yodith Tekabe²

✉ Betelehem Ketema
beth.ketema@aut.ac.nz

✉ Heuiwon Han
heuiwon.han@aut.ac.nz

Yodith Tekabe
yodith.tekabe@austin.org.au

¹ Department of Oral Health, School of Acute and Primary Health, Faculty of Health and Environmental Sciences, Auckland University of Technology, Auckland, New Zealand

² Hamilton Centre, Austin Health, North East Region, Melbourne, Australia