

**QUALITY CARE IN UNEQUAL LANDSCAPES.
THE MEANINGS OF QUALITY HEALTHCARE IN HUMANITARIAN
SETTINGS**

A thesis submitted to The University of Manchester for the degree of
Doctor of Philosophy
in the Faculty of Humanities

2021

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Word count: 77697

Abstract

This research seeks to answer the question *What are the meanings of quality healthcare in humanitarian settings?* The research is multidisciplinary in its approach and draws on literature from the sociology of health and illness, nursing, science and technology studies and anthropology. It employs an ethnographic approach using the following methods: participant observation and formal and informal interviewing techniques.

Médecins Sans Frontières (MSF) is an influential international medical humanitarian organisation. In 2019, MSF provided healthcare in 436 projects in 70 different countries around the world (Médecins Sans Frontières, 2019). My fieldwork took place at three MSF project sites: Agok hospital in Agok, South Sudan, the MSF day care centre in Athens, Greece and the primary healthcare clinic in Chios, Chios Island, Greece, facilitated through MSF Operational Centre in Geneva (MSF-OCG).

The conceptual framing for this study places quality as a process, mediated and determined by the collective relationships in the healthcare assemblage. Staff, patients, materials, spaces, ideas, legislation, security and assumptions are all actants that can impact on the quality of care provided. The care assemblage in humanitarian settings is dynamic, shifting and unstable, reacting to imbalances in resources, implementation of changes and fluxes of increased physical work or emotional intensity.

In taking a qualitative approach to quality, framed in ethnographic methodology, this research recognises the variability in relationships of care giving in the messy context of humanitarian settings. The research does not test a hypothesis of what quality is or measure the performance of quality using specific data points. Rather, in recognising the variabilities in the care assemblage this work emphasises the importance of looking beyond things that can be counted to understanding quality as a relational process.

This work is a response to the limited critique of the quality narrative and the untouched research agenda around the applicability of transferring the quality narrative from higher income, resource rich countries to resource poor settings. In addition, it addresses the paucity of knowledge on the everyday practice of health professionals in humanitarian settings. On a wider scale, the significance of this research lies in the raising of the question. In an inequitable landscape, raising the question of quality forces the recognition of inequalities, both globally and within the humanitarian system.

Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning

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Dedication

For my Mum and Dad, Patsy and Carl Atterton.

Acknowledgements

I wish to thank MSF-OCG for the opportunity to pursue this research, with special thanks to Dr. Tammam Aloudat for his supervision and guidance in the first two years of this process. Extended thanks and gratitude to the staff in the project sites in Agok, Chios and Athens for their participation, support and for welcoming me into the team.

My supervisors Bertrand Taithe and Rubina Jasani have my upmost respect for their valuable advice, encouragement and persistence, for which I will be forever grateful. I wish also to thank my colleagues at HCRI and SALC for their encouragement and advice over the years, with particular thanks to the admin team for their kind direction. To my PhD colleagues past and present who I have missed in the past year, thank you for your moral support, motivation and friendship.

With love-filled gratitude and appreciation to my family and friends near and far, young and old, here and gone, who have made this achievement possible. In a myriad of ways, you support me with love, understanding and reassurance. For all these things, and all these people, I am very thankful.

Introduction

This research seeks to answer the question '*What are the meanings of quality in humanitarian settings?*' The research is multidisciplinary in its approach and draws on literature from the sociology of health and illness, nursing, science and technology studies, and anthropology. It employs an ethnographic approach using the following methods, participant observation and formal and informal interviewing techniques. This work is a response to the limited critique of the quality narrative and the untouched research agenda around applicability of transferring the quality narrative from higher income, resource rich countries to resource poor settings. In addition, it addresses the paucity of knowledge on the everyday practice of health professionals in humanitarian settings. On a wider scale, the significance of this research lies in the raising of the question. In an inequitable landscape, raising the question of quality forces the recognition of inequalities, both globally and within the humanitarian system.

In raising the question of quality, the following questions are asked; what influence does staffing, particularly the organisation and cohesion of staff groups have on the care assemblage and the quality of healthcare. Research has suggested that the tensions and inequalities in staff groupings in humanitarian work are inherent to humanitarian practice, drawing a binary between 'national' and 'international' staff (Roth, 2012; Smirl, 2008). My research brings nuance to these arguments and complicates it, drawing on the tensions in professional relationships and highlighting the need for a broader approach to staff support in the field. Secondly, how is quality constructed by materials in the field? Standards and protocols guide and inform practice, but how does their usage differ to accommodate different levels of expertise and knowledge, and

fluctuations of materials and resources. Drawing on the contrasting field sites, this research highlights how other materials construct quality in the field. Thirdly what claims does MSF make to quality in healthcare, and what is the significance of these claims in practice. Quality in healthcare speaks to a universal ideal. MSF works in many diverse settings; this research will question the relationship between the context of the project and the claims to the quality of care provided.

The case partnership between the University of Manchester and Médecins Sans Frontières enabled a unique research opportunity. The strength of this partnership has been demonstrated by supervisory support, visits to the Geneva office, and the attendance and completion MSF pre-departure training course. To conduct this research, I joined MSF as a nurse. As a staff member of MSF, I was embedded into the teams and incorporated into operational and security planning. This had two key benefits for the research, firstly it enabled access to the settings and the opportunity to conduct in-depth qualitative research. Secondly it ensured that I was protected in line with existing MSF precedent under the policies and procedures with regards to my health, safety and security. There is an established precedent of ethnographic research where research arrangements are accepted for their risk versus benefits compromise between institutional access and research independence (Farmer, 1992; Fox, 2014; Redfield, 2013). As a standard bearer for medical humanitarian interventions, MSF prides itself on a critical and reflective approach to its processes, policies and healthcare provided. This commitment and familiarity to research within the organisation served to strengthen the acceptance and approval of my research. This research partnership coupled with the skills and expertise of the principal researcher, offered a unique

opportunity to gain valuable insight into a neglected but essential element of health care provision. The support and access granted through this partnership provided an opportunity for a new approach to understanding humanitarian medical care provided to crisis-affected populations. This research will contribute to the wider debate on standards of care in resource poor and unstable settings, and provide new insight into how quality is understood, negotiated and practiced by humanitarian medical teams. It will also provide MSF with additional understanding to supplement their effort in improving the healthcare they provide in their projects, as part of their strategic ambitions.

The academic credentials and professional experience of the principal researcher provide solid grounding for this unique research study. The multidisciplinary approach taken is supported and validated by an academic and vocational career that brings together sociology, nursing, global health and the humanities. My undergraduate BA/hons in Sociology led to a nursing career, practicing first in Stockport and a year later in Manchester, following professional accreditation in 2008. Retaining my wider interests and academic appetite during my professional career, my successful application to the London School of Tropical Medicine and Community Health earned a postgraduate diploma in Tropical Nursing in 2011. My interests in global health were pursued further with a Master's program in Humanitarianism and Conflict Response which brought together key elements of my academic interest, enabling the development of critical analysis and wider knowledge of the history and current debates in humanitarianism.

My professional career developed alongside my academic pathway and provided a vocational counterpoint to my studies. Working in a large city centre accident and emergency department gives one invaluable insight into both the human condition and the systems that affect and manage health, maintaining my interest in the sociology of health and its inherent inequalities (Hui et al., 2020; MacKichan et al., 2017; Morris et al., 2005; Smith et al., 2016). Professionally I progressed from a Staff Nurse to a Senior Sister, with the technical, professional and managerial skills this required. In this period, I took the opportunity to take part in a Health Foundation funded quality improvement project, thus gaining first-hand experience of design and planning of a structured quality improvement project. The project 'Making the journey safe: recognising and responding to severe sepsis in accident and emergency', set out to understand the barriers to providing safe and effective care for the patient presenting with severe sepsis in the Accident and Emergency department (Pinnington et al., 2016). Sepsis is an umbrella term that has been adopted to refer to the body's inflammatory response to infection and associated sequelae to a number of pathogens (Baudouin, 2008; Dellinger et al., 2013). Due to the high morbidity and mortality rate an early directed goal approach has been sought. The sepsis bundle; oxygen, blood cultures, administration of antibiotics, fluid challenge, measure lactate and patient monitoring is held as gold standard treatment, (Castellanos-Ortega et al., 2010; Conde et al., 2013; Nguyen et al., 2007; Turi and Von Ah, 2013). As guided by the Health Foundation, the project used the Safer Clinical Systems (SCS) tools as developed by The Health Foundation and Warwick university (Spurgeon et al., 2019). The SCS approach is modelled on processes from 'safety-critical industries', employing a framework of proactive risk management. Hierarchical Task Analysis (HTA) and Failure Modes and Effects Analysis (FMEA) are tools that focus on risk and hazards, cause and effect. They

are used in industry and manufacturing for example to identify potential failures in geothermal power plants and other power generation systems (Arabian-Hoseynabadi et al., 2010; Feili et al., 2013) and to analyse the security of supply chains (Li and Zeng, 2016; Liu et al., 2018) These tools look to identify points of increased risk in a system. Applying these tools to the process and pathways of patients and staff in the department, twenty-seven areas for improvement were identified according to the areas of risk. Following an options appraisal with staff and with consideration to additional factors such as cost effectiveness, interventions were chosen pertinent to three themes: improving time to treatment, improving communication and improving awareness. Interventions implemented included staff training, the introduction of staff briefings to encourage teamwork and communication, small boards in each patient room with the nurses name on to improve communication between nurse and patient/family, and additional ergonomic interventions including the organisation of materials, a 'sepsis trolley' and a sepsis sticker (Pinnington et al., 2016). Comparative analysis demonstrated a 34% increase in patients receiving the sepsis six in one hour, a decrease in length of stay by 1.9 days and a 50% reduction in 30 day mortality (Pinnington et al., 2016). In respect of these results, the project report was used as part of a successful business case to appoint an additional staff nurse in the ambulance receiving area in the department.

The meanings of quality in healthcare

Quality takes many guises in healthcare systems and structures. It is both adjective, noun and superlative, making promises of undefinable measure. In the National Health Service in England, quality is an umbrella term that is applied to a diverse and all-

encompassing range of methods, processes and outcomes (Griffiths et al., 2017; Littlejohns et al., 2017) . It is in the provision of care in its totality (Duggirala et al., 2008; Hommel et al., 2016), and in the measure of a single service (Shipman et al., 2016), it is in the success of an intervention (Cross et al., 2018) and the absence of complication or acquired infection (Adler and Adler, 2002; van Dishoeck et al., 2016), it is in the attitude and friendliness of the health care staff (Santana et al., 2020) and the comfort of a ward (Wensley et al., 2017). It is measured, indicated, improved and reported. Nurses, doctors, policy makers, service management, allied health care professionals and patients all have concern with quality, but each retain nuanced and sometimes contradictory narratives of its evidence, importance, method and effect (Attree, 2001; Burhans and Alligood, 2010; Pflueger, 2015; Suhonen et al., 2018; Zaheer et al., 2018). The expansion of the quality narrative shows us that quality healthcare is more than 'good' care. The dominant quality debate in countries within stable healthcare systems has seen the proliferation of measures and systems of quality assessment and quality improvement in pursuit of safe, efficient and effective care (Carayon et al., 2014; Wiig et al., 2014) Audits, adherence to standards of evidenced based medicine, reporting systems and investigative bodies determine quality into numerical values (McCarthy and Rose, 2010; Thomas et al., 2010; Timmermans and Berg, 2003). Statistics indicate quality through proxies of waiting times, length of stay, cleanliness of wards, and in hospital falls and pressure sores (Chen et al., 2016; Giambrone et al., 2016; Johnston and Magnan, 2019; Jull and Griffiths, 2010; McCarty et al., 2018; Toffolutti et al., 2017). Quality in health care has gained political significance, economic weighting and has been embedded within the governance of health care and health care systems.

Frameworks to measure quality in healthcare systems has favoured a disaggregate approach (Campbell et al., 2000; Donabedian, 2005; Institute of Medicine, 2001; World Health Organisation, 2006). The structure-process-outcome framework for measuring and evaluating quality attributed to Avis Donabedian remains influential (Donabedian, 2005). In this framework, structure encompasses the location and physical structure of the setting and extends to include the demographics of the patient population, workforce and recruitment and training. Process encompasses the processes of care and clinical activities; the care delivery, use of guidelines in practice, the communication between teams and colleagues and the engagement with family and carers. The outcome domain covers patient outcomes, including mortality rates, infection rates, and patient experience. This approach remains influential in assessing quality in healthcare and designing frameworks for quality and safety in hospital departments (Hansen et al., 2020; Lecky et al., 2014) and has been applied to low income and humanitarian settings (Alatinga and Williams, 2014; Alvarado et al., 2015; Kersten et al., 2013a; Olujide, 2016; Ssemugabo et al., 2020).

As a concept malleable to context, there is a circular determining correlation between how quality is measured and how quality is defined. Chosen measurements or indicators act as proxies and function to make generalised claims applicable to a whole system, service or organisation. These claims to quality, the quality rhetoric, exercise an implicit power that can shape the perception of the public, attitudes and subsequent actions (Dechaine, 2002). Quantitative studies, in particular random controlled trials (RCTs) are held as the most scientific and therefore the most valuable by leading journals, policy makers and donors and hold strong ground in stable, comprehensive

health care systems. In less stable, under resourced contexts with increased and complex variables, their successful application and value is questioned (Yamey and Feachem, 2011). In lower income countries, the effectiveness of interventions 'remains untested and therefore unproven' (Buekens et al., 2004). Vincanne Adams argues that the shift to evidence based medicine (EBM) in global health has 'created a platform for the buying and selling of truth and reliability, abstracting clinical care giving from the social relationships on which they depend' (Adams, 2013, p. 55). It can be argued that EBM and the gold standard of RTCs in global health creates an illusion of stability and statistical truth in the messy context of global health, and neglects the importance of *putting the patient first* (Adams, 2013).

The conceptual framing for this study places quality as a relative process, mediated and determined by the collective relationships in the healthcare assemblage. Staff, patients, materials, spaces, ideas, legislation, security and assumptions are all actants that can impact on the quality of care provided. The care assemblage in humanitarian settings is dynamic, shifting and unstable, reacting to imbalances in resources, implementation of changes and fluxes of physical work and emotional intensity. In taking a qualitative approach to analysing quality, framed in ethnographic methodology, this research seeks to recognise the variability in relationships of care giving, in the messy context of humanitarian response.

Quality healthcare in Médecins Sans Frontières

This field study was conducted with thanks to Médecins Sans Frontières (MSF). My fieldwork took place at three MSF project sites: Agok hospital in Agok, South Sudan, the

MSF day care centre in Athens, Greece and the primary healthcare clinic in Chios, Chios Island, Greece, and in the MSF Operational Headquarters of the Swiss section of MSF, MSF-OCG. Médecins Sans Frontières, seen by many as the ‘paradigmatic medical humanitarian agency’ (Jézéquel, 2015, p. 126) is a prominent and influential organisation, one that remains at the forefront of debates in global health and humanitarian medicine (Davey, 2014; Taithe, 2004). Formed in 1971, the growth of the organisation has provided an interesting lens for many academics to view the complexities and contradictions of the humanitarian endeavour, and the image of MSF has moved well beyond that of the “unshaven, cigarette-smoking French man” to a multinational, more professionalised organisation (Redfield, 2005, p. 332). Held by some as the ‘consciousness of the humanitarian world’ (Rieff, 2002, p. 84), the individual medical humanitarian act is held as central to the work of MSF (Médecins Sans Frontières, 2006a). The duty to an individual by an individual speaks to the primacy of the ‘doctor-patient’ relationship and a deontological moral framework over the universalistic approach of public health.

The scope and reach of MSF interventions have broadened far beyond its original imaginings. Today, MSF provides health care across over 70 countries worldwide, supported by 3,627 internationally hired staff and 37,670 locally hired staff. In 2019, MSF conducted 10,384,000 outpatient consultations, admitted 840,000 patients, performed 112,100 major surgical interventions, assisted 329,900 births, gave 400,200 individual mental health consultations, treated 2,638,200 cases of malaria and commenced 59,400 people on first line antiretroviral treatment for HIV (Médecins Sans Frontières, 2020). The total expenditure for 2019 was 1,685 million euros, an increase

of 77 million euros from 2018. MSF prides itself on its financial transparency and accountability and its reliance on private funds. Ninety six percent of its funding comes from its 6.5 million strong individual donor base and donations from private institutions. Of the total expenditure, eighty one percent goes on ‘social mission’ expenditure, constituting in the main part the programmes and programme support (Médecins Sans Frontières, 2020). These numbers give an indication of the extent of the work of MSF, their global reach, and their position as a standard bearer in medical humanitarian aid. Not only providing healthcare, MSF invests in developing the capacity for research to reflect on its own practice, and to push back against failure and barriers in the international arena. A number of *satellite* autonomous entities exist that retain an ‘organic link’ to MSF (Vidal and Pinel, 2011). In the 1980’s MSF Logistique and Epicentre were created to ‘manage internal aspects of operations to ensure quality’ (Vidal and Pinel, 2011, p. 22). Other satellites include the Campaign for Access to Essential Medicines, set up in 1999 with the prize money from the Nobel Peace Prize in the same year, and the Drugs for Neglected diseases initiative (DNDi). The DNDi model was devised in response to the paucity of research and development into neglected tropical diseases (NTDs), and the inadequacy or nonexistence of treatments (Fonseca et al., 2020; Pécoul, 2004; von Philipsborn et al., 2015). Leishmaniasis, Chagas disease, human African trypanosomiasis (sleeping sickness), Dengue plus other NTDs are responsible for high levels of morbidity and mortality in the world’s poorest populations and are therefore neglected as unprofitable by pharmaceutical companies (Chirac and Torreele, 2006; Vanderelst and Speybroeck, 2010; Yamey, 2002). Relying on strong partnerships between industry and academia, DNDi is a collaboration between seven institutions: the Oswaldo Cruz Foundation in Brazil, the Kenya Medical research Institute (KEMRI), the Indian Council for Medical Research (ICMR), the

Malaysian Ministry of Health, the Institut Pasteur in France, the Special Programme for Research and Training in Tropical Diseases (TDR) and MSF (Pécoul, 2004). The objectives of DNDi are to deliver new treatments for NTDs, and to establish a portfolio that spans the entire 'drug discovery process' (Chatelain and Ioset, 2011). DNDi utilises public-private product development partnerships to achieve this (Burrows et al., 2014; Chatelain and Ioset, 2011). Significant achievements include improved treatment to non-complicated *Plasmodium falciparum* malaria with fixed dose combination artesunate-amodiaquine (ASAQ) in collaboration with the French multinational pharmaceutical company Sanofi-Aventis (Bompart et al., 2011), and artesunate-mefloquine (ASWQ) in collaboration with Farmanguinhos, Brazil (Wells et al., 2013).

MSF field projects are managed by five Operational Centres (OC), Geneva, Paris, Amsterdam, Barcelona-Athens and Brussels. Twenty-three sections support the OCs, through fundraising, recruitment and campaigns to raise awareness. Each section is linked to an association, a body of current or former field and office members. There are currently 25 MSF associations whose members participate in general assemblies and an annual international assembly to contribute their voice to the direction of the movement. Each OC has its own dedicated research and reflection centre. The Centre de Réflexion sur l'Action et les Savoirs Humanitaires (CRASH), affiliated with OC-Paris was set up in 1999. It publishes current research on the field, invites debates and discussion as well as publishing reflective accounts of the challenges of MSF practices and decisions made in the past. The Unité de Recherche sur les Enjeux et Pratiques Humanitaires (UREPH) was created in 2006 and reports to the General Direction of MSF Switzerland (MSF-OCG). The Speaking out series, published with open access to the public is also worth particular attention. Currently numbering thirteen studies, this

series examines and analyses the actions and decision-making processes made by MSF during crises which lead to the organisation speaking out. Originally designed as an educational tool for MSF members, the series include studies of MSF's involvement in Srebrenica 1993-2003, Ethiopia in 1984-86 and Rwanda 1994-1997.

In 2017, Rony Brauman and Michèle Beck published a paper on medical quality in MSF (Brauman and Beck, 2017), documenting the proceedings of a conference held on this topic by the CRASH of which they are both permanent employees. The paper details the tensions between the operational centres and the field in the development and acceptance of operational standards, practises and imagined limitations, of how to understand the meanings of quality in humanitarian settings. In trying to define quality, a contributor offers the following definition, *"quality is the right balance, as some people put it, between "what we can do and what we ought to do." It's a balance between quality and common sense, between what we can do and what we ought to do. Just because you have the resources doesn't make it the right thing to do. (NR)"* (Brauman and Beck, 2017, p. 36). This quote exemplifies the crux of the dilemma of the organisation. This formulation of quality, or rather equation of quality, is demonstrating a moral construction of duty *'what we ought to do'*, mediated by practical limitations *'what we can do'*. The document illustrates the complexities of practicing and talking about what quality healthcare is, could be, and should be, in humanitarian settings. In separating the components of what *'can'*, and what *'ought'* to be quality care against *'the right thing'* it demonstrates the primacy of the *'moral concern'* of humanitarianism. More so, it supports the view that humanitarians present *'their values of life and care as fundamental, elementary matters of human conscience'* (Redfield, 2012b, p. 451). This suggests that the moral imperative makes malleable the boundaries of both what is

possible and what is the right thing to do. As a balance between these points, quality is in limbo, suggesting that what can be done is not enough, and what ought to be done is not achievable.

As stated in the opening statement of the CRASH publication, ‘the question of quality in the work of Médecins Sans Frontières has been asked from the very beginning of MSF’s existence’ (Brauman and Beck, 2017, p 9). The commitment to, and accountability for quality have been implicit, absorbed in the commitment to ‘neutrality and impartiality in the name of universal medical ethics and the right to humanitarian assistance’ as laid out in the Charter, the formal statement of MSF’s core principles from its inception in 1971. The Chantilly Principles adopted by MSF in 1995¹ addressed quality more directly. Of the ten principles adopted, notability, accountability and transparency stated: ‘Faced with populations in distress, MSF has an obligation to mobilise and develop its resources. Aiming at maximum quality and effectiveness, MSF is committed to optimising its means and abilities, to directly controlling the distribution of its aid, and to regularly evaluating the effects. In a clear and open manner, MSF assumes the responsibility to account for its actions to its beneficiaries as well as to its donors’ (Médecins Sans Frontières, 1995). The quality of practice in MSF was addressed more directly 10 years later during the La Mancha Process². Intersectional differences,

¹ The Chantilly Principles formulated in 1995-6 had the objective of reaching agreement on the ambitions of MSF across all sections. MSF had grown to five founding associations (France, Belgium, Holland, Switzerland and Spain) and thirteen delegate office sand an International Council. Internal disagreements ‘spilled over into external operational approaches’ (Binet and Saulnier, 2019, p. 13). The details of the interaction and compromises made between the sections during the Chantilly discussion in 1995-1996 by Laurence Binet and Martin Saulnier make for a fascinating read (Binet and Saulnier, 2019). The end result of these negotiations were the Chantilly Principles, comprised of ten principles that defined the role and identity of MSF, and four practical rules for operating (Médecins Sans Frontières, 1995).

² The La Mancha process, launched in 2004 by MSF’s International Council, and culminating in La Mancha Agreement following a conference in 2006, was heralded as an opportunity for all levels of staff to discuss how to improve the work of MSF and define what MSF does. La Mancha was a recognition by MSF of the

internal discrimination against national staff and concerns of the quality of care provided in the field were key themes of the La Mancha process. Unafraid to call out the 'historical ghosts of western imperialism and colonial exploitation', La Mancha provided a platform to openly address the 'structural discrimination' in MSF and 'refocus the question of the national personnel on the problems of MSF operational efficiency' (Blackburn, 2006, p. 2). In recognition that over 80% of MSF were 'local staff', that is staff living and recruited from the countries where MSF projects are based, steps were outlined with the view of giving more recognition, voice and equal standing to this staff group. The need to 'seriously improve' the quality of the medical work was also highlighted (Gillies, 2006). Dr Joanna Liu, prior to her position of President of MSF International (2013-2019), contributed one of the 150 articles published within the book *My Sweet La Mancha*. Speaking of quality of healthcare in the actions and decision making of MSF, Liu argued that it was a 'medical imperative' that MSF should be delivering the same standards of care as in higher income countries. She was speaking to the lengthy wait to change practices in the field, despite strong evidence-based support, speaking in particular of the slow uptake in use of intraosseous access in the field (Liu and Male, 2005).

As an organisation, MSF is trying to find its way in how to talk about, measure and be accountable for the quality of the healthcare provided in its projects. A further piece of research published by CRASH sought to update knowledge and 'contribute to future operational approaches' to the patient perspective of quality and patient centred care (Barnett, 2018, p 1). This paper concluded that patient-centred care is a 'complicated

need to move forward together after significant intersectional divisions, and the difficulties encountered in its growth (Fox, 2014, p 43-59).

multidimensional concept' and to move forward towards patient centred care required 'that everyone of MSF's field sites is approached using in-depth qualitative research methods to understand both clinical and nonclinical factors that could pose as a barrier' (Barnett, 2018, p 12). My research goes some way to answering this call.

In 2016 when my research began, OCG had published their 2016 -2019 Strategic Plan, this was only the second time OCG had published and implemented an organisation-wide strategy. Improving health care was identified as one of the main goals of the strategic plan, with the objective of 'making it a continuous and long term commitment' (Zimmermann, 2016, p 3). Within the strategic plan, the objectives and therefore defining characteristics of quality were identified as safety, effectiveness and patient centred care (Médecins Sans Frontières, 2016c). The methods, language and approach to quality and improving health care as outlined in the document demonstrate a strong association with the body of literature and evidence from health systems in stable countries, where this formulation of quality and quality improvement has been legitimised.

Whilst MSF is known for the 'self-critical perspective on the loftiness of its ideals' (Fox, 2014, p. 103), a critique on the evolving quality narrative and its impact is lacking. Opposition always exists in the face of a possible increase to 'bureaucratic burden' of the field teams (Brauman and Beck, 2017, p. 85), yet critical reflection and forethought is required to consider the impact of adopting the mechanisms of the quality narrative into the humanitarian space. Criticising approaches to quality in health care activates a moral embargo reminiscent of that applied when criticising humanitarianism (Berry, 2014). The benefit of this research is to both open the debate, and to provide evidence

of the challenges and barriers to providing quality care in the field. In doing so, this research brings to the conversation new insight into the ways in which quality of care can be understood and improved in humanitarian settings.

Chapter outline

Chapter one gives a literary context of the dominant quality narrative. Taking an alternative approach to a literature review, the aim of this chapter is to give the reader insight into the dominant quality debate. Quality in healthcare has become a key priority within healthcare systems in higher income countries. In the UK, the increased focus on quality in healthcare came in the late 1990's in the response to a number of publicised failures in healthcare within the NHS (Davies: 1999, Smith: 1998, Secretary of State for Health: 1998). Similarly, in America, research into the quality of healthcare by the Institute of Medicine was followed with the publication of *Crossing the Quality Chasm*, (2001) which identified a quality 'chasm' in capabilities and practice, brought to light by high numbers of malpractice claims. This chapter draws on literature to demonstrate the association of the growth of the quality debate with economic and political drivers.

Beginning with the dominant quality narrative, this chapter draws on literature to demonstrate the dominant quality narrative as a bureaucratic endeavour, that for the main part has objectified elements of healthcare provision under the umbrella of quality. Highlighting the drivers behind the quality debate, the chapter demonstrates how the associated rhetoric, terms and mechanisms have been adopted into global health approaches. This chapter highlights the untouched research agenda around applicability of transferring practices from higher income, resource rich countries to

resource poor settings. Despite the huge impact that medical humanitarian organisations have on populations in need, academic investigation and debate into quality in healthcare in these settings is insufficient and fragmented.

Chapter two details my research design and methodology. The unique research partnership coupled with the skills and expertise of the principal researcher, offered a unique opportunity to gain valuable insight into a neglected but essential element of health care provision. The support and access granted through this partnership provided an opportunity to design a study that would provide a new approach to understanding the humanitarian medical care provided to crisis-affected populations. Participant observation, and the dual role of being a staff member and a researcher provided unique insight and challenges, both of which are explored within the chapter.

Chapter three provides context to the three field sites: the hospital in Agok in South Sudan, the day care centre in Athens, Greece and 'the garage' clinic in Chios, Greece. The field sites were chosen for the opportunity to cross examine the dissimilar settings. The first part of the chapter is on the context for Agok hospital. This section begins by providing the reader with a historical context of the location of the hospital, Abyei Special Administrative Area, in relation to the wide history of conflict and instability in South Sudan. The purpose of this is to give the reader an understanding of the instability of the region and the requirement for health services in this region. Rather than providing a broad historical context, the second part of the chapter situates the projects in Greece's recent political climate, drawing on literature to demonstrate the

impact of the movement of refugees from 2015 onwards to Greece, Greece's financial situation and the position of Greece in relation to Europe's immigration policies. The contextual considerations are the gaps in the state system that are unable to meet the health needs of the refugee population and the relationship between the living conditions of the population and their health. Contextual factors are relevant for the impact they have on the populations whom MSF seek to engage with, and the functioning of the projects. This chapter gives a detailed insight into the context of my field sites with a descriptive portrayal of the projects.

The three empirical chapters that follow draw on my field research. My research approach draws insight from the conversations, practice and materials used in the field settings, and analyses these in relation to the wider remit of MSF and humanitarian practice, and the wider quality debates. The objective of this research is to investigate the parameters of quality in humanitarian settings to develop an understanding of the challengers, barriers and drivers of quality healthcare provision.

Recognising the importance of teamwork and team cohesion in providing quality care, chapter four focuses on how these concepts play out in the project settings. Different claims to quality are made by each project site. In Agok hospital, the claim is to provide essential quality care. Quality care is mediated by the unstable connections between staff, management, patients and materials. Building on themes of teamwork and communication as central to the assemblage of quality care, the ward round is a natural point of departure for investigating the challenges of multidisciplinary teamwork in the humanitarian setting. In Greece, claims to quality are made around the concept of

holistic care. The project design is envisaged to meet the complex needs of the refugee and migrant population in a setting of multiple actors. In this dynamic of interconnectedness, the Greek context shapes the care practices of MSF. Drawing on the proximity between the staff and patients, this chapter brings nuance to understanding concept of 'burn-out' amongst staff. Despite the differences between the sites, framing quality through teamwork allows for important comparisons across the settings.

Chapter five focuses on the role of protocols and guidelines in structuring quality in the field. Protocols and guidelines interact with patients, illness, health, medications, staff skill and knowledge, practices and routines. In doing so, they mediate coherence and connectivity as well as friction and disengagement. Guidelines and protocols function to standardise practice. In MSF, the protocols and guidelines are part of the ecology of emergency humanitarian interventions (Jean-Hervé Bradol and Claudine Vidal, 2011). Created to 'respond to a need for coherence, continuity and capitalisation of experience' (Médecins Sans Frontières, 2019), they are a safety net for staff to both guide and support their practice. What is included and what is omitted in the protocols and guidelines infers the priorities of MSF and makes claims for what quality is in the humanitarian setting. In the clinical setting of Agok hospital, the guidelines and protocols bridge the divide between amateurism and experience and combine constructions of expertise. In Greece the protocols are enacted differently, revealing tensions in their design for settings of resource scarcity.

Drawing on my research from Agok, chapter six puts forward clinical practice as a key focus of quality. Looking in detail at the process of intravenous infusion, this chapter

highlights the connections between the elements of the process itself and their association to wider factors of influence. In the medical humanitarian landscape, the narrative and practice of quality is not fixed. Viewing the articulation and practice of quality as a network of associations brings a unique and important perspective to the meanings of quality in healthcare. In pursuing this argument, this study recognises the challenges of the unstable setting and importantly reveals the gaps and tensions that signal barriers to the pursuit of quality healthcare. In its starkness, focusing on the minutia of a process reveals that some elements are prioritised whilst others are neglected, demonstrating the shifting and contradictory nature of pursuing quality in complex settings.

Clarification of terms

Many of the terms and definitions used in the literature of humanitarian practice are problematic. At this point I wish to outline some of terms that I will use in this work, to clarify the meanings I attribute to the terms and give some reason for why I have chosen said term over others. I have attempted to reduce the use of jargon, though some remains primarily because its usage conveys the intended message. 'The field' is one such term, used to denote the project site, or more abstractly the place where humanitarian work takes place. As a researcher, this takes on an additional meaning as it is used to denote where one goes to do field research. Staff in MSF are employed on different contracts. The term expatriate or 'expat' is frequently used in the literature and in common parlance in MSF to refer to staff working for MSF on international contracts. Unless using the term within a quote, I will use the term international staff to denote staff employed on international contracts. 'Expatriate' implies further connotations

and suggests sentiments of choice, mobility, freedom of movement and transience, which would be problematic within the body of this work.

Recognising the inequality of the contrast, people who live outside their native country without the embodied sentiment of choice, mobility, and freedom of movement are referred to using the terms refugee, asylum seeker and migrant depending on the circumstance and context. The term migrant is not defined under international law. The International Organisation for Migration (IOM) identifies a migrant as 'a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons.' (International Organization for Migration, 2021). As defined by the 1951 Refugee Convention, a refugee is 'someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion' (UNHCR, 2010). According to the UNESCO definition, an asylum seeker is someone who has applied for protection as a refuge and is waiting the determination of his or her status. (UNESCO, 2017). Whilst providing some definitions for these terms, their application is awkward and disjointed, for example the UNESCO definition for a refugee is someone 'who has already been granted protection' (UNESCO, 2017). The services in Greece are available to the refugee, migrant and asylum seeker population, as well as other vulnerable people. In not knowing the exact circumstance of each person I therefore use these terms interchangeable in this study.

I have chosen to use the term 'patient' to refer to people who use the services provided by MSF. The debate around appropriate terminology for the people who use health

services continues (Costa et al., 2019; Thode, 1999). Terms like 'service-user' and 'beneficiary' or 'client' are used in the literature but my feeling is these terms over emphasise the suggestion that healthcare is a consumerist activity. Beneficiary is used within MSF, however I feel it is presumptive, suggesting that the patient automatically benefits from the interaction with the service. The use of patient is criticised for aligning with the paternalistic tendencies of healthcare provision, and a narrow focus on medical conditions rather than the whole person, and an embodiment of suffering (Lines et al., 2015). Research has shown preference of the term 'patient' over other suggested terms amongst users but the debates on terminology continue (Christmas and Sweeney, 2016; Simmons et al., 2010). In this study I use the term patient(s) to refer to individuals and groups of people who are seeking or using the healthcare services provided.

This research is not seeking to test what quality is, or to measure the performance of quality using specific data points. Rather in recognising variations and the importance of context, materials and individuals within them, this research will question how these factors contribute to the practice of quality healthcare. In questioning the meanings of quality in healthcare in humanitarian settings, the emphasis is on the plurality of the answers. This research emphasises the importance of looking beyond things that can be counted to understand quality as a process, relative to the interaction and relationship of staff, spaces, materials and other actants in the care assemblage.

Previous research into medical humanitarianism has focused on international organisations, recipient populations, and the wider theoretical debates that seek to challenge the dominant discourse of global health (T. Allen, 2015; Farmer, 2003; Fassin, 2010a; Renée. C. Fox, 1995; Redfield, 2013; M. I. Ticktin, 2011). While questions on the

provision, access, impact and the ethical complexities of decisions made have been brought to light in academic literature, few studies have considered the relevance of the diverse collective of staff working for medical humanitarian organisations, or how the theory and practise of both medicine, care and humanitarianism play out between ideals and realities of 'quality.' Humanitarian medical organisations are grappling with the concept of quality in healthcare. With a term of such ambiguity, what does it mean when applied to unstable, resource poor or crisis effected settings? If quality healthcare has been taken on as the next humanitarian 'universalist objective' (Marriage, 2006), what does this mean in the diversity of the humanitarian settings. In an inequitable landscape, raising the question of quality focuses the recognition of inequality. Achievement of quality care is a relational process, not an abstract concept. This is a timely discussion that adds caution on the propagation of the dominant quality narrative on humanitarian medicine and adds to the call for a reimagining of the humanitarian sector (Aloudat and Smith, 2020).

Chapter 1. Framing the debates on quality. Literature and Policies

Introduction

Quality is a central topic in medical and health systems literature. Quality healthcare is the pursuit of health systems, organisations and government bodies. Quality is providing *the best care*, it is being efficient in time, cost and use of resources, it is respecting the needs and wishes of the patient and protecting their dignity and privacy. The language of quality has become so central that the multitude of definitions are intertwined with how it is pursued, achieved and measured. Separating the literature from policy is therefore impossible when conducting a literature review of quality in healthcare. An academic body of literature on quality healthcare exists. This chapter will form a literature context of this important and neglected topic of research.

This chapter begins by mapping the development of the quality narrative in the United Kingdom (UK) and America, highlighting the tipping points that mark cultural shifts in the quality debates. Drawing on literature from the National Health Service (NHS) in the UK, this chapter contextualises the strength and span of quality rhetoric, focusing primarily on the mechanisms built within the NHS. These mechanisms of clinical governance, quality assurance and quality improvement are widely accepted, and have been applied outside the remit of stable health systems in high income countries. The aforementioned mechanisms have a different but interlinked function. Clinical governance is described as a framework or a number of ‘pillars’ by which healthcare organisations are accountable for ‘continuously improving’ and safeguarding quality healthcare (Macfarlane, 2019). Quality improvement (QI) sits within this framework and relates to the use of specific tools and methods to identify a process that requires

improvement. QI employs a structured approach to employ process and outcome measures and to demonstrate measurable improvement (Jones et al., 2021). Quality assurance relates to the measures and processes in place in order to provide a level of confidence that organisations are reaching a set standard of quality. Quality assurance practices seek to prevent failures or are in place to monitor and capture failures and/or suboptimal practice. As will be drawn out in this chapter, national structures and systems in the UK such as the Care Quality Commission and the nursing and medical regulatory bodies are in designed with the objective of assuring quality in the NHS (Dixon et al., 2012).

Drawing on literature on the growth and expansion of the quality domain, this chapter will argue that the structure of the quality debate and the framing of quality it has developed is not neutral. The structures and measurements used to frame quality care articulate with a particular understanding of both healthcare and quality. Historical policy legacies have an impact on contemporary policy space (Thow et al., 2020). A vertical approach to health has framed a vertical approach to quality; its limits, how it is measured and what quality means. Priorities and therefore research and funding are manipulated within this normative paradigm.

This literature review presents two components relevant to the quality debate in humanitarian medicine. This first is the normative quality debate using the example of the NHS to demonstrate the associated apparatus that has grown under the umbrella of quality. We call this the normative debate as the structure and theorising of quality and

associated apparatus have become the dominant understanding of quality in healthcare. Quality in healthcare is both market driven and market driving, a political tool embedded in the governance systems of healthcare structures. The second is the ideological context of Global Health, where preference for vertical programming provides the fertile ground for accepting the top-down technocratic approach to quality and using it as a vehicle to encourage changes. In reviewing the relevant literature and debates, this chapter identifies both where my research fits and the significance of its contribution. In doing so, this chapter argues that the adoption of the quality paradigm must be done with caution and with careful considerations. This chapter will argue that a critical approach to quality in healthcare is necessary.

This chapter draws on literature to question how the application of the quality narrative to humanitarian practice shifts the meaning of quality, making visible again the contradictions and tensions in addressing stark global inequalities (Calhoun, 2013). Bringing together literature from sociology and medical anthropology this chapter will critically deconstruct the quality narrative and demonstrate that caution be taken on its application to humanitarian medicine. Drawing on the literature, this chapter supports the argument that quality must be seen as an evolving process, mediated by the relationships of actors who engage with it. In the inequitable and unstable landscapes of humanitarian settings, failing to recognise the significance of the assemblage of relationships will result in failings in terms of quality and exacerbate the existing divisions and contradictions of the humanitarian landscape. Organisations like MSF have the opportunity to apply learnings from the often-unheard critical analysis of

quality in healthcare debates and proceed with thoughtfulness when considering what quality means in humanitarian settings.

Mapping the quality narrative

It is widely agreed that the beginning of the current quality 'boom' in healthcare can be mapped from the 1980/90s, and the turn of the millennium (Armstrong et al., 2015). In this period a number of high-profile reports and investigations in America, the UK and a number of other high-income countries are important markers in the development of dominant quality debate. The Harvard Medical Practice study is a pivotal point in the quality trajectory (Allen et al., 2016). Part of a study into medical injury and malpractice litigation to estimate the incidence of adverse events³, the Harvard study was conducted in response to the increasing malpractice -insurance premiums in America (Brennan et al., 1991). The retrospective case study was conducted into 51 randomly selected acute care hospitals in New York State in 1984, excluding psychiatric hospitals. The study concluded that out of the 30,121 medical records systematically reviewed, adverse events occurred in 3.7% of the hospital admissions. Of the 3.7%, 14% of the adverse events contributed to death (Leape et al., 1991). This study was the precursor to further retrospective case studies in America, and Australia (Gawande et al., 1999; Wilson et al., 1995). Whilst there are inconsistencies in the incidence rate and the classification of severity used, the reports were interpreted as showing significantly high rate of adverse events (de Vries et al., 2008). The 'Harvard method' approach continues to both inform investigation into patient safety and is framed as an essential 'first step' for organisations toward improving quality and patient safety (Aranaz-Andrés et al., 2008;

³ An adverse event is understood as an 'unintended injury or complication resulting in prolonged hospital stay, disability at the time of discharge or death and caused by healthcare management rather than the patients underlying disease process' (de Vries et al., 2008).

Baker et al., 2004; Mendes et al., 2009; Rafter et al., 2017; Soop et al., 2009; Sousa et al., 2014; Vincent et al., 2001; Wilson et al., 2012a).⁴

The Institute of Medicine (IOM) reports '*To Err is human: building a safer healthcare system*' (Institute of Medicine, 2000) and '*Crossing the Quality Chasm: A new health system for the 21st century*' (Institute of Medicine, 2001) were influential documents at the dawn of the millennium, indicating a cultural shift, or new wave in the approach of health care systems to quality (Armstrong et al., 2015; Travaglia, 2009). Gaining international and global attention, they put the spotlight on quality and safety in health care and marked an acceleration and expansion in the quality debate. The IOM report defined quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." (Institute of Medicine: 2001: 244). Despite being 20 years old, the Institute of Medicine definition for quality remains a keystone in the quality narrative (The National Academics of Sciences Engineering and Medicine, 2018; WHO - OECD - World Bank, 2018).

The six 'aims' for quality improvement put forward in the report have been widely adopted to demonstrate six characteristics of quality healthcare (Campbell et al., 2000;

⁴ Using this Harvard method, research demonstrates that the incidence rate of adverse events has not shown significant improvement. Research in Sweden identified 12% rate of adverse events (Soop et al., 2009), in Spain 8.4% (Aranaz-Andrés et al., 2008), Mendes in Brazil 7.6% with 66.7% identified as preventable (Mendes et al., 2009) in the UK 10.8% with half identified as preventable (Vincent et al., 2001), in Portugal 11.1% with half identified as preventable (Sousa et al., 2014). Of the limited research in 'developing' countries, an overall rate was given as 8.2% of admissions with a range of 2.5% - 18.4% Of these events, 83% were judged to be preventable, while about 30% were associated with death of the patient (Wilson et al., 2012b).

Donabedian, 2005; Institute of Medicine, 2001; The Health Foundation, 2013; World Health Organisation, 2006). They are as follows (Institute of Medicine, 2001, p 244).

- Safe – avoiding injuries to patients from the care that is intended to help them.
- Effective – providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (Avoiding use and overuse, respectively).
- Patient-centred –providing care that is respectful of and responsive to individual patient preferences, needs, values and ensuring that patient values guide all clinical decisions. (Person-centred care is used often as a replacement for ‘patient’ further representing a person orientated approach, rather than illness/disease orientated (The National Academics of Sciences Engineering and Medicine, 2018)
- Timely – reducing waits and sometimes harmful delays for both those who receive and those who give care.
- Efficient – avoiding waste, including waste of equipment, supplies, ideas, and energy.
- Equitable – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socio-economic status.

The IOM structure provided a vehicle for the quality debate.⁵ The literature demonstrates that safety, effectiveness and person-centred care are the three pillars of healthcare most widely used (Darzi, 2008; Doyle et al., 2013; Powell and Mannion, 2016; Raleigh and Foot, 2010; Swinglehurst et al., 2015). In the UK, the publication of *An organisation with a memory* (Donaldson, 2000), was a watershed moment for the NHS in the UK in terms of patient safety policy. A number of Public Inquiries revealed egregious failures (Bevan and Cornwell, 2006). Amongst others⁶, the inquiry into the high number of children's deaths at Bristol Infirmary was a turning point that heralded nationwide changes in the structure of the NHS, and the regulatory system of medical practitioners (Davies et al., 2000; Department of Health, 2002).

In response to these 'tipping points' (Sheingold and Hahn, 2014), the Labour Government introduced a number of reforms under the 1999 Health Act which imposed a 'Duty of Quality' on NHS trust boards. The reforms integrated financial, performance and clinical quality, and sought 'continuous improvement' through processes of assurance, innovation and accountability (Peak et al., 2005; Scally and Donaldson, 1998). A turn to the methods of quality assurance (QA) and quality improvement (QI), brought a system approach to addressing risks and hazards within a system, pushing

⁵ As a point of interest, the six points used by the IOM did not appear out of thin air at the turn of the millennium. Similar formulations of quality had been in the literature for some time. R.J. Maxwell's advice to NHS Management in 1984 had the following six dimensions which form an interesting comparison: Access to services; relevance to need (for the whole community); effectiveness (for individual patients); social acceptability; efficiency and economy (Maxwell, 1984, p. 1470).

⁶ The public inquiry into the actions of General Practitioner Harold Shipman who in January 2000 was found guilty of murdering 15 patients under his care. It is estimated that in total Harold Shipman murdered 250 of his patients over 25 years of his professional career (Home Secretary and the Secretary of State for Health, 2007). These cases amongst a series of others, crudely termed 'butchers and gropers' (Abbasi, 1998) 'shattered any lingering credibility in the reliance on self-regulation by the medical profession as a means of assuring quality of care in the NHS' (Bevan and Cornwell, 2006, p. 345).

the debate away from focusing on individual error to the recognition of systematic risk. These 'industrial' approaches are similar to those applied to industries with a heavy influence on safety such as the airline industry. Clinical Governance, the underpinning concept of the Donaldson report was proposed as a new framework and a new comprehensive approach to quality (Nicholls et al., 2000). The success of the vision relied on the relationship between clear standards of service, dependable local delivery and the formation of bodies to monitor and report on the achievement of trusts. The duty of quality was laid at the door of each NHS chief executive⁷, holding them 'accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will 'flourish' (Department of Health, 1998).

In addition, a new independent regulatory regime was set up to enforce the duty of quality. Institutional mechanisms and practices were introduced including the National Institute for Clinical Excellence⁸ (NICE) which set national standards of care,

⁷ The role of the Chief Executive personifies the tensions and challenges of the 'modern' NHS, bridging the spheres of public and private, administration and management. It may be of interest for the reader to note that the changes made under the Thatcher Government following the Griffiths report in 1983, that made clear the prioritisation of managerialism over clinical leadership signalling the idea of Chief Executives was rejected, seeing the role as 'incompatible with the professional independence required by the wide range of staff employed in the service' (DHSS, 1979; quoted in Sausman, 2001, p. ii14). With the Health and Social Care act 1999, the role of the chief executive extended beyond financial and managerial performance to the 'duty of quality', expanding the managerial role into the clinical realm through responsibility for the clinical standards within the organisation. See Sausman (2001) for an interesting commentary on the role of the Chief Executive at the time of these changes.

⁸ NICE is a UK national advisory body, created in 1999 to 'drive up the quality of care' to improve clinical standards in the NHS. In 2012 its status was changed from a special health authority to non-departmental public body, established by the Health and Social Care Act (2012). The current role of NICE is to 'provide guidance and support to providers and commissioners to help them improve outcomes for people using the NHS, public health and social care services'. It does this by producing 'robust evidence-based guidance and advice, developing quality standards, and providing information services for commissioners, practitioners and managers across the spectrum of health and social care.' (Department of Health and Social Care and National Institute for Health and Care Excellence, 2018). The body has not been without its controversies, particularly in relation to its alignment of quality with cost effectiveness. (Fitzpatrick, 2009; Pharmacocon. Outcomes News, 2007; Spall, 2009).

benchmarks and targets, against which audits were assessed (Sally and Donaldson, 1998). To monitor performance and advise on and review the processes of clinical governance, the Commission for Health Improvement (CHI) was established as the first quality regulator, in liaison with the National Performance Framework and the National Patient and User Survey. Sponsored by the Department of Health, the CHI was the first organisation to have the role of assessing clinical performance of the NHS with the aim of improving the quality of patient care⁹ (Patterson and Lilburne, 2003). A literature review conducted in 2011 of the key concepts of clinical governance demonstrates the growth of its scope and increasing complexity as more themes and concepts are brought in under its umbrella heading (Travaglia et al., 2011). The influence of Clinical Governance has spanned outside of the UK, and governance as an approach to quality forms the main narrative of the quality debate in global health (Australian Commission on Safety and Quality in Health Care, 2017; Behzadifar et al., 2019; Ravaghi et al., 2014).

An important part in the development of this quality framework is the changing position of the patient, and the rise in what can be termed ‘consumer participation’ in healthcare (Graffigna, 2015; Iedema et al., 2006). In the UK, a focus on patient-centred care (PCC) is predominantly framed as a shift of and sharing of power from the providers of healthcare to those receiving it, an empowerment of patients. The ‘semantic networks’ with which PCC is associated (Fassin, 2012), speak to values of respect, dignity, personalised holistic care and the empowerment of patients. These

⁹ The CHI was the first organisation in this role. In 2004 the CHI ceased to function and was replaced by the Commission for Healthcare Audit and Inspection (CHAI). In 2009 the CHAI was abolished, along with the Commission for Social Care Inspections and the Mental Health Commission. A new body, The Care Quality Commission (CQC) was formed with the extended remit of the dissolved commissions according to the Health and Social Care Act 2008 (2008).

values are reflected in literature reviews investigating the term, which highlight ‘patient participation and involvement,’ ‘relationship between patient and professional’, and ‘the context where care is delivered’ as the three main themes (Kitson et al., 2013). The implied assumption of this model of quality rests on the philosophy of both valuing the patient and of equity in that all patients/ persons should be centrally involved in their healthcare.

PCC by its nature is difficult to measure as in its full fruition as it represents an ideology rather than a single process, leaving it vulnerable to inappropriate measurement and objectification through standardizing and regulatory processes (Turrini, 2011). Despite this, the increasing prominence of PCC as a proxy for quality can be charted from the turn of the millennium, with an increasing dominance within the quality debate over the past decade (Epstein and Street, 2011; Frampton, 2013; Kitson et al., 2013; Marshall et al., 2012; The Health Foundation, 2016). PCC has been presented as an approach that is ‘directly related’ to quality of health care, (Jardien-Baboo et al., 2016, p 397), and is ‘an essential component of building universal health coverage’ (The World Health Organisation, 2015, p 6).

In the NHS, choice of health care provider is translated as agency, and mechanisms of feedback, such as the friends and family test (FFT) are in place to give weight and value to the opinions and experiences of service users, although how the mass of data collected is used to this end is questionable.¹⁰ This network is supported by reviewing

¹⁰ The FFT was introduced in 2013 as a source of patient feedback on services, based on the premise of whether a person’s experience of the service would lead them to recommend it to a friend or family member. The cost of collecting and collating the data from this mandatory questionnaire has been estimated at £12 million in the first four years (Robert et al., 2018), demonstrating the cost of quality

boards who monitor and assess healthcare settings, allowing patients to make 'informed choices' about where they choose to receive their healthcare (Department of Health: 2007, NHS England: 2016, Care quality Commission: 2016). This framing narrative partially obscures the core economic component. In the UK, patient centred care as understood through patient choice is linked to funding mechanisms for hospitals. Payment by results, a fixed-price funding mechanism was implemented by the UK government in 2005. Market-based reforms and service-related tariffs give hospitals financial incentives to attract patients, and finance follows patient's choices (Cooper et al., 2011). The quality debate and the terms legitimated within it are linked in many ways to the political and economic system in which they operate and the economic core narrative runs simultaneously within the quality debate (Mannion and Davies, 2008). Policies and politics are entwined, the ubiquity of *quality of care* supports its convenient position as a vehicle for change, and a 'statement of aspiration' (Freedman and Kruk, 2014). Structural reform in the name of quality is ongoing in the NHS, demonstrating quality as a vehicle for driving and implementing reform (Blaize-La Caille, 2018). The 2012 Health and Social Care Act under the coalition government brought extensive restructuring in health and social care (Powell and Mannion, 2016), including additional measures to address the accountability of professional groups who must regularly demonstrate that they are fit to practice (Ho and Baker, 2012; Kolyva, 2013; Paton, 2017; Walshe et al., 2017). System wide responses appear to be reactive after failings are revealed. It must be stressed at this point that in 2020, the cyclical restructuring has not deterred the occurrence of devastating malpractice and

measurement (Schuster et al., 2017). Introduced as a way to support local quality improvement through listening to the views of patients, the success of this tool lies in how this information is processed and utilised (Dean, 2014; Melvin, 2015). In 2013 The Keogh Report, a review into the quality of care in 14 hospitals following the failings at Mid Staffordshire NHS Foundation Trust, stated that real time patient feedback must reach 'well beyond' the FFT (Keogh, 2013).

mismanagement within NHS Hospitals. Most recently, the emerging findings of the Ockenden Report were published on the 10th December 2020. The interim report has been published following 250 clinical reviews of the 1,862 cases raising concern of poor care, significant harm and fatalities in the maternity unit at Shrewsbury and Telford Hospital NHS Trust, between the year 2000 – 2017 (Ockenden, 2020). Quality assurance mechanisms are in place with the objective to capture system failings, for example with institutional mortality comparisons. This report again demonstrates the challenge of capturing failings in a timely manner, and the importance of creating a system where the voices of patients, families and staff are listened to and heard (Dixon et al., 2012; Ockenden, 2020).

The quality narrative in Global Health

Beginning with three recent reports on quality by influential ‘stakeholders’ in global health, this section demonstrates the evolution of the quality debate as a powerful discursive construct in Global Health. The quality debate is explicit in the global health narrative and policy paradigm. Drawing on literature from anthropology and sociology to critique global health policy, the following section will critique the implicit features of the quality debate. The adoption of a technocratic market driven quality rhetoric in the global health narrative must be seen as the continuation of a selective, technical approach that is aligned with the ideology of global health.

Delivering Quality Health Services: A global imperative for universal health coverage, a joint publication by the World Health Organisation (WHO), the Organisation of Economic and Cultural Development (OECD) and the World Bank, calls for the delivery

of effective, safe and patient centred care. This is the first time these three multilateral organisations have co-authored a global report (Veillard et al., 2018). This is significant in the evolution of the position of the World Bank in global health (Ruger, 2005). The report suggests five key actions for ‘building quality into the foundations of health systems’¹¹ and outlines improvement interventions to be implemented at organisational, national and international levels (WHO - OECD - World Bank, 2018). In the same year, the National Academies of Sciences, Engineering and Medicine (NASEM) published its report *Crossing the Global Quality Chasm: Improving Healthcare Worldwide*, drawing direct links to its eponymous predecessor. Articulating that despite two decades of investment and research, the ‘quality chasm’ remains, the report insightfully recognises that ‘the quality of health care in every country is much worse than it should be’ (Berwick et al., 2018, p 1317). The third report, *High-quality health systems in the Sustainable Development Goals era: time for a revolution*, produced by the Lancet Global Health Commission on High Quality Health Systems (HQSS) focuses on health systems, specifically process metrics (Kruk et al., 2018a; Kruk and Pate, 2020).

Whilst the reports diverge in modelling, measurements and specifics of recommendations, they share more similarities than differences, holding a general consensus between them. This agreement is firstly in the poor progress made over the past 40 years. The preliminary research by the HQSS team used data from the 2016 Global burden of disease study¹² to estimate the mortality for conditions targeted in the

¹¹ The five key actions are: ensure a high-quality workforce, ensure excellence across all health facilities; ensure safe and effective use of medicines, devices and other technologies; ensure effective use of health information systems; develop financing mechanisms that support continuous quality improvement. (WHO - OECD - World Bank, 2018, p 55-56).

¹² The first Global Burden of Disease (GBD) study was in 1990. It endeavours to measure disability and death from a wide range of causes. The GBD in 2019, led by the Institute for Health Metrics and

Sustainable Development Goals (SDG's) for 137 lower- and middle-income countries (LMIC). Using these methods, they estimated that 5 million deaths in 2016 were 'due to poor quality care' (Kruk et al., 2018b). The HQSS report estimates that 8 million lives would be saved by high quality health systems in LMICs. All of the reports give a dismal global picture, with quality of care being worse for the most vulnerable groups across all contexts (Kruk et al., 2018a).

In addition, each report advocates the need for system wide changes. The NASEM report makes a clear argument for this stating that 'theory and evidence accumulated over the past half century or more make clear that the quality of care is determined far more by the design of the systems in which people work (such as culture, norms and expectations, the learning environment, the organisation of care processes , and incentives) than by the people themselves' (The National Academics of Sciences Engineering and Medicine, 2018, p 6). The NASEM report looks to future health, the use of new technologies, and bases its 13 guideline principles on 'what are likely to be the new and emerging systems of the 21st century' (The National Academics of Sciences Engineering and Medicine, 2018, p 10). The 'call to action' of the WHO/OECD/World Bank report prescribes high level actions to governments, health systems, citizens, patients and health workers. Each report predicated itself as providing a novel understanding of what is needed to solve the global quality problem; 'time for a revolution' implores Margaret Kruk and colleagues (Kruk et al., 2018a). The reports place their confidence in national strategies, strong regulation and a culture of 'continuous learning'; of accountability, closing gaps, transforming workforces, building

Evaluation (IHME) brought together data on 204 countries and territories on 369 diseases and injuries and 87 risk factors. The GBD estimates mortality, incidence, years of life lost, (YLLs), years lived with a disability (YLDs) and disability-adjusted life years (DALYs) (Abrams et al., 2020).

resilience and empowering people to engage in care, and the redesign of systems with quality 'built in'. The authors, affiliated organizations, financial partners and publishing networks of these reports demonstrate the centrality of this narrative to the global health approach to quality. Unavoidable in the narrative of these three reports, is the chasm between the complexity and diversity of the LMICs grouped together and the simplicity of the governance approach proposed, in addition to the reductionist approach to covering all elements of healthcare under the umbrella term of quality. Which leads one to ask, 'where's the complexity?' (Topp, 2017). Thus, giving strong impression of the paradigm of global health as a 'fragmented galaxy of stakeholders', where discourse and reality are not aligned (Taylor, 2018).

To quote the title of the HQSS report, the high-level actions and recommendations do represent a revolution, but in the cyclical sense of a rotation of the same ideas and the same inequitable distribution of power rather than a transformation as insinuated by the authors. This is not to say that the focus is not commendable, and one cannot disagree that quality and access must go 'hand in hand' for universal healthcare (UHC) to be achieved (The National Academics of Sciences Engineering and Medicine, 2018, p. 6). However, critical questions must be asked and addressed. These reports are the most recent of a long line that have proposed (similar) objectives, advice and key targets accordingly. In 2000, the *World Health Report*, published by the WHO laid the responsibility for health care with the efficiency of health care systems (World Health Organisation, 2000b). Setting out that 'the differing degrees of efficiency with which health systems organise and finance themselves, and react to the needs of their populations, explain much of the widening gap in death rates between the rich and the poor, in countries and between countries around the world' (WHO: 2000: xii). The

report advocates for a 'new universalism' as a framework for health care. New universalism is defined as 'high quality delivery of essential care, defined mostly by the criteria of cost-effectiveness, for everyone, rather than all possible care for the whole population or only the simplest and most basic care for the poor' (World Health Organisation, 2000b, p. 15). The report openly advocates for 'good health at low cost' through selective programs that target diseases that account for 'large, avoidable burdens of ill health' and the development of 'clusters of interventions'. This report reflects two of the dominant assumptions of Global Health. Firstly, that a medical/technical approach to health is sufficient to solve the problems of world health, and secondly that this relies on the development of the private sector and increasing presence of private finance. These two points are made clear in the report, 'demand' is offered as a lever to 'make money follow the patient' (World Health Organisation, 2000b, pp. 15-16). The report and associated critique make clear the ideological divide of approaches to health and healthcare (Almeida et al., 2001; Navarro, 2000). Critiques demonstrate the methodological issues and inadequacies of the report. These issues include the heavy use of non-peer reviewed references, inappropriate measures and indices, and prominence of ideological position rather than evidence based. As made clear by Almeida *et al* (2001) as a report by the WHO, these concerns are wider than matters of technical and scientific significance, 'but are profoundly political and likely to have major social consequences (Almeida et al., 2001, p. 1696).

Schuftan (2016) argues that UHC the most recent driver of which is 'leave no one behind' is a 'market driven' concept and argues for a human rights approach to achieving equitable healthcare (Schuftan, 2016). Supporting this view, Charles Shaw argues that adopting the quality debate under the ambition of universal health coverage

'has generated a demand (and market) for defining and monitoring *good services*' arguing that UHC 'tends to focus on one dimension of quality – access to care' (Shaw, 2015, p. 226). The meaning of universal health care has changed significantly due to political and economic drivers. The 'Health for All by 2000' asserted health as a human right and promoted universal accessibility to a national primary health care system, defined in the Alma Ata agreement (Binns and Lee, 2015). The Alma Ata declaration of 1978¹³ is frequently evoked to demonstrate the failings of its vision (Macarayan et al., 2018; The National Academics of Sciences Engineering and Medicine, 2018; World Health Organisation, 2000b). The Alma Ata declaration and its opposition provides important historical context for the current quality debate and demonstrates further the inherent contradictions between contemporary global health and its claims towards quality universal healthcare.

This approach to health and health care signified a break with the vertically integrated approach to healthcare as seen in the polio and malaria campaigns. The recognition of health as a fundamental human right, of the relationship between social and economic factors as social determinants of health, and the importance of community participation framed health and health care within the paradigm of social justice. The Alma-Ata

¹³ The International Conference on Primary Health Care took place in Alma Ata, Kazakh Soviet Socialist Republic in September 1978. The Alma-Ata declaration and the Global Strategy for Health for All by the year 2000 were adopted in 1979 at the Thirty-second World Health Assembly (World Health Assembly, 1979; World Health Organisation, 1981). The Declaration embodied a socio-political understanding of primary health care that made clear the need for an alternative economic system to facilitate this vision. At the heart of making this feasible was the recognition of the 'existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries' (III) The Alma-Ata Declaration stands out in the history of Global Health as it recognized that the basic importance of reducing this gap was to radically change economic order to allow for social and economic development. See <http://un-documents.net/s6r3201.htm> for the document in full. (Accessed 28 September 2020).

declaration stood with and relied upon the success of the Declaration on the Establishment of a New International Economic Order as adopted by the United Nations General assembly in 1974. Embodied within these documents was a drive for quality in health care, through equality. The essential component of achieving this was facilitating a level playing field through economic and social development, including sharing of technologies. In recognition of the pervasive effects of economic colonialism, the defining characteristic of the NIEO was 'an attempt to eliminate economic injustice and equalize economic opportunity, conducive toward the unfolding of productive capacities capable of responding to basic needs in all parts of the world. Beyond dependence towards self-reliance' (Laszlo et al., 1978, p. xxv).

In 1979, the same year as the 32nd World Health Assembly that endorsed the Alma Alta declaration, a small conference entitled 'Health and Population in Development' took place in Bellagio, Italy, sponsored by the Rockefeller Foundation. This conference was focused on a paper entitled 'Selective Primary Health Care, An interim Strategy for Disease control in Developing countries' (Walsh and Warren, 1980). This paper presented an alternative approach to health care, that of selective care, which emphasised attainable goals through cost-effective planning (Cueto, 2004). Within this paper, supported by costings from the World Bank, total primary care is rejected for 'categorical disease control', where the priorities for disease control are based on prevalence, morbidity and mortality, and 'feasibility of control'.(Walsh and Warren, 1980, p. 145). High priority at the time of the paper was given to diarrheal disease, measles, malaria, whooping cough, schistosomiasis¹⁴, and neonatal tetanus as they were

¹⁴ Fresh water snails are the intermediate hosts for the *Schistosoma* that cause schistosomiasis, also known as bilharzia or snail fever. It is acquired by humans when the larval forms of the microscopic parasitic flatworms (cercariae) penetrate the skin in infested water. Worms mature and mate and some

assessed to have high prevalence, morbidity, mortality and effective control. Taking a biomedical view of health and illness, diseases without cost-effective medical treatment were allocated a medium or low priority, including dengue fever, tuberculosis, meningitis, typhoid, malnutrition and respiratory infections.¹⁵

The political and moral 'idealism' of the Alma Ata and the NIEO which provided the context for the Health for All movement was pushed away by the wave of neoliberalism of the 1980's, the effects of which routed themselves in the structural adjustment programs imposed by the International Monetary Fund (IMF) and the World Bank (Magnussen et al., 2004; Packard, 2016). As Baum notes, 'these adjustment policies – which lowered real wages, reduced food subsidies, and slashed budgets for public health and education – harmed rather than benefitted the health of poor people' (Baum, 2007, p 38). The terms of loans enforced by the Bretton Woods Institutions¹⁶ were tied to policies that sought to expand market-driven economic reforms and reduce or remove public services. Health services were systematically underfunded, with severe and lasting effects (Hall and Taylor, 2003; Shoman et al., 2017; Stubbs et al., 2017). In this new political climate, the 'interim strategy' put forward by Walsh and Warren (1980) of

eggs are released in urine and stool. Other eggs are trapped in the organs, particularly the liver, intestines or urinogenital tract causing an immunological response leading to acute and chronic ill health. The disease is prevalent in communities with poor access to clean water and poor sanitation. Early attempts to control the disease focused on snail control. A control project in St. Lucia in the 1970's – 1980's compared the effects of snail control, chemotherapy and improved sanitation. The study supported the use of chemotherapy as the most cost-effective intervention, estimated at \$0.88 per person per year, compared to \$4.80 for water supplies (Gilles, 1986). Mass drug administration (MDA) continues to be the main strategy in response to the disease (Shen et al., 2017; Toor et al., 2019). Today, schistosomiasis considered the second most socioeconomically devastating disease after malaria affecting an estimated 221 million people worldwide (LoVerde, 2019).

¹⁵ Eighteen infections in total were identified as medium or low priority. Treatment for some of these infections were identified as 'expensive, difficult, toxic or inefficacious', namely leprosy, tuberculosis, and African trypanosomiasis, and the paper advises investment in research and development.

¹⁶ The Bretton Woods Institutions are the World Bank and the International Monetary Fund (IMF), so called because the meeting in 1944 when they were set up was held in Bretton Woods, New Hampshire, America.

selective disease specific programs, became synonymous with the strategy of international health (Pandey, 2018). As specified in their original paper, the target population for categorical disease control was women and children, specified in the paper as children aged 0-3 and 'women in the child bearing years' (Walsh and Warren, 1980, p 151).¹⁷ Selective Primary Health care was fully adopted by UNICEF, despite them being a co-sponsor of the Alma Ata conference (Cohen, 2005). From the 1980's, UNICEF launched limited vertical programmes on growth monitoring, oral rehydration therapy, breastfeeding and immunisations, that became known as the acronym GOBI (Wisner, 1988). The Millennium Development Goals (MDGs) and Sustainable Development Goals (SDGs) demonstrate the continued prevalence of disease specific 'lateral' programs (Schneider, 2006; Travis et al., 2004), continuing the historically rooted discourse that health is a 'technical' matter (Baum, 2007; Schuftan, 2016). Technical or disease specific programs have failed to ensure that many low-income countries reached the MDG health targets, and furthermore, those with most stark health inequities have made the least progress (Dinala et al., 2020; Johns et al., 2013; Moucheraud et al., 2016; Oleribe et al., 2015; Smith and Taylor, 2013). Any gains made towards these goals must be treated with caution as they obscure the deep and growing inequalities in and across countries (Bhutta and Black, 2013; Gwatkin, 2017; Mason et al., 2017; Taylor, 2018) .

¹⁷ Women and children are targeted in global health policy, and measures relating to these groups are often used as proxies for overall quality of a program or intervention. This can be linked to ideas of vulnerability, the status of women, pregnancy and young infancy is conceptualised as fragile/need to be protected. Investigating this prioritisation would be interesting, and I would suggest here it is a mix of the religious/social construction of these groups as vulnerable and the need to be protected, and the associated but also slightly different formulation of survival and 'bare life', represented by woman and baby. However, I also wish to remark on the exclusion of able bodied, school age/working age men and women and how their exclusion from healthcare affects the health, growth and wellbeing of the society

Thus far, this literary context has demonstrated that the meanings of quality in health care are a political issue. In global health, quality is selective and measurable, with woman and children as proxy indicators for a nation's health and well-being. Fitting this selective approach, quality improvement frameworks have been advocated as a way to 'improve the appropriate, evidence-based use of limited resources' in low- and middle-income settings (Leatherman et al., 2010; Massoud et al., 2012). Reflections from the quality debate in higher income countries can be seen within this literature (Berendes et al., 2011; Haj-Ali et al., 2014; Rannan-Eliya et al., 2015). There is a paucity of academic research on the application and success of these methods, and quality is understudied in the literature (Alatinga and Williams, 2014). A literature review conducted by Reema Harrison and colleagues (2015) on patient safety and quality of care in 'developing countries' demonstrated a link between WHO campaigns and the subsequent rise in interest of specific areas of research, highlighting the WHO Patient safety study of unsafe care, Clean Care is Safer Care (2005) and the WHO Global Survey of Maternal and Perinatal Health 2007-08. This research drive can be understood in the context of countries wishing to achieve the MDG's and SDG's, further demonstrating how political will and financial incentive influences research, and the narrative of the quality debate.

The quality narrative in humanitarian medicine

On a grand narrative, the quality debate in humanitarian practice is intertwined with debates around professionalism and accountability (Barnett, 2012). Accountability has numerous interpretations in humanitarian settings (Madianou et al., 2016). The Joint Evaluation of Emergency Assistance to Rwanda (JEEAR) (Borton et al., 1996) is seen as

a significant juncture in this trajectory (ALNAP, 2016). The evaluation revealed substantial inadequacies of the humanitarian response and put the blame on NGOs for being unprofessional, irresponsible, ignorant and inexperienced (Borton et al., 1996). Investigated actions were reported not only as wasteful, but ‘also may have contributed to an unnecessary loss of life’¹⁸ (Borton et al., 1996, p 59). The evaluation was followed with a proliferation of initiatives proposing to improve accountability and competence of humanitarian actors. The ALNAP network, The Humanitarian Ombudsman Project, The Sphere Standards and the Humanitarian Partnerships are some examples of these initiatives, which developed amidst calls for increased professionalization of the sector (Dufour et al., 2004; Hilhorst, 2002; Hilhorst, 2005; Terry, 2002; Walker, 2005).¹⁹ The Sphere handbook, and the Sphere Project that led to its first edition in 2000 requires further attention at this juncture. The impact of the Sphere on the humanitarian quality narrative, namely the legitimisation of the ‘universalist quantification of needs’ has had a lasting effect on the normative understanding of quality as quantifiable minimum standards to meet basic needs (Glasman, 2020, p. 25). As aptly analysed by Joël Glasman, the process of developing the Sphere guidelines evoked a consensus amongst

¹⁸ The evaluation estimated that between 50,000 and 80,000 people died in the internally displaced persons (IDP) and refugee camps in Zaire, Tanzania and Rwanda in 1994 principally from cholera and dysentery. These deaths were considered avoidable, and attributable to the failings in coordination and accountability of the humanitarian response, with the report also recognising the lack of engagement with the beneficiaries (Borton et al., 1996). For reflective insight on the role and decision making of MSF in Rwanda over this period there are three *Speaking Out* case studies available at <https://www.msf.org/speakingout> (Accessed 20th March 2021).

¹⁹ Alongside the development of these initiatives, attempts were made at a structural level with the aim of improving coordination and response between the number of NGO’s and organisations. The Cluster Approach (OCHA) and the Foreign Medical Teams Working Group (WHO) which later became the Emergency Medical Team Initiative are examples of system restructuring. With the aim of strengthening both preparedness and response at a global and national level, The Cluster approach was adopted in the wake of the response to the South-east Asia earthquake in 2005 which had demonstrated repeated failings of coordination and delivery of care (Stumpfenhorst et al., 2011; United Nations Emergency Relief Fund, 2005). The Foreign Medical Teams Working Group was initiated in 2010 following evidence of the lack of accountability, transparency and coordination of humanitarian workers and reports of unacceptable practices in the delivery of international emergency medical assistance following the earthquake in Haiti (Chu et al., 2011; Cosgrove, 2007; Inter-Agency Standing Committee, 2011).

a wide range of NGO's and participants. Glasman demonstrates how this consensus was crafted through a number of mechanisms, through demonstrating a wide 'buy-in', and minimising critiques by translating them into technical discussions and incorporating critiques into the process by framing them as 'debate' (Glasman, 2020, p. 146-150). This demonstrates the process by which norms become universal, by shifting problems of political origin to technical problems.

Research into the quality of surgical care delivery outcomes in resource limited settings has received a notable wealth of attention within academic literature (Awais et al., 2014; Bertol et al., 2014; Boillot and Herard, 2014; Chu et al., 2011; Chu et al., 2010; Teicher et al., 2014; Wong et al., 2014). The high incidence of trauma and subsequent demand for surgical intervention, coupled with high burden of unmet surgical need, justifies the wealth of research. Quality in this literature is formulated through the adherence to standard guidelines and ability to achieve minimum standards of practice to allow for procedures to take place, with particular focus on limb trauma. Research interest and vital funding frequently have political drivers and this attention to the practices of foreign medical teams performing surgical interventions must be seen in the context of sudden onset disasters. This can be seen as prompting an interest for foreign medical teams to invest in this line of research and demonstrate the value of their work.

Using surgical outcomes as proxies for provision of quality care, namely mortality and post-surgical infection, studies are able to demonstrate clear results. This is reflective of the preference for quantitative methodology to assess quality. This approach is

complemented and reinforced by economic drivers that push for demonstrable results. The methodology used directly impacts the boundaries of what is being measured, namely which components of quality. A study looking at quality of care in emergency orthopaedic surgery conducted by MSF questioned how quality can be ensured in unstable settings such as those in conflict or following a sudden onset disaster, focusing on the implementation of the minimum standards of care for orthopaedic surgery as endorsed by MSF (Alvarado et al., 2015). In assessing the outcome of the structural and process elements through intra-operative mortality and postoperative infection rates, the study found that 'low intra-operative mortality and postoperative infection rates across all study sites provide a fair indication that our quality of care is high' (Alvarado et al., 2015, p. 1907) However further analysis of the study shows that 3 out of the 6 study sites, data on post-operative infection 'could not be captured' (Alvarado et al., 2015, p. 1905). The study by Alvarado and colleagues exposes some of the key issues and challenges in researching quality in humanitarian settings. Retrospective data collection is problematic. Taking the example of MSF, it is only within the last two years that data collection to one uniform external portal has been in place. As I learnt from the medical data personnel in OCG Geneva, prior to the implementation of the current system field sites used a multitude of systems to record their data.²⁰ The first problem prior to data input on a computer system is the correct and efficient documentation by the medical staff. A comprehensive literature review by Anisa Jafar (2015) demonstrated poor and incomplete documentation in medical notes as a common problem within humanitarian practice due to inconsistencies in medical record keeping by foreign medical teams in sudden onset disaster response, and the absence of

²⁰ Fieldnotes. May 19th 2017.

minimum standards of how this should be done (Jafar et al., 2015). As record keeping is 'an integral aspect' of healthcare delivery the current paucity in this area 'undermines the quality of care provided' (Jafar et al., 2015, p. 221).

Anthropological interest in humanitarianism and humanitarian aid has emerged over the last few decades, spawning from a number of diverse but associated branches of interest: refugee studies, medical anthropology and political anthropology, alongside the growth of humanitarian action within the geopolitical global sphere (Apthorpe, 2014; Biehl and Petryna, 2013a; Ticktin, 2014; Véran, 2020). Increasing attention can be noted on medical humanitarianism, the study of the relationship between humanitarian moral endeavour and biomedical actions in the pursuit of saving lives and relieving suffering (Abramowitz and Panter-Brick, 2015; Farmer, 2003; Renée C. Fox, 1995; Nguyen, 2010; Ticktin, 2006; M. Ticktin, 2011). The growing interest has produced ethnographic studies on specific international organisations, focused on a specific country or region, and on populations such as displaced populations or those affected by conflict (Abramowitz and Panter-Brick, 2015; T. Allen, 2015; Farmer, 2003; Marriage, 2004; Redfield, 2013). These studies are an exploration of the theoretical paradoxes of the moral imperative to relieve suffering and the 'cognitive dissonance' of humanitarian principles and actions on the ground (Marriage, 2004). Both anthropological studies into humanitarianism, and the sociology of health and illness make clear the importance of the structures on to which humanitarianism is mapped, and the 'histories and sentiments that figure in humanitarian discourses and practices' (Ticktin, 2014, p 282). What quality means in humanitarian settings must recognise and

talk about the inequalities on which the quality discourse is being placed (Adams, 2013; Aloudat and Smith, 2020; Fassin, 2010a; Joseph, 2013).

A corpus of sociologically informed work brings a further critical insight to the quality debate in healthcare. Justin Waring and colleagues praise the dominant quality narrative for its contributions to understandings of quality and safety, the improvements made and technologies implemented such as standardisation, alert systems, checklists and risk and hazard management (Waring et al., 2016). Yet they put forward that the structural approach taken to understanding quality has not gone far enough to account for the influence of cultural, social and institutional factors that impact health care and health care practices. Sociological analysis reveals both sites of power and control in health care, and the asymmetries of knowledge (Nugus et al., 2010), which speaks to power asymmetries in humanitarian settings (Abimbola, 2019; Owen, 2010). Sociological insight allows us to see the 'hidden' work performed. As a technocratic medical model, the dominant quality narrative makes no room to recognise the acts taken by professionals and non-clinical workers that contribute to quality health care. This can be seen in the 'creative nature of care practices' (Turrini, 2011), the everyday 'organising work' of nurses (D. Allen, 2015) and the 'local tailoring and judgement' of non-clinical staff (Swinglehurst et al., 2011). As with anthropology, sociological insight situates the researcher amidst the practices of care. It is here where I situate my research, to contribute to the quality debate that sees quality as an evolving process, mediated by people, materials and the spaces in which care takes place.

Humanitarian settings are unstable spaces of care. The instability is evident in the unstable connections between staff, materials and resources, the patients and the spaces in which the care takes place. Providing health care involves 'persistent tinkering in a world full of complex ambivalence and shifting tensions' (Mol et al., 2010, p 14). This is the logic of care, the 'art of tinkering with unstable bodies in unstable settings' (Tantchou, 2018, 271). The materiality of care is a growing topic in social sciences (Martin et al., 2015). Building on science and technology studies and the work of Bruno Latour and colleagues (Latour, 2005), materiality has gained ground in health and nursing literature (Araujo et al., 2019; Pink et al., 2014; Wilhoit, 2018). In detailing the interaction between people, things and space that mediate quality, my research builds on the critical body of work found in anthropology and sociology and fills the gap in the literature to question the meanings of quality in health care in humanitarian settings.

Humanitarianism can be understood as an ethos, a moral imperative and a form of governance; whose history, evolution and development can be aligned with technical progress, capitalism, geo-politics and religion (Barnett, 2011; Calhoun, 2008; Feldman and Ticktin, 2010; Laqueur, 1989; Reid-Henry, 2014). Humanitarian organisations remain conceptualised in the moral imagination as volunteer organisations, evoking ideas of charity and compassion, motivated by the moral imperative to alleviate suffering (Fassin, 2010b; Redfield, 2013). The quality debate in the sphere of humanitarianism negotiates a challenging frontier between the normative assumptions of the dominant quality apparatus, and the diversity and fragility of the settings it bids to inform. Again, within humanitarian medicine the decisions on quality of care are politicised. Quality in health care becomes the parts of the system 'that are deemed as important enough to be measured and promoted' (Goldenberg, 2012). Nathan

Emmerich and colleagues identify the political function of the quality of care narrative as one that 'can be used to engender the formation of social movements and promote change' but equally one that 'aligns with the socio-political context of contemporary governance, the management of public services and with the specific 'organisational format' of its associated bureaucracy' (Emmerich et al., 2015).

Médecins Sans Frontières holds a unique position as medical humanitarian organisation both in its historical legacy and current position as an international humanitarian organisation. Held as the 'paradigmatic medical humanitarian agency' (Jézéquel, 2015) and the 'conscience of the humanitarian world' (Rieff, 2002, p84), MSF prides itself on a critical and reflective approach to its processes, policies and healthcare provided. Central to the work of MSF is the individual medical humanitarian act, as carried out by MSF staff. To understand how quality is enacted, and the barriers and challenges encountered, requires a study on the people, place and materials; the assemblage of things that mediate quality. In the unequal landscape of the humanitarian setting recognising quality as an evolving process, mediated by people and things is particularly important. This research will add to the debate of quality in humanitarian settings by demonstrating the importance and influence of this approach.

Chapter 2. Methodology

Research design

The fieldwork for this research was carried out across two distinct periods. The first from October 2017 to February 2018 in Agok, South Sudan and the second from June 2018 to September 2018, in Athens and Chios in Greece. The field sites were chosen with guidance from MSF Geneva, with considerations of access, language, risk and safety, and how my presence and participation as a medical practitioner would be facilitated in the field settings. For research purposes the sites were chosen with attention to their diversity: different socioeconomic situation of the country and different field project design. The timing of the research was arranged with the gatekeeper and key contact in Médecins Sans Frontières Geneva headquarters.

To gain access to the field and to ensure full insurance, I was employed as a member of Médecins Sans Frontières. As an experienced nurse, with 3 years supervisory and management experience, and a diploma in tropical nursing I met the essential requirements for a successful application. I attended the pre-departure training in Geneva from the 15th – 22nd May 2017 alongside 20 other potential ‘first missioner’s’. This pathway was facilitated by the predetermined partnership between MSF OCG and Manchester University, specifically the Humanitarian and Conflict Response Institute. This partnership did not unduly influence the research or the research findings.

In addition to the two field sites, I visited the MSF headquarters in Geneva on a number of occasions. This included two visits to spend time in the office, plus the pre-brief and debriefs that occur as part of the procedures of going ‘on mission’. During these times, I

spent time in and around the medical operations offices, and had a number of informal interviews and conversations with staff and attended a number of meetings. These contacts granted me access to internal grey literature such as site reports and evaluations, and personal correspondence as a result of these meetings. The headquarters is a unique field setting in that it is both a site of research and a place to contextualise the themes and data from the field project sites in the wider debate and structure of MSF.

The methodology I applied in this research allows one to both zoom in and zoom out on the field of focus. Long periods of participant observation in the project settings were complemented with formal and informal interviews. Participant observation enabled observations and to later contextualise these in wider structures, to 'build up the sense of a relational logic' within and between sites (Gay y Blasco and Wardle, 2007, p. 64). This chapter will explore my methodological approach and the strengths and challenges it brought to my research.

Ethnography as 'an empirical lantern'

Ethnographic research has provided valuable insight into the contradictions and moral ambiguities of humanitarian practice, and the nuanced and fragile relationships between health, governance, health care and human suffering (Abramowitz and Panter-Brick, 2015; Carruth, 2014; Parkinson and Behrouzan, 2015; Redfield, 2013). In its interpretivist turn, organisational ethnography seeks to both 'depict the liveliness of organisational life' and elucidate both its 'hidden dimensions' and 'actor-context' relations (Yanow et al., 2012, p. 334 - 335). The shift in anthropology towards the study

of organisations was in seen response to Laura Nader's call to "Up the Anthropologist" (Schwartzman, 1993). Nader's work challenged anthropologists to 'study the colonizers, rather than the colonized, the culture of power rather than the culture of the powerless, the culture of affluence rather than the culture of poverty' (Nader, 1972, p. 289). In turning the gaze upward, to 'study up', organisational and employment ethnographies are one response to this call (Schwartzman, 1993). The wealth of research into the distribution of power and the hierarchies of race, gender and class and geopolitics in the organising of workplaces are testament to the value of this shift (Bank Muñoz, 2008; Kondo, 1990; Plankey-Videla, 2012b).

Studying up brings it owns challenges and dilemmas. Being 'elite' or managerial grants the power to 'shield' from researchers, a differential less available to the powerless when researchers are studying 'down' (Plankey-Videla, 2012a). Power and agency can also enable people to control and maintain their image (Ostrander, 1993). In line with the organisational hierarchy, to use Laura Nader's terms it could be said that I was studying up, down and 'sideways' (Hannerz, 1998; Hannerz, 2006). Role, status, experience and knowledge muddy this prescription of positionality and make the stratified labels uncomfortable.

Who am I talking to? Unclear boundaries of consent in ethnography.

Taking into account my shifting roles and presence in the clinical settings brings the process of informed consent to the fore. As is the process when conducting research inside organisations, organisational consent was granted for the project. This was done

at Headquarters level by my gatekeeper in Geneva, at Coordination level and Field level.²¹ Consent was therefore gained from the organization, and from the management team in each project. The management in each field project and head of mission knew about my research and gave full support. An outline of my research had gone ahead of me to each field project, detailing the research and who I was. Once in the field my professional and researcher position was negotiated with the team management. In Agok, the management team were concerned about the reaction from the main staff body. The concern from the medical coordinator was that my research may be seen as another quality 'assessment'. Concurrently with my arrival, the culminative review test (CRT) was taking place in the hospital. This involved a series of observations performed by the bedside training team to observe the application of knowledge and technical skills of the nursing team. A meeting was arranged for me between the senior management and the medical coordinator so I could discuss my research and answer their questions, and together we could decide on the best role. In this meeting it was decided I would join the Bedside Training Team. The medical coordinator who had been on numerous missions in Agok and knew the project well suggested that I present my research to staff as 'collecting ideas about quality' which I took on board and felt was a representative explanation of my research. Rather than presenting the objectives of my research to the wider body of staff once in the field, I gave smaller explanations about my research to the staff as I was working with them, or outside the working hours. I gave a more detailed explanation to those I interviewed and to those that I had informal discussions with in order to gain informed consent, which I obtained in written form or verbally. Greece followed a similar pattern. In Athens my role and expectations

²¹ Coordination is in a main city, often the capital city within the project country. In South Sudan, coordination was in Juba, and Athens in Greece. Field level refers to the project sites.

were discussed with the key management personnel, and I informed and discussed my research with other colleagues. In Chios again I discussed my role with the key management team.

Much has been written about the challenges of informed consent when using 'messy' ethnographic methods (Murphy and Dingwall, 2007; Plows and Moeller, 2018) , and there is an understanding that there is a balance between the 'maintenance and recognition of consent' with the practical necessities of 'blending into the social setting' (Plankey-Videla, 2012a, p 3). In addition, with broad topics such as quality, the focus of the study may shift over time, as does the relationship between the researcher and those in the research field (Adler and Adler, 2002). Returning to the conversation between myself and relevant managers in Agok, to present my research as 'collecting ideas on quality' demonstrates how different groups or individuals may understand the project in different ways. However keeping this broad definition is beneficial as the focus of the research and even its design can change and emerge throughout the research (O'Neill, 2002). It is important that one approaches consent as a sequential process, that lasts throughout the research, and that is relational to the shifting processes and relationships. Confidentiality is one of the researcher's tools used to protect those who become part of the research, but as a researcher one must be aware of the ethical considerations of informed consent. Although to many of my interviewee's confidentiality was not a concern, to keep continuity I identify people in my research by their job role in the project and not by name. Any names used in the body of the study are changed. Dilemmas around informed consent, access and ethnography will be further explored in the body of this chapter, relating specifically to my research methods.

Participant Observation, on being and seeing

My MSF role meant I was a “regular” member of the team’ (Coy, 2001). I took on each of the job roles and had the responsibility of completing my daily tasks and workload. It could be argued that in the ‘true’ sense of participant observation I was a ‘complete member’ of the team (Adler and Adler, 1987). That said, I was an additional member of staff. I did not set out objectives with my line manager at the start of my mission or take over from someone as they finished. I was an ‘extra pair of hands’, so whilst I had my own roles, as will be explained below, my experience was slightly removed due to my position as a researcher and within the team, a member once-removed. Having a dual role, a professional role and researcher role facilitates access to places and people (Sufrin, 2015).

Immersion is assimilated with authenticity, following the notion that in being there and being part of the world being researched, the researcher seeks to provide an ‘authentic’ account (Allen, 2004). In Agok I was part of the bedside training team. The bedside training team is dedicated to staff training, in particular the nurses and nurse aids, but also in facilitating wider training covering the midwives and clinical officers. The team comprises a team leader and three trainers, one national staff, one relocated staff and one international staff, my position as international staff was in addition to the normal structure. The main role of the team is as the title suggests, to provide ‘on the job’ training, supporting the staff on the wards during working hours. In addition, the team provides structured teaching called ‘am’ training, which took place in the mornings led by the team leader. The bedside training team is also responsible for carrying out biannual quality assessments that take place involving all nursing and midwifery staff.

As a bedside trainer I was working alongside and in collaboration with other international staff. My working day was on the wards, primarily the inpatient department (IPD). The four months in this role allowed me to build relationships and good rapport in the ward I worked the most, and in other areas of the hospital and with the wider team. Outside of working hours I lived in the compound with the international staff team.

In Athens, my role changed a number of times. MSF Greece welcomed my coming and utilised it well. A plan had been drawn up prior to my arrival in line with gaps in the team due to staff holidays. My role therefore changed three times, firstly I worked with the management team inputting data from case files into the data base. Following this I worked clinically, firstly as the travel medicine nurse and then as the non-communicable disease (NCD) nurse. In addition, I worked with the psychiatrist with regards to arranging the repeat prescriptions of medications. Each role was for two weeks. Changing my role three times provided both challenges and benefits to my research. The benefits lay in being structurally embedded in the team, as in Agok. As a project that suffered with gaps in roles due to staff shortages, being a gap fill validated my position in the Athens project as being useful. Colleagues were thankful as the inability to fill the gaps I was taking would have led to a significant increase in workload/ pressure on other colleagues, although I did detect a slight concern in my introduction to one of the managers who commented *'oh you are the girl who can do everything'*²². The changing of roles had different effects, in one sense rather than being one where competence and relationships were built through time, this shifting role

²² Fieldnotes 27th June 2018.

prolonged the feeling of temporality as with each new role I was physically positioned in a different space within the DCC, and my connections with and access to different people shifted in accordance with the demands of the role. Some groups I continued to engage with in all roles. For example, the receptionist and the cultural mediators were both primarily located on the ground floor reception area in the morning, where we would greet and chat with each other daily. Due to their roles, both were visible and present throughout the building. The receptionist, who nicknamed me '*Buckingham*' due to my English accent (albeit northern), played a large part in the coordination of activities and people throughout the centre.

In Chios I worked in a nursing role alongside the existing nurse. Due to my time in Athens being pre-prepared by the team, and my agreement with this format, Chios was my shortest placement. Thanks to the variation of my roles in Athens I arrived in Chios with an 'assumed position of knowing' (Pellatt, 2003, p. 31), due to the transferable experience I had gained in Athens and knowledge of the context. This gave me confidence and felt that my input was both valuable and had a positive impact on the project in Chios. In my nursing role, I came with both professional experience and experience specific to the needs of the project. My role included triage and management of patient flow, assisting the doctor and midwife, and conducting travel medicine consultations. Chios was a new project, 'a young motivated medical team without the MSF experience' (Médecins Sans Frontières, 2018m) and the team had only recently moved from being a mobile clinic near to the Vial camp, to a static location 'the garage' 25 minutes' walk away.

As part of my participant observation in clinical areas and other spaces in the setting, informal conversations and discussions were pursued when opportunities were presented. Turning the epistemological eye to the connections between peoples, objects, spaces and materials, participant observation was used to observe how these connections shape quality in practice. Conversations are an important part of participant observation, they can be used to qualify and question what is being observed, and can bring detail and nuance to the social phenomenon being witnessed (Patton, 2015). These chats and discussion took the form of “unstructured, open-ended conversation in everyday life” (Haviland et al., 2014, p. 56). Conversations would lead on from, or in reference to, a particular event or instance. These conversations happened during the medications round, or in the quiet of the night shift in Agok, in the corridors and break room in Athens, and on arrival to ‘the garage’ in Chios before the first patients arrived. In addition to the methods described above I also used interviews. Through interview, the researcher can ‘obtain description of the life world of the interviewee with respect to interpreting the described phenomena’ (Kvale, 1996). Conducting interviews creates a space away from everyday practices where an individual’s experiences and reflections can be explored, and where facts or information can be established.

As put forward by Nigel Rapport, in interviews individuals are prone to ‘detach themselves, to question the value and justification of the roles and practices in which they are implicated, and to envisage themselves with different relationships and preferences’ (Rapport, 2002, p. 153). The interview space allows an individual to reflect, analyse, conjecture and express emotion in relation to past, present and future events. For example, my interviews with staff enabled a wider discussion of the setting and

MSF, as well as exploring personal stories. Qualified as a 'professional conversation' with a 'professional stranger' where knowledge is constructed, and probed (Agar, 1980b), in my field research my interviewees and I were not strangers, although the formality of the engagement brought a sense of unfamiliarity. To minimise distractions and interruptions, interviews were sometimes held in offices or spaces peripheral to the work setting. I felt that this air of covertness added an element of secrecy, which felt uncomfortable, an expression of the tension between my dual role as nurse and researcher. This feeling was emphasised by the awkwardness if we were interrupted during the interview. In Greece it was possible to arranged some interviews in more relaxed settings, for example over an afterwork drink. However, this also was stopped and rearranged as friends of the interviewee arrived serendipitously and the interview postponed.

As an MSF staff member, the progression of my field work increasingly situated my presence as an 'experienced member' of MSF. This however was not a simple trajectory. In Agok I was both a novice researcher and a novice MSF-er. This period of learning has similarities with an apprenticeship, and the term has been used to bring focus to the period in which the novice researcher develops the art of seeing and interpreting (Jones and Smith, 2017), a period of 'intensive enculturation' (Tedlock, 1991, p. 71). In Greece, my position as an outsider in one sense was emphasised due to the small number of other international staff and Greek being the common language amongst staff. This said, my responsibilities in the roles embedded me in the team. In Chios, the small team in and short amount of time I had to build rapport with the team presented different challenges. Jeff Juris and Alex Khasnabish, in their research on social activism see ethnography as 'an attitude and perspective involving an ethic of openness and

flexibility and a willingness to allow oneself to be transformed in the research process' (Juris and Khasnabish, 2014). This sentiment is pertinent to the development and growth of myself as a researcher and an engaged member within the setting being studied.

My position as a staff member was additional to the normal team. Added to my position as a researcher, and the short length of my stay in each setting I remained in a fluctuating position of insider/outsider. Whether one can achieve complete immersion, and whether that is desirable are some of the key questions around participant observation (Gold, 1958; Spradley, 1980). Didier Fassin advocates for a position on the 'threshold of the cave'. This he sees as ideal, negating the effects of being 'in the cave and settle for mimicking its shadows' and being outside but seeing 'nothing of what is getting played out inside' (Fassin, 2010a, p. 42). Brian Moeran (2007) puts forward an argument for shifting positions, from outsider to insider, from participant observation to observant participation. This he argues, is facilitated through access, targeting²³ and immersion, with the shift 'from front stage to back stage', enabling the researcher to 'gain information and knowledge that is otherwise available only to insiders' (Moeran, 2007, p. 2).

²³ Within Moeran's work targeting is used to refer to the process of facilitating introductions to the correct people for the research (Moeran, 2007). At the outset, this is frequently those with power/ authority or decision makers. The term 'gatekeeper' is also used in the literature.

Research strategies in multi-sited ethnography

My research strategies changed across the different sites. I adapted techniques according to the balance between working and research and the links and connections I made as part of the team. In her work on Sudanese diaspora in Germany, Cordula Weissköppel asserts that multi-sited ethnography must be understood not only as different locations, but as the use of a range of research *strategies* (Weissköppel, 2005). In Agok, informal conversations occurred during the day and also outside of working hours. The time spent by the international staff in the common area in the compound, playing cards, chatting, relaxing, provided much opportunity for informal chats. Informal interviews with other staff were more serendipitous, where I might take the opportunity to sit with some colleagues whilst they wait for the next 'movement'²⁴ to take them to the market or walking back from church on a Sunday. One of the best places for informal chats was in the hospital itself, in quieter periods, outside of my own working hours, such as on Sunday, or during the nightshift where I would return to the hospital to both support and chat with colleagues. The project design, being a hospital where staff were working 24/7 created the opportunity for me to find the space to facilitate these conversations.

The working pattern in Greece followed office hours Monday to Friday. There were fewer opportunities to have long informal conversations due to my own working responsibilities and the structure of the setting. The living compound in Agok had provided further opportunities, which was different in Greece as people lived in their

²⁴ The well recognised white Toyota MSF vehicles had a number of 'movements' arranged by the logistics team and drivers throughout the day (Smirl, 2015). Some movements were to take staff to and from the market.

own houses and apartments. In light of this I conducted 12 interviews. These interviews were more formal as they were pre-arranged and recorded, however the interviews remained semi-structured with 'questions emerging from the dialogue between interviewer and interviewee' (Dicocco-Bloom and Crabtree, 2006, p. 315). In Chios, my position and length of time in the project again affected my research strategy. My role was as an additional nurse in clinic. The small staff group were close as they had begun the project together, supporting each other through the trials and tribulations of a new project and new experiences. The team in Chios was under a lot of pressure from the workload and challenges of the project. In addition, as I was only there for one month, it was challenging to build good rapport in such a short time. Adapting my research strategies to the context, I relied on participant observation, with informal chats at opportunities during working hours. This section has demonstrated why participant observation and interviews were chosen as methods for my research and how my changing position in each site impacted my day-to-day practice and experiences and the research strategies I employed as a researcher. The positionality of the researcher, and my influence or contribution to what I was observing in the field will be discussed in detail in the next section.

The multiple identities of researcher-practitioner

Sociological and anthropological framings have moved on from the simplistic 'dichotomous doctrine' of insider versus outsider and the perspective benefits and challenges each brings (Muhammad et al., 2015). The construct of positionality is used to lay focus on the position of the researcher in relation to communities being studied, and their ways of seeing and interpreting the data. Considering positionality highlights the complexity of the relationships of the researcher to the research and to the

population being studied. The experience of multiple identities is common to the participant observer researcher. This 'messy, qualitative experience' (Marcus, 1986, p. 22) invokes many personas, a notably complex constellation when working within the organisation that one is studying. This can attract both positive and negative characteristics to these relationships. The assumption that the researcher can be ontologically separated from that which she is researching has long been contested in social sciences. As a researcher, 'personhood' is an 'essential and ever-present aspect of the research' (Dwyer and Buckle, 2009, p. 55). In her ethnographies of Ghanaian hospitals, Matilda Aberese-Ako encountered both trust and mistrust between her and her research participants. Taking into account the influence of the multiple identities she employed as part of the research process and the reactions to these, the author concluded that personal experience of the research process enhances the understanding of the research (Aberese-Ako, 2017). Lisa Stanley demonstrates how ones 'biographical experience' also frames the data collected and informs theoretical debate on the importance and influence of positionality (Stanley, 1991). Nancy Plankey-Videla (2012a) notes how she emphasised different aspects of her biography depending on whether she was engaging with managers or workers in her ethnography of female workers in a textile factory in Moctezuma, central Mexico. With one group she would emphasise her expertise and scholarly merits, and the other she highlights that she 'underscored my biography and our (assumed) shared experience of motherhood' (Plankey-Videla, 2012a, p 12).

Although I had no prior experience of working in the humanitarian sector, my professional and academic career gave me a good comprehension of medical

humanitarian practice. Whilst I see these factors as part of my responsibility as a researcher, it was clear how my academic expertise in the area of humanitarian studies was beneficial to me as a 'first missionary', particularly in terms of *knowing what to expect* and the period of assimilation to the project, the context of the project and the health needs of the population and the uncomfortable tensions of humanitarian medical practice that brings together very different world views and experiences. Conducting research in an area that is familiar to the researcher reduces the "culture shock" (Holland, 1993), and allows the researcher to begin with a good level of understanding and knowledge of the field (Johnson et al., 2008; Strudwick, 2014). Alongside my field diary I kept a journal where I noted my own thoughts and feelings, to reflect on my own assimilation to the projects. As the days passed, keeping these two aspects separate was challenging, for the extra time this took but primarily as it was not possible to fully separate the two. As a researcher and novice employee for MSF, my own experience of working and living in the field settings could not be separated from my research, these boundaries made even more blurred as in both sites my actions and interactions were contributing and part of the very thing I was researching, the quality of care. This fact is the distinct benefit of this research design, but this meant finding a way to talk about myself in the research. Reflexivity, that is the 'recognition of the researcher's integral part of the social world being studied' allows one to both reflect on and distinguish one's own position in relation to that which is being researched (Pellatt, 2003, p. 28). Reflecting on an early ethnographic encounter at the beginning of my field research in Agok highlighted the importance of my own personal experiences in understanding and processing my observations. I will detail this process below.

Agok hospital, whose paradise?

Each MSF operational center has its own internal magazine published for its staff and members. These magazines include articles and blogs about specific projects, information on other OC's and comment on the current debates and internal discussions of MSF. TAG is the name of Operational Centre Geneva's magazine. To inform my desk-based research on MSF I had gained access to the back copies of the magazine, from April 2004 onwards. In the magazine there was two articles of interest on Agok, written by staff members when they had returned from the field. Written in 2015, Agok had a formidable reputation as a difficult mission; the compound living, 40-degree heat, cold showers and squat latrines; all of which added to the perception of Agok as a 'classic' MSF project. This reputation was built on the legends of logistical challenges of managing velvet soil and exploding concrete. The purpose of the articles was to encourage potential international staff to consider Agok, with tales of movie nights in the compound, and the availability of fresh fruit and Nutella (Remion and Powell, 2015).

The article, entitled 'Agok Paradise – an unforgettable experience (full board and travel included)', describes the setting as 'pure, unadulterated MSF work' (Remion and Powell, 2015). Agok hospital is conceptualised as a 'classic project', 'typical MSF' despite the recognition that the projects characteristics are not common across MSF. Agok is a stand-alone hospital, serving a huge population otherwise bereft of secondary care. The political, social and economic complexity of the region means that MSF functions with minimal input from the Ministry of Health or other government bodies, aside from labour laws that regulate and attach financial measures to the admission of international staff. As I was told, the name 'Agok Paradise' was conceived as an ironic nod to the challenging conditions of the project in its earlier years of development.

These conditions have now changed and during my stay I noticed the term was still used was still used by the international staff, although now with recognition of the comfortable conditions. The individual tukul provided for each staff member, fresh fruit and vegetables every week, international order of 'home treats' including Nutella once a month, and a comfortable common space to chat, watch movies, play cards and relax. Agok Paradise was used in an endearing, if not still slightly ironic manner.

My first two weeks in Agok was my orientation. I worked two to three days in different departments in order to get to know the layout of the hospital, the staff and the functioning and the processes of the hospital. In triage I worked with Jacob a nurse employed on a local contract. Jacob had worked for four years as a nurse in Agok. An experienced and respected member of the team, he would take the position of supervisor on nightshifts when required, a demonstration of his seniority and experience. One afternoon we were chatting about his upcoming leave, the long journey he would take to visit to his family who lived far from Agok, 'and after my leave I will return to Agok Paradise'²⁵. His use of the term took me by surprise. My reaction of surprise was a cause for reflection, and I realized that I had assigned this term to the use of international staff. I asked him why he called it Agok Paradise. He said for lots of reasons, because the services the hospital provided, because he could work, the employment the hospital provided, that the hospital was here and its good supply of medications. The above encounter, early in my research was both informative and enlightening. It demonstrated for me the presence of preconceived ideas and the importance of recognising them in myself, not to negate them, but as concepts to be

²⁵ Fieldnotes. 26th October 2017.

analysed in relation to the wider research considerations. Analysing this encounter, raises themes of space, of discursive agency and status. The international staff conception of 'Agok Paradise' speaks to the idea of humanitarian space as liminal or auxiliary, a space separate to the surrounding environment (Smirl, 2008). In the case of Agok Paradise, a space complimented with 'home foods' and other objects and trinkets that replicate the 'strange semblance of home' with movie nights and material goods (T. Allen, 2015, p 96). This particular instance brought to light the ideas around the social worlds constructed by different groups around objects, and concepts, of spaces and 'imaginaries' (Smirl, 2015) and the importance of reflecting and unpacking my own ideas and assumptions as part of the research process.

Situating the 'I' in ethnography

My staff role, and the immersive living and working conditions of the settings placed me as an actor within the settings I was studying. The research design and methodology dispel any notion of the possibility of me as the researcher being an objective observer. The reality that I was witnessing in the settings did not exist independent of me being there. As an actor in the setting, I built relationships, had clinical responsibility, I cared for and interacted with patients and had a place in the multi-disciplinary team. To negate or exclude the I from my research would not be telling the whole story.

Judith Oakley, in her commitment to ethnographic fieldwork as the emersion of the researcher into the social world being research, argues that autobiographical reflexivity is an essential part of the fieldwork (Oakley, 1996). In 'maintaining the primacy of the self, autoethnography is a methodological approach that posits personal experiences as the source of the empirical data from which to conceptualise social phenomenon'

(Prasad, 2019, p. 4). The intellectual origins of autoethnography can be traced to theories born out of critique to the ontological and epistemological positivist assumptions of social sciences. Increased concerns about representation, identity and the limits of scientific production of knowledge are some of the challenges to the social sciences that foresaw its development (Adams, 2015). Its path has been laid by approaches that incorporate reflexivity and narrative ethnography, nurtured within qualitative sociology and anthropology (Adams et al., 2015; Doloriert and Sambrook, 2012).

The practice of autoethnography confronts tensions between the researcher and that which is being researched. It analyses these tensions as part of the research, to inform the research (Adams, 2015; Mackinlay, 2019). Using personal experience as a source of empirical data it endeavours to “systematically analyse (graphy) personal experience (auto) in order to understand cultural experience (ethnos)” (Ellis et al., 2011a, p. 273). In his fieldwork in Palestine, Ajinesh Prasad uses autoethnography to show the ‘discursive and mutually constitutive’ relationship between himself as the researcher and the people and things that he was researching (Prasad, 2019). Autoethnographic insights have the potential to be able to ‘enrich the story, ethnography or case study and enhance the reflexivity of the methodology’ (Humphreys, 2016, p. 853). As a sole method of research, criticisms highlight the danger of ethnography constituting ‘romantic constructions of the self’ (Atkinson, 1997, p. 343), and researcher self-indulgence that lacks methodological rigor (Collinson and Hockey, 2005; Le Roux, 2016). As has already been ascertained through this chapter’s presentation, my work is not an autoethnography. However, the arguments presented in favour of ethnography,

added to my own biography, provide the importance and justification for including the 'I' within my research.

Recording data

I used a number of methods for recording data depending on the setting. In real time I used a small notebook depending on the context. My own decisions were made to record what I thought was relevant and significant (Agar, 1980a; Anspach and Mizrachi, 2006). In Chios, I had the benefit of being able to pop into the mobile clinic vehicles at opportune moments to record short notes. In all projects, in the evenings I would record additional notes on my laptop and reflect and augment notes that I had taken during the day. My proximity to the field meant that my field notes were taken contemporaneously, allowing for small notes to be written when possible and then built upon in the evening (Emerson, 1995).

The process of writing fieldnotes, the micro analysis of the everyday encounters is a place for reflection and to gain critical distance, to engage in a process to make the familiar strange (Ybema and Kamsteeg, 2009). This constant problematising and ongoing 'reflective conversation' is advocated by scholars as a way to remain at a critical distance (Mulhall et al., 1999). Scholars have highlighted the 'natural alliance' between anthropology and nursing in methodology, conceptual approaches, and identification with the actors (Dougherty and Tripp-Reimer, 1985). I would argue that this extends further to include experience and the ability to reflect in a critical manner that is inherent in nursing practice and professional development. Writing field notes, taking time to reflect, and regular contact with my supervisors and other networks for personal support assisted me to retain the correct balance in this equation. Themes that

arose during my field research were annotated and built upon, and later informed my research analysis. On completion of my fieldwork, my interviews were transcribed in full.

Using an ethnographic approach, being embedded within the settings, positions the researcher to draw analysis from how quality health care is shaped and mediated within the setting. My own biography and developing and shifting positionality gives value to my own experiences as a way to 'illuminate' the field being studied (Ellis et al., 2011b, p. 740). The roles of researcher and nurse are in many ways complimentary, but this did not dilute the necessity to consider and reconsider my positionality within the evolving research process. This unique research opportunity has enabled an in-depth study of the field sites and an original perspective on understanding quality in healthcare in crisis-affected settings.

Chapter 3. Context

Introduction to chapter

The two field sites for this research were chosen to allow for explicit and implicit comparison of what quality healthcare means in resource poor and crisis-affected humanitarian settings. Agok hospital is situated in a disputed area of South Sudan. South Sudan, a low-income country with absent or unstable social structures, has undergone many years of underdevelopment, war and civil unrest. Serving a catchment area of 140,000 people, the MSF project is responding to the essential and emergency needs of a population with no other access to hospital-level care.

In Greece, the field sites were the MSF day care centre in Athens and the MSF primary health clinic near to Vial camp on Chios Island. In these projects, MSF is responding to the significant gaps and barriers to meeting the health needs of the refugee and migrant population. Conceiving the target population as one with complex and evolving needs, the project is designed around a holistic approach to healthcare incorporating a legal, social and medical aspect into the support provided. Drawing on the relevant historical, social and political aspects, this chapter will provide a detailed context to my project sites in Agok, Athens and Chios.

Part 1. Agok Hospital, South Sudan

A brief history of the Abyei Special Administrative Area

Agok is in a region called Abyei Special Administrative Area (ASAA). The demarcation of ASAA stands out on any map of sub-Saharan Africa. The geographical location of ASAA is a significant element in understanding the turbulent history of the area. Coloured

grey due to its contested legislative status the flattop hexagonal shape creates an abrupt breach of the Sudanese/ South Sudanese border.

There is a wide body of scholarship on the violent history of this region and its contemporary relevance. Colonial constructs, intra-tribal tensions and ‘blood memories’,²⁶ Kleptocratic rule, economic dysfunction and oil field ownership are some of the key features of the narratives, intertwined with ethnic, tribal and geographical binaries (Collins, 2008; Copnall, 2013; De Waal, 2015; Deng and Logan, 2019; Johnson, 2016; Nyaba, 2019a; Thomas, 2015; Turse, 2016). This chapter will provide an informative insight into how these historical contours connect with the current situation in the region.

History of the Southern States

A long history of underdevelopment of the southern regions underscores the disparities of Sudan and South Sudan (Johnson, 2016). During the Anglo-Egyptian Condominium period (1899 – 1947), Northern and Southern Sudan were administered with significant difference, with Southern States remaining ‘on the periphery of central government thinking’ (Johnson, 2016, p 10). The policy of the Southern Province’s structurally enforced disparities between northern and southern Sudanese areas, and had a long and lasting impact on the socio-economic development of the area (Johnson, 2016; Nyaba, 2019a).²⁷ The administrative process of independence of Sudan strengthened

²⁶ ‘Blood memories’ is a term used by historian Stephanie Beswick in her work *The legacy of war, ethnicity, and slavery in South Sudan* to indicate the ‘long historical memories of wrongdoing by other Southern peoples over the centuries [that have] tended to dominate particularly among and within the Western Nilotic societies of Southern Sudan’ (Beswick, 2004, p 2)

²⁷ The Anglo-Egyptian Condominium administered Sudan from 1899 - 1947 with Britain holding the dominant position as laid out in the Anglo-Egyptian Treaty of 1899. See also pages 1- 7 of Johnson (2016) detailing the historical structure of North-South relations dating to pre-1820. The administrative approach can be seen in the ‘Southern Policy’ of 1930. See also (Nyaba, 2019b).

and reinforced these inequalities, as demonstrated in the 'Sudanization process' which granted positions of power and authority to those from the northern states and not the south²⁸ (Collins, 2008, p64-65).

The first Sudanese civil war broke out in the shadow of the Sudanese independence in 1956.²⁹ In response to the systematic discrimination against people from the Southern States, southern fighters led the rebellion fighting for more autonomy and regional representation. People of the Abyei Area joined the resistance movement of the South, and fighting spread to the Abyei region in 1965 (Deng, 2010). The atrocities of war in this area saw mass murder of civilians, and conflict between the Ngok Dinka and the Misseriya tribes in the grazing areas (Johnson, 2016, p 5). The First Sudanese Civil War ended in 1972 with the signing of The Addis Ababa Peace Agreement by the SSLM and the Government of Sudan (GOS), bringing a period of relative peace (Shinn, 2004a).³⁰

Addis Ababa Agreement

The Addis Ababa Agreement determined the southern provinces of Bahr el Ghazal, Equatoria and Upper Nile as constituting a self-governing region within Sudan, to be known as the Southern Region. Importantly, it also made a provision for a future referendum for Abyei, which would give residents the vote on whether to be part of the newly formed Southern Region. Until this referendum was held, Abyei was under the

²⁸ In 1953 A Sudanization Commission was created in preparation for decolonisation. Around 800 British and Egyptian posts were 'Sudanized' with all but six junior posts being appointed to northern Sudanese. This led to great discontent and the feeling that with the departure of the British, the southern Sudanese were now colonized by the North. (Collins, 2008, p 64-65).

²⁹ Also known as the Anyanya Rebellion. Anyanya or Anya Nya means snake venom in the Madi Language. Initially a fractious guerrilla movement, the Anya Nya, under the leadership of Lagu created the Southern Sudan Liberation Movement (SSLM) as a political organisation (Shinn, 2004b).

³⁰ David H. Shinn documents continued violence in this period in Juba (1974), Akobo (1975), Wau (1974 and 1976) and the Southern garrisons of Rumbek and Kapoeta in 1976 (Shinn, p 245).

office of the President and granted a special administrative status. This part of the Addis Ababa Agreement was not honoured, and the people of Abyei were denied the right to the referendum. The failure to honour this part of the Peace Agreement is seen as a key factor in the outbreak of the second civil war in 1983 (Deng, 2010; Johnson, 2007).

The prolonged war came to represent a 'network of internal wars' due to increasing complexity and factions (Johnson, 2016, p 127). An estimated two million people died within the 22 years of conflict between 1983 and 2005, and the fighting and civil unrest devastated significant parts of the country. The war ended with the Comprehensive Peace Agreement (CPA) which set out a number of protocols to stabilise the country as a whole, including the opportunity for Southern Sudan to secede with a referendum scheduled for 2011. The Peace Agreement again included special provisions for the Abyei area. The process of agreement between the Government of the Republic of the Sudan and The Sudan People's Liberation Movement/Sudan People's Liberation Army (SPLM/SPLA) began in Machakos, Kenya on the 20th July 2002, with the final signatures penned on the 9th January 2005. In its totality, the CPA was composed of eight protocols, one of which was the Protocol on the resolution of tensions in the in Abyei Area.³¹

The Abyei Protocol

The Abyei Protocol set out a number of important features relating to the administration of the area, with the aim of resolving the numerous tensions. Firstly, it made provisions for how the land area was to be defined. This was put to the Abyei

³¹ The other seven protocols are as follows; Protocol of Machakos (principles of governance and government structures and the right to self-determination for the people of Southern Sudan); Protocol on security arrangements, protocol on wealth sharing, protocol on power sharing and the protocol on the resolution of conflict in southern Kordofan/ Nuba Mountains and the Blue Nile States. See <https://unmis.unmissions.org/comprehensive-peace-agreement>

Boundaries Commission (ABC), who were tasked with defining and demarcating the borders of the AASA according to the 9 Ngok chiefdoms as per the year 1905.³²

Secondly it defined who the residents of Abyei were, identifying the Ngok Dinka and other Sudanese residing in the area, notably omitting nomadic tribes from residency status. Thirdly, it protected the rights of the Misseriya and other nomadic tribes to move through the territory of Abyei and graze cattle. In addition, the protocol established Abyei as having administrative status. This was to be administered by a locally elected executive council and set out how oil revenue was to be shared between the area, the SPLM and the Government of Sudan. Vitrally, it also established the Abyei Referendum Commission which would conduct a referendum in Abyei to decide if the region would be aligned with the North or the South.

The ABC report brought disagreement from all parties involved, partly caused by misrepresentation of the findings by the government delegation to the Misseriya tribe, and the relation of the boundaries to the oil fields in the area.³³ The main resistance was from the Government of Sudan who claimed the ABC experts had exceeded their mandate and therefore refused to implement the recommendation of the report. The SPLM's reaction to this was to suspend its participation in the Government of National Unity³⁴ in October 2007, 'leaving an administrative and political vacuum' (International

³² The ABC was comprised of 5 delegates of the Sudan government, 5 delegates of the SPLM and 5 international experts. The international experts were chosen by the UK, USA and the Intergovernmental Authority on Development (IGAD), based on their knowledge 'in history, geography and other relevant expertise' (The Abyei Protocol, 2005). The 'experts' conducted interviews on the ground and looked at historical charts, maps and documents held in a number of archives. See (Johnson, 2007; Johnson, 2008). Douglas Johnson was one of the experts selected for the Abyei Borders Commission.

³³ Although depleting, South Sudan is viewed as oil rich. In 2003, oil from the Abyei region produced an estimated 25% of Sudan's total oil production (Widge, 2015). Other sources suggest that 60% of the oil produced outside the South comes from Abyei (Johnson, 2008)

³⁴ The cabinet ministers for the Government of National Unity (GNU) sworn in by Sudanese President Omar al Bashir in September 2005. The GNU/GONU was a power sharing initiative signalling a step forward in the Peace agreement. John Garang, the SPLM/A chairman was to be the first-vice president of

Crisis Group, 2007, p 1). Reports demonstrate that both sides, the Sudanese Armed Forces and SPLM, increased military presence in the Abyei area in response to this tension. In May 2008, heavy fighting broke out in Abyei town, forcing 60,000 civilians to evacuate and causing devastation to the town (Human Rights Watch, 2008).

As set out by the CPA, the 2011 secession referendum took place and Southern Sudan voted for independence, however the Abyei referendum was suspended indefinitely. The African Union High-level Impact Panel proposed for a referendum for Abyei in 2013 but this also didn't take place. Human Rights Watch reports that intermittent clashes between armed forces of the North and South took place from January following the referendum. In July 2011, just weeks before the formal separation of South Sudan, further looting and destruction of property occurred in Abyei, in the shadow of massive human rights violations committed in Darfur by Sudanese forces (Human Rights Watch, 2011).

Independence of South Sudan

The moment of South Sudanese independence, on the 9th of July 2011 is reported as a point of celebration and hope for the South Sudanese, accompanied with 'unprecedented, even hysteric, euphoria' (Nyaba, 2019a, p 14). However, the independence celebrations were short lived and within two years the new country had entered a state of civil war. Successive peace agreements have been signed between

Sudan but died in a helicopter crash on the 30th of July. Therefore, the first Vice-President representing the SPLM and Southern Sudan was Salva Kiir, and Second Vice-President Ali Osman Mohammed Taha from the government National Congress Party. (The New Humanitarian, 2005)

President Salva Kiir and Riek Macher in 2014, 2015 and 2016 but all successively broke down, bringing associated violence and conflict.

In 2017, the UNHCR stated that the South Sudanese crisis has become ‘the largest and most complex emergency in Africa’ (United Nations High Commissioner for Refugees, 2017, p 3). An estimated 1.9 million people were internally displaced during the period and an estimated 2.5million fled the country (United Nations Office for the Coordination of Humanitarian Affairs, 2018). The movements of people is seen as one of the factors leading to the longest epidemic of cholera over this period, a disease endemic in the country due to the paucity of hygiene and sanitation systems and lack of safe drinking water (Burki, 2018). The five year war brought ‘unprecedented levels of food insecurity’, increased violation of human rights, increased mortality and morbidity, and an estimated 7 million people in need of humanitarian assistance (United Nations Office for the Coordination of Humanitarian Affairs, 2017). A further peace deal was signed in September 2018, signalling an end to the five-year war.

South Sudan is ranked as 3rd on the fragile states index (Fund for Peace, 2019). In 2019, an estimated 2.47 million South Sudanese were documented as refugees in other countries, with a further 200,000 people living in POC (Protection of Civilians) sites in South Sudan (Human Rights Watch, 2019). World Bank figures estimate that 66% of the 13, 293,122 population is under 30 years of age,³⁵ with a medium age of 18.³⁶ The

³⁵ Full data available at: <https://databank.worldbank.org/source/world-development-indicators/preview/on> Figures for South Sudan are predicted based figures from 2008.

³⁶ United Nations, Department of Economic and Social Affairs, Population division. World Population Prospects: The 2017 Revision. The U.N. medium-fertility variant is used for forecasted years. See <https://population.un.org/wpp/>

literacy rate among the population is very poor. The most recent data available is from 2008, which put female literacy at 19.9% and male literacy 34.84%.³⁷ Health service provision across South Sudan is severely insufficient. Globally, the country has some of the worst health indicators. Global Health Observatory figures estimate the maternal mortality rate at 4500 maternal deaths in 2017. The under-five mortality rate, that is the number of children who will die before they reach five years old is estimated at 96 per 1000 live births. (World Health Organisation, 2019). These figures evidence the country as one of the most dangerous in the world to deliver a baby or to be a child under 5 years old. The large majority of public health infrastructures have been destroyed or are dilapidated. OCHA estimates that 1 in 5 health structures are functional, with added reports of outdated or absent essential surgical or medical equipment and weak human resources and management. Of the health delivery services that exist, eighty percent are provided by NGOs (United Nations Office for the Coordination of Humanitarian Affairs, 2018). These figures are estimates for South Sudan as a whole, though data surveillance and collection is flawed and incomplete, with 'no data' frequently indicated for the area of ASAA.

Agok hospital, Abyei Special Administrative Area

MSF initially had a project in Abyei in 2006, set up in response to the rising health needs of the population due to political instability. The 2008/9 violent clashes in Abyei led to the complete destruction of Abyei town, and the reported displacement of 50,000 to 80,000 people to Agok. As a response to this, MSF moved its operations 40km south of

³⁷ UNESCO Institute of Statistics. Being from 2008, these statistics are prior to South Sudanese Independence, however there is no further explanation for their configuration. See <http://uis.unesco.org/en/country/ss>

Abyei and set up the hospital in Agok initially as an emergency response. Mobile clinics remained in Abyei until 2010, but then were suspended due to safety and security reasons in July 2010 (Médecins Sans Frontières, 2011). The Agok hospital is the only secondary health care facility for an estimated 140,000 people, with a catchment area covering the ASAA south of Abyei town and extending into areas formally known as Warrup State and Unity State.

To the West of the hospital is the town of Agok and the large Agok market, approximately 30 mins walk on foot. Juljok is to the East, characterised by a junction of kiosks. The kiosks sell a range of items from biscuits to cigarettes to candles and soap, plus other services and businesses such as phone charging via a small solar panel. A number of tea shops and shisha bars host small groups of people on plastic chairs sipping hibiscus tea. Past a small market area people sit with fires selling bags of roasted nuts, and the road ends at a large dusty football pitch. The cluster of buildings seen around the football pitch include a primary health care centre, first operated by GOAL an Irish NGO, then later Save the Children. There is a Catholic church, which in 2018 during my stay was gradually being reconstructed with bricks and corrugated iron. The river is part of a network of waterways which flow into the Bahr el-Arab and Bahr el-Ghazal rivers, making the Abyei area an essential area for cattle grazing, even in dry season.

The majority of the population of Agok and the wider Abyei region are part of the Ngok Dinka tribe. The Dinka tribe, the largest South Sudanese ethnic group³⁸ are pastoral people who are 'distinguished by their passionate attachment to, and identification with cattle, which are inextricably linked to all aspects of social, religious and political life (Deng, 1972; Impey, 2013, p 199). The pastures in the Abyei area are used by both the Ngok Dinka and the Misseriya Baggara Arabs on a seasonal rotation, with the Misseriya travelling into the area from the North during dry season. The crossing of the border by the Misseriya has historically resulted in disputes and episodes of cattle raiding.³⁹ There have been community led improvements but migration movements remain a 'destabilising factor' for peace in the region (Médecins Sans Frontières, 2018i).

The hospital project is entirely run by MSF. Good relationships are required and upheld between MSF and local authorities. My first few days in Agok coincided with the last few days of the outgoing field coordinator. The Chief Administrator of Abyei had organised a celebration in Agok town in which MSF and specifically the field coordinator was celebrated and thanked, and the incoming field coordinator welcomed. As well as providing healthcare to the population of Agok and surrounding areas, MSF is the biggest employer in the area. In December 2017, the number of national staff totalled 380 with a mixture of fixed term, short term and open-ended contracts. The HR manager informed me that every recruitment opportunity received a very large number of applications, and from my own experience meeting people outside of the hospital

³⁸ The Dinka and Nuer are from the same ethnic group of Nilotic people. Dinka is used to relate to broad ethnic group with a number of languages and dialects. According to Southall (Southall, 1976) in their native tongue, 'Jieng', and 'Naath', dinka and nuer respectively both mean 'people.'

³⁹ See Johnson (2008) 'Why Abyei matters. The breaking point of Sudan's Comprehensive Peace Agreement', for a discussion of the migration and relationships between the Misseriya and the Ngok Dinka prior to 1972. See also Deng (2010) who attributes the roots of the tensions to British colonial administrative processes in the area in the early 1900's.

setting, once formal greetings had been made, many people would ask me about how they can get work at the hospital. The draw of healthcare provision and employment has brought more people to live in the vicinity of the hospital.

Other health actors

In Agok, the instability of other actors has an effect on the community and the services of MSF. The primary healthcare centre in Juljok was previously run by GOAL, an Irish NGO. In April 2014, MSF handed over the OPD services from the hospital to GOAL. In early 2017 GOAL abruptly lost their funding for all six PHCC's in the region, including Juljok, leaving a significant gap in services for the population. As a response MSF conducted an 'emergency intervention', taking over the PHCC in Juljok (Médecins Sans Frontières, 2018g). In the 9 weeks that MSF intervened 16,433 OPD consultations were conducted in the PHCC and the mobile outreach screened 4,722 children under 5 years old and 1,095 lactating women (Médecins Sans Frontières, 2018a).

Fragility in services results in an increased workload in the hospital. In March 2017 following the withdrawal of GOAL an increase of admissions in all departments was noted at the MSF hospital, including 40% increase in admitted maternity patients, with 'notable late presentation of patients adding complexity for the treatment' (Médecins Sans Frontières, 2017b, p. 3). Save the Children (SCF) is also active in South Sudan. In 2016, SCF lost their funding and withdrew from the region.⁴⁰ Following MSF's mobilisation to identify a potential partner and appropriate funding to take over the

⁴⁰ At this time Save the Children had been supporting the United Nations World Food program as an implementing partner for the Food For Asset (FFA) program. (Médecins Sans Frontières, 2016a)

services, a period of funding was secured and in April 2017 and MSF handed over Juljok PHCC to SCF, with the objective of taking on all the former activities of GOAL.

Whilst I was in Agok there was a renewed attempt to hand over anti-natal care (ANC) and PMTCT (prevention of mother to child transmission) to SCF in Juljok. Trainings were being held where the midwives spent time in Agok hospital, with support from the lead midwife supervisor. Unfortunately, SCF continued to face multiple challenges, in staffing and resources and significant support from MSF was continuing. Continued challenges led to increased ANC presentations at the hospitals, and increased maternity and neonatal admissions (Médecins Sans Frontières, 2018i). This irregularity in the services of other actors leads to mistrust in by the population, resulting in underuse and subsequent overuse of more trusted services (LaVeist et al., 2009).

The patient journey, Agok hospital

Agok hospital was described to me as a 'mushroom project' due to the expansion of the project over the years. In 2010 the hospital had an inpatient department with 20 beds, including maternity care, an Inpatient Therapeutic Feeding Centre (ITFC) and services for tuberculosis (TB). At this time, there were 10 international staff and 145 national staff. In 2011, following the cessation of the mobile clinics, MSF was providing both primary and secondary health care in Agok, including surgical capacity for emergency obstetrics. Jumping forward to 2014, the hospital capacity had grown to providing medical and surgical emergency care, basic emergency obstetric and newborn care (BEmOC), chronic care, including TB, HIV, diabetes, and treatment for snake bites and neglected tropical diseases. 2015 saw the addition of the community malaria project.

Over four hundred and twenty full time employees work in the hospital including human resources administrative staff, cleaners, cooks, clinical officers, nurse aids and health promoters. For the staff working the daytime shift, the working day is from 8am to 6pm. Clinical staff arrive in the morning through the front gate, the women often in colourful dresses and the men in pristinely ironed shirts and trousers and shined shoes. Handshaking is both a friendly and formal greeting, indicated by different patterns in the rhythm of the greeting, and the sounds of hands slapping together and greetings in Arabic, Dinka and English are exchanged 'chu bak', 'sabah el kheir' 'good morning'.⁴¹

Patients arriving to the hospital come first to triage, through an entrance from the roadside on the north side of the compound. The triage building, a stand-alone rectangular building is cool and shady inside. The materials used to build it are mixed. Corrugated iron sheeting provides the roof, in line with other hospital buildings. A concrete and brick room in the north westerly corner of the room houses the chest fridges to store the vaccines, with a metal door keep them secure. The other walls are made of thinly slatted bamboo fencing rolls, with occasional shadow netting and white tarpaulin to keep out the elements. Inside, there are number of long wooden benches, parallel with the eastern wall. This is the waiting area for triage. In front of the benches there is a line of work tops and tables with triage paraphernalia; thermometers, MUAC bands⁴² and tabletop, bucket and standing weighing scales, indicating the high risk of

⁴¹ Alternating right hand slapping at handshake position with slapping the left-hand side of one's own chest whilst exchanging hellos and good wishes was a joyous and dynamic friendly greeting. One that totally flummoxed me resulting in much laughter when it was initiated with me.

⁴² MUAC, the acronym for mid upper arm circumference is used for quick screening and rapid nutritional assessments. Laid flat, the strip of plastic has measurements along its length which are divided into three colours, green, orange and red. The band is placed around the mid upper arm to measure the circumference which gives an indication of the presence and severity of malnutrition. As a humanitarian device, the MUAC band mediates the concept and practice of humanitarian aid, rendering 'previous decisions invisible and controversies inaccessible' (Glasman, 2020, p.92). See Joël Glasman (Glasman,

malnutrition for the population attending the hospital. Each time an under 5-year-old is screened for malnutrition a dot is marked in a file, to be counted, logged and reported as an indicator for monitoring and screening of malnutrition (Abrams et al., 2020; Maphosa et al., 2020).

Following triage, the patient is called to the Emergency Room (ER), where they are seen by a clinical officer. The ER is a square building, flanked by the longer concrete buildings of the Inpatient Department (IPD) and the ITFC. There is a door on each side of the ER, the through route making an invisible division that cuts the room in half. One half of the room is dominated by a large wooden table, with long wooden benches at each side and additional scattered plastic chairs. One or two Clinical Officers (CO) work from here, seeing patients who are called through from triage. The table is covered with files, books and admissions paper. Other people around the table include an administrator who writes down the details of each person seen and a translator. There is a large sink in one corner of the room and to the other side an area where the nursing assistant performs and monitors rapid tests to check for malaria, blood glucose levels and haemoglobin levels. In the other half of the room four trolley beds jut out perpendicular to the wall. This is where patients are examined, and where clinical examinations are performed. The space is small and can get easily crowded in an emergency. Initial investigations are taken as required, vital signs, blood tests and emergency medication such as antibiotics, malaria treatment or fluids. If the patient is to be admitted they move from ER to the appropriate ward.

2020, pp. 92-121) for a critical historical inquiry into the development of the MUAC band and the results of its industrialisation.

From ER, the rest of the hospital is accessed by following raised concrete paths, in place throughout the hospital grounds as defence against the mud in rainy season. For the majority of my stay it was dry season, the dust that blew into the wards was everywhere including on the top of the vials of medication on the shelves and the other equipment. Wards were 'deep cleaned' on a roster over the weekend, with the TB ward cleaned every weekend. Each ward is an individual building, meaning that the dust and mud, of the outside world are very much a part of the hospital grounds. Patients and carers move in and out of the wards, and off and on each other's beds, bringing food and water to those who are unable to walk to the kitchen, or bringing and snacks from the kiosks outside the hospital ground.

Each patient is accompanied by a 'caretaker'. In the absence of a close relative, the caretaker can be a friend or member of the extended family. The presence of a caretaker or 'guardian' is common throughout Sub-Saharan Africa primarily due to lack of human resources in the health care sector (Hoffman et al., 2012; Söderbäck and Christensson, 2008). Caretakers are present with both child and adult patients and play a large role in the care of the patients and therefore in the provision of care in the hospital. Although it was uncommon, as her only relative, a 10-year child was a caretaker for his older female relative throughout her stay in the hospital. Caretakers assist with and support what are termed basic care needs, washing, toileting, feeding, assistance with mobilisation. These duties also extend to washing the clothes and going to the kitchen to collect the meals at lunchtime. Frequently caretakers for one patient also assist with other patients, for example looking after children while the mother leaves to perform other duties and assisting with duties that require more than one caretaker. Literature on the role and impact of caretakers is limited (Beer et al., 2012; Nwosu et al., 2020),

particularly on the relationship between caregivers and health professionals (Hoffman et al., 2012). Existing research has highlighted points of tension between the hospital and the caretakers, demonstrating a lack of trust from poor communication between staff and caretaker, and tensions due to lack of knowledge on part of the caretaker on how to perform care, thus adding to the work load of the nursing staff due to tasks being performed incorrectly (Hoffman et al., 2012). The responsibilities of care placed on caretakers raises further concern when one considers the impact of literacy, knowledge and education on the safety and management of the patient and patient advocacy (Nwosu et al., 2020), and the financial, mental and physical burden placed upon them by this responsibility (Akpan-Idiok and Anarado, 2014; Muliira and Kizza, 2019; O'Neil et al., 2018). In Agok, long stays in hospital with the patient means neglecting other family members and other responsibilities at home, often a long distance away. The deputy head nurse explained the role of the caretaker as 'the set-up of the hospital and also the nature of the people here'. The division of tasks between those performed by nursing staff and those performed by caretakers was more 'blurred', compounded by a high workload for a minimum number of staff.⁴³

Patients are provided with a thick dark woollen blanket, which is collected from the locked cupboard by the nursing staff when they are informed of an expected admission. A small plastic bucket with a lid and a plastic potty is under each bed and a low plastic table sits between each two at the head end. A string, resembling a washing line, tracks the head and foot end of each bed from a height, often running down the length of the ward. In the ITFC a plastic chair accompanies many of the bed spaces to improve the

⁴³Interview, Deputy Head Nurse, 23rd January 2018.

position for carer and child during enteral or breast feeding. The number of beds in each ward varies. The bed occupancy rate (BOR) is calculated with the number of total hospital beds as 148. The available number of beds is 205, which are all used in peak seasons (Médecins Sans Frontières, 2018a) . The largest number of beds are in IPD, with its peak in malaria season, the smallest number are in the Critical Monitoring Unit (CMU). CMU is an eight-bedded ward where the sickest patients in the hospital are looked after. The nurse-to-patient ratio is the highest here – two nurses to eight patients in addition to two nursing assistants, the same ratio as for the whole of IPD.

In most wards, two lines of beds run down opposing walls facing each other. The beds are old metal frames, with a white plastic covered mattress. IPD and surgery both have tents in addition to concrete buildings, as does the tuberculosis ward. The tents get incredibly hot in the 40-degree heat and shadow nets are constructed over the top of them in an attempt to cool the temperatures inside. As well as the heat, the geographical location of Agok continues to cause distinct challenges for building and waste management. The soil is alluvial across this region, as it is the historic flood plain of the Nile and its tributaries. Known as 'black cotton soil' this soil has the properties of high swelling in rainy season, and shrinkage in dry season, due to the presence of the mineral montmorillonite. This shifting causes instability for constructions, often seen as cracks in the buildings (Khalid, 2014; Srikanth Reddy et al., 2018).

To give an indication of numbers and presentations in the hospital, in 2017, Agok hospital had 9,806 admissions with the peak in August and lowest in May. The most common presentations over the year were severe malaria (66%), lower respiratory tract infection (9.3%), snakebite (6.1%), acute watery diarrhoea (5.4%) and anaemia

(2.5%). The overall mortality rate was 3.2%, with a mortality rate of 3.5% in children under 5 and a neonatal mortality rate of 8.5%. The global bed occupancy rate for the hospital for 2017 was 104.6% (Médecins Sans Frontières, 2018a). In the same year, the inpatient therapeutic feeding centre received 1,051 admissions, the second highest number in the hospital's history (Médecins Sans Frontières, 2017a). The common presentations are seasonal. Malaria hits its peak in the middle of the rainy season, due to the conditions required to support the life cycle of the plasmodium vivax. Following the rainy season, the dry arid temperatures and dusty habitats choke the air and decrease the fertility of the land, exacerbating respiratory conditions and food insecurity.

Part 2: Greece. The day care centre, Athens and 'the garage', Chios

The contemporary situation for refugee and migrants in Greece

In 2015, 856,723 people were recorded as taking the Eastern Mediterranean route from Turkey to Greece to seek asylum within or beyond Greece (UNHCR, 2016). The majority of the population in this period came from three countries, Syria, Afghanistan and Iraq. For Europe, this was seen as an 'unprecedented population movement', since the Second World War (Kakalou et al., 2018, p. 421). The political response in March 2016 was the EU-Turkey deal, seen as a 'historic blow' to human rights.⁴⁴ This deal legislated for "irregular" migrants crossing to Greece to be returned to Turkey, and a commitment from Turkey to act to reduce and restrict sea and land crossings and close the Balkan

⁴⁴ The EU Turkey deal has come under severe criticism, particularly for the "one-to-one initiative". According to this initiative, Turkey will receive returned "irregular" Syrian migrants, stipulated in the EU-Turkey Statement as those "not in need of international protection" and "irregular migrants intercepted in Turkish waters" (European Council, 2016). For each person "returned, one Syrian in Turkey will be resettled in the EU. The deal stipulates that the UN Vulnerability criteria will be taken into account in this selection, whilst also saying that "priority will be given to migrants who have not previously entered or tried to enter the EU irregularly", i.e. *good* migrants. This forced population exchange has to be considered against the numerous reports that demonstrate Turkey is not a safe country (Amnesty International, 2016).

migration route. UNHCR figures of people arriving by sea in 2016 and 2017 were 173,450 and 29,700 respectively showing a significant decrease (UNHCR, 2016; UNHCR, 2017). By 2018, order blockades and other deterrence policies and politics resulted in an estimated 62,000 people being trapped in Greece due to geographical restrictions imposed on their movement (Bjertrup et al., 2018), a number which has since increased.

Approaches to refugees and migration in Europe exists amidst the tension of progressively restrictive legislation, and the defence of human rights in the framework of 'European moral geographies' (Cabot, 2014)⁴⁵. The increasing need for humanitarian intervention in middle- and higher-income countries is disturbingly becoming a permanent global picture. The refusal or rejection by states of their responsibilities to provide care and support demonstrates the failure of European countries and European policy in meeting the basic needs and respecting human rights (Turner, 2015). The so-called 'crisis' of the influx of refugees to Europe, and the vilification of these populations (Chouliaraki and Stolic, 2017) must be brought into question when compared with the high number of refugees present in other countries, for example Lebanon (Abbas et al., 2018). Shifting the focus, many believe that rather than a crisis of refugees, the situation should be read as 'a European " right-to-asylum crisis, " a crisis of its fundamental principles, namely, the protection of asylum seekers' rights and the accompanying principle of non-refoulement' (Sciruba, 2017, p. 141).

⁴⁵ As highlighted in the work of Heath Cabot (2014), the Greek context brings a unique framework when considering the response of European states to the increase in movement of refugees and migrants. He notes that in contrast to many other European sovereign states, Greece does not have a colonial history that links it with the migration routes of those now seeking safety. Its marginal position, on the frontier of West and East, Islam and Christianity, have seen its lands and shores being occupied.

The stark and brutal examples of the unwillingness and obstructive behaviour of European countries to see equity in human lives are numerous; it is shown in the obstruction and abandonment of people trying to make perilous sea crossings⁴⁶, the accusations and legislation used to prevent people and groups wishing to assist⁴⁷, and in the actions of countries that violate human rights (Albahari, 2016; Camilli and Paynter, 2021; Jumbert, 2018). Restrictive policies and the inability of the systems in place to meet essential requirements for the refugee and migrant population results in an exacerbation of needs, and significant deterioration of people's health and well-being (Hermans et al., 2017; Orcutt et al., 2020).

Managing populations, The 'hotspot' approach

The Hotspot System was laid out in the European Agenda on Migration in April 2015 as a temporary measure, whereby the EU assists member states with registering of people arriving to the islands.⁴⁸ Chios Island is a 'hotspot', along with Lesbos, Samos, Kos and Leros. In reality, the Hotspot System enforces forms of containment through 'obstructing, decelerating and troubling' the movement and mobility of migrants and refugees (Tazzioli, 2018). The functioning of the hotspots is to identify, sort and 'manage' the refugee and migrant population (Scheel and Ratfisch, 2014; Spathopoulou et al., 2020). The Reception and Identification Centres (RIC) mandated by the European Agenda on Migration identifies, takes fingerprints and registers arrivals. In doing so,

⁴⁶ 17,000 asylum seekers and migrants are known to have died crossing the central Mediterranean (North Africa to Europe) since 2013, with estimates of many more deaths going unrecorded due to absence and disruption to search and rescue efforts (Camilli and Paynter, 2021).

⁴⁷ NGO's and individuals have been accused of colluding with smugglers. In Greece this has led to arrests of individuals (Robinson, 2016; Strickland, 2018).

⁴⁸ European Commission, Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions: A European Agenda on Migration, COM(2015) 240 final, Brussels, 13 May 2015.

people are sorted into those eligible and ineligible for asylum. The process at the reception centres is intended to address 'initial reception needs', 'identify vulnerabilities'⁴⁹ and undertake security checks (FRA. European Union Agency for Fundamental Rights, 2019). Research demonstrates the inadequacy and neglect of vulnerability screenings resulting in under-identification and long waits (Danish Refugee Council, 2017). Hotspots effect detention⁵⁰, even when the camps are classed as 'open' such as Vial camp in Chios, and are a mechanism of deportation (Spathopoulou et al., 2020). The hotspot system is part of the mechanisms and processes of migration control that identifies and sorts people into legally defined categories (Sciurba, 2017). These categories are imbued with different degrees of 'deservingness' that carry with them rights to movement and access (Kasperek, 2016; Papoutsi et al., 2019; Spathopoulou et al., 2020; Tazzioli and Garelli, 2020).

Significant delays in the asylum process leads to long stays on the islands. There is inconsistency in provisions, information and assistance from the services at the camp. Overcrowding in the camps and inadequate shelters, increases the risk of violence, and sexual and gender based violence specifically (FRA. European Union Agency for Fundamental Rights, 2019). These concomitant issues amongst others affect people's

⁴⁹ Vulnerability is a medicalised condition. *Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of applicants for international protection* vulnerable persons are cited as minors, single parents with minors, pregnant women and victims of rape, torture or other forms of sexual, physical, psychological harm, including human trafficking and female gender mutilation (Kofman, 2019). Article 20. Similarly, Article 14(8) of Law 4375/2016 in Greece defines vulnerable people as 'Unaccompanied minors; persons who have a disability or suffering from an incurable or serious illness; the elderly; women in pregnancy or having recently given birth; single parents with minor children; victims of torture, rape or other serious forms of psychological, physical or sexual violence or exploitation; persons with a post-traumatic disorder, in particularly survivors and relatives of victims of shipwrecks; victims of trafficking in human beings'

⁵⁰ Geographical restrictions are applied to people registered in the 'hot spots. By law, people are not able to leave until the asylum process is complete, unless they receive vulnerability status or are pursuing family reunification under the Dublin Regulations No. 604/2013. This was the process at the time when I was in Greece in 2017/2018.

physical and mental wellbeing, both exacerbating existing health conditions and creating new ailments (Ben Farhat et al., 2018; Bjertrup et al., 2018). The direct link between environmental factors and health is evident in the high incidence of respiratory disease, back ache from poor sleeping conditions, lice and insect bites, and the high unmet need for mental health support, all in part attributable to the long processes, restriction of movement and living conditions in the camps (Hermans et al., 2017).

Strategies of visibility and invisibility are employed by refugees, asylum seekers and migrants as methods of safety and survival⁵¹ (Antonopoulos and Winterdyk, 2006). A number of undocumented people circumnavigate the system, those who have never been registered and those who did not leave after failed asylum applications. Legally trapped within Greece, living in official and unofficial camps, squats and apartments and on the streets, the living conditions endured by the refugee, asylum seeker and migrant population are 'unacceptable' (Médecins Sans Frontières, 2018). Although the MSF project in Greece was set up for 'people on the move' the reality is that many people are unable to move on from Greece, resulting in a long waiting game and increased mental and social suffering (Ben Farhat et al., 2018; Bjertrup et al., 2021).

⁵¹ What I must emphasise at this point is that despite the imposing mechanisms and processes of the apparatus of migration control and other legal constraints, the refugee and migrant population are not without individual agency. Although the scope of this thesis does not allow for a detailed analysis of this point, I wish to highlight studies that have demonstrated people's ability to demonstrate a considerable degree of individual agency (Greene, 2020; Schöpke-Gonzalez et al., 2020; Twigt, 2018; Zaman, 2020).

The Greek healthcare system and its responsibility to the healthcare of refugees and migrants

“if you’re going to the national health service in Greece, as we say, you’d better not be sick...”

Field coordinator. Athens.

The Ethniko Systema Ygeias (ESY), the Greek National Health Service was established in the 1980’s. The portrayal of the ESY as inefficient (Spanou, 2008; Tountas et al., 2005) is supported by its fragmented development, a pattern attributed to ‘party political competition, political favour and corruption’ (Bolton et al., 2019, p 263). In March 2017, The Panhellenic Medical Association in March 2017 projected that the Greek national health service was on the brink of collapse (Mijatović, 2018). The system continues to suffer the effects of austerity measures which have had demonstrable effects on the health of the population and on the allocation of resources to meet the increasing health needs (Greek Ombudsman Independent Authority, 2017; Kondilis et al., 2013; McKee et al., 2012). These measures include a 20% cut in treatment, diagnosis and disease prevention programmes, a 73% cut in maternal and child health services and 25,000 job losses (Mijatović, 2018; Simou and Koutsogeorgou, 2014). Research continues to highlight structural inadequacies and poor management in the ESY, taking into account the prominence of ‘under the counter payments’ and associated corruption and falsification of accounts (Liaropoulos, 2012; McKee et al., 2012). The two tiered (parallel) private and public system, an ill-functioning primary health care system and poor electronic medical systems leading to repetitions of tests and prescriptions are some of the key problems plaguing the stability of the system (De Paoli, 2018; Kotsiou et al., 2018; Moris and Kousoulis, 2017).

Primary health care is not a widely functional system in Greece (Tountas et al., 2002). Despite reforms being introduced recently under the then current government of Alexis Tsipras, the implementation of primary health care has stagnated and according to one of the doctors practicing at the clinic, is resisted by the main body of the medical profession (Simou and Koutsogeorgou, 2014). GPs' are very few, fewer than 3% of the doctors and are 'not highly esteemed amongst the health professionals' (Oikonomou and Mariolis, 2010, p 456). Without a functioning primary healthcare system, acting as a gateway to secondary care, people have direct access to specialists by using a telephone booking system. The process of getting an appointment to see a doctor was explained to me by one of the staff in the DCC. To get an appointment with a doctor or specialist, one must ring the telephone booking system and make an appointment by requesting the speciality required. On attending the appointment, the specialist may request examinations, for example blood tests or an x-ray. If so, the doctor gives the patient an electronic prescription to get the test done in a state hospital. The person must then ring again the telephone booking system to make an appointment to get the tests done. The electronic prescription is only valid for one month, if the person cannot get an appointment within one month then they must again make an appointment with the doctor (through the telephone booking system) to get a renewal of the prescription. With no primary healthcare system, patients have direct access to secondary care, and doctors to micro-level autonomy (Bolton et al., 2019).

Despite the weakness of the Greek healthcare system, the state assumed primary responsibility for the healthcare and needs of the refugee and asylum-seeking population, resulting in the downsizing and ultimately withdrawal of many actors and NGOs. The Hellenic Centre for Disease Control and Prevention (KEELPNO) took prime

responsibility. A report written by the World Health Organisation in June 2018 gave a glowing report on the activities of KEELPNO, writing specifically of a visit to Eleionas Camp⁵², but speaking more generally of the primary health care system in Greece since the implementation of the Primary Health Care Reform Plan in August 2017. As stated in the report;

‘60 000 migrants and refugees currently living in Greece.. [have].. access to primary health care (PHC) services, coordinated for migrants and Greek citizens alike by the Ministry of Health. This approach means that migrants can access medical support, as well as cultural mediation to ensure that services are appropriate. They are also guided in navigating the health system so that they can, for example, receive the medication they need to manage chronic conditions. Greece has invested in PHC, despite experiencing a severe financial crisis’ (WHO: 2018).

This statement, along with the tone and general assumptions made by the report are distinctly different, are in fact contradicted by the situation I witnessed and as is reported by NGOs and advocacy groups. In February 2018, the Observatory of the Refugee and Migration Crisis in the Aegean published an open letter submitted by a group of NGOs about the conditions in Vial camp on Chios Island, and the response of the European commission. The letter of complaint⁵³, reported the ‘atrocious’ accommodation conditions, ‘inadequate’ food provision, ‘alarming’ delays in the asylum

⁵² Eleionas camp is situated in an industrial area in the western suburbs of Athens. Despite being in Athens the location of the camp was a barrier for access to education and work, as children in the camp found it difficult to get to school and no transport was provided. It was the first official temporary accommodation for asylum seekers to open in Athens in 2015. Containers are provided for accommodation with shared toilets and showers. The population at the camp is mainly from Afghanistan and Syria. Figures from 2020 suggest there are 2,000 people in the camp (FEANTSA, 2020).

⁵³ <http://www.statewatch.org/news/2018/feb/chios-ngo-open-letter-to-com-6-11-17.pdf> (Accessed 12 March 2019)

procedure, and lack of medical care. The letter, written in November 2017 cites that there are only two doctors present for the whole camp population, and between 5-9pm only one nurse. These concerns were further confirmed by the Commissioner for Human Rights for the Council of Europe, Dunja Mijatović following a visit to Greece in June 2018. The report highlighted that despite legislation on universal health care, 'the public health sector which has been severely affected by successive austerity measures, is under extreme pressure and lacks the capacity to cover all the needs for health care services, be it of the local population or of migrants' (Mijatović, 2018, p 8). Whilst commending the good will of the Greek people, she deplored the failures of the system to provide the legally entitled rights of the applicants to international protection and highlighted the barriers to healthcare exacerbated by the living conditions. The barriers highlighted in this report were evident in my field research and support the view that the National Healthcare System in Greece is 'overwhelmed, dysfunctional, underfunded and pushed to the limit' (Médecins Sans Frontières, 2018h).

There are significant barriers to accessing healthcare in the complicated Greek health system, making patient's rights 'not obvious'⁵⁴. Whilst on paper the refugee and migrant population have access to the Greek health care system regardless of legal status, in practice this is not the case (Gunst et al., 2019; Kotsiou et al., 2018; Kousoulis et al., 2016). Clear information is not provided on how to access healthcare, compounded further by the scarcity of essential staff including translators and doctors in the healthcare system and RICs (Joseph et al., 2018). To access health and social care requires a social security number. The challenges to obtaining the social security

⁵⁴ Interview. Patient-centred lawyer. Athens, Greece. 3rd August 2018

number are a clear demonstration of the multiple barriers in the system. Social security provision, is provided to persons with a Social Security number, known as an AMKA number (Αριθμός Μητρώου Κοινωνικής Ασφάλισης) which a person can receive from a Citizens' Service Centre (KEP). In a direct omission of information, refugees and asylum seekers are routinely not given the information about the importance of this or how obtain an AMKA number (Gunst et al., 2019; Kotsiou et al., 2018; Kousoulis et al., 2016). The systematic obstruction by KEP staff was highlighted in a joint report of 25 organisations including MSF for cases of violation of asylum seekers' rights published by Solidarity Now (2017). This report evidenced the obstructions by the employees of the KEP in the systematic violation of the existing legislation, through denying people their AMKA numbers despite applicants meeting the legal requirements.

In Chios, the MSF team took action to assist people to obtain their AMKA number. Pieces of paper were handed out with the information written on to present to the KEP staff, including the office address of MSF. The request on the paper was written in Greek to address any language barriers, with a space for the office staff to document the number. The deliberate obstruction to health care access has been made more explicit recently with a change in Government. Since July 2019 the right to access an AMKA number for non-Greek nationals has been withdrawn, meaning that those who did not already have an AMKA number are now unable to access free health and social care, apart from emergency care (Devi, 2020; Orcutt et al., 2020).

Médecins Sans Frontières in Greece

The objective of the projects in Greece is to provide improved health care for vulnerable refugees and migrants through specialised health care, travel medicine and targeted

advocacy. Specialised care is provided in sexual and reproductive health, mental health services, and non-communicable disease management. The medical staff are qualified in the Greek health system and highly skilled in their role. Many of the staff had previous experience of working for other organisations supporting refugees and migrants, in mobile clinics in the camps, or in the hotels that were taken over as accommodation prior to the camps being built. Nationally employed staff fill the management positions in the field projects, with minimal international staff positions. In the Day Care Centre, the Project Medical Referent (PMR) was an international role, and an unfilled vacancy existed for the Sexual and Reproductive Health Activity Manager and the Mental Health Activity Manager. In Chios, the PMR was again an international contract, this had been vacant for some time but was filled in the last week of my stay. The disputed necessity for international staff was raised by the HR manager on my initial briefing in Athens, who stated that the projects ‘run themselves’⁵⁵, therefore not necessitating international staff for supervisory roles due to the Greek staff being very well skilled. This was echoed by the Head of Mission (HOM), who added that the advantage of having some international staff in the field is for the ‘diversity’ and ‘wider experience’ that they can bring to the project.⁵⁶ The supporting staff group is multi-national. The cultural mediators and health promotion team originate from many different countries including Iran, Morocco, Egypt, Libya, Algeria and Afghanistan, some of whom originally came to Greece as refugees. Due to the very strict laws surrounding tax, MSF Greece employed a separate team to manage local contracts, an indication of the complicated and changing nature of employment regulations and taxes.

⁵⁵ Fieldnote. 26th May 2018.

⁵⁶ Field notes. 26th May 2018.

These services are supported by a social services component which links with services outside of the project, educational health promotion activities and a legal component which provides legal support and counselling of selected cases. Travel medicine, a new avenue for MSF, was being piloted in Greece. The objective of travel medicine is to provide advice, treatment and information to people intending to move including materials to promote continuity of care both during the journey and once they have arrived in their country of destination. The definition of travel medicine by MSF is given as follows. 'Travel medicine is meant to help healthy travellers avoid illness and to provide support and resources to travellers with pre-existing morbidities. It is about empowering the traveller to look after his/her own health thanks to adequate knowledge (health promotion, patient education), pertinent information (available resources before, during, and after travel) and medical means (therapeutics, vaccines)' (Balinska, 2019).

The materials given during the sessions include an MSF health card (detailing medical conditions, medications, investigations) a World Health Organisation yellow book (recognised immunisation record) and 3 months' supply of their regular medications. For people with immediate plans to leave, copies of any formal letters of investigations and results are given along with advice on keeping the documents safe. To aid with communication, a sheet with pictures is provided so that the person using it can point to a picture of what they need; food items, a bed, a telephone. A hygiene kit is provided including some basic items, and a 'children's mental health kit' for children which includes some colouring pens and sheets to colour, and some finger puppets.

Travel medicine is the main arm of the innovative elements of the Greek projects. When speaking to the HOM on my arrival to Greece, he likened these innovations to previous campaigns and changes within MSF. He made the association with MSF's decision to provide care and treatment to people with HIV/AIDS, which in the beginning was met with opposition as long-term treatment was not in the remit of MSF as an emergency medical humanitarian organisation (Fox, 2014). These debates, around the direction and development of MSF as a movement are a pertinent feature of MSF discussions. The HOM saw the Greek project as a new direction for MSF, that of '*protection*' and stressed that MSF couldn't answer all the needs of this identified group, the aim is '*not to be bigger*' but to '*push the button*' for '*global change*'⁵⁷. As a pilot project, travel medicine and the wider project design of the Greece project suggest a new way to practice humanitarian aid. The connections with the patient groups and services, the responsive programming as seen in the health promotion team, and the direct involvement with legal and social issues speak to a different kind of approach.

The Day Care Centre. Athens, Greece

The Day Care Centre (DCC) is on a busy small one-way street in central Athens. The bordering districts are Neopoli (New City), known for its expensive restaurants, cafés bars and nightlife and Exarchia (Anarchist), an area typically known for its radical left-wing politics and activism. The position of the centre makes it easily accessible by public transport with a bus stop directly opposite and a metro station within 10 minutes' walk. From March 2016 MSF provided SRH and mental health services through mobile clinics in some of the camps in Athens, along with vaccination campaigns. In

⁵⁷ Fieldnotes. 26th June 2018.

September 2016, the DCC opened providing SRH and mental health services. After recognising the gap in health care services for non-communicable diseases (Redditt et al., 2015; Yun et al., 2012) MSF services in DCC extended to include an NCD clinic. The specific objectives of the project are to provide specialist care to the population, and secondly targeting advocacy to improve access to healthcare. The social work services based in the centre assists people with information and access to other medical and non-medical services. A patient-centred lawyer is employed to help navigate the legal-medical position of the refugee and asylum-seeking population. The health promotion team give teaching on wider subjects both within and outside of the centre. The cultural mediators employed assist the interactions with the DCC and escort patients to other health care providers when needed.

In the 'magical building...where every different corner is being used for something else'⁵⁸, services and support are divided across the four floors of the DCC. The wide staircase dominates the right-hand section of the building on entering from the street, reaching down into the basement and turning up to the third floor. On the ground floor, the front of the building is the reception area, with a waiting room and a second room where each new attendance is seen by a social worker to identify their needs. At the back of the building are a number of rooms used by the midwives and gynaecologist. On the first floor, to the left at the front of the building there is a small waiting room, for those with non-communicable diseases who are waiting to see the doctor or nurse. There is a bench on one side and an orange sofa on the other. A filtered water dispenser with plastic cups is available for patients and staff. In the corridor hot water and tea

⁵⁸ Fieldnotes 12th August 2018.

bags are provided with large paper cups, and a tray of fruit, apples and bananas are available for the patients to take as they wish. Two closed white doors lead to the NCD consultation rooms and the cultural mediator's office. The NCD service sees patients with a diagnosis of Hypertension, type I and type II diabetes, COPD and asthma, hypothyroidism, cardiovascular disease and epilepsy. The service is focused on management over diagnosis. Patients suspected of having a non-communicable disease that falls within the remit of the service must have proof of diagnosis, or if not must attend a different polyclinic which provides diagnostic services. People requiring diagnosis are directed to the Médecins Du Monde (MDM) polyclinic in Athens.

Two more consultation rooms at the back of the building on the third floor are occupied by one of the three psychologists and the travel medicine nurse. The third and fourth floor move away from the clinical centrality of the floors below. The third has an open space office at the front, where the sexual and reproductive health supervisor, the health promotor supervisor and the logistics manager have desks. A further section of this space is partitioned to create a space for the health promotion team to meet. Again, at the back of the building are consultation rooms for the psychiatrist and the psychologist team. From the third floor, a different small set of stairs goes up to the fourth floor where the field coordinator and the HR department have their offices and there is an access door out on to the flat roof and hot Athenian air.

The ground floor is the busiest. The doorway is crowded with empty pushchairs and prams, which are too big to accompany their normal occupiers. 'Beneficiaries' as is the term used in the project, and the friends, children or relatives that have accompanied them sit on the stairway due to lack of space in the waiting room. The receptionist is

continually circled all morning by beneficiaries and by the cultural mediators who await their next assigned consultation depending on the native language required. The sounds of the children playing, of games and videos from people's smart phones, and the general chatter echo up the stairwell and through the building. The working areas are quieter the higher you are, the third floor feels quite removed from both the clinical component and the hustle and bustle that accompanies it.

The highest number of consultations are performed by SRH. Of the 160 new registrants to the service in May 2018, the majority were women from Syria seeking SRH support and the midwifery team had 715 appointments across the month. In the same month, the non-communicable diseases department had 155 consultations, 10 of which were first consultation. For the mental health team, which consists of three psychologists and one psychiatrist who works one day per week, the total number of consultations was 121, with 108 appointments where the patient did not attend (Médecins Sans Frontières, 2018j). Additional barriers including transport problems and ineffective or miscommunication can influence non-attendance of appointments (Farley et al., 2014; Robertshaw et al., 2017). To try and counteract this, an additional service was set up whereby the CM team would contact patients prior to their appointment via telephone as a reminder service.

The functions of the centre are not confined to the walls of the DCC building. The Health Promotion Team (HP) performs outreach to the communities in the area. This team of seven is led by the Health promotion supervisor. They give health promotion sessions, distribute health related materials such as mosquito nets, and also give information on the services provided at DCC thereby improving access. Many of the team on the HP and

cultural mediator team are from the refugee population and have formed good relationships with the communities.

The Garage. Chios, Greece

The MSF project in Chios follows the same model as that of Athens, but with a much smaller team. One midwife, one doctor, one nurse and one psychologist completed the medical team, supported by one health promotor, five cultural mediators, one social services staff and support from a lawyer. The primary health care doctor in Chios saw all primary health presentations, adults and children, whereas in Athens, the NCD clinic saw only adult patients with specific previously diagnosed conditions. The most common presentations to the primary health care doctor in Chios were respiratory and urinary infections, chronic conditions, muscular skeletal pains and skin conditions, in line with wider common findings of primary health care needs of the refugee population in Greece (Hermans et al., 2017). The medical and support staff travelled from the MSF office in Chios town to the clinic each morning. A typical day will be described below.

In the MSF office in Chios town the working day starts at eight in the morning. The staff all meet at the office in Chios town for a short meeting with the field coordinator to highlight any issues for the day; *'today the midwife will leave the garage from 2pm to go to the woman's centre'*, *'today the midwife will not be at the garage but will be visiting people within their apartments'*, *'today the doctor must leave the garage at 1pm to visit a disabled man in his apartment'*; and to discuss any ongoing issues. The continued delay in receiving the point of care haemoglobin machine was frequently mentioned, which had been on order for '2months', *'we are still waiting the green light'*.⁵⁹ After the

⁵⁹ Fieldnotes. Chios. 9th September 2018.

meeting 'πάμε!⁶⁰' and the team collect the three lidded plastic storage boxes of medications, the two cold boxes containing vaccinations, the red emergency bag and head out through the door and down the stairs to the roadside and the two white 7-seater minivans. The team in the vehicles consists of two or three cultural mediators, one health promotor, the cleaner, one midwife, one doctor, and two nurses (including myself).

The drive to the garage takes around 15 minutes, first going along the sea front of the town of Chios before taking a left turn inland. Chios is the fifth largest of the Greek Islands, most famous for its mastic (plant resin) trade, a unique produce of its Southern region. Chios town is on the east coast. Looking across the Chios Strait from the harbour you can see the Cesme Peninsula of Turkey with the naked eye. The clinic is situated outside of Chios town on the road towards Vial camp, a further 10-minute drive. The building was previously used as a mechanics garage. The characteristic floor to ceiling red metal sliding doors are on the front and side of the building. Both doors are left open throughout the day, unless its windy when they are closed slightly to prevent the dust whipping in from the outside. The space inside is open, aside from a small glass fronted office space to one side. The mechanics 'pit' has been filled in and the floor painted white. This is now the waiting area. Six two-seater sofas made from wood pallets, painted white, with blue and grey cushioning are spaciouly arranged around a white plastic table. A large standing fan and a water cooler stand in two corners of the waiting space in front of the windows of the empty office. A row of plug sockets along this wall are accessible for people to charge their phones. On the windows above the

⁶⁰ Pronounced páme meaning let's go!

plugs is a poster with the WIFI password 'msfchmsfch'. Some patients remain in the waiting area after being seen, often sitting on the benches to the side of the space, to continue to use the WIFI. Connectivity and other digital practices enabled by free WIFI enables 'agentive actions of those subjected to power' (Greene, 2020, 735). It is a lifeline for refugee and asylum seekers to access information and connect with others (Vernon et al., 2016).

Three mobile clinic vans provide the consulting rooms. They are parked inside the garage on the perimeters of the waiting area. Two are the size and shape of an ambulance, with the entrance at the rear of the vehicle leading into a small room, with a full-length examination couch along the left side, and a desk at the back. The doctor and the midwife each use one of these vans. The third vehicle has two rooms, one consultation room accessed from the rear door used by the psychologist, and one from the side of the vehicle used by the nurse and health promotor. Long white benches sit adjacent to the length of the vans, on the periphery of the waiting area. These are used to seat the next patients to see the doctor, or by those who have finished their appointment and are awaiting the ride back to the camp.

After opening the garage and bringing in the equipment, one minivan with one cultural mediator continues to Vial camp, collecting first the large gazebo and a number of plastic chairs from the store cupboard. The gazebo is set up at Vial camp. The daily station set up is not inside vial camp, but rather adjacent to the perimeter fence. The people staying at the camp have also exceeded this perimeter fence. Large 'Rubb Hall' type tents, and a number of containers are situating opposite the pick-up point, and

flimsy tents and makeshift shelters take all available space along the road as you leave the site.

One cultural mediator stays at the camp for the day assisting people with information and assisting the driver in directing which patients are to be taken to the clinic in the van and which can walk. Patients with pre-made appointments have a slip of paper, the colour identifying the service with whom they have an appointment. Pink for SRH, blue for the doctor, green for the psychologist, yellow for travel medicine. Patients who have difficulty walking can also get a lift, elderly patients, disabled patients, pregnant ladies, families with children. As expressed by the cultural mediators it is difficult for all people to manage the 25-minute walk along the road in the heat.

Patients do not need an appointment to attend the MSF clinic in Chios. People start to arrive from 9am and gather in the waiting room on the wooden, cushioned, benches.

There was no formal triage, each patient would be spoken to as they arrived by myself or the other nurse with the assistance of the cultural mediators. A number system was being trialled and a slip of paper would be given to each patient as they arrived with a number and time. There were regularities to the attendance of people to the clinic.

Follow up appointments for chronic disease management, blood pressure checks, vaccination appointments and antenatal appointments would bring the same people back. Faces became familiar. Coughs and colds, and unresolved back pains would bring others back. Patients who attended the MSF clinic frequently spoke of the dire conditions in which they were living in. As reported by MSF, the conditions are 'at least unacceptable... with lack of shelter, bad food, rats and mosquitoes, difficult access to the

doctor of RIS⁶¹ or to get appointment for specialised doctors, violence and difficult access to the toilets (especially morning hours for women), scabies... lack of facilities for washing dishes, clothes etc' (Médecins Sans Frontières, 2018k). Vial camp in Chios is overcrowded. Officially the capacity is 1,274. In July 2018, the number of people staying there was 2,060 (Médecins Sans Frontières, 2018k). The shelters in the camp vary from metal containers, large Rubb Hall tents, to small camping tents and other makeshift shelters. Chronic ailments are exacerbated by the living conditions in the camp. Common stories of pregnant women sleeping on the floor in flimsy tents, overcrowding, poor sanitation, poor food and nutrition brought repeated cases of back pain, body aches, stomachache, respiratory problems, insect bites and lice to the primary care doctor (Fotakis et al., 2020).

This chapter has set out to achieve a number of things. Primarily it provides an in-depth and informed contextual foundation for my research sites. Drawing on the political history of South Sudan and the Abyei region has demonstrated the importance of MSF in the region. The systematic underdevelopment of the region is reflected in the health and well-being of the population who are threatened by food insecurity, diarrhoeal disease and the seasonal push and pull of malaria and malnutrition on a backdrop of neglected tropical disease. Financially independent, MSF has been a stalwart in the Abyei region as other NGOs collapse or are pulled out due to changes in funding priority. This builds a good reputation with the population, whilst simultaneously emphasising the mistrust held with other providers whose medications and continuity is less stable.

⁶¹ Reception and identification service.

In Greece, the political and legal framing of the population has dictated that the project has gone beyond medical health care to include social care and legal advice. MSF has adapted the project in response to the restrictions and challenges that the host country impinges on the refugee and asylum-seeking population. In doing so MSF has in new ways maintained the ethos of the individual medical humanitarian act as central in the 'case by case' approach dictated by an obstructive state system. As will be explored in the following chapters, a 'holistic one stop shop' is the intended framework for the day care centre in response to the complex needs of the population.

In addition, this chapter has provided insight into the clinical settings of each project site. Detailing the spaces inhabited by the patients, the clinical actors and the artefacts within them, constructs the care assemblage in and around these clinical spaces.

Patients and staff, greeting, sitting, waiting and moving. The dust and the heat and the noises, caretakers, blankets and prams. Drawing the reader into the settings through these descriptions illustrates the analysis throughout this study to bring to life examples of the everyday realities of the project sites and those within them.

Chapter 4. Teamwork in humanitarian settings

Introduction

The division of labour and the associated mobility of staff within 'spaces of aid' is a central axis of critique of humanitarianism (Carpi, 2019; Farah, 2020; Owen, 2010; Pascucci, 2018; Roth, 2012; Smirl, 2015). In recognising this, this chapter as the first of my empirical chapters will explore the staff structure and question the ways it mediates and translates quality of care in humanitarian settings. National and international staff are a dominant construct in understanding the operation and organisation of teams in humanitarian settings (Ager and Iacovou, 2014). In response to this, this chapter draws on the organisation of staff to understand how the role of teamwork and team cohesion influences clinical practice. Good teamwork and good communication play an essential role in providing quality care (Ballangrud et al., 2017; Firth-Cozens, 2001; Rafferty et al., 2001). Previous research has established a relationship between the well-being of staff and patient outcomes (Aiken et al., 2012; Kirk and Edgley, 2021; Wang et al., 2019). Building on this, this chapter puts argues that understanding staff cohesion and teamwork is a vital component in the pursuit and achievement of quality care.

In the clinical setting of Agok hospital, quality care is mediated by the unstable connections between staff, management, patients and materials. Drawing on these connections this chapter will reveal the tensions and challenges within them, and the barriers posed to the pursuit of quality care. In Greece, the MSF projects take on the role of primary health clinics and work alongside and in collaboration with other services. Carving a place in the messy assemblage of other healthcare services, MSF has formed a novel approach utilising the concept of holistic care. Illuminating the bonds and connections facilitated by staff in the pursuit of holistic care, this chapter juxtaposes this

approach to patient-centred care with the high incidence of ‘burn-out’ encountered by the staff in the project. The contrast of the project settings provides a unique opportunity to draw out and contest the meanings of quality in health care in humanitarian settings.

South Sudan. Diagnostic categories of humanitarian management

In their discussion of *l’humanitaire imparfait*, Mariella Pandolfi and Alice Corbet reference the work of Agamben (1998) to highlight the ‘diagnostic categories of humanitarian management’, which they take to mean the labels used to highlight the blunt categorisation of peoples and their eligibility/access to humanitarian assistance (Pandolfi and Corbet, 2011). This categorisation can be turned inversely to the humanitarian staff structure. From an organisational perspective, three groups can be identified in Agok, international or ‘expat’ staff, local staff and relocated or ‘reloc’ staff. The labels attached to these groups are used both formally and informally, in common parlance and in formal reports. They are diagnostic in that the different groups are delimited by implicit and explicit boundaries influenced by living arrangements, access and security measures and professional status. To understand the implications of these labels and to give insight into the organisation of the medical teams, this chapter will first detail the organisational structure in Agok.

The organisation of the medical teams in Agok hospital are as follows. The field coordinator has overall responsibility and leadership of the project; medical, logistical and administrative. Following the chain of command in the medical stream, the medical team leader (MTL) has the next position of responsibility over medical activities. The medical activity manager (MAM) is the line manager for the medical team comprised of

one anaesthetist, two surgeons, two medical doctors, a paediatrician, a TB and HIV doctor, and 17 clinical officers (CO). The role of the clinical officers deserves attention here.

COs clerk patients, see, treat, diagnose, prescribe medications and discharge patients, they are 'like doctors, but with less initial training'⁶². They work across all departments in the hospital. CO training is a three-year diploma level course, which on completion awards a Diploma in Clinical Medicine and Public Health. The development of the clinical officer role is a clear example of task shifting, both in South Sudan and globally. The WHO defines task shifting as a process whereby "specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resources for health"(World Health Organisation, 2008, p 2). It has been promulgated as an answer to the devastating shortages of doctors and other highly skilled medical staff in developing countries, and a means to build a sustainable health system, achieved by a reliance on non-physician clinicians (NCPs) which include CO's (Callaghan et al., 2010; Mullan and Frehywot, 2007). Task shifting has led to NCPs taking on many skills including echocardiography screening for rheumatic heart disease (Sims Sanyahumbi et al., 2017), emergency obstetric and neonatal care (Nyamtema et al., 2016) and the management of non-communicable diseases (Labhardt et al., 2010). The role is problematic. The focus on a strengthening health systems approach that supports NCP's as cheaper alternatives denies higher skilled educational and training opportunities. Whilst being thought of 'like doctors', CO are not paid as doctors, nor

⁶² Explanation given to me on initial briefing on arrival to Agok. Fieldnotes. 12th October 2017.

enjoy the same employment mobility. The qualification as clinical officer is often not transferable. The curriculum at the National Health Training Institute (NHTI) in Maridi, South Sudan, is specific to South Sudan. A survey of graduates showed that the high retention of graduates (99%) in South Sudan was due to the 'low international tradability' of the qualification (Ngatia and Kimotho, 2010, p 42). In a system of 'task multiplication' (Pfeiffer and Chapman, 2015), the limitations of health workers and the resultant quality of patient experience risks being neglected (Dlamini-Simelane and Moyer, 2017). In Agok, the majority of the clinical officers are employed as relocated staff from outside the local area. Some of the COs had been working in Agok for five years. In the year leading to my arrival in Agok in October 2017, four clinical officers had been employed on local contracts. It is within MSF's long-term vision to reduce the number of relocated and international staff roles to be replaced with local staff to facilitate sustainability and an eventual handover of the project.

Returning to the organisational structure in Agok, the midwife activity manager has responsibility for the midwifery department including neonates and the respective nursing teams. Activity Managers⁶³ are accountable for the resources allocated, including staff, equipment and the budget, and they provide strategic input with regards to their area of the project amongst a plethora of other responsibilities. Supervisors are responsible for a component of the overall activities. In being responsible for the direct management of the team the work of the supervisors is more 'hands on', in contrast to the management responsibilities of the activity manager. The neonatal supervisor and

⁶³ Medical Activity Manager, Nursing Activity Manager and Maternity Activity Manager are examples of activity managers.

the midwife supervisor⁶⁴ are responsible for supervising the clinical activities of their nursing and midwifery teams, for ensuring MSF protocols, values and universal hygiene standards are followed and for staff planning including the staff roster.

The Head Nurse is directly supported by the Deputy Head Nurse. The current Deputy Head Nurse had worked for MSF in Agok and region for 10 years. The Head Nurse has the management responsibility for seven department supervisors who in turn supervise the nursing and support staff of each department: emergency room triage, clinical monitoring unit (CMU), inpatient department (IPD) and isolation, inpatient therapeutic feeding centre (ITFC), TB HIV and chronic care, operative theatre and the laundry, hygiene and sterilisation. The protracted trauma and instability in the area and wider South Sudan has affected the societal structures required for consistency in education and training of the population. When the hospital project was first set up there were very few qualified staff in the local area. Since 2014, relocated staff, as the name implies, have been relocated from within South Sudan. The purpose is to ameliorate the skill mix, knowledge and experience of the medical and nursing staff. This situation is changing. Stability in the area has meant that some schools have reopened giving people the opportunity to achieve their certificates in skilled professions. In response to this, some contracts of relocated staff are not being renewed, and the positions are opened as local vacancies.⁶⁵

⁶⁴ The neonatal supervisor, maternity supervisor, training nurse supervisor are international contract positions. Ward supervision position are local contract positions.

⁶⁵ These changes are for a number of reasons. They must be seen as a reflection of how projects shift and change to local circumstance and also budgetary requirements. People were concerned about the impact on the quality of care in losing staff who had 3/4/5 years' experience. The operative theatre ward supervisor was on a relocated contract and had worked in the project for a number of years. His contract was not renewed, and the position was taken on under a local contract. Equally, a number of the clinical officers' contracts were not being renewed and filled on local contracts. Budgetary concerns are a feature of these changes. All projects had to 'flat line' their projected budget costs for the following year. Relocated staff are more expensive to employ in part due to additional entitlements that the contract

The staff group delineations are replicated spatially, both in the layout of the site and in the functioning and processes of the hospital. This is most obvious in the living arrangements. International staff and relocated staff both live within the hospital compound in two separate areas. Until 2016, the international staff and relocated staff lived together in the same living compound space. In an internal site report from 2016, the effort put into the opening of the new compound is celebrated as a measure to improve security for those relocated staff who had been living outside the compound due to lack of space (Médecines Sans Frontières, 2016). The result of this separation were separate living areas for the relocated and international staff. This next section will detail the two living areas.

A bamboo and wire fence runs the parameter of the 'ex-pat compound'. On entering the gate at the north east corner, the 'living tukul' is straight ahead. Tukul is the name for the houses common in this area of South Sudan. Typically, large circular constructions made from wood and earth to form the walls, with a dried grass thatched roof. The living tukul is not a tukul as such, but a larger metal framed building with a congregated iron roof and a mixture of shadow nets and various materials for the walls. It is an open building with entrances on three corners of the building and the main arch facing into the compound, making it a through-road as well as a stopping place. A mix of cushioned sofas, chairs and benches encircle two low coffee tables down the length of one side of the room. Three fridges stand alongside each other on the opposite wall, filled with personal food items, bottles of water, coke, sprite and Tusker lager. Remnants of times and people past can be seen on the walls of the building, a faded 'merry Christmas'

allows. The international position of Health Promotion Manager was terminated and filled by a local contract HP supervisor role.

banner, dreamcatchers, penned messages, and shelves filled with well-thumbed fiction and MSF guidelines. The living tukul is one of the places that people would gather together, play cards and listen to music. A staff meeting was held there weekly, followed by pizzas that would be served and eaten in the living tukul. All of the international staff group were rarely together in the living tukul, some through personal preference, others distracted by the high number of smokers that congregated in this area, others because they worked long and late all day, every day. People socialised in a number of locations on the compound; outside a particular person's tukul, the dining tukul, the hammock, the relocated compound and the teashop outside the compound were some of the popular areas. Groupings changed place and members as the group dynamics shifted with people beginning and ending their missions. Social groupings were formed and reformed around numerous factors, ties of native language, start date of mission, age, gender, personal relationships, experience or position in the mission.

There are 31 individual tukuls in the international staff compound, three double tukuls and three large double canvas tents. In the living compound this design has been adapted. The huts are smaller, square and made from bricks with a concrete floor. The tents remained empty and were used only on a temporary basis for visitors or when the tukul roof were being rethatched. Walking along the concrete path from the living tukul to the dining tukul, rows of tukuls stretch out on the right like little streets. The individual tukuls have a double bed, an electric fan, a square plastic table, plastic chair and a wardrobe. There are open windows on three of the four walls with mesh covering to keep out the mosquitos. Blinds made from white plastic sheeting can be rolled up to entice a breeze to circulate the hot air inside, or down during the rains. Three times a week the rooms are cleaned, and items of clothing are taken to be washed and can be

collected from the laundry room the next day. The 'dining tukul' is again not a tukul but a long structure which houses the laundry, the dining area and the kitchen. Fresh food is flown in from Juba every week bringing fresh fruit and vegetables, cheese and meat and the dry food order arrives once a month, which includes items such as Nutella, honey and Pringles crisps. The cooks prepare breakfast, lunch and dinner every day, aside from occasional BBQ nights and pizza nights when it is prepared by some of the staff.

The relocated compound is accessed through the international staff compound to the southern side of the project site, or through a separate gate on the east side past the water tower and towards the rub halls. The living quarters include 6 two-person brick tukuls, adjoined to the first compound, and the rest are large green canvas tents. The tents are on raised concrete bases, with a raised concrete path going down each row to protect against the water and mud during rainy season. Each tent is shared by two people, a single bed against opposing walls with a wardrobe, table, fan and chair. There is one long building that houses the kitchen, dining and living area space, perpendicular to the rows of tents. Hung on the wall at one end of the building is a large projector screen connected to a TV that frequently plays soap operas by day and football in the evenings. For relaxing and dining there is a long table with plastic chairs and a number of sofas in the area closest to the screen. The kitchen is at the opposing end, through an open doorway, with an adjoining covered foyer area where the kitchen staff also cook on open fires, and BBQ's stacked with goat are lit and monitored, all cleared for music and dancing on alternate Saturday nights.

The '*luxuries*'⁶⁶ of expat living was a raised point of contention with some of the senior experienced members of the international team, who made casual association between luxuries afforded, the working structure and the working ethics of international staff. In speaking of the 'luxury' of the international compound, the medical activity manager said there was '*too much choice*', comparing it to a previous mission where luxury was '*a mosquito net and a bucket*'⁶⁷. To understand how the staff felt about the division and living arrangements was challenging. Staff events such as celebrations for staff whose contracts were ending, or celebrations at Christmas gave some insight, as a main feature of these gatherings were the lengthy speeches given by staff members. An OT nurse supervisor whose relocated contract was not renewed spoke of the fences dividing the two compounds, '*we should not let the fences divide us, we are all here to do the same job*.'⁶⁸ He implored that staff should make more efforts to do things together in social time. At the Christmas celebration for staff, held in the space between the hospital, living compounds and offices and in front of the training room, a call for unity was again echoed in the speeches. This time it was in relation to the divisions implied by the labels of 'local' and 'reloc' by one of the south Sudanese nursing staff emphasising 'we are all national staff'.⁶⁹

⁶⁶ Fieldnotes. 5th December 2017.

⁶⁷ Fieldnotes. 11th November 2017.

⁶⁸ Fieldnotes. 20th October 2017.

⁶⁹ Fieldnotes. 16th December 2017. Speeches were a central part of all gatherings. In leaving parties or celebrations people would be expected to make speeches of thanks and gratitude. These speeches were emotive and would include stories or some part of the journey of the relationship between the speaker and the staff member leaving. An opportunity to speak was given to anyone when arrangements were led by South Sudanese staff and some international staff. Within the international staff group some people did not like the ritual of speeches, this culminated in speeches being stopped for a period.

Short lived objectives

The proportion of first mission-ers amongst the international staff in Agok was 58%, significantly higher than the desired proportion of 30% (Medecins Sans Frontières, 2018). The perceived negative attributes of first missioner practice is in their lack of experience, difficulties in adjustment to the context, and resulting reduced ability to 'get on with the job' (Owen, 2010). An experienced international staff member explained that for him first mission-ers were '*the biggest headache*,'⁷⁰ bemoaning the challenges of managing three during his 9-month period in Agok (myself included). His experiences highlighted the tensions between professional experience and expectations of practice and the practices in the field. Speaking specifically of protocols he recognised the challenges; '*there is a difference in the way how MSF put the protocol in place, or the way that MSF perform the procedure. It is totally different to what people are doing at home or what people are used to, so it's difficult to adapt*'⁷¹. This difficulty in adapting results in a period of low performance and emotional and mental challenges (Lal and Spence, 2016). With limited understanding and sometimes unrealistic expectations of the projects, staff find it hard to adapt (Albuquerque et al., 2018). The balance, or compromise between the environment, standards and practice that one is used to at home, and the environment, standards and practice one perceives when beginning a mission is one of the first challenges to overcome. A first missioner nurse expressed his initial feelings to the project in the following way; '*...the chaotic, the chaos in itself, so how the ward is organised, the trash that lies around everywhere,...the...that everything feels dirty for you because you are used to having clean hospitals... and the environment, and... I had problems the first few days to work there because I was so, because I didn't*

⁷⁰ Fieldnotes January 13th 2018.

⁷¹ Interview. Agok. Bedside training team supervisor. 15th January 2018

*know what to do because actually, I don't want to get involved in this, because it felt like, this is not how hospitals should look like and when I work along this, it would mean I justify this, but in the end you have no choice though so... I took a few days to accept that this is what it is, and this is not Europe'*⁷²

In her research on staff retention in humanitarian organisation, Sara Albuquerque interviewed nurses who had completed a number of field missions with MSF Sweden, framing their experiences using Van Gennep's theory of 'Rites of Passage' (Gennep, 1960). The three phases, described by Albuquerque as separation, transition and incorporation are aptly used to capture the experiences of the nurses during a single mission and overtime. Their feelings of fear, uncertainty, vulnerability, unmet expectations and lack of meaningfulness were identified to be marking the transitional or 'in-between' period⁷³ (Albuquerque et al., 2018). These phases were echoed in my research, '*I might as well not be here, they could run it themselves'*⁷⁴ (speaking of the nursing staff), evidenced the vulnerability and uncertainty of not finding one's role. The discontent expressed was in part due to the fact that this international staff member had '*not realised*' the role that she would be doing, with responsibility for staff rostering and other management roles rather than hands on nursing as she had expected⁷⁵.

International staff recognised a pattern in their adaptation to the project, from feeling

⁷² Interview. Bedside training nurse. 18th January 2018.

⁷³ In van Gennep's original French language publication, the term *liminaire* was used to describe the second transition stage (Joseph, 2011). Liminality, a concept that has been taken up in anthropology and other disciplines alludes to a state of being on the margin. The English translation to *transition* according to this reading is misleading. Where the other two stages are transitional in nature, the second stage is a period with particular characteristics. It is 'in-between' in relation to the other stages, but its defining characteristic is a state of liminality, on the margins (Gennep, 2019). See the introduction of the second edition of *The Rites of Passage* by David I Kertzer for a discussion of the influence of the book, and of the concept of *liminaire* or the *marge*. (Gennep, 2019)

⁷⁴ Fieldnotes. 15th October 2017.

⁷⁵ Field notes. 15th October 2017.

lost or angry to a state of adjustment, rather than 'incorporation'; *'I just don't think about it anymore, I just do the best I can and that is something that we are here for'*⁷⁶ stated an international nurse on reflection on his shifting perspective. Adaption was expressed as being able to get on with the job, or rather having the confidence to pursue their role. In the interview, the nurse assimilated his experience with *'every first missioner'*, demonstrating that he considered this to be normal, and in recognition that others who had more experience and maturity in the field would have different points of reference from which to understand and adapt to the context. This was affirmed by a more experienced international staff member, an anaesthetist who reasoned that *'if this is someone's first time then they use their home experience as a comparison because that is all they have, if they have been on mission before then it is easier because they compare it with previous places they've been and don't expect so much.'*⁷⁷

For the wider hospital staff this cyclical fluctuation is on a repeated loop as international staff come and go, *'they are coming for 6 months, it is three months to know the project (laughs) then the other three months to implement the things, the time is not enough, it is difficult to the one who is coming and to the one who is leaving because the things are not stabilized'*⁷⁸ reflected the Deputy Head Nurse. National staff are directly affected in their daily practice by the changing activities of incoming and outgoing staff and the accompanying implementation of different practices. The Deputy Head Nurse's use of *'stabilized'* highlights the instability brought with the change of staff and the precarity their adaption within the project creates (Owen, 2010; Pascucci, 2018). The Deputy Head Nurse had worked with MSF since 2007 in Abyei. He saw the fluctuation of

⁷⁶ Interview. Bedside Trainer, Agok. 18th January 2018

⁷⁷ Field notes. 12th November 2017

⁷⁸ Interview. Deputy Head Nurse, Agok. 23rd January 2018

challenges as *'depending on the person'*, alluding to the importance of personal characteristics demonstrated by how the person approached the project and communicated with the wider team. It is expected that changes come with new international staff, and there is an expectation on international staff to make changes. In the pre departure training I attended in Geneva in May 2017 with other *first mission-ers*, the course convenors advised us to *'take a pencil and write down all the things that are wrong, because after some time you won't be able to see them'*,⁷⁹ placing the value on the idea of *'fresh eyes'* bringing new a new perspective and new ideas. In Agok, the Deputy Head Nurse expressed that not all change is good, *'there can be changes, but there must be a plan, or give time to analyse and to see why it is being put in place and why we want to change it now. If it can be understandable and people can adapt it then yeah, but if changes come because you don't like the way it is, or you have your own opinions then that can be negative and this is what keeps going on, it is an ongoing issue. Changing, changing, things'*⁸⁰

Changes and fluctuation of practices brought challenges to the teams. The Head Nurse spoke of a blood transfusion form that her predecessor had implemented, under the pretence it was easier to use. Monitoring a patient during a blood transfusion is very important to ensure any adverse effects are noticed early and acted upon (Jones, 2018). A blood transfusion form is used by the nursing team to document clinical observations at set times during the length of the transfusion. A baseline set of observations, (respiratory rate, heart rate, blood pressure, temperature and oxygen saturations) are taken prior to the start of the transfusion, then at fifteen minutes post transfusion and

⁷⁹ Fieldnotes 17th May 2017.

⁸⁰ Interview. Deputy Head Nurse. Agok. 23rd January 2018.

in gradually widening time intervals during and post the transfusion. Observations are monitored in real-time and minutes post infusion and charted on the form. The layout of the form is important, understanding it and associating it with the significance of the task requires training, keeping in mind that levels of English literacy amongst the staff are a consideration. In the beginning of her mission, the Head Nurse saw that the form used was incorrect as it was not the official MSF approved template. She therefore removed it and implemented the MSF blood transfusion monitoring form. Such changes cause frustration for the staff, require further training and take time and energy for all involved. The Head Nurse spoke of the contradictions and confusions evident to the staff from this line of events and considered the impact of reoccurring events such as this one, *'I think that in the long run it affects the trust of the staff, because of course, that last person who was really confident, who was really well like by the staff, who said "this is really the most important thing you will do this year", he might be followed by someone who says whatever he [the previous person] said is wrong. That might be one of the keys in the lack of investment that we sometimes see, maybe they think that the next expat will not be so interested in this one [new thing]'*.⁸¹ The lack of understanding of the project, and of the people and staff, and the hurry to implement new changes causes distress, *'to come in without first understanding the people, and then pushing people it will affect the work'* explained James, a nurse who had worked in Agok hospital since 2015, *'the pressure here, of the work, is too much. The number of the patients alone is enough. It is a good thing to give you some pressure but then, somebody also pushing you somewhere who thinks you do not understand it well, you feel people are not looking at you, the work you are doing, despite I am doing a lot, they are not looking at the work I am doing.'*⁸²

⁸¹ Interview, Head Nurse, international staff, Agok. 20th January 2018

⁸² Interview, nurse, relocated staff, Agok. 9th January 2018.

There are some measures in place to try and promote continuity during changeover of international staff. Ideally there is a handover period, but this is often hampered by staff shortages and gaps in the project. Humanitarian agencies struggle to retain experienced international staff (Loquercio, 2006). In the pre-departure course I attended, we were informed by the course convenors that less than 50% of people who do one 'mission' with MSF go on to do a second mission⁸³, a figure supported by research into retention rates in MSF-Holland (Korff et al., 2015). Reasons for this are multiple, including career plans, relationships, home commitments and lack of occupational support (Asgary and Lawrence, 2014; Dubey et al., 2016; Loquercio, 2006). Due to the structure of MSF, a deficit of international staff with MSF experience results in gaps in the field, contributing to increased stress and poorer performance, a loss of skills and poor organisational memory (Albuquerque et al., 2018). An end of mission report is written to aid handover and support the continuity of objectives started in the hospital. The MAM doubted the impact of these reports saying that they did not change from person to person⁸⁴. The Head Nurse also reported that that the end of mission report she had received on arriving had been useful, as had not been a face-to-face handover. Yet despite this, once she had begun her role, she had '*not looked at it*' again, until the end of her mission where she realised, she had not followed its guidance. She expressed hope that the next Head Nurse would continue with the objectives she had started but recognising the professional specialism required for some of them she was doubtful.⁸⁵

International staff demonstrated flexibility in how they pursued their role and formulated their objectives for the project. With limited time and a large list of possible

⁸³ Fieldnotes. Geneva, 19th May 2017.

⁸⁴ Interview. Medical Activity Manager, Agok. 11th November 2017.

⁸⁵ Interview. Head Nurse. International staff. Agok. 20th January 2018.

projects, some objectives utilized the individual's area of expertise or interest. A Head Nurse with a background in anaesthesia made surgery one of her focuses, particularly the process of sterilization in the operating theatre. After reviewing the current system, a new autoclave was installed with her support and the WHO checklist for before and after surgery was (re)introduced. The surgeon had been in Agok a number of times. He was pleased with the interest and connections developed between medicine and surgery under the lead of the Head Nurse, stating that in the past little progress was made between medicine and surgery because 'the MTL, Head Nurse and Field Coordinator all hated surgery'⁸⁶.

The increased focus in surgery of this period led to other initiatives. Ward rounds were restructured, and continuity of care was addressed by the appointment of a clinical officer within surgery. The commitment of the Head Nurse to the sterilization process highlighted the technical aspects of the task and she was able to increase the pay level of the sterilization technician the same as the nursing assistants. In her interview⁸⁷ which we conducted towards the end of her mission, she expressed mixed feelings on what had been achieved, and the sustainability of her input. The Head Nurse had been on a short 'gap fill' mission and worked long hours, staying in the hospital for hours before and after other international staff. Despite the steps she had made in surgery, she expressed regret she had not had enough hours to complete all objectives, '*I am drowning in paperwork*' and regretted not achieving her desired objectives with the nurse supervisors or being present in the wider hospital as much as she had wanted '*I have not reached this*'. One of her concerns was that changes in international staff would

⁸⁶ Fieldnotes. Agok. 6th January.

⁸⁷ Interview, Head Nurse. International staff. Agok. 20th January 2018.

again mean *'that everything that used to be green will now be pink'*. In an attempt to prevent this, she explained that she had taken the idea to write a letter with the surgical supervisor, addressed to future surgeons, outlining the different processes and procedures, to avoid confusion and bad communication *'most of it is based on previous surgeons not being nice to the national staff'*. It detailed the procedures, for example what to do when a surgeon goes to review a patient in ER, wards rounds, what the role and responsibility was of different member of the team and people's expectations.

The incentive to write the letter came from complaints by the surgical nursing team and wider team on the conduct of the surgeons, and the repetitive challenges. Surgeons are typically on short term placements. These shorter periods give people less time to assimilate with the project which can be a challenge for all parties. A Canadian woman was the first surgeon I met in Agok. She made it clear she had no interest with having any formalities with the national staff, and felt she was there to 'just do the job'⁸⁸. In the operating theatre she would sit and read her book until everything was ready for her to proceed. A complaint was made to the Head Nurse about the surgeon due to the way she shouted at the ER staff when she went to review the patient. It was this event that prompted the letter being written, but the surgeon had left by then and no further action could be taken. The surgeon was no more outwardly friendly with the international staff, until the final weeks of her short mission when a shared event that had had brought her and couple of staff member closer, made her soften her approach and became more approachable. The 'hardness' of some international staff is understandably resented by the national staff who must deal with this roller-coaster of

⁸⁸ Fieldnotes. 20th October 2017.

work ethic. International staff are remembered by others for '*pushing too hard*'⁸⁹, particularly in the first months of their mission. The frequency of this pattern of behaviour, deserves more study to understand the causative factors and ways to encourage a smoother, more collaborative approach.

Revealing how these contested spaces provide barriers to quality care puts a fresh focus on the imbalanced relationships in the staff groups. Tjioflat and Karlsen (2016) highlight the damaging presence of one-way communication and the paucity of the 'cross-cultural encounter' when working in the professional capacity of an expat nurse. Earlier work suggests friendship as a way to build capacity (Girgis, 2007). The historical presence of disparities between international and national staff evidence the argument that they are 'intrinsic to the structure and conditions of international humanitarianism' (Shevchenko and Fox, 2008, p 120). That this disconnect or tension exists is not a revelation of this research. However, the importance of addressing this in the pursuit of quality of care for the patient is a key contribution. Research in the context of disaster and development have demonstrated how workers in the aid sector 'map onto existing structural hierarchies and inequalities that impede the resourcefulness and creativity of local aid workers' (Ong and Combinido, 2018, p. 87). My research supports this in demonstrating that the shifting objectives pursued by the international management team, and poor communication with the wider hospital team is a point of friction. Considering again the stages of the 'rites of passage' (Albuquerque et al., 2018), I would suggest that the vulnerabilities and insecurities of the international staff play a part as they learn to manage the initial pressures and responsibilities. Better

⁸⁹ Fieldnotes. 9th January 2018.

communication and collaboration as a staff group as a whole and particularly with the national staff and national management team would be positive step to improve individual assimilation to the project and the institutional memory of the project.

The logics of care. Ward round in the Inpatient department

The ward round is central to hospital activity, it dictates patient care processes, it is an opportunity for learning, and is an enactment of teamwork and communication. It gives insight to a microcosm of interprofessional relations. How medical professionals work as a team is a determinant of the quality of care delivered to patients (Walton et al., 2016). Research has shown that the roles of team members and their participation and interaction within the team has an effect on patient outcome (Bae et al., 2010; Bradfield, 2010) and a collaborative approach to patient centred care requires team work (D'Amour et al., 2005; Nowaskie et al., 2020). In IPD, ward round starts at 9 in the morning and resumes again after lunch time, lasting into mid-afternoon. The people present for ward round include an arrangement of the following: a clinical officer, a translator, a nurse, a nursing assistant, a doctor and a councillor. A silver trolley accompanies the team as they move through the ward. The items on the trolley include a BP cuff, stethoscope, saturation monitor and axilla thermometer, 'point-of care' handheld HB and glucose monitor device, surface bacterial disinfectant and wipes for cleaning instruments, a bottle of hand sanitiser, a large wall clock used for timing respiratory rate and heart rate, the ward round book for noting patient plans, and the councillors book used to book appointments with the councillor.⁹⁰

⁹⁰ Councillors will come and see a patient for a number of reasons. A common use for the book is arrange a councillor to see a patient prior to a HIV blood test being taken.

The patient notes are kept in a plastic pocket on the end of each bed. The clinical officer reviews each patient with the notes, requesting additional investigations if needed. Some investigations can be taken at the bedside by the nursing staff using the point of care testing equipment. Others are requested using the laboratory request and result form. The form is completed by the clinical officer and then left in the plastic wallet to be taken to the labs once the samples are taken and returned from the lab with the results once completed. Clinical observations may be requested by the clinical officer, and missing lab blood results chased, both of which are actioned by the nurse or nursing assistant. The CO documents the review in the patients notes, and the plan is written in the ward round book by the nursing team. Whilst the team and trolley may begin as detailed, other tasks then take the attention of the different members of the team. The ward is staffed by two nurses and two nurse assistants. Medication rounds are a very time-consuming task, and the morning round begins with another silver trolley filled with medications and associated paraphernalia and takes the attention of at least two of the nursing team. Admissions continue throughout the day, increasing the pressure for rapid actions to be taken for the patients who are discharged during rounds.

In all settings, ward rounds are a 'ritual' of hospital life (Turnbull et al., 2005), bringing the semblance of stability with procedure and multidisciplinary interaction. They are a forum for reviewing the patient, sharing information, changing medications, examining the patient, interpreting results and developing prognosis and plans of care. Ward rounds are an opportunity to hear the narrative of the patient and family, and the multidisciplinary team (O'Hare, 2007). With a defined structure and purpose, ward rounds facilitate the appropriate care plans and aid safe care delivery, and provide

opportunities for teaching and learning (Kvarnström, 2008). The three international doctors are the senior doctors in the hospital. Each took different approaches to ward rounds and reviewing patients. Some would attend with the CO and take an approach to discuss the patients together, a chance for learning and supervision. Others would see patients independently, therefore requiring the time of the translator, the nurse, and equipment to assist. The medical activity manager explained part of the role as follows.

'our job is to go with the CO's and make sure they know what they are doing, and train them ..to see patients with them , and ok, so I've got a whole load of patients, I do a mixture of that..., I often see patients when called to by the COs like [previous MAM] was largely doing, and he was probably doing it better than me in some ways, you know he'd be called to the patient with the CO, and he'd discuss it, and I do quite a lot of that, but I've also got a whole range of patients , I haven't got that much time, I've got a whole range of patients in my mind and I'm actually trying to figure out how to give them the best care and it's a lot quicker just to go and see them, make a decision and act on it, and that's not really.. it's good for saving lives in the short term, it's not really what our job is supposed to be in my mind.'

Medical Activity Manager, International staff, Agok.

The multitude of pressures are evident in the above explanation. In recognising that part of his role was to support the staff, the wish to give *'the best care'* drove an individual approach, seeing this as the way to 'save lives' but compromising the development of his professional colleagues, even though he recognized this was part of his role. In a busy environment with a high ratio of patients to care professionals, time and speed factors in the decisions made. When COs spoke about previous international

staff members, behaviour was remembered for whether it was inclusive of the team or individualised. Staff spoke about the difficulty of international doctors '*taking their own patients*'⁹¹, and not allowing the clinical officers to review them, or be involved in their care, or the pursuit of working patterns that meant doctors spent a lot of time in the office rather than in the hospital.

Elements of the ward round and associated practices were a source of frustration for many staff. I discussed the process of ward round with the supervisor of IPD. The supervisor was well rehearsed in the issues and challenges involved in the ward round. He voiced his concerns and frustrations when we were talking about the use of the ward book. Used correctly, the ward book is a valuable item for the running of the ward, as it contains the plans for patients following ward round and can be referred to for plans and required action, rather than the more time-consuming task of looking in individual patient notes. The main concern of the supervisor was that the '*MDs*'⁹² did rounds separately to the COs '*where no one can follow them*'⁹³, and therefore the outstanding tasks are not communicated or written in the book. Conversely, he had received complaints from the medical team that the nursing staff were not completing all the outstanding tasks on the patients, which was resulting in delays in care. In support of his nursing team, he emphasised the high volume of tasks for the small nursing team, investigations, lengthy medication round, difficult cannulations, vital sign observations, emergencies, admissions, discharges. He said that he had voiced these challenges to the head nurse and in meetings, but nothing had changed '*different MDs they do things*

⁹¹ Fieldnotes. 20th November 2017.

⁹² The international doctors are commonly referred to as MDs in Agok, an acronym for medical doctor most commonly used in America and Canada.

⁹³ Fieldnotes. 11th January 2018.

*differently*⁹⁴. In speaking of the same issue, the head nurse said that after receiving complaints from the IPD supervisor about the way ward round was conducted she had raised the issue with the medical team, but with minimal impact *'I have discussed this several times and I think this will take another round of discussion'*⁹⁵, signifying the additional divisions in categories of hospital management, that of doctors and nurses.

No room to suggest. Management of professional status in Agok hospital

Following ward round in the Critical Monitoring Unit (CMU), most patients were moved to IPD, leaving one patient. This gave me time to chat to the nurse. Kueth has worked in Agok for 3 years on a relocated contract. Prior to that he worked in a Ministry of Health hospital and has also worked for MSF in the past on an emergency project. We spoke about ward rounds and the relationship between COs and nurses. I asked how he felt about the communication between the clinical officers, doctors and nursing staff. After a short pause he stated that *'for the nurses there is no room to suggest'*⁹⁶. He gave the example of the head-to-toe assessment, saying that when it was introduced it was to be a regular assessment done by the nurses, however the COs would not look at it or take it into consideration. Because of this the nursing staff stopped doing it. I asked why he thought the relationship was like this, and he said *'because of MSF, because MSF values COs over nurses'*⁹⁷.

Frustrations between staff groups were highlighted by my research. Similar frustrations to those above were voiced by another nurse on IPD. Employed on a local contract, John

⁹⁴ Fieldnotes. 11th January 2018.

⁹⁵ Interview. Head Nurse, Agok. 20th January 2018.

⁹⁶ Fieldnotes. 13th November 2017.

⁹⁷ Fieldnotes. 13th November 2017.

had previous experience with the Ministry of Health and with other NGOs prior to working at Agok hospital. He proudly said that *'God has blessed me that no one has died on my time'* and that he is *'always thinking of the safety of the patient.'*⁹⁸ As we chatted, his frustrations as the conversation developed were about the structure of the hospital teams and the lack of development opportunity for nurses. He spoke about the different levels of superiority of staff and frustration that *'some do not do the work they are supposed to do'*. He compared Agok to different settings he had worked where the nurse was *'listened to'* on the ward round. James, a nurse who had been with MSF since 2015 also felt that nurses' voices were *'not heard'*, one solution he put forward was for joint meetings between the medical and nursing teams.

'If challenges are there in the hospital, if challenges are being observed and then people want to be addressed and things to be done in the right way. For me I suggest that the MTL or the MAM or the MD, all those expats, should look for ways of bringing these two teams, the MD's the CO's the nurses, and the supervisors maybe, if one or two meetings were organised. then things are communicated properly. This would help the quality of the care'

Nurse. Relocated staff. Agok.

When the hospital was being established in Agok, there were very few qualified nurses. Nurse aids were employed, and with experience they were promoted to staff nurses. According to figures obtained during my mission in Agok, all nurses except two were qualified to diploma (3 years schooling). The Deputy Head Nurse informed me that of

⁹⁸ Fieldnotes. 29th January 2018.

the forty-three nurses employed, only two nurses remained in the hospital who had been promoted from nursing assistant position. This landscape is now different, but this imaginary continued to inform assumptions held about the nursing staff. In addition to this, assumptions made about the capabilities and actions of the nursing staff failed to take into account a wider understanding of their actions or processes.

These assumptions came out in interviews and discussions I had with staff. The nursing team were described as having a '*lack of initiative*'⁹⁹. This was in reference to the number of calls received by management to sort out small problems, in this example for drug shortages on the ward which required permission to contact the pharmacy to then obtain the required drug. The alternative action suggested by the supervisor would be for the staff to take the initiative to borrow from other wards. This perhaps seems simple; however, I later learned from speaking to the staff that they didn't borrow from other wards as previous managers had enforced the practice of not borrowing due to the problems, it caused with ward stock management. The reflection that '*things just drop out of their heads when expats change*'¹⁰⁰ was expressed to me in relation to how performance and quality went down with international staff changeover. Reflecting back on the impact of changing international management staff, the changes enforced, and practices side-lined or centred, gives a wider picture of the impact of changes. The outgoing midwife activity manager sadly commented that '*things are already slipping*'¹⁰¹ in the later days of her handover, frustrated with the different management styles and priorities pursued by the new incumbent. That things '*drop out of their heads*' must be seen in the context of shifting management practices and priorities.

⁹⁹ Interview. Head Nurse. Agok. 20th January 2018.

¹⁰⁰ Field notes. 5th February 2018.

¹⁰¹ Field notes 15th January 2018.

A complaint made by the Health Promotion Supervisor about the quality of care for a patient in IPD prompted a reaction from the Medical Team Leader (MTL) and renewed impetus on quality of care in the hospital. The MTL attended the Monday morning meeting in the ER to speak to the nursing teams, *'You must use your eyes, to look and ask what does this patient need? Ask yourself, is what this patient needs is a wash. ... is what this patient needs is the blankets changing?... Is what this patient needs is mouth care? If we are not providing good care I am failing my job, the head nurse is failing her job, the bedside training team are failing their jobs.'*¹⁰² The complaint was in reference to a 7 year old girl who was being treated for cerebral malaria. The girl was accompanied by her father. They were from Mayom, a different state, and had been transferred by MSF from the MSF primary health centre there. As with many people from Mayom, the girl and her father spoke Nuer, not Dinka as was spoke in Agok. The father stayed with his daughter day and night for the weeks that she stayed in hospital. Her condition never improved. She was in a coma fed via naso-gastric tube, totally dependent on the medical staff and her father for all cares.

The WHO definition characterises the clinical syndrome of cerebral malaria as coma at least one hour after termination of seizure or correction of hypoglycaemia, presence of *Plasmodium falciparum* and no other cause to explain the coma (World Health Organisation, 2000a). Without both basic and sophisticated laboratory capabilities to recognise and detect other causes, the diagnosis of cerebral malaria is typically treated alongside a trial and error approach to the possible presence of a number of other bacterial and viral causes of acute non -traumatic coma (Njunge et al., 2017). The girl

¹⁰² Fieldnotes. November 20th, 2017.

did not have a catheter. The complaint from the HP supervisor was that the girl had been laid in her own urine. As an indwelling medical device, long term catheters carry with them a high risk of infection (Waskiewicz et al., 2019). Continence sheets or pads were not regular stock in the hospital, and the thick woollen blankets were on short supply in the hospital. At night blankets were in a locked cupboard, with only the supervisor having access. Complaints of not changing the blankets enough was interpreted as not caring about patients. I later learnt that due to the shortages of blankets, the nursing team had been told they could only change the blankets every three days. Previous to this, I had not thought to ask the question. What is further highlighted in these examples is the lack of wider context considered by those making these assumptions, and the lack of voice exercised by those who could counteract this snapshot approach.

Teamwork, team cohesion and communication require improvement in Agok. It was evident that for international staff, the path of least mental, emotional and physical resistance was an individualised approach to their workload. Talking about her increasing tiredness towards the end of her mission, the paediatrician spoke of how she began to lose patience, demanding '*where's my baby!*?¹⁰³' to the nursing staff when a patient had been unexpectedly moved. For others pursuing an individualised path through '*taking their own patients*' or dedicating a lot of time to one or two specific patients can be seen as way to pursue a feeling of individual accomplishment. The pursuit of one doctor for a '*genius diagnosis*'¹⁰⁴ and subsequent personalised care for a

¹⁰³ Fieldnotes, Agok, 5th February 2018.

¹⁰⁴ Field notes. 23rd January 2018. The '*genius diagnosis*' expressed was post-kala-azar dermal leishmaniasis.

patient would mimic MSF's ethos of the centrality of the individual medical-humanitarian act. But without sharing the responsibility of patient care with other team members, these learnings have no wider benefits.

As is explored throughout the study, the role and expectations of nurses is a double-edged sword. Beyond the historic power and agency, differentials between doctors and nurses (Sweet and Norman, 1995; Thompson and Stewart, 2006), a pervasive 'imaginary' existed about the staff groups in Agok (Smirl, 2015). Powerful assumptions and expectations around nursing synonymize care with nursing, endowing the staff group with 'an impossible burden of responsibility' (Mackintosh, 2000). At the same time as a group they remain disempowered and undervalued within the hospital team, and the traditional medical hierarchy (Walton et al., 2016). The devalued position of nurses in ward rounds, multidisciplinary team dynamics and decision making is well researched (Busby and Gilchrist, 1992; Manias and Street, 2001; Weber et al., 2007; Wei et al., 2013). Research has shown nurses' involvement and inclusion is both desired and wanted by all parties (Swenne and Skytt, 2014) and is key to quality patient care and safety (Herring et al., 2013). Despite this, they remain excluded due to a number of factors including organisational constraints, time and the medical hierarchy (O'Hare, 2007; Walton et al., 2016). In Agok this is compounded by a lack of voice and agency.

In her study of organisational culture and humanitarian principles, Dorothy Hilhorst demonstrates that staff perception of their work has a 'direct bearing on the quality and impact of humanitarian assistance' (Hilhorst, 2002, p. 497). The importance of relationships and their impact on the quality of care has been demonstrated in further research (Kersten et al., 2013b). The gaps between international and national staff in

humanitarian organisations are demonstrative of the wider asymmetries in the production of knowledge and representation, and therefore must be recognised and addressed (Abimbola, 2019; Hedt-Gauthier et al., 2019; Mbaye et al., 2019). Using the lens of quality care, this chapter has added nuance to this argument. The binary of national and international staff needs further investigation when considering its impact on the quality of care in humanitarian settings. Insights from nursing and medical staff who have seen numerous staff come and go, indicate that the same repeated challenges are met which centre on a lack of understanding of the capabilities of the staff, an emboldened desire to make significant changes, and an organisational approach that ascribes more value to some professional roles over others.

The healthcare workers in Agok work in unstable spaces where shifting practices and management 'engenders a permanent uncertainty' (Tantchou, 2018, p. 272). Changes are implemented, enforced and then abandoned, making the implementation of routines impossible (Street, 2012). Practices of long-term staff are seen as a snapshot by those arriving, and do not take into consideration the historical ties of practices. This is further impeded by persistent and reinforced imaginaries. Previous work in humanitarian settings has demonstrated the impact of pervasive imaginaries. Lisa Smirl (2015) in her work "Spaces of Aid", highlights that "the experience of aid workers and their key position in interpreting representations and reproducing local knowledge'(Smirl, 2015, p.4). Following this argument, the imaginaries created around the nursing staff result in a perpetual situation, that impacts the communication and teamwork in the hospital, and the pace of change to improve the quality of care.

The disconnect between professional groups in Agok, that lack of shared objectives and understanding is an additional barrier to the provision of quality care. This is not a measurable quantifier of quality, yet this doesn't negate its importance. Staff satisfaction in their role, well-being, and team cohesion must be recognised as important factors in promoting quality of care. The pressure of working in an unstable environment is a challenge for all staff. The inequalities between groups, reinforced by the spatial and organisational structure and practices must be recognised, and addressed with consideration and participation of all staff. These actions need to be understood in the context of the challenges faced and expectations held by all staff. Moving forward with understanding and improving quality care requires a redress of caring for staff to encourage and pursue better team cohesion.

Greece

The project organisation in Greece spins the relationship of staff, patients and space on its head from how things are in Agok. The target population of the project are thousands of miles away from their home countries, in a resource rich country that demonstrates severe austerity towards them. The management and supervisory positions are filled by primarily Greek national contract staff, with a multi-national team of cultural mediators and health promoters also on national contracts. 'International staff' contracts are minimal in the field projects, though remain in positions of superiority for example the medical activity manager, and medical coordinator.

Holistic care is envisaged to address the patient as a whole person, going beyond the linear medical model to meet the complex needs of the patient group. This section explores the meanings of quality through the claims made to holistic care. Perhaps counterintuitively to the holistic model of care for patients, 'burn-out' amongst staff was talked about a lot in the Greek settings and the number of staff reported as suffering the effects were understood as high. Examining the relationship between these factors as part of the care assemblage, this section will draw on my research in Athens and Chios to question firstly how staff wellbeing is impacted by the project design, and secondly what this tells us about the meanings of quality in healthcare in humanitarian settings.

Addressing complex patient needs

The needs of the people who have come to Greece to seek refuge and asylum are numerous and complex, and are exacerbated by the social, political and economic response of the Greek state and other countries in the wider European continent (Ben Farhat et al., 2018; Cabot, 2014; Lamb, 2016). In March 2016, the border between

Greece and the Former Yugoslav Republic of Macedonia (FYROM) was closed, one of a number of actions intended to stop the movement of refugees further into Europe. This led to an 'immobilised' population, subject to 'enforced-waiting' and uncertainty (Bjertrup et al., 2021). The poor living conditions, barriers to healthcare and lack of access to work and education (Karantinos, 2016; Vasilopoulos, 2020), in a population that wish to move forward geographically, contributes to an increase in mental health problems for this population (Ben Farhat et al., 2018; Eleftherakos et al., 2018).

The Day Care Centre (DCC) in Athens is a 'pilot project', a trial model of a new approach within MSF to meeting the needs of vulnerable populations in middle- and high-income countries. The vision is to support complex needs not met efficiently by existing services, to 'fill the gap' (Médecins Sans Frontières, 2018h). Some of these needs are met within the project site, which provided services for non-communicable diseases (NCD), sexual and reproductive health (SRH) and mental health services. Additional needs are met by liaising with other services available. The assemblage of the services in the projects in Greece draw connections between an existing state/private health system, non-governmental organisations, and a large under-served refugee and migrant population. In doing so they negotiate and mediate an entanglement of shifting relations. Travel medicine and advocacy are key components of this approach focusing on the needs of populations on the move and speaking out to voice the atrocities experienced by people whilst on the move and within Greece. The vision for this project is best described in the words of the Medical Coordinator.

The specificity of this mission is really to have for people a holistic approach, for example if you have a woman who is coming, and she is pregnant and you do ANC¹⁰⁵ consultation it's not really efficient because this woman will have many needs, not only to follow her pregnancy. She may have been a victim of sexual violence, so you need also to care about potential infection or injury, she needs to see maybe a psychologist, so you need to check also her mental status, because if she has been a victim of sexual violence she has been traumatised. Even without [incidence of] sexual violence, just to make the journey and to pass all through the difficulties and challenges is already traumatising. Plus, these people, when they left, it's because something has happened, they didn't just leave like this [clicks fingers], they left because already they have witnessed violence, they have been a victim of violence or they have been afraid for their lives, or the lives of their families. So already they are traumatised when they leave, and it is just adding and adding and when they arrive here it's just... difficult. And maybe this pregnant woman she may have high blood pressure or diabetes, so she needs to be checked as well, and maybe she is homeless, so she needs to have a social worker working on finding a shelter for her. Or has difficulty with her papers so she needs the legal officers, so you see there is many needs, so if you insert only one need this is not the quality that you want to give, when you talk about quality of care it's not only the medical quality, the medical quality is not the most difficult part of our job, its easy, actually... what is difficult is to have a patient with many needs and bring the quality through the services we provide, in order to answer their needs - this is here what we consider quality. So, the projects are really focused on this different holistic response, follow up of people and also empowering of people.

Medical Coordinator. International staff. Athens.

¹⁰⁵ Anti-natal clinic

The medical coordinator describes the services provided by MSF in relation to the complex needs of the patient population, here giving the example of a woman who is pregnant, who also needs to access many additional services. In Athens I worked in a number of different departments, and also sat in with other professionals to observe and gain understanding of the project. To provide an understanding of how the centre works and the different factors that make up the care assemblage in the DCC, the next section will draw on my observations in these different departments to give details of the services provided and the complex needs of the patients who attend.

The assemblage of care in the day-care centre, Athens

In the DCC the largest waiting room is on the ground floor. The reception desk is in the far corner on entering. A high ledge runs its length, where on standing the receptionist or other colleagues can rest papers to inscribe appointments, translate numbers and instructions into Arabic, Farsi or other languages, or encircle directions on maps for hospitals and other facilities. At 9am the reception is teeming with people. The white MSF vests distinguish the cultural mediators within the throng, each negotiating information, appointment times, process, advice and concerns, between the beneficiary and the receptionist who meticulously writes down each attending persons case number, service, and order in queue into a large lined notebook, transcribes some details on a small appointment card which is given to the patient and writes a number in large script on a post-it note to signify the place in the queue. The majority of the people in this waiting room are female, awaiting sexual and reproductive health services. Partners, friends and accompanied children wait in the corridor at the entrance to the building or outside the front door on the street.

The SRH service is the busiest department in terms of patient numbers, seeing around 40 people per day. The midwife supervisor had worked in the DCC since it opened in 2014. She explained to me how the service had grown. *'We started having one examinations room, up to now we have three, and if we had more it would even be better. So, we have more midwives- there was only me and now we have three midwives and one gynaecologist. We had a gynaecologist once a week, now we have three times per week the gynaecologist, who is female also. We see almost 650 beneficiaries per month, and we used to see 100 at the beginning, 150, and we thought that was too many. We have improved our services by using better ultrasound machines ... doing more tests in order to share with the hospital, in order to help them we do many tests here such as the glucose intolerance test. We do the vaccinations, we do the IUD insertion, medical therapies. So, we have increased the number of our consultations and at the same time the count of our services'*¹⁰⁶.

A range of services are offered by SRH. Family planning, condoms, IUD insertion, the contraceptive pill, urine pregnancy test, medical termination of pregnancy, anti-natal clinic and post-natal clinic and consultations for sexual violence. I sat with one of the midwives to observe some of the appointments. The midwife had worked at DCC for 8 months. Prior to this she had worked for Médecins Du Monde in the refugee camps around Athens. The clinical room was clean with white walls. A white desk in one corner in front of the window, and examination couch and movable white screens on the opposite side of the room. Two silver trolleys wiped clean housed the necessary equipment; urine dipsticks, equipment to take blood and diagnostic rapid tests. An

¹⁰⁶ Midwife supervisor. Athens. 6th August 2018

ultrasound machine stood next to the trolleys. The first woman attended for a pregnancy test. A Farsi speaker from Afghanistan. The consultation was conducted in Farsi and English with a cultural mediator. As her first appointment at DCC, basic information was taken about her medical history and her pregnancy history. She explained she did not want to keep the baby if the test was positive. The midwife explained that there are options that they can discuss after the test if it is positive. The test was negative. The second patient arrived with her 4-month year old boy. She had attended to get an IUD fitted. On vaginal examination prior to insertion an infection was detected by the midwife. The midwife explained to the patient that the IUD cannot be fitted today, first the infection needs to be treated with antibiotics and a further appointment made to fit the IUD. The woman received one intramuscular injection of antibiotics and a number of pills for her and her husband to take. The midwife explains to me that had the husband been with the patient he would have also received the injection, but as he is not here an extra pill is given for him. Condoms are also provided with the advice to use them or refrain from sexual intercourse until the infection is cleared.

The social workers were also situated on the ground floor in a room off from the waiting room. Each new patient attending the clinic sees one of the social workers to determine their needs. The data gained from the questions asked feeds a monthly report, giving data on the nationality and country of origin of the patients, the length of time they have been in Greece, and the type of accommodation that they are living in. It is also an opportunity for other needs or issues to be identified. I observed the work of the social

workers for a day in their office.¹⁰⁷ A woman attended with her two young children. The family was Syrian and had left Lesbos island paying for their own boat ticket. They were staying in a hotel in Athens. The husband was already in Germany and the woman did not want to claim asylum in Greece as she was planning to go to Germany illegally when they found the opportunity. The woman was pregnant and had attended the clinic for a termination of pregnancy. The woman seemed upset and anxious in the consultation. After the registration was finished the family were seated back in the waiting room to await the midwife. Elements of the consultation had made the social worker suspect a history of sexual violence. The social worker called ahead to the midwife to inform her of the suspected sexual violence case.

On the first floor of the DCC are the quieter areas of the non-communicable diseases clinic (NCD). At the time of my being there, there were 160 active patients on the case files of NCD. NCD clinic is by appointment, however known patients often came to the clinic without an appointment. I worked in the NCD clinic when the nurse was on leave. Drawing on my fieldnotes, a day in the clinic including the following events.¹⁰⁸ An elderly man from Tanzania attended to '*get a stamp*' for his prescription from the pharmacist. The doctor explained to me that the medication would be very expensive for him to buy himself, '*what else can he do!?*'. Another man attends for a check-up appointment. The doctor examines the patient behind the curtain and the cultural mediator sits on a chair at the desk. The conversation flows easily, and one would be forgiven for thinking it was three-way conversation due to the expressiveness and intonation used by all parties. Depending on the consultation, the appointments can last

¹⁰⁷ Fieldnotes. 29th August 2018.

¹⁰⁸ Fieldnotes. 20th August 2018.

20 minutes, 30 minutes, or up to an hour if it is the first appointment of a new patient. A couple arrive in the morning, both diabetic. They live in 'awful' living conditions in a camp on the outskirts of Athens. Their appointment is not until the afternoon, but the bus taking people from the camp into Athens only runs once a day in the morning. Next, an elderly woman accompanied by her daughter and grandson are invited through from the waiting room by the doctor. The woman, who had a complex history of hypertension, raised cholesterol, diabetes, and a recent eye complaint, was vocally happy on seeing the doctor and was giving prayers. She had just found out her sons were on a survivors list in a prison in Syria.

In the afternoon, a woman I had met a month previously attended NCD for a follow up appointment. She had insulin dependent diabetes. The previous consultation had been a PSEC (patient support and education clinic) with the nurse which covered the pathology and risks associated with diabetes, how to self-care and what proportion of your dinner plate should be vegetables '*not potatoes!*'¹⁰⁹. The doctor's consultation started with asking how the patient had felt in the past weeks since the previous appointment. The woman complained of aching arms, headache and difficulty sleeping. I checked her blood sugar which was high at 212mg/dl (11.7mmol/L). The doctor asked further questions about how she took her insulin, at what time in relation to meals and how much. She also asked about her diet and day to day activities. The doctor knew the woman '*from the camps*' where she had worked previously, and after the consultation said to me that the woman did not seem as happy and active as she had been in the past. On weighing the lady, she had put on 5kg since she was last weighed. The doctor

¹⁰⁹ Fieldnotes. 11th July 2018.

advised 30 minutes walking every other day to help her lose weight and also to have some time to herself to help her feel better. The woman disclosed that she had problems with her left knee. The doctor examined it and gave thorough advice on how to take care of knee injuries; avoid walking upstairs or steep hills, sleep with a rolled-up towel under the knee for support. She also advised that losing some weight would be of benefit as it would take some of the stress from the knee. The last point made the woman laugh.

Here we have explored the departments in the DCC through my observations and interactions. Many things interact with the health and wellbeing of the patients who use the DCC. Barriers to the pursuit of a healthy life seep through the snapshots provided in the text. Sexual and reproductive health is an important component of humanitarian assistance, including access to family planning (Asgary and Price, 2018; Ben Abdelahfidh et al., 2019; Kaufman et al., 2020). Personal safety and security, and access to sanitation and hygiene are daily concerns for reproductive health in migrant and refugee women (Metusela et al., 2017; Schmitt et al., 2017) and women and children are at increased risk of adverse health outcomes in a refugee context (Balinska et al., 2019; DeJong et al., 2017). Managing chronic disease can be an increased challenge for refugees and migrants in unstable and precarious living conditions. The observations suggest some of the many challenges felt by people trying to stabilise the symptoms and management of their health for diseases attributed to external factors, specifically 'lifestyle' (Whitmarsh, 2013). For the refugee and migrant population there are significant barriers to pursuing the chronic disease public health message of compliance and empowerment (Whitmarsh, 2013; World Health Organisation, 2002). Financial barriers prevent access to medications (Dator et al., 2018; Skull and Murray, 2005;

Tsimtsiou et al., 2020) and limited resources hamper healthy lifestyle habits such as fresh vegetables or the freedom and space to exercise (Kayali et al., 2019; Murphy et al., 2017). Poor access to healthcare services due to spatial arrangement of refugee camps and health services are further exacerbated by restricted means of transport (Saleh et al., 2018). Experience of trauma and the associated anxiety and stress impact social functioning (Cardozo et al., 2004), exacerbated by poor access to legal support and information (Ben Farhat et al., 2018; Chuah et al., 2018), and separation from family members (Choumanivong et al., 2014). These are the experiences of the people who use the service, the stories listened to, and challenges faced everyday by the staff in the provision of care. Building on this, the next section will consider the connections and relationships required to join the dots, to assist with access to other services and facilitate holistic care outside the walls of the clinic.

Making connections, utilising relationships

The functionality of the centre, whilst envisioned as a '*one-stop shop*'¹¹⁰, necessitates a relationship with other services outside of the DCC in order to provide continuity of care for patients. To meet the health needs of the patient population, the staff in the DCC in Athens navigate the 'complex network of relationships' both within the health care system and other areas (Kentikelenis and Shriwise, 2016, p. 13). Staff spoke of some improvements made in the public hospitals, specifically in the availability of translators, and the attitude of medical staff towards the refugee population in the hospitals. Despite this, significant barriers remained in place (Bradby et al., 2020; Joseph et al., 2018). One way that these barriers are overcome and negotiated is through the

¹¹⁰ Interview. Medical Coordinator. Athens, Greece. 7th August 2018.

personal relationships that staff in the DCC in Athens have with staff in other organisations. The importance of personal connections was demonstrated to me on many occasions in the DCC. I encountered an urgent matter during a hallway discussion when I was working alongside the midwives. The discussion took place between the midwife, the social worker, and the cultural mediator assistant supervisor. A woman in her third trimester of pregnancy had attended the clinic to see the midwives. As per routine, a HIV test had been performed and the woman had tested positive for HIV. This was the first time the woman had made contact with a health service during her pregnancy.

Due to the changes in the placental barrier during pregnancy, the risk of mother to child transmission (MTCT) of HIV in women not receiving antiretroviral treatment (ART) is increased in the later stages of pregnancy (Luzuriaga and Mofenson, 2016). This highlights the importance of timely access to healthcare (Singer et al., 2019). The time frame was short, and the pressure was on to make a referral to a hospital team that would '*act quickly*' to access ART and plan for the labour. Two hospitals were suggested, and two names of people known to work there. One, the husband of a colleague at the day centre, and the other an old colleague, but who '*may not be of any help as he works in the wrong department*'¹¹¹. It was decided that the midwife would try to call the colleague by phone with regard to her husband (the colleague was on holiday), and the social worker would wait for this information. When the discussion was finished, I continued with the midwife, and asked about this discussion. She explained that '*because of the Greek system it was difficult*', and they did not have a lot of

¹¹¹ Fieldnotes. 24th August 2018.

time for this patient to make the arrangements. Knowing people in the hospital, referring through personal connections would help to ensure the patient received '*the right care*'. Refugee and migrant women have unique and complex needs with regards to reproductive health services and sexual health (Mengesha et al., 2018) and there is increasing unmet needs (Dopfer et al., 2018; Rade et al., 2018). Major gaps remain in HIV services in Greece and other European countries, despite some improvements (ECDC, 2013; ECDC, 2017). The right to access care is uneven across Europe, and there is restricted access to ART particularly for undocumented migrants (Cuadra, 2012; Deblonde et al., 2015).¹¹²

The value of connections was also demonstrated in the NCD clinic. One day when working in the NCD clinic I entered the doctor's room towards the end of an appointment. The patient was being discharged. It was a jovial engagement with thanks and best wishes being exchanged between patient to doctor by the cultural mediator, with some additional Arabic blessings being spoken by the doctor much to the delight and gratitude of the patient. Whilst the man was being discharged from the NCD service he had additional chronic complaints that were outside of the remit of the MSF clinic. The doctor wrote a referral to the Spanish Red Cross who were situated in the same area as MSF. On the back of the referral letter, she wrote a number of lines in Greek.

¹¹² The barriers to access exist for other vulnerable groups in Greece. HIV incidence in Greece is rising, compounded by significant cuts in prevention services (Simou and Koutsogeorgou, 2014). An increase of new HIV infections in intravenous drug users (IVDU's) of 1500% was evidenced in central Athens in 2011 in a study that linked the increase to the economic recession (Paraskevis et al., 2013). A significant number of new infections amongst migrant and refugee populations are contracted after their arrival in Europe (ECDC, 2013; Fakoya et al., 2015). This is also the case outside of Europe. In Australia, 50% of new diagnosis of HIV for migrants in Australia were acquired after arrival (Sacks-Davis et al., 2020). This further demonstrates the paucity of healthcare support and prevention services for at risk populations and missed opportunities to both provide support and decrease risk further transmission (Dias et al., 2019).

After the appointment, I asked the doctor about her additional note. She explained that she had worked there previously to working with MSF and still had a number of friends there, so she was writing a personal letter to facilitate the handover of care.

These examples demonstrate how the benefits of patronage, a process well established in the Greek healthcare context, works for the benefit of patient access to services.

These connections do not only ameliorate the pathway but may also forge it through the barriers and challenges of the Greek context. Considering this reveals the network of relationships at play. Personal connections also facilitate care pathways. An elderly man, who one of the health care promoters visited regularly, had got confused over his numerous medications. The healthcare promotor brought the medication in to show the doctor, worried that the man was taking the wrong doses. It amounted to a shopping bag full of half empty packets mixed up and in the wrong worn cardboard packaging. At the end of her working day the doctor went through the bag, grouping the medications into little bags labelled with post it notes.¹¹³ Part of the functioning of the project, and the care provided is influenced by negotiations that take place between the project and other organisations through both personal and formal connections. I must make clear that this patronage is not based on money or personal gains. The networks rely on a like-mindedness to wish to support those who encounter barriers in the usual systems, on caring.

¹¹³ Fieldnotes. 20th August 2018.

Caring for staff

By working and living in the setting, staff know the system and the ways to facilitate patient care pathways. Overtime, they develop relationships with the patients who have been rendered immobile by the state. This increased proximity to the lives lived by the patients is understood by management to be a major factor in the emotional burden and stress felt by staff and the high incidence of 'burn out'. The medical coordinator in Athens called the situation 'unique' in her 13 years of experience with MSF.

While we can say oh Greece, it's not Sudan, it's not Chad, it's a country where you can finish your day and go in a café, you go in a beach... you have restaurants it's a beautiful country, but even though people, they are getting very emotionally err... affected by the situation of people. You don't have blood in the streets, so you don't have this mechanism as a humanitarian , because first of all the frame is done for this because you have the security, briefings, and you are followed very closely , so you develop mechanisms mentally speaking, you know when you go to Sudan , when you go to chad, when you go to Iraq, you are already prepared mentally, when work in Greece you are not prepared because you don't expect to reach this level of violence mentally speaking.

Interview, Medical coordinator, Athens.

In addition to and exacerbated by the emotional violence of the setting, staff spoke of the frustrations of never doing enough '*you feel very disappointed... We are doing a great job but sometimes you feel that it's not enough what you're doing, and you want to do more, and when you can't do it, it's very frustrating.*'¹¹⁴ A midwife, who

¹¹⁴ Interview. Health promotion supervisor. Athens. 19th August 2018.

disclosed that she had taken sick leave due to burn out reflected *'you cannot do everything, you cannot save the world, you are coming with this feeling that, okay I'm, going there and I'm going to save them all, and when you realise it's not what you have to do here, you feel disappointed.'*¹¹⁵

The medical coordinator raised a number of issues that she saw as accounting for the high amount of emotional burden in the team. One was the lack of mechanisms to mentally prepare staff and support them as in other contexts where *'you are followed very closely'*. This supports the view that organisational measures can have a positive and preventative impact. Support was felt to be lacking by a number of the team members, and there were significant tensions between the management and a number of staff. Mental health support was available for the staff but was seen as *'not enough'* by one of the staff, who stated *'I think that the clinic first needs to take care first of the staff and afterwards of the people coming, otherwise we will not be able to support them for sure'*¹¹⁶. In Greece, the pursuit of holistic care finds the staff more involved as actors in a *'profound political struggle'* (Rieff, 2019) rather than neutral providers of aid. The holistic approach challenges the long-term critique of humanitarianism as an intervention that denies full subjecthood to people accessing humanitarian assistance (Feldman and Ticktin, 2010), and more as knowing professionals. As expressed by the Medical Coordinator, *'they are entering the life, they are entering the feelings, they are entering the emotions. A midwife in the day care centre, when she follows a pregnant woman, I mean she knows everything about her, she share with her her family, she show her the pictures of her kids, of her work before'*¹¹⁷.

¹¹⁵ Interview. Midwife supervisor. Athens. 6th August 2018

¹¹⁶ Interview. Nurse. Athens. Athens. 1st August 2018

¹¹⁷ Interview Medical Coordinator. Athens. 7th August 2018

As explored by cultural historian Bertrand Taithe, the conditions of burnout and compassion fatigue have been part of the humanitarian narrative since the nineteenth century, though its adoption at the institutional level has been gradual (Taithe, 2019). Now well recognised as a risk factor in healthcare (Adriaenssens et al., 2015; Bakker et al., 2000; Stewart, 2009) and in humanitarian settings (Ager et al., 2012; Jachens et al., 2019; Tassell and Flett, 2007) burn out is understood as result of a combination of emotional exhaustion, depersonalisation and a feeling of reduced personal accomplishment. Current literature supports the hypothesis that it is not the nature of the work that has the strongest association with negative outcomes, but the organisational elements (Jachens et al., 2019). Staff voiced frustration with the organisational structure, feeling that they were unable to voice their options and share problems, and felt undervalued in their role.

At my time in the clinic a number of changes had happened, there was a shift in coordinating responsibility from Operational Centre Geneva to the Greek office. Some staff who had been there for the two years since the project had opened, saw the changes as detrimental to the support given to the staff. The decrease in international positions had led to less diversity and more stasis in the team, and the regular visits from referents in Geneva had stopped, *'we were feeling that, someone at least listens to us. They know our names. We talk. They listen. They talk to us. Then this diversity is lost,.. that's what MSF is, different cultures, different experts and national staff, and now we are only Greeks.'*¹¹⁸ The format of staff meetings was raised as an example of staff not being listened to, or given the opportunity to speak. At the beginning of the project staff

¹¹⁸ Interview. Receptionist Athens. 8th August 2018.

meetings had included everyone, *'we were participating, we were talking, all.. and everyone was free to say something, we had a topic, and we were talking and solving our issues that we had together'*.¹¹⁹ Staff meetings as they took place at that time I was there were very brief, often started with the field co saying *'Ok, I haven't got a lot to say today but..'* followed by a brief update on the context, reported movements of people, and the illegal 'pushbacks' of refugees and migrants by the authorities at the Greece/Turkey land border of Evros¹²⁰, where a new project had recently been set up (Greek Council for Refugees, 2018; Kovner et al., 2021; Mobile Info Team, 2019; Oxfam, 2017). A dominating feature of the 20-minute staff meetings I attended were staffing issues. The medical activity manager, the SRH activity manager and the mental health activity manager, all international positions, were all vacant, in addition to a second psychiatrist open to Greek applicants.

I was in Greece during a period of change in the DCC, and I noted in my field diary how the conditions of established staff groups, the emotional weight of the work and the elements of the organisational structure made office tensions very visible. MSF Greece had responded to the stress felt by the teams, mental health support was provided on request, and away days were scheduled monthly to encourage team building. Yet there remained on some levels a lack of understanding or recognition of the experience and challenges of the staff as valid. The international staff, and Greek staff in senior management positions had extensive experience with MSF. As demonstrated by the medical coordinator, comparisons were made with their experiences in other settings to

¹¹⁹ Interview. Receptionist Athens 8th August 2018.

¹²⁰ An alternative route to Greece from Turkey is the northern land route to Evros which crosses a large river. According to an internal MSF report, 2,900 people arrived via Evros in April 2018, half the estimated number for the whole of 2017 within one month (Médecines Sans Frontières, 2018).

frame the experiences of national staff in Greece *'here, there is no blood on the streets'*¹²¹, offered the Head of Mission questioningly on my orientation day. The NCD doctor, explained a conversation that she had with her line manager about the issue *'it's not a huge reach between expats and national staff but there is like, but there is a clear division, and this has to do with MSF in general, all the organisation actually. I was having this very honest discussion with my expat coordinator, that she made the comment for example that people so get so tired here, maybe they are not supposed to work in this context, and I tried to explain to her that it is the first time for all of us, we are young and with a lot of energy and a lot of... things to give to people, but we have been doing this none stop most of us for minimum 2 years now and that is the big difference.'*¹²²

In Agok, the fluctuation of management engagement and the discontinuity in the dropping and picking up of different objectives in staff changeover affect the continuity of quality care in the project. In the context of a high workload and minimal staff structure, 'the most important thing' benefits some services and therefore some patients over others. At the foundation of each problematic are discordances between staff groups and an unequal weighting of the responsibility of quality on the nursing staff. Structural agency is personified in the international staff members, as new activities are pursued with intent and much energy and then abandoned demonstrating a repetitive pattern of epistemic failure in the institutional memory of the project (Carpi, 2019). Postulations such as *'it just falls out of their heads'* feeds into an imaginary

¹²¹ Fieldnotes. 26th June 2018.

¹²² Interview. Doctor, International staff. 12th August 2018.

that neglects the professional competency of the staff and transfers an understanding of the challenges of the sustainability of practices on to the national staff.

In Greece, the design of the project encourages proximity between the patients and the staff in the centre. Staff rely on personal connections and knowledge of the Greek system to provide continuity of care and to negotiate the barriers in the healthcare system. The claims to quality through a holistic approach seek to meet the needs of the population in and beyond the walls of the centre. The increased stasis of the staff in management positions and the high-income setting with multiple additional actors brings different challenges to the care assemblage. The challenges of the lives of the refugee and migrant population, the frustrations and loss of hope of people living in unacceptable conditions in and around Athens and in Chios are taken on by the staff. This closeness of being 'in their lives' is interpreted by some as causing increased emotional stress amongst the team. In addition to the emotional violence of the project, the tensions between national and international staff remain present, and there is a need for increased organisational support and understanding that negates the impulse for comparisons of blood-filled streets with beaches and sunshine and values all staff and the challenges of working in a crisis affected setting.

Chapter 5. Constructing quality: mediating boundaries, limits of care

Introduction

Drawing on encounters at the MSF Operational Centre in Geneva (MSF-OCG) and my field research in South Sudan and Greece, this chapter will explore how quality is constructed by the material artefacts used in the field. Insights into MSF-OCG demonstrate the dynamic exchanges that contribute to development of protocols and guidelines at the operational level. What is included and what is omitted in the protocols and guidelines infers the priorities of MSF and makes claims for what quality means in the humanitarian setting.

In the clinical setting of Agok hospital, the guidelines and protocols bridge the divide between amateurism and experience, they mediate actions and constructions of expertise. Limited diagnostics and treatment options are framed in their application. In the MSF projects in Greece protocols are enacted differently, revealing tensions in their design for settings of resource scarcity when applied in higher income settings. Rather than systematically guiding actions to navigate the paucity of resources and investigations, the protocols are evoked to limit actions and efforts and to confirm the boundaries of MSF's interventions. Working in a higher income country brings increased scrutiny to the tensions between the remit of MSF and the possibility of action. The setting allows for an expansion of humanitarian action into the social and legal aspects of health and well-being as well as assisting people to connect with other services. This new approach both shifts the narrative of quality and raises new questions at the boundaries of its actions.

To frame this argument, this chapter will draw on the concept of boundary objects. A boundary object is something that enables the sharing of practices, ideas and knowledge (Star and Griesemer, 1989b). It is an artefact that coordinates the convergence of different social worlds or sites of difference and works to structure or mediate the relationship between them (Abbott, 1995; Allen, 2009; Seymour and Clark, 2018). A boundary object 'qualifies the way in which actors establish and maintain coherence between interacting social worlds' (Trompette and Vinck, 2009). As boundary objects, the protocols and guidelines disseminate knowledge through a structured process. This is mediated in its interaction with health professionals and other actants in the care assemblage.

Negotiating standards. A contemporary insight

In March 2017 I spent a number of days in the MSF head office of Operation Centre Geneva. During my visit there I attended a medical meeting, the agenda of which was led by the medical advisors for surgery and emergency care. The meeting was centred around two presentations on minimum standards and diagnostic packages in the field. Reminiscent of Bruno Latour's insight into the social production of scientific fact (Latour, 1986), this meeting demonstrates the interplay of actors that culminate to produce something that is then presented to the field as fixed. Protocols and guidelines interact with patients, illness, health, medications, staff, skill and knowledge, practices and routines. In doing so, they mediate coherence and connectivity as well as friction and disengagement. An aim of guidelines and protocols is to standardise practice and they speak to an idea of universalism in their creation and anticipated use. As artefacts, protocols and guidelines 'condense the signs of historical and cultural context in which they are created' (Impedovo et al., 2017, p 21). They are the objectifications of a series

of processes, ideas and debate. In MSF, the protocols and guidelines are part of the ecology of emergency humanitarian interventions (Jean-Hervé Bradol and Claudine Vidal, 2011). Created to ‘respond to a need for coherence, continuity and capitalisation of experience’ (Médecins Sans Frontières, 2019), they act as a safety net for staff to both guide and support their practice.

Two presentations took place within the meeting¹²³, the first presentation was entitled ‘*Establishing a set of minimum standards for surgical patients in the OCG*’ and proposed a set taxonomy to denote surgical capabilities across MSF OCG projects. This was an OCG proposition, with aspirations to become an intersectional agreement. The objective was to categorise the surgical capabilities of each project in accordance with meeting set minimum standards to ‘*guarantee the best possible outcome*’. The matrix for these categories was distributed to each participant as a handout, and photos accompanied the slides from the field demonstrating field settings as examples of each category. The purpose of the presentation was to get the ‘go-ahead’ from OCG, and the presenting team were planning to present to the operational team to get further agreement with the categories and methodology.

The second presentation ‘guiding diagnostic packages for operations’ was led by the medical advisor to laboratory health services. In contrast to the first presentation, the document presented was intersectional and was described as ‘sort of’ finalised in October 2016. Three diagnostic packages were proposed: basic diagnostic package, recommended diagnostic package and desirable diagnostic package. Each package was

¹²³ Fieldnotes. 16th March 2017.

charted against three types of MSF programs: basic health care centre or mobile clinic with no laboratory services, primary health care clinic with a small laboratory, and hospital setting with a general inpatient and out-patient department. Ten diagnostic areas provide subheadings for forty-three diagnostic elements. Under the basic, recommended and desirable column a yes or no indicated the inclusion of the diagnostics in the package, or more specific details of which diagnostic test. To give an example, malaria can be diagnosed using a rapid diagnostic test (RDT) or smear test which is the microscopic examination of a blood smear (Bourgeois et al., 2010; Boyce and O'Meara, 2017). As per the guidelines for a basic health care centre under the subheading parasitology, RDT is indicated for basic, recommended and desirable package. In the hospital setting with laboratory and microscopic capabilities, RDT + smear is recommended for each package.

The meeting was an interactive engagement. Particular points of controversy were raised during this presentation in relation to the decisions to not have access to certain diagnostics in certain field settings. This distinction was discussed in some length when the meeting considered the recommendation to not have the functionality to test for HIV in basic health care settings with no laboratory services. On the document the box is checked as 'no' for basic diagnostic packages, and yes for recommended and desired packages. This was challenged by some of the attendees at the meeting who felt strongly about not having the facilities to test for HIV within the basic package. Not performing HIV tests means delay in treatment and the potential spread to more people (Giguère et al., 2021). Despite initial long debates in the 1980s and 1990s of whether providing HIV treatment was in the remit of MSF (Bradol and Szumilin, 2017; Fox, 2014), MSF has extensive experience in providing HIV care and treatment (Ferreyra et al., 2018; Fox

and Goemaere, 2006; Klarkowski et al., 2009; Ssonko et al., 2017). The ensuing discussion revolved around the requirement for further services in addition to diagnostic services for HIV, including the need for patient counselling and the availability of treatment/referral pathways (Bateman, 2013; Wanyenze et al., 2011).

What was evident from both the presentations was how more time was needed to fully explore the contestations by the audience. The questions and interjections were received with a mix of defensiveness and discomfort, in part due to the short time allocated. Being an observer to this meeting provided a great insight to the enormity of the decisions made, the complexity of the space between operations centre and field, and the difficulty in gaining agreement and making the 'right' decisions. The two presentations speak to related but different elements of the debates of standardisation within MSF. The diagnostic packages proposed had been assembled to aid the setting up of projects, developed in recognition of the timely task of deciding and discussing the implementation of diagnostics tools when opening a new project. This speaks to the concept of the 'kit', a collection of specific items and equipment related to a specific setting or context, that enabled ease of use and standardisation of practice (Jean-Hervé Bradol and Claudine Vidal, 2011).¹²⁴ As exemplified in the document, 'the diagnostic packages consist of three different approaches in order to allow for flexibility in the implementation process but also to ensure basic standard services coherently across

¹²⁴ Jean-Hervé Bradol and Claudine Vidal trace the beginning of MSF's use of protocols and 'kits' to the Sakeo and Khoa I Dang refugee camps in Thailand in 1979, identifying this as the first major independent mission by MSF. Due to the debates by the MSF team in this setting, in recognition of the time wasted in preparing to take equipment to the camps each day, the 'kit' or 'semi mobile equipment' evolved. The kits were assembled according to a specific list of equipment and medications, allowing for both ease of use and standardisation of practice. This work identifies Thailand in the 1980's as the nascent setting of what the authors argue became a key part of the 'specific "ecology" of emergency humanitarian interventions, the development of specific guidelines and protocols relating to practice (Jean-Hervé Bradol and Claudine Vidal, 2011).

MSF projects' (Diagnostic package team. Feb/17). In stratifying the packages, the aim of the guideline was for all settings to achieve basic (minimal) standards of diagnostic ability but to seek to achieve the higher levels.

In comparison, the standardisation of surgical sites does not fit as comfortably with the ethos of MSF. The categorisation of all surgical project sites, meaning the application of minimum standards across the board, speaks to ideals of universality in humanitarian practice that MSF have historically contested. As argued in chapter one of this study, the processes of codification and standardisation that fit into the narrative of professionalisation and accountability, prioritise and emphasise the universal over the contextual (Lewis and Mosse, 2006). Tensions between technical know-how as expertise and contextual 'value driven' commitment remain central to these debates (Farah, 2020; Roth, 2012; Steinke, 2020). Standardisation has become synonymous with quantifiable framings of quality in humanitarian response, and the achievement of minimum or basic standards (Glasman, 2020). The possibility and value of universal standards across diverse contexts remains questionable (Dufour et al., 2004; Médecins Sans Frontières, 2006b; Ruelas et al., 2012; Van Dyke and Waldman, 2004). In a lecture on the Sphere standards in 1998, Dr. James Orbinski, MSF's International Council President at the time presented the argument of MSF. He emphasised that the approach risked the reduction of humanitarian action to a 'technical and purely professional pursuit' and that standards can 'become a cover for masking the active or passive failure to achieve humanitarian principles, responsibilities and goals' (Orbinski, 1998). Although this was 20 years ago, that fact that such an approach to minimum standard categorisation had not yet been applied in MSF indicates the persistence of these

sentiments, a reflection of a commitment to the principles of volunteerism, independence and proximity to the populations where MSF works.

Stefan Timmermans and Marc Berg conceptualise the medical protocol as ‘a technoscientific script which crystalises multiple trajectories’, (Timmermans and Berg, 1997). Scripts are both resisted and pursued, shifted and adapted. Assumptions about that world are revealed in the elements present in the script and those that are absent. In their work, Timmermans and Berg put forward the need for what they term ‘local universalisms’, highlighting the need for flexibility in application. The flexibility was recognised in the propositions for guiding diagnostic packages, it provides the script, but is never ‘totally final’ (Minutes from meeting, March 16, 2017). The development and specifics of a protocol are reflective of a specific construction of knowledge, cultural and historical context. They incorporate an invisible infrastructure in their design and application (Star and Griesemer, 1989b). Medical guidelines demonstrate the role of boundary objects in their ‘interpretive flexibility’ and ‘incorporation of an invisible infrastructure’ (Trompette and Vinck, 2009). Their interpretive flexibility is demonstrated in the different ways they are used, or coarticulate with other materials in the care assemblage. For example, they may be adapted due to the unavailability of a product such as gloves or sterile gauze, or skill set of the practitioner. Considering the role of these artefacts as boundary objects, we will now turn to the setting of Agok hospital in South Sudan.

Balancing competence and experience: materials of standardisation as boundary objects in Agok Hospital

In Agok hospital, clinical guidelines in English and French are crammed on the bookshelf in the 'ex-pat living tukul' and occupy space on the plastic tables and wooden benches of nursing stations on the wards. The large wooden table in the emergency room, the centre point for administrative tasks and patient consultations, is laden with a plethora of international, national and site-specific protocols, along with the associated paperwork and observation charts. In every ward, posters of guidelines and information cover available wall space next to the nursing stations. Predominantly in English and therefore limited in their reach and effect for the national staff group of nurse and nurse assistants, many of whom have limited English literacy. For those with the means and the method, protocols and guidelines have a digital presence. The international guidelines can be downloaded on smart phones to be accessed at the patients' bedside and on the ward, or carried on the MSF USB stick, part of the paraphernalia exclusive to the international staff team. Designed for resource-poor environments where clinical investigations, medications and treatments are limited, MSF protocols are informed from a number of sources. They are simplified appropriations of (euro-centric) evidence-based practice, accounting for reduced diagnostics and limited accessibility to pharmaceuticals, and limited resources (Jachetti et al., 2019). They are developed and revised regularly according to culminations of field experience and feedback from the field. In Agok, the protocols for malnutrition have been adapted to account for the tall and thin physicality of the patient population. Initial malnutrition assessment takes into account weight comparable to height as a key indicator. Previously measured in comparison to a 'reference population', the protocols and measuring techniques were

adapted when it was realised the system was falsely indicating malnutrition (Leidman et al., 2019; Roberfroid et al., 2015).¹²⁵

The protocols form the treatment plans and are therefore a common meeting point between different staff and staff groups. They are referred back to when discussing practice and progression, they provide structure and essential guidance to those new in the field and concrete back up when actions are being questioned. The consistency of MSF to work with its own protocols maintains the relationship of trust held by the community, and strengthens the medical identity of the organisation amongst other actors (Abu Sa'Da, 2012) . In Agok, the deputy head nurse made this clear explaining that even if the outcome for patients is not good, *'the people know that MSF followed the protocols and did everything that they could'*¹²⁶. Drawing on my fieldwork observations and interviews, the following discussion draws on key boundary points where care was mediated in accordance, or not, with protocol guidance. These insights demonstrate the multiple factors that interact with how quality care is pursued in the care assemblage.

At the boundary of risk. Unclear decision making

Providing comprehensive care for neonates, that is babies in the first 28 days of life, is a relatively new component of care for MSF. MSF-Operational Centre Barcelona (MSF-OCB) began offering specialised neonatal care in 2009 (Dörnemann et al., 2017), the advanced neonatal care clinical and therapeutic guidelines for internal use in MSF-OCG were produced in 2015 (Médecins Sans Frontières, 2015) and the Neonatal Policy was

¹²⁵ This is specific to the measuring technique and inclusion criteria for infants who are 6 – 59 months, using the MUAC score and clinical presence of oedema over the Z score which relies on the weight and height of the child in comparison to a reference population. These specificities of the settings challenge the universal standard approach to malnutrition (Glasman, 2020).

¹²⁶ Interview, Deputy Head Nurse. Agok. 23rd January 2018.

finalised in 2016 (Médecins Sans Frontières, 2016b). The increasing attention to neonates is not unwarranted. Complications of prematurity¹²⁷ and associated low birth weight are a leading cause of death for children under 5, and neonatal deaths account for 40% of under-five mortality (Liu et al., 2016). Research in MSF facilities has demonstrated the positive impact of the dedicated neonatal units in resource poor settings, without hi-tech equipment and limited specialised staff (Dörnemann et al., 2017; Ndelema et al., 2016; Thomson et al., 2017).

The neonatal ward in Agok is within the same building as the maternity ward. Electric fans hang down from the high ceiling throughout the ward but to little avail.

Temperatures in Agok reach 30 – 40 degrees Celsius. In this heat, the temperature inside the ward becomes so hot that the metal bed frames are hot to touch. At night the temperatures drop significantly. In line with other ‘low-tech’ MSF facilities, there are no incubators to regulate environmental temperature for neonatal patients as would be expected in ‘high-tech’ environments (Ndelema et al., 2016; Thomson et al., 2017).

There were two raised ‘warming beds’ next to the nurse’s station, resembling an incubator, made from wood with three sides raised, but not enclosed. Foil blankets and hats were used to aid warming.¹²⁸

¹²⁷ Babies born at less than 37 weeks’ gestation.

¹²⁸ Mother and baby skin to skin ‘kangaroo care’ is encouraged by MSF in line with World Health Organisation recommendations for babies weighing 2000g or less at birth. The recommendations are for ‘continuous kangaroo mother care as possible’ or intermittent care if not possible. The benefits are cited to include the prevention and treatment of hypothermia, frequent and exclusive breastfeeding, prevention of nosocomial infections and fostering the mother to child bond (Conde-Agudelo et al., 2003). The midwife explained that it ‘was not easy’ to get the mothers to do kangaroo care. Discussions with national staff highlighted poor explanation of the technique and that both staff and patients ‘were not convinced’ Fieldnotes. 28th October 2017.

I was in the neonatal department one afternoon when the Medical Activity Manager (MAM) came in to speak to the CO on duty.¹²⁹ The MAM had reviewed the case notes of a neonate who had died, and the CO had been on shift whilst care was being provided. From reviewing the case notes, the MAM concluded that a presumed cause of death was neonatal sepsis. In Agok neonatal sepsis was indicated for 8.3% of the deaths in 2017 (Médecins Sans Frontières, 2018a), although this figure could be higher due to the inaccuracy of recording only one diagnosis in the data entry, when multiple diagnoses are often present on the patient medical chart. A retrospective study of an MSF managed neonatal unit in Aweil Hospital in South Sudan reported neonatal sepsis as the leading cause of death over the four year period studied, concluding it was responsible for 49% of deaths (Thomson et al., 2017). For the patient in question, the clinical observations recorded by the nursing staff had shown repeated hypothermia, a danger sign for neonatal infection, but this had not been acted on and antibiotics had not been started. In the discussion that followed, the reasoning given by the CO was that the temperatures were recorded overnight, stating he related the low temperature of the baby to the temperature of the environment. They went through the observation chart together referring to the protocol, with the MAM identifying the occasions of hypothermia and emphasising the missed opportunities to act.

In the daytime, due to the high temperatures in the wards the international paediatrician explained she had a process to differentiate between *'who has the fever because of the environment temperature, and who is sick with fever, ... because we do not have the lab capacity to differentiate'*^{130.} Her system took into consideration the time of

¹²⁹ Fieldnotes 19th October 2017.

¹³⁰ Fieldnotes. 25th October 2017.

day, and whether the temperature lowered following tepid sponging. Trepid sponging is a process of cooling the body with damp cloths. It was common practice for the nursing staff to advise the caretaker to perform tepid sponging on a febrile child as an initial intervention. The MSF nursing guidelines for management of a child with hyperthermia advises tepid sponging as a method to control body temperature in addition to an antipyretic. In the hepatitis E protocol, where aspirin and non-steroidal anti-inflammatories are contraindicated due to liver pathology, and paracetamol is given with caution, persistent fever that is non-reactive to tepid sponging is an 'alarm sign' for indicating suspected hepatitis E. Neither the MSF clinical guidelines nor the MSF advanced neonatal care guidelines advise tepid sponging for treatment of hyperthermia (Médecins Sans Frontières, 2015; Médecins Sans Frontières, 2018c). The MSF nursing guidelines however, do advise tepid sponging in the section *Management of Hyperthermia in Children*, although the focus is on the prevention of convulsion and does not mention possible infection (Médecins Sans Frontières, 2014, p. 112). Research into the effectiveness of tepid sponging builds an unclear picture which overall shows no clear benefit in usage for hyperthermia (Mukhtar and Elnimeiri, 2014; Purssell, 2000), and there is a long established concern with the association with vasoconstriction and heat retention caused by tepid sponging (Aynsley-Green and Pickering, 1975; Lim et al., 2018).

Hyperthermia and hypothermia are both 'danger signs' in the detection and management of neonatal infections (Médecins Sans Frontières, 2015; Médecins Sans Frontières, 2019). In the absence of more sophisticated and rapid investigations, the presence of one danger sign is an indication of possible infection, and therefore prompts antibiotics. The advanced neonatal guidelines give short time frames for responding

with antibiotics if temperature does not improve with initial interventions. Thirty minutes if an infant's temperature doesn't improve with warming, and fifteen minutes if then a raised temperature isn't reduced on removal of clothes (Medécins Sans Frontières, 2015). For the international staff, a grey area existed associated with their position of authority and expertise, they expressed the freedom to '*think outside the box*'¹³¹. Here, this is expressed as the creation of additional rules to negotiate the high temperature on the ward, informed by an adversity to over-prescription of antibiotics (Ain Ibrahim et al., 2020; Fuchs et al., 2018; Vatne et al., 2020).¹³² I bring together these two examples to demonstrate the relationships between multiple actants in the care assemblage that interact in care provision. What I wish to emphasise here is the additional challenges raised in an unstable clinical environment. I use the term unstable to highlight the extreme environmental temperatures, the lack of equipment to provide environment stability (incubators) and the additional rules added to the invisible infrastructure of protocol related practice by those with the agency to do so. In resource poor settings with limited diagnostic capabilities or assistive technology, medical staff negotiate a difficult position in the unstable care assemblage of the humanitarian setting (Schnall et al., 2019; Tyndall et al., 2020).

Boundaries of practice

Improving quality through capacity building was an identified objective of Agok, proposed in part by the transfer of skills and knowledge from international to national

¹³¹ Interview, Medical Activity Manager, Agok. 11th November 2017.

¹³² There are wider consequences to the lack of specificity. Preventing antimicrobial resistance in resource poor settings is hugely challenging and is a further demonstration of how areas in the world deprived of good health care continue to suffer the extended consequences. Not treating the patient in front of you with antibiotics for a possible bacterial cause to their illness risks their death, over treatment of the population with unnecessary antibiotics is contributing to global antimicrobial resistance (Mohamed Moctar Mouliom et al., 2019; Tadesse et al., 2017).

staff. The training team was central in this aim, with a mandate to ‘demonstrate and transfer competencies’ using bedside coaching.¹³³ Nursing practice in Agok is guided and informed by a 245-page document entitled Nursing Guidelines (Médecins Sans Forntières, 2014). The A4 size booklet is found on every ward. It is divided into twelve sections and explains step by step the procedure for sixty-eight nursing processes and interventions. As stated in the foreword, the purpose of the document ‘is to provide recommendations and practical tools... it is not a training guide [and] does not attempt to justify choices of recommendations, and gives little or no background to the anatomical, physiological or pathological concepts involved in care’ (Médecins Sans Forntières, 2014).

Teaching takes a predominantly technical approach, the format speaks to the social constructionist model which prioritises practice or action as a way to enact knowledge transfer (Orlikowski, 2002). In line with the ascertain that ‘knowing is action’ (Tsoukas, 2005, p 5), a practice based approach is taken both in teaching and assessment.

Trainings with the nursing staff prioritised ‘know how’, the ‘capacity to perform or act in particular circumstances’ (Orlikowski, 2002, p 251). Teaching was focused on what to do and how to do it rather than explanations of why. The practice demonstrated is the ‘information carrier’, rather than the theoretical elements that inform them (Ringberg and Reihlen, 2008). The Quality-of-Care assessment performed yearly focused on the technical application of the protocols in practice. The bedside training manager explained the assessment.

¹³³ Individual field evaluation. Bedside training nurse objectives. Internal document.

The quality-of-care assessment is one who just focus on assessment of technical care. It is one of the components of quality of care that is put in place by the headquarters. So, we assess in total 19 cares in all hospital including maternity. And each department have specific care to be assessed and each care is assessed on 10 criteria. So those criteria allow us to see for example, the care if they are well provided, what are the care that we need to reinforce... so we can also access and to see. For sure we cannot assess 100% the training but what we can do is to inform the staff before doing the assessment, we tell them I am coming to observe you giving blood transfusion for example, so you have to apply what you learn on the training or you have to apply what the guidelines say. So if you do it according to the guideline this means you don't need training for example, and there is knowledge, the knowledge is already there, but if people didn't apply it, or people didn't do it according to the protocol, then we can say ok maybe people need training on that. Yeah that is it – how to assess globally the quality of care.'

Interview. Bedside Training Supervisor. Agok. 15th January 2018

When I first arrived in Agok the quality-of-care assessment was being carried out in the hospital. The bedside trainer, at that time a nurse from Canada was frustrated with the process, *'sometimes I just have to wave the white flag'*¹³⁴ she said defeatedly. Her frustrations were with her role of *'enforcing the protocols'*, of using sterile swab or cotton wool to clean area of skin prior to cannulation and cleaning the top of vials used to constitute intravenous medications prior to opening/ penetrating. The same frustrations were felt by the following bedside trainer *'this is the example which, which annoys me the most like, if it's just cleaning the vial with iodine before you penetrate it,*

¹³⁴ Fieldnotes. 16th October 2017.

just you try to convince people that this is important, even though that is way harder than I expected,¹³⁵

To teach actions rather than the knowledge that supports the actions, does not encourage autonomy in practice or the development of reflective critical thinking, *'you are given the practice, but not the reason behind why you are doing something'*¹³⁶ explained one of the nursing staff. For example, skills and knowledge in asepsis and aseptic non touch technique are transferable across nurse practices and procedures, yet this wasn't taught as a component separate to a procedure. In teaching MSF nursing procedures, an immovable component was the specific chronology of actions. The rigidity of the protocols and their presence as the backbone of practice some tension amongst the staff. *'They'll just say it is in the protocol'*¹³⁷ said a staff member when questioning the proposed use of sterile gauze in a nonsterile procedure. Further frustration was expressed by one of the bedside trainers *'the protocol on how to insert a urinary catheter, I mean there are so many things to, so many ways to do it right as long as they do it as they work, sterile, aseptic, if they do a salto'*¹³⁸ before they do it, *I don't mind as long as it's clean'*¹³⁹. The rigidity of the nursing protocols created tensions and frustrations in all staff groups. To be a successful platform in sharing and disseminating knowledge and practice protocols require some give, to 'bend to local universalisms' (Timmermans and Berg, 1997, p 287), or at least to allow discussion.

¹³⁵ Interview, Bedside training nurse. International staff. 18th January 2018.

¹³⁶ Interview, nurse, relocated staff. Agok. 9th January 2018.

¹³⁷ Fieldnotes. 9th November 2017.

¹³⁸ Somersault

¹³⁹ Interview. Bedside training nurse. International staff. Agok. 18th January 2018.

The concept of capacity building is problematic. An unequal dynamic is assumed in its pervasive and accepted discourse (Hilhorst and van Leeuwen, 2005). In development literature, capacity building is held as a key component of sustainable development (Muneer, 2011; UNEP, 2002). In practice, the transferring of skills and knowledge is a challenging objective and rests on problematic assumptions. The action implied by 'transfer' is problematic. Inherent in this approach is the assumption of 'expat' as 'expert' which suggests the staff as passive receivers of knowledge and devalues the knowledge and skills of national staff in the field (Farah, 2020). The approach taken to capacity building does not create resilience or progress in its task. Frustration from both nursing staff and the bedside training team arose in relation to the lack of flexibility in the nursing protocols. Nursing staff felt that teaching was repetitive and did not provide background knowledge for 'real learning', and many nurses expressed an enthusiastic attitude to learning. Frustrations in the bedside training team with the rigidity of the teaching methods and the protocols themselves threatened a unified message from the team.

Boundaries of life

The infectious disease ward in Agok is for people with suspected or confirmed pulmonary tuberculosis. I worked on the ID ward for a few days in my first weeks in the hospital. On the first day I worked alongside a male nurse who had been on the unit for 1 month. A young female patient was in the tent with her mother-in-law as her caretaker, who sat on the empty bed next to her. Her husband had died, and her children were with a neighbour. The patient's mother-in-law had accompanied her to the hospital due to her worsening condition, weakness, lethargy, shortness of breath and weight loss, and was distressed at the responsibilities left at home. She was

extremely thin and malnourished with old pressure sores on her bony extremities and sores in and around her mouth. The young woman was HIV positive with suspected pulmonary TB.

Co-infection with HIV and TB accelerates disease progression (Shankar et al., 2014). The combination causes significant problems in TB detection and treatment as HIV can cause atypical presentations of TB and a lower concentration of TB bacilli in sputum, resulting in poor sensitivity of the sputum tests (Mugusi et al., 2006; Padmapriyadarsini et al., 2011; Perkins and Cunningham, 2007). As stark evidence of global public health inequalities, areas and countries with the highest burden of TB are also the areas with neglected and insufficient social structures, fragile health services, inadequate funding and poor epidemiological surveillance capabilities (Deribew et al., 2012; MacNeil et al., 2020) . Despite prolonged international attention, commitments to combat TB have had limited successes (Claeyé and Jackson, 2011). As a result of this public health failure there is increasing prevalence of both drug resistant TB and extensively drug resistant TB (Migliori et al., 2010).

I asked the nurse about how further pressure sores would be prevented and how we could provide mouth care. He indicated that it is the carers responsibility and that she had been told to turn the patient regularly. The patient and her carer were from a village some distance away and did not speak Arabic or the local Dinka language. We called for a translator from ER so that we could explain the importance of turning and providing mouth care with clean water. The following day I followed the ward round with the C.O. The patient had deteriorated and was not taking diet or fluid by mouth. The plan from the C.O. was proactive, responding to the malnutrition by prescribing

high protein milk, a naso-gastric (NG) tube and regular pain relief. Continuing the ward round, the C.O expressed that unless step by step plans are written in the notes for the nursing staff, certain care practices such as pressure sore relief or care will not be done. Back at the nurse base, the South Sudanese doctor said to me that he thought she would live *'as she had survived three days [in the hospital] already¹⁴⁰'*. An NG tube was inserted that day as she was not tolerating food. The Medical Activity Manager came to the ward to review the patient after the NG tube had been inserted, after looking at the medical file he voiced to me *'we should let them die'*.¹⁴¹

Working on the TB ward has unique physical and emotional challenges. It is located in the north west corner of the hospital compound. Knee high orange plastic fencing marks the entrance point to the area, indicating that additional precautions must be taken. The ward is designed according to stages of diagnosis. The tent in the foreground is for suspected cases with eight to ten beds, each end of the tent rolled up to promote airflow. The tent sits parallel to a single-story concrete building. A concrete veranda runs the length of the front of the building, wide enough to comfortably house equipment; a metal cupboard for fluids and equipment, a square plastic table, and two large plastic bins. Behind is a brick building with four rooms, negative test result, positive test result (2 rooms) and diagnosed multi drug resistant TB (MDRTB). The nurse's station is away from the isolation ward and linked to the chronic care clinic. Each staff member writes their name on their facemask at the start of the shift and keeps it in a small plastic bag when back at the nursing station. Plastic aprons, a staple in personal protective equipment are not used and are not available in the hospital. The

¹⁴⁰ Filednotes 31st October 2017.

¹⁴¹ Filednotes. 31st October 2017.

TB ward is staffed by one nurse and one nurse assistant. The stigma associated with TB impacts people's health seeking behaviour, affecting access to services and poor treatment adherence (Ahmed Suleiman et al., 2013; Chang and Cataldo, 2014; Mbutia et al., 2020). In the hospital, this stigma also affected the staffing of the TB ward. It was difficult to recruit staff to work on the ward, and some staff in the hospital would refuse to cover shifts on the ward. The staff were frustrated by paucity of staff numbers. For a number of weeks only one staff member was on duty overnight '*they want you to give good care, how can you give 100% quality with little staff*'¹⁴².

The young woman died in the hospital. The Medical Activity Manager (MAM) arranged a case review to reflect on the case as a learning point for palliative care. Case note reviews are a common method of retrospectively reviewing the quality of care provided during a patient's stay in hospital (Hutchinson et al., 2013). In Agok, conducting case note reviews was identified as a way to monitor quality, provide teaching and learn from adverse outcomes. The format and frequency of the case reviews depended on the medical activity manager who organised and led the sessions. The review took place in the training room, led by the quietly spoken, heavily French accented MAM and aided by a projector screen and a power point presentation. Bullet points and tables detailed the case and the care provided, drawing comparisons between what was provided, with further recommendations and treatment plans from 'best practice' and the limits and capabilities of what can be achieved in Agok hospital.

¹⁴² Fieldnotes. 19th January 2018.

There were eight people in attendance, three clinical officers, one anaesthetist, two nurses and two bedside training nurses including myself. The trainings were held from 4 – 5pm and a number of others joined as the session progressed. One of the nurses who attended worked on the TB ward. The session began with a presentation of the case, demographics of the patient, presenting symptoms, past medical history, and the treatments, observations and interventions. The case was presented chronologically with the details taken from the patients notes and interpreted by the MAM into a PowerPoint. The discussion that followed centred on palliative care. The MAM emphasised the importance of good communication between the COs and nurses and the importance of recognising when a patient is palliative in order to making an early and clear plan. In the case being discussed, the patient had not been clearly identified amongst the team as being for palliative care until very late, despite the early postulation from the MAM. The anaesthetist emphasised that the key to palliative care was '*proper nursing care*'. Supporting this, the expat bedside trainer suggested that each task (mouthcare, management of pressure sores, regular turns) required to look after patients could be '*prescribed on the drugs cardex*' to ensure it was carried out. This angered one of the nurses who on standing said, '*you can't prescribe nursing tasks for nurses.*' The room felt uncomfortable. Following the case review I walked back to the TB ward with one of the nurses, he had come late to the meeting due to workload on the ward. He said he didn't understand why they had to '*blame*' someone, that he didn't think case reviews should be like that where it '*felt like blame.*'¹⁴³

¹⁴³ Fieldnotes. 16th November 2017.

The exchange in the case review meeting demonstrated the paucity of communication between the different staff groups. Tensions arose around the distribution of tasks between nurses and COs. The organisation of nursing care in Agok hospital is understood as having a task orientated approach.¹⁴⁴ In current usage, it is a criticism levelled at nursing for its depersonalized care (Fassin, 2008; van der Walt and Swartz, 2002). Held in contrast to that of a holistic approach to nursing care, derogatory use of task based care is premised on the idea that tasks are pursued and completed in an isolated fashion, 'technique- and efficiency-centred rather than patient- and dignity-centred' (Fassin, 2008, p 268). A crude example would be a nurse giving medications during a ward round without noting or actioning that the patient had repeatedly missed or refused the medication or changing a dressing without paying heed to other areas of the skin that were at risk of breakdown. In essence, the task alone is focused on, rather than the patient. With regards to quality of care, this approach is constructed negatively as it neglects a wider view of the patient as a whole.¹⁴⁵ The suggestion by the bedside trainer to prescribe the cares required into tasks angered the nursing team present in the meeting. These insights taken together construct a number of narratives around nursing care. As a staff group, nurses have an increased load of responsibility for patient care and research supports the view that quality care 'lies with them' (Sadeghi-Bazargani et al., 2015). This was reflected in Agok. What quality care is, or the

¹⁴⁴ The origin of task orientated nursing is attributed to a historic British nursing model (Hadley et al., 2007; Hadley and Roques, 2007; van der Walt and Swartz, 2002).

¹⁴⁵ In a meeting organized between the bedside training team, the MTL, head nurse and deputy head nurse about improving quality in the hospital, task orientated care was a key topic of discussion. The process of handover between shifts, that focused on medications rather than the condition or wider care needs of the patients was evidenced as key demonstration of task orientated nursing in Agok. This fed into persistent imaginaries about how the nursing team organized their work in ways that prioritised observations and medications but neglected personal cares such as hygiene.

‘normativity of care’ is frequently conceptualised as the interaction between the nurse and patient (Mol et al., 2010).

The importance of palliative care has long been recognised as an essential part of healthcare. As defined by the WHO in 1990, the goal of palliative care is the ‘achievement of the best possible quality of life for patients and their families’ for patients whose disease ‘is not responsive to curative treatment’ (World Health Organisation, 1990).¹⁴⁶ Despite some early initiatives, including the first palliative care centre in Africa being set up in Zimbabwe in 1979 (Downing et al., 2012), the global need for palliative care has not been met, with the greatest outstanding need identified amongst vulnerable populations in low and middle income countries¹⁴⁷ (Ddungu, 2011; Knaul et al., 2018; Powell et al., 2017). There is renewed interest to address the challenges in making palliative care a priority in humanitarian practice (Daubman et al., 2019; Hunt et al., 2020; Schneider et al., 2018; Smith and Aloudat, 2017; The Sphere Association, 2018; Waldman and Glass, 2020; World Health Organisation, 2018).

The increased push for palliative care to be made a priority issue in humanitarian response has been attributed to changes in the field (Hunt et al., 2020). Firstly, the growth in concern with NCD’s within humanitarian response, and therefore the increasing number of patients requiring end stage disease management (Powell et al., 2017). Secondly the challenges of the Ebola response which demonstrated a high need of palliative care due to the lack of curative care, high need of supportive care and high

¹⁴⁶ This early definition was specifically in relation to cancer care, with a wider definition to palliative care being adopted by the WHO in 2002.

¹⁴⁷ As a point of note, significant gaps exist between what is seen as best practice and the realities of palliative care provision in higher income countries (Iliffe et al., 2016; Spetz et al., 2016).

mortality rate. In addition to these drivers, the response to the covid-19 pandemic is demonstrating further need for an improved palliative care response (Rosa and Davidson, 2020).

The script of what a 'good death' is in Agok did not exist. Without having a protocol or guideline to act as the boundary object between the staff groups to allow for guidance, discussion, contribution and translation, finding a meeting point, or starting point was challenging. Research has shown that obstacles to palliative care in humanitarian settings include the lack of guidance and training, access to essential medicines, resource allocation, cultural sensitivity to ideas of death and dying, and the primacy of saving lives in humanitarian practice (Hunt et al., 2020; Nouvet et al., 2018). The expression of the certainty of death from the international doctor 'we should let them die', and the open-endedness of possible life from the South Sudanese doctor 'she will live' highlight further the space exposed by diagnostic uncertainty and discordance in approach, bringing into focus the challenges of providing quality care for the palliative patient in humanitarian settings.

MSF protocols are developed for use in contexts of resource scarcity. They act to bridge the tensions between medical practice and resource availability and mediate the sticky encounters global connections through medical engagement (Tsing, 2005). Turning to Greece, the second part of this chapter will question whether in higher income countries where a multitude of actors present both opportunities and barriers to the provision of care, the protocols lose their significance as boundary objects. Rather than acting as meeting points for different trajectories to reach a shared understanding, I will argue

they are less visible in a setting with numerous actors and an established health care system.

Greece. Beyond the clinic walls. Holistic care without boundaries

Because here we treat every patient as a unique human-being. On the one hand we have of course the protocols of MSF which is very important in order to have the same line globally, but on the other hand we adjust every protocol, every treatment, according to our beneficiary's need. So we are flexible on that and the midwives are very flexible. I have given this opportunity to them to be flexible and to adapt everything to the human's needs.

Midwife Supervisor 6th August 2018, Athens Greece.

With highly qualified health professionals, the protocols are not as prominent in guiding practice. The physical copies of guidelines and protocols did not have an overtly noticeable presence in the clinical areas. They were there, a file on the window ledge behind the doctor's desk in the NCD clinic and filed neatly in the midwife's mobile clinic cabin in Chios, but their role as boundary objects, as physical artefacts that gathered people, or essentially drew borders to the limits of care, was not as evident. In Greece, MSF is delivering care in a high-income country. The projects in Greece are a new approach for MSF. Employing a lawyer and a social work team and placing an emphasis on the plight of people outside of the walls of the clinical setting shifts the focus and remit of the project. Building on the holistic model as described in chapter 4, turning to Greece this chapter will question in the absence of protocols as boundary objects, what is at the edge of this new remit of MSF.

Improving standards to meet the context

Here in Greece it feels difficult to lower.. how do you say... we were providing less than people would get in a public service.. but not meaning that they wouldn't get the right

treatment. But for example for blood pressure tablets they used to take.. many of them coming from Syria which had a high medical standard, they used to take combination pill, an ACE inhibitor plus a diuretic, which MSF cannot provide so we provided it in two drugs... I think MSF is not used to work in a country with a high standard or in a high middle-income country. So... it's mostly used to work in very difficult contexts like Africa or south east Asia where MSF usually has a higher standard than the public system. So here in Greece MSF faced a higher standard, we had to adapt a bit the services.

Interview. Athens. Project Medical Referent, 21st August 2018

Data on the demographics of people using the MSF services in Greece show that the largest portion of people are from Syria. The second largest are people from Afghanistan followed by Iraq, then the continent of Africa which in the situation reports produced in Athens was not differentiated into the 54 countries on the African continent, though this information is taken on intake (Médecins Sans Frontières, 2018j; Médecins Sans Frontières, 2018l; Médecins Sans Frontières, 2018m). This picture fits with wider studies of the demographic of the refugee population seeking primary healthcare (Kakalou et al., 2018). As explained above by the Project Medical Referent (PMR), people from countries with a good healthcare system, such as Syria, are accustomed to a high standard of healthcare including the availability of pharmaceuticals. In response to this shift in dynamic, some medications were adapted from guidance as given in the essential drugs list (Médecins Sans Frontières, 2018e). Insulin is one example, *'we agreed that we will provide people with an insulin pen instead of the vials. Because in Africa or in Middle East, MSF works with the vials because its much cheaper. So here we agreed that because people are already used to a higher standard, that we continued it, for insulin I think it's more about the storage, about the application.*

*It's difficult to move with needles and with vials. So for them its more easy and more safe to provide the pen'*¹⁴⁸. Providing more convenient and safe forms of medication to patients because they are more readily available seems like a sound judgement and ethically just. There is wider consideration for safety, both in transportation and administration, and the safe disposing of needles in addition to ease of use.

Paradoxically, providing less convenient forms of medications in more challenging settings is not so palatable in comparison. In Agok hospital, newly diagnosed insulin diabetics would have long stays in hospital covering immediate management and the program of patient education and training for diabetes care, insulin management and blood sugar control (Médecins Sans Frontières, 2018d). Under the chronic care team in the hospital, once at home patients would return to the hospital for follow up, assisted with the provision of transport fees.

The prevalence of diabetes is rising globally, raising increasing concern in crisis-affected countries where epidemiological data remains poor (Kayali et al., 2019). The International Diabetes Federation estimates a 98% growth in the number of adults with diabetes in Sub-Saharan Africa in the 20-year period from 2010, predicting a figure of 47.3 million by 2030 (International Diabetes Federation, 2019; Mbanya et al., 2010). Lack of research and investment in diagnosing, treating and managing diabetes in lower income countries worsens the situation and projected course of the disease (DiMeglio et al., 2018). Research conducted by MSF into clinical outcomes and program costs in a outpatients diabetic clinic in North Kivu, Democratic Republic of Congo challenges the conception that providing diabetes care is too complex and expensive (Ansbro et al.,

¹⁴⁸ Interview. Athens. Project Medical Referent, 21st August 2018.

2019). Current insulin preparations are sensitive to temperature thus lack of refrigeration required for storage and transportation causes significant difficulty, compounded by the paucity of research on the relationship between temperature and degradation on newer insulins, and the inertia to develop a thermostable insulin preparation (Ogle et al., 2016). Providing extra concern, research has shown the incidence of atypical presentations in Sub-Saharan Africa and the additional barriers this produces (Carruth and Mendenhall, 2019; Gill et al., 2009). Diabetes care demonstrates the inequalities across the medical landscape or 'medicoscape' of global healthcare and humanitarian assistance (Hörbst and Wolf, 2014). The universalisms to which the international policies prescribe, bend inadvertently to support these inequalities, trapped in the dilemma of pervasive global health inequalities.

What are the limits then for interpretative flexibility when set in a land of (more) opportunity? With pharmaceuticals, finance and budget is a constraining factor, however I employ this question more widely to consider the role of team members. Speaking to the field coordinator, the ability or knowledge of the limits of MSF comes with international experience, of understanding the 'mindset or MSF'. He acknowledged that staff sometimes '*want to do things that seem a bit too much.. aiming for more than, I don't know if I can say, that would be necessary, always.. they want to do more than is acceptable, let's say, and then you say guys, guys, okay, we have a very clear protocol, just follow the protocol and you can do what you have to do*'¹⁴⁹. In a context of relative abundance, the protocols can then be used to rein in and limit the interventions given, to assert the boundaries of the capabilities of MSF. From this statement we can detect

149 Interview. Field coordinator. Athens. 27th August 2018.

the ethical/moral awkwardness of enforcing limits when opportunities are available. Although the interviewee declined to give a specific example of this in practice, the next section will draw on the roles of the health promotion and cultural mediator team, to question how quality is constructed in the limit of unclear boundaries.

(Re)Drawing boundaries. The role of the Cultural Mediators and Health

Promotion Team

Cultural mediators are integral to facilitate access to the health care system in Greece. Their role is essential in assisting people to negotiate the complicated Greek healthcare system, to bridge the social-cultural differences in seeking healthcare and healthcare provision. They are 'intercultural agents' who give advice to navigate unsurety and tensions, and ensure people are heard (Barsky, 1996). Within this role therefore is a significant power and agency in the translation and navigation of exchange (Baker, 2010). In Athens, the cultural mediator team numbered fourteen, including the supervisor and supervisor assistant. Together they were fluent in Farsi, Arabic, French, Greek and English. Based primarily in the DCC, they liaised with patients in the reception, supporting them on arrival, and accompanied patients during consultations to provide both translation and cultural mediation.

As the name suggests, cultural mediation is in place as a support to both the patients and the health professional, to ensure full understanding, consent and with respect to cultural sensitivities. The cultural mediator team have a number of roles and responsibilities in addition to providing cultural mediation during appointments. They escort patients to appointments outside the centre, for example to hospitals where there are no translation or mediation services. As a mediator the interaction is two way,

professional to patient and patient to professional each conducted through the CM. This can put a lot of emotional burden on the CMs, both through the distressing stories they must listen to and translate every day and the responsibility placed on them by the patient group.

You get a lot of involvement mostly from the patients because they try to drag you and grab you because you're, you know, the only part connecting them to anything else. You're the person that they can talk to no matter if they know that you cannot, you know, fix them, medically speaking, and this is, I think, one of the biggest challenges to know how to deal with that. You know, the pulling down thing, the emotional pull-down.

Interview Cultural Mediator. Athens, 29th August 2018.

The mediation is not simply an exchange of words and explanations, the weight or burden of the emotions stay with the cultural mediator, *'you say she's in extreme pain, but you just hear it. I feel it a bit more.'*¹⁵⁰ In their role as escorts for the patients to other service providers, cultural mediators experience first-hand the animosity directed at the refugee population and at themselves for assisting them. Holly, who had worked as a cultural mediator with MSF since 2015, first in Lesbos, spoke of the difficulties encountered in hospitals when escorting a patient.

A mediator in the hospital, it's not a mediator. You know, you stop being a mediator because you have to deal with all the paperwork. You have to deal with angry staff that are angry at something else, but, you know, because you're there and because you are

¹⁵⁰ Interview Cultural Mediator. Athens, 29th August 2018.

nothing. You are not a doctor. You are not nurse. You are not the patient, but even if you were the patient, they would yell at you for some reason... When we first started, in early '16, I think, I was the only person in a vest [MSF vest] and I felt like I was being looked at as an alien because nobody knew, nobody understood. They would not give us attention, even if you were lining up, you know, to get to the cashier or whatever, they would tell you half words, to give you difficulties sometimes.'

Interview Cultural Mediator. Athens, 29th August 2018.

This provision of assistance to organisations outside of the MSF clinics is a common feature of the two MSF projects I worked with in Greece. There is a shortage of cultural mediators in the health system (Greek Ombudsman Independent Authority, 2017; Mijatović, 2018). MSF CM staff spent a number of hours in the hospital to facilitate access to the services for the refugee and migrant population. The challenges of working in these different settings was raised by the supervisor.

As you can see from the feedback that it's a much different environment that they work. Here, it is more organised, they know what to do, they have the schedule, its more easier for them. But there, the specialists are, let's say, not so nice with the patient sometimes... one of the specialists hit a small child and was racist with the mother and the cultural mediator of course left... now he is back [in the hospital] but, you know, they are treating him very, very good and if somethings happens, he will withdraw. Unfortunately, the health workers in Greece are not having so much humanitarian sensitivity because they don't have any experience with that. So, they cannot just understand very well and sometimes they are mean or racist to them.

Cultural mediator supervisor. Athens. Interview 8th August 2018

On Chios Island, Chios hospital suffered from an 'absence of specialists...especially psychiatrists, gynaecologists and generalists... not only for the refugees but for the whole population (Médecins Sans Frontières, 2018k). A Memorandum of Understanding (MOU) was formulated between the main hospital in Chios town and MSF. An example of a formal level of negotiation, MSF uses MOUs to establish operational collaborative partnerships. Although not legally binding, MoU's carry some weight placed on mutual respect. The arrangement was for MSF to supply cultural mediators to the hospital to assist with services for the refugee and migrant population, and in return the hospital would facilitate the referrals made, i.e., provide the appointments and healthcare as required. One MSF cultural mediator with trilingual skills of Arabic, Greek and English attended the hospital daily from 08:30 -16:30. An additional Farsi speaking cultural mediator worked at the hospital each morning, coming to 'the garage' in the afternoon. Figures show that in July 2018 this support facilitated four hundred and sixty-seven appointments, demonstrating the importance of this role. (Médecins Sans Frontières, 2018k). Further facilitation of cultural mediators to the hospital occurred on a daily basis, depending on need. On a Friday afternoon, when *the garage* closed to allow for managerial and administrative tasks, all five cultural mediators attended the hospital to provide patient support, a demonstration of the paucity of the Islands services, and the willingness of MSF to assist in the wider health system in recognition of the inequity of access to services (Kotsiou et al., 2018; Kousoulis et al., 2016).

Providing assistance to other organisations is not a novel role for MSF. In Agok, training was provided to the midwives of the nearby primary health care clinic, distributions such as blankets and mosquito nets takes place in both settings' collaboration with other actors such as the World Food Program and KEELPNO, and training opportunities

are frequently shared to practitioners outside of MSF. In Greece however, the regularity of the assistance and acknowledgement by all parties of the inadequacies of the health service seemed to be a step further and the consistency is relied on by all parties. NGO support for the health systems is essential for the access and utilisation of state health structures by the refugee, migrant and asylum seeker population (Kotsiou et al., 2018).

Health Promotion is a common role in MSF teams. In Agok, the team would speak to people while waiting in triage, to inform them about water points and the importance of regularly washing their hands, in the wards they would do sessions on specific diseases or self-care, and in ITFC they would conduct music and singing session to encourage activity between the children and carers and provide sessions on breastfeeding. In Greece the health promotion team are key in promoting the services MSF offers and encouraging people to access the services. The Health Promotion Team supervisor explained the role as the 'PR¹⁵¹ of the clinic. The Health Promotion supervisor was a Greek nurse by background, who like many of the team had previous experience working with the refugee population.¹⁵² She managed a multinational team of seven with languages of Arabic, Farsi, Greek and English. In the reduced team in Chios, at the time of my placement there was one health promotion person who both managed and delivered the health promotion activities. Originating from Iran, she spoke fluent Farsi and English, and divided her time between the clinic and Vial camp. An Arabic health promoter had been part of the team but had left prior to my arrival. In Athens, Alice a health promoter originally from Egypt explained the role as follows.

¹⁵¹ Public Relations.

¹⁵² Previous experience was with MSF for example mobile clinics in the refugee camps or on one of the 'hotspot' Islands, or for other organisations for example supporting refugee populations in hotels prior to being moved to camps.

My job from the beginning is a health promotor is one who is trying to gain the trust of the people to introduce them with MSF also to know their challenges in urban Athens, what is exactly their basic needs here and also to try to refer them to other organisations, so we always go outside for the promotion, to talk with people. First of all we distribute for them the leaflets of the day-care centre to introduce them about our services, then we listen to their stories, before, I took many testimonies from the people, in aim to try to make their voice reach...outside Greece, to reach to all the world, what it is exactly that they are facing. Also, we are trying to raise awareness about some specific topics of health, .., so we started from the beginning to do some sessions like anti-natal care, post-natal care, breast feeding, family planning, and especially with family planning there are so important. And also, personal hygiene and sexual violence, sexual transmitted diseases and after that we added NCD topics, like heart disease and so on. Finally, with [the current supervisor] we added more topics, more important for the people who are living, especially in squats and many places that they need the basic healthcare, like dental hygiene, oral hygiene and many many other topics like sexual education and so on.

Interview. Health promoter, Athens 28th August 2018.

As indicated by Alice, the shelter and accommodation used by refugee and migrant population is varied. The mobility of people and resource allocation are affected by legal status, including the legally allocated status of vulnerability, which ‘constitutes a significant criterion in prioritising individuals and families among those who qualify for accommodation outside of camps and other services as well as relocation elsewhere in Europe’ (Kofman, 2019, p 2195). Refugee camps, apartments and squats are some of the places where people have varying degrees of security and shelter, and social integration (Kotronaki et al., 2018; Kourachanis, 2019). In Athens, the Health Promotion team had

built up a level of trust that allowed them to visit the squats in the city *'to know their challenges, to know their need, to know their life, how they are living, what is the problems they are facing.'*¹⁵³ Issues raised are fed back to the team at DCC. Not all requests or grievances can be answered, as many of the needs are outside the remit of the project.

We are trying to help, but sometimes, we can't find even the organisation. We have a specific service we can't do everything, and at the same time, the people are asking about cash money, they are asking about milk, for newborn babies, they are asking about papers. we have a referral form to refer the people to, every day we are asking [the supervisor], search for us, we need more organisations, more places, that we can refer the people to, because it is difficult when you hear the person talking, talking a talking and then you say sorry I can't help you. Really it is a big challenge.

Interview. Health promoter, Athens 28th August 2018

While extending the opportunity for grievances to be shared, the inability to do anything about it is a source of tension at the boundaries of the remit of MSF. Drawing on the roles of the CMs and the HPs demonstrates how the work of the DCC and the garage expands beyond the walls of the project site, revealing unclear boundaries at the edges. The work of the HP's and CM's is engaging with the 'politics of living', the 'surviving, claiming, acting' of people's lives (Feldman, 2012). In her work based on ethnographic field work with Palestinian refugees in Jarash camp Jordan, Feldman understands how people experience the 'dynamics of being' of living within and in relation to mechanisms of humanitarianism. The work of Ilana Feldman raises important questions which are relevant to the work of MSF, particularly as it extends

¹⁵³ Interview Health promoter, Athens 28th August 2018.

beyond the borders of the clinic through the valuable work of the health promotion team. In Greece, the 'material artifacts of assistance' and the relationships produced influence health, opportunities and 'life possibilities' (Feldman, 2012, p. 157). Taking a broader perspective to these connections, these influences appear to benefit some groups over others.

Patients on the periphery. The struggle to centre the neglected

The assertion that refugee sites are not 'neutral sites of humanitarianism' (Turner, 2015, p. 22) can be applied more widely to the urban settlement areas of Athens and Chios. As a culmination of the history and culture of host contexts, and the restrictive and marginalising effects of refugee and migrant legislation and social support, inclusion and exclusion from public spaces including spaces to receive health care has been shown to be racialised (Spicer, 2008; Spiegel and Qassim, 2003). The movements of people from Sub-Saharan Africa are relatively small but significant component of migrant flows but are one of the most stigmatised (Campani and Lapov, 2015; Schapendonk and Steel, 2014). The rhetoric of the 2015 onwards 'refugee crisis' was first constructed around Syrian refugees due to the increased movement of people due to the Syrian civil war, which in 2017 was 6.3 million Syrians (UNHCR, 2016; UNHCR, 2018). A study following the implication of the EU Turkey deal demonstrated how Syrian refugees were granted refugee status, with many Afghan asylum applications also successful. In comparison, most applications from people from the Democratic Republic of Congo were rejected (Eleftherakos et al., 2018). Mechanisms within the system of refugee management such as translators, whilst still poor are facilitated toward the target group of Syrian and Afghani refugee and asylum seekers (Kofman, 2019).

When the DCC was first set up, only Arabic CM's were employed. This grew to include Farsi speaking and then French speaking CMs and HP's. The languages spoken in the centre, specifically the skills of the cultural mediators and the health promotion team, has a huge influence the accessibility of the services and patient experience of the services. As described within the role of the HP's and CM's, knowledge of MSF and access to the services is facilitated by word of mouth, and the presence of the HP's in various settings and locations. The internal and external relationships that converge at the intersection of the medical humanitarian setting can work to inadvertently exclude some patients or patient groups.

In Chios, the single member of the health promotion team spoke English and Farsi. As previously stated, part of the role of the HP is to spread awareness of the services available. The effect of this singular route of communication with the Farsi speaking population was clear with the implementation of the travel medicine clinic, and the promotion of the services in the camp. The impact of having only a Farsi speaking HP to promote this service was demonstrated by the high number of the Farsi speaking population attending for appointments, an affect snowballed by word of mouth in the camp. Uptake by other groups for this service was minimal in comparison. In both Athens and Chios, some team members felt that French speaking populations were underserved. In Chios, the tasks of the CMs were spread across the hospital, Vial camp and 'the garage'. As in Athens, CMs would also accompany people to appointments when necessary. The one French speaking CM also spoke Arabic, therefore splitting his work role. This sometimes meant that he was unavailable when francophone patients required interpretation and assistance. He found it frustrating when he wasn't able to 'speak for his people' showing concern that the new doctor who had arrived could only

speak a small amount of French, and citing a instance when a different cultural mediator with very limited French had accompanied a French speaker to an Ophthalmologist appointment.¹⁵⁴.

In Athens, a member of the health promotion team who later worked in the advocacy team identified the challenges in her role of reaching the French speaking African communities in Athens.¹⁵⁵ She explained how going to different locations during working hours was not a successful tactic, *'so we would go to Omonia Square, but Omonia is full of Arabic speakers, and there is no French speakers there during the day because they work, and we would be sent to Victoria Square, but it is only Farsi speaking going to Victoria Square in these working hours'*. Different groups of refugees and migrants in Athens live and socialise in different locations in the city, and access to and association with these areas can be related to ethnicity, country of origin, language and working opportunities (Balampanidis and Polyzos, 2016; Papatzani, 2021; Tsoni, 2013). She explained how the francophone refugee and migrant African population in Greece were not considered as vulnerable, and therefore had less access to things, namely apartments. Her concern was raised for their health and wellbeing due to an advocacy report she had recently completed on sexual violence. *'I don't want to be exaggerating, but almost every woman that we saw coming here from Congo was a victim of sexual violence. It's the same for Cameroon. I mean its huge, its huge. more of them are travelling alone. African women travel alone. they come here because they have to escape the country where they have been raped already, and then they get raped in Turkey, and then they get raped in Greece; this is a common pattern that we have observed in this report.'*¹⁵⁶

¹⁵⁴ Fieldnotes. 25th September 2018.

¹⁵⁵ Interview health promoter /advocacy. Athens. 29th August 2018.

¹⁵⁶ Interview health promoter /advocacy. Athens. 29th August 2018

The high incidence of sexual violence and rape is a horrifying reality in the journeys of many people travelling to and within Europe (Freccero et al., 2017; Freedman, 2016). A study by MSF in the clinic in Lesbos Island, Greece into sexual violence against migrants and asylum seekers showed that 81% of cases were survivors from Africa. Half of the total number of incidents occurred in Turkey, 35% in the country of origin and 5 % on the Island of Lesbos (Belanteri et al., 2020). The increased risk to physical and mental health deterioration due to these vulnerabilities are compounded by the additional barriers to healthcare access.

At the time of our meeting, Sian had handed in her resignation at the DCC. She had been working for the advocacy team and she had resigned in part due to the feeling that the role wasn't achieving anything. The advocacy report to which she had contributed, which brought together testimonies of sexual violence, with the intention of shining the spotlight on the prevalence of sexual violence experienced by refugees and migrants, and to contravene the legislatively supported assumption that Turkey is a 'safe' country had been completed and sent to Geneva. *'I don't know what will be done with this work, because again, we did it, we did the data collections, we draw the observations, we draw recommendations out of our work, and then we had to send it to Geneva, so from now it's not in our hands anymore. I don't know what their expectation are out of this report. The work was very interesting... but again, there is a little bit of frustration in this as we can't use our homework, if you know what I mean'.¹⁵⁷*

¹⁵⁷ Interview health promoter /advocacy. Athens. 29th August 2018.

Her advocacy work also included raising awareness on the practice of not allowing undocumented new mothers to be discharged home with their babies, which resulted in a change in legislation in Greece (Médecins Sans Frontières, 2018f). Despite these achievements, she felt they were small in comparison to what needed to be done, or the impact of what she would report to her managers, *'you come back with the information that you've seen, and you have testimonies, and you have people who talk to you, and they say, yeah, but OK, this is not really our point here, I know it's sad, oh what a pity, but sorry this is not our point of interest at OCG.'*

In Greece, the holistic design of the project, and the availability of services in a high-income country blurs the boundaries of where care stops. The committed involvement of staff outside the walls of the clinic brings new questions to what the boundaries are for the remit of MSF in Greece. Is this mission creep, or a new innovative way to meet the needs of a growing population of people on the move? Without the context of resource scarcity, or a collective 'MSF mindset' the boundaries of care were hard to delineate, and the protocols and guidelines lose their role as mediators of quality.

Chapter 6. Quality in process

As the final empirical chapter, this chapter takes a different format than the previous two in that it draws solely on my research in Agok. My intention is to delve into the minutia of a clinical process. As a whole, this study expresses quality as relative to the associations of different people and things in the care assemblage. Understanding quality in this way allows the consideration of heterogeneous actants; people, materials and spaces. The co-articulation between these actants, the dynamic forming, re-forming and disconnect of associations, reveals the assumptions and theories inherent within these associations. This framing challenges the simplistic assumption that quality is primarily mediated by the setting, and questions the norms that exist within, and are reinforced by, the dominant narrative of medical humanitarian aid provision.

This chapter will explore the unstable care assemblage through the lens of a healthcare process. Looking in detail at a process reveals the connections between the elements of the process itself and their association to wider factors of influence. A process is a series of actions that contribute to a definitive aim. It is a collection of composite elements, an interaction of people, of objects and the application of theory, skills and knowledge. This chapter will focus on the process of intravenous administration and monitoring.

Centring my analysis on an everyday process focuses the lens of quality on mundane materials and how they are employed in the care assemblage.

The chapter will explain the importance of the process of IV administration. To do this it will explain the process and materials used in IV administration and explore the debates in healthcare practice. It will then give a detailed description of the inpatient department where I worked when in Agok. I have chosen this process because the

materials and process associated with IV infusion were prominent in debates and discussions around care practice, safety and resourcefulness on the ward, and involved a range of team members. I therefore put forward that focusing on the minute detail of a process enables a broader and comprehensive understanding of how quality is enacted in unstable settings.

Intravenous Administration

Intravenous (IV) administration refers to the process of infusion of a solution directly into the body's venous circulation. Intravenous administration is an essential and critical part of the management of many patient presentations in secondary care facilities and emergency care (Lee et al., 2015). It is a daily practice and is therefore both familiar and relevant. A common use of IV administration is for fluid therapy. Intravenous fluid therapy is required in many patient presentations according to the pathophysiological effects on fluid balance in the body. The requirement for IV fluid therapy can be categorised under the four R's: resuscitation, routine maintenance, replacement or redistribution (National Institute for Health and Care Excellence (NICE), 2013).¹⁵⁸ The body loses fluid in many ways. Regular bodily functions including sweating, defecation, micturition and vomiting cause the body to lose fluid and in extremis these bodily functions cause significant fluid imbalances. Blood loss as a result

¹⁵⁸ Resuscitation: Fluid resuscitation is the urgent requirement of fluid or blood products in response to a depleted circulatory volume, such as in the case of massive blood loss in trauma. Severe dehydration, caused by losses of fluid and electrolytes via the gastro-intestinal tract such as in acute watery diarrhoea, also requires fluid resuscitation. Pathologies can also cause severe internal losses, for example the redistribution of fluid in sepsis. Routine maintenance: Maintenance fluids are needed if a patient is unable to meet their fluid and electrolyte requirements by oral or enteral routes. A combination of fluids is prescribed to meet target daily requirements. Replacement: Replacement fluids are intended to replace external losses such as through fever, through the skin in burns patients or through the GI tract. Redistribution: The redistribution of fluids in the body is a complex issue in fluid management. Clinical signs include gross oedema and fluid retention. (National Institute for Health and Care Excellence (NICE), 2013).

of internal or external trauma requires replacement, as does the fluid loss from damage to the integumentary system as in the case of burns or cutaneous conditions such as Steven-Johnson Syndrome. Fluid loss can be defined under two categories. Absolute volume deficiency and relative volume deficiency. Absolute volume deficiency is attributable to massive fluid loss and the need to restore circulation, for example in acute severe diarrhoea, or massive blood loss. Relative volume deficit is the shifting of fluids within the body due to the body's compensatory mechanisms, for example in response to nephrotic syndrome, severe burns or sepsis (Malbrain et al., 2018; Puskarich et al., 2014; Roumelioti et al., 2018). The primary mechanism of relative volume deficit is dysregulated vasodilation.

Before detailing the process of IV fluid administration and monitoring, it is important to consider the key debates in the literature around IV fluids. The key debates focus on what fluids and how much; the benefits of colloids over crystalloids and vice versa, and the delicate balance of fluid resuscitation and fluid overload (El-Nawawy et al., 2019; Malbrain et al., 2018; Silversides and Perner, 2019). In 'developed' countries, the wealth of research is vast, in recent years a key focus has been on correct fluid protocols for sepsis as one part of early goal direct therapy (Dellinger et al., 2013; Saleh, 2018; Turi and Von Ah, 2013). As a reflection of global inequalities, bringing the debate to resource poor settings demonstrates a scarcity of research (Opiyo et al., 2014). A recent random controlled trial on fluid prescription in resource poor settings gained much attention. This research and its critiques are applicable to my argument as it is revealing of the tensions between (western) medical discourse and its application, and settings with resource scarcity. We shall consider this trial in the following section.

In 2011, a three-arm random controlled trial supported by the Medical Research Council, United Kingdom, investigated the association between bolus fluid resuscitation and mortality. This study carries weight, holding the methodological accolade of a randomly controlled trial published in a highly respected journal, which won the BMJ paper of the year in 2012 (Maitland and South, 2012). This study was known as the FEAST trial, an acronym for the full title 'fluid expansion as supportive therapy in critically ill African children' (Maitland et al., 2009; Maitland et al., 2011). It was conducted in a number of hospital sites in Tanzania, Kenya and Uganda. Children eligible for inclusion were those between 60 days and 12 years old and presented with severe febrile illness complicated with either impaired consciousness (prostration or coma), respiratory distress (increased work of breathing) or both, and with impaired perfusion. Impaired perfusion was evidenced by one or more of the following; prolonged capillary refill (more than 3 seconds), severe tachycardia¹⁵⁹, weak radial pulse volume or lower limb gradient (Maitland et al., 2011).

The objective of the study was to test if the 'adoption of treatment algorithms for the treatment of hypovolaemia and prevention of shock (irrespective of aetiology) could be of great benefit' (Maitland et al., 2009). As correctly highlighted in the protocol for the FEAST trial, the early recognition and resuscitation of children with paediatric septic shock, following standardised guidelines 'in countries with neonatal and paediatric care facilities' has demonstrated good results (Maitland et al., 2009). One of the objectives of this study was to see if this could be transferred to resource poor settings. The paper concluded that 'fluid boluses significantly increased 48-hour mortality in critically ill

¹⁵⁹ Rates defined as (>180 beats per minute in children younger than 12 months of age, >160 beats per minute in children 1 to 5 years of age, or >140 beats per minute in children older than 5 years of age).

children with impaired perfusion in these resource-limited settings in Africa' (Maitland et al., 2011, p. 2483). The study concludes that 'the results of this study challenge the importance of bolus resuscitation as a lifesaving intervention in resource-limited settings for children with shock who do not have hypotension and raise questions regarding fluid-resuscitation guidelines in other settings as well' (Maitland et al., 2011, p. 2494).

Despite the additional papers produced by the FEAST team (Ford et al., 2011; Maitland, 2015; Maitland, 2019) reporting of the study failed to answer some essential questions pertaining to its application. Limited detail is given on the staffing and resources in the centres and the management of the patients, particularly in relation to speed of management. Data on blood transfusions is very limited, an essential component when considering the treatment for malaria and anaemia. While research has demonstrated the time critical response of blood transfusion for children with severe anaemia (English, 2000; English et al., 2002), administration of blood in resource limited settings is a known challenge due to the limited stores and access, and the sub-optimal practice of transfusion (Brick and Peters, 2014; English et al., 2002; Lackritz et al., 1997; Maitland, 2015).

The study's unpublished data regarding blood transfusions is alluded to in Olupot-Olupot *et al* (2014), the team behind the FEAST study, in a paper on a Phase II trial of standard IVs increased transfusion volume. It states that of the 1,422 children transfused, 23% received two or more transfusions (Olupot-Olupot et al., 2014). However, there is no detail of timings of transfusion or post transfusion blood counts. A key criticism of the trial, and one of the reasons put forward for the increased mortality

rate of the bolus arm, is the effect that intravenous fluid would have on the circulatory system of a child with severe anaemia, further diluting the blood and therefore have a negative effect on perfusion, resulting in circulatory collapse. The significant flaws in the research design, particularly the criteria used for identification of participants, and the limited ability to investigate the specific pathogens means that the broad conclusions made, applicable to 'shock', are dangerous (Duke, 2011; Ford et al., 2011; Southall and Samuels, 2011).

The children in the study are critically ill. Hypoglycaemia, raised lactate and reduced consciousness independently have high indicators for mortality (Achoki et al., 2010; Anthwal et al., 2018; Puskarich et al., 2014). Granted, this is identified in the title, however the rhetoric of the study and further papers is to expand these findings to paediatrics with sepsis, a dangerously generalised term whose definition and diagnosis remains controversial (Kalil et al., 2018; Murri et al., 2018). Many of the critiques laid against the adoption of sepsis guidelines in 'developed' countries apply to this research, seeing flaws in the oversimplification of terminology and associated difficulties in diagnosis, the failure to make wider public health recommendations, and the recognition of the complexities of pathology progression, which requires extensive medical and nursing resources (Carlson and Rubenfeld, 2007; Cheng et al., 2008; Kalil et al., 2018; Murri et al., 2018).

Whilst this point may be seen by some as superficial, one cannot proceed without noting the apparent ignorance and/or arrogance in building the acronym FEAST as its title when 45% of deaths of the age group studied on the African continent are associated with undernutrition (World Health Organization Regional Office for Africa,

2020). The study has received a significant amount of accolade and critique. In its favour, the study illustrates the tensions between medical practices and the context in which they are practiced. Importantly, it demonstrates a tension between the standards and guidelines of the 'developed' world and their application in specific settings in Africa. In response to resource scarcity, the attempt has been to develop a 'one-size fits all' approach, both in testing the early goal directed (EGD) algorithms (to give fluids) and in the conclusions (to withhold them) (Murthy and Kissoon, 2013). In 'developed' countries, it is worth noting that there are significant critiques on the benefit of strict protocols, and the lack of attention to the aetiology of presentations that are treated under the umbrella of 'sepsis' (Anthwal et al., 2018; Sharma, 2014; Yealy et al., 2014). Determining the underlying pathogen, which effects the severity and process of the body's response, and therefore impacts the fluid requirement, is essential. This is a significant challenge in resource scarce settings, where the minimal technology, equipment and resources impede diagnosis's, monitoring and care provision.

Materials used for IV infusion

The materials required for IV fluid can be understood in two parts; equipment used to gain access to the patient's venous system, called venous cannulation, and materials that assist in delivering the fluid to the patient. Venous cannulation is the insertion of a cannula into a patient's vein. Cannula insertion is an aseptic technique, as the cannula in situ is a direct port into the blood stream. Once the cannula is in situ, the area is monitored for complications. As per MSF protocol, and in line with widely accepted protocols, the cannula should not stay in situ for more than 3 days. Noted complications include phlebitis (inflammation of the vein) and extravasation (infiltration of the infusion into the surrounding tissue) (Hadaway, 2009). Cannulation sites should be

checked regularly and removed if there are any signs of complications, and re-sited as required.

Most common sites for insertion are the dorsal metacarpal veins and cephalic vein of the hand and lower forearm, or the veins of the antecubital fossa. Cannulating the veins in the lower limbs and feet is not recommended due to increased risk of infection, particularly in mobile patients. Having a cannula on the hand increases the risk of acquiring infection to the site through direct contact with potential contaminants when performing personal tasks, such as eating, washing and toileting, despite this it is a common site for cannulation due to easy visualisation of the veins.

Guidelines and protocols that document cannula insertion step by step can be 20 pages long. In brevity, the key points are that aseptic non touch technique (ANTT) should be used throughout. Handwashing, donning of gloves and the cleaning of the chosen site with an alcohol swab are the first line of defence. All materials should have been prepared prior to the beginning of the procedure and be accessible on a clean tray or trolley. ANTT mean that keys parts are kept sterile, by not touching them, to reduce the risk of microbial contamination to the site which can occur through cross infection from the health practitioner to the patient or from skin flora. A small plastic tube (the cannula) is inserted into the vein. The needle, which sits inside the tube allows for the vein to be punctured. The distal part of the tube that sheaths the needle is slid into the vein and then the needle removed and disposed of into a sharps box. The cannula is flushed with normal saline using a syringe, to ensure the cannula is in situ in the vein, and then the port is capped. The external part of the cannula has two wings that sit flush

with the skin. These are secured to the site with pieces of tape, and the site where tube goes through the skin into the vein is covered with a dressing¹⁶⁰.

Three types of giving sets were used in Agok, adult, paediatric and blood giving set. Medical supplies including equipment and medications are imported to Agok via the MSF logistic centre in Bordeaux, France and arrive as part of the international order. The sets are sterile when in the sealed packaging. On removing the adult set from the packaging, at one end of the line, there is the 'spike' is sheathed with a cover. Moving down the line a small way is the clear drip chamber. The line has two clamps. One is a small plastic clamp that can be manually pushed on or off the line to stop or start the infusion. The second is the roller clamp which is used by the health care professional to control the flow of the infusion. This works by the wheel gradually narrowing the lumen through compression. At the end proximal to the patient is a 'male' luer-lock fitting which connects to the cannula once the line is primed. Luer lock is a standardized system of small-scale fittings. The different fittings are known as 'male' and 'female' and fit together to create a leak free seal. Both the adult and paediatric giving set at full length are approximately 160cms.

The paediatric giving set follows the same basic design with one significant difference. Between the spike and the clear drip chamber is a larger 150ml graduated chamber. The chamber is transparent with graduations every 1ml and has an air inlet and injection portal. The graduated chamber on the paediatric set allows for a measured amount of fluid to be added to the chamber, and therefore allows more accurate

¹⁶⁰ This overview of cannulation is not intended to be a step-by-step guide, rather an overview of the what and how, to enable the lay reader to visualise the process.

monitoring. Fluid can be added to the chamber via the injection portal with a syringe and needle, or as with the adult set, connecting to a bag of fluid using the spike at the distal end. There is a clamp between the spike and the chamber, which can be applied to close the lumen of the tube once the required amount of fluid has run through.

Intravenous fluids come in bags of various volumes; 1000 ml, 500ml and 250ml being three examples. Intravenous fluids are divided into two groups, colloids and crystalloids, the difference primarily refers to their molecular composition and associated action.¹⁶¹ The essential drugs guidance used by MSF lists 5 infusion fluids: glucose 5%, glucose 10%, modified fluid gelatin, Ringer lactate and sodium chloride 0.9%. (Médecins Sans Frontières, 2018e). Each 'bag' has a punctured hole in the centre of the top edge to hang the fluid on a drip stand. Each fluid bag has two ports. To administer intravenous fluids, the giving set attaches the bag of fluid to the patient. The winged seal on one port is snapped off and the 'spike' from the giving set is inserted. The second port is a self-sealing needle port. This port is used to draw fluid from the bag using a needle and syringe, or to add medications.

The process of infusion is achieved by gravity infusion. The flow rate is calculated using the drip rate formula. The drop factor is the number of drops from the infusion set equal to a millimetre of fluid. For the adult set the drop factor is 20 drops to 1ml, a paediatric infusion set is 60 drops to 1ml. An infusion set for giving blood and blood products is 15 drops to 1ml. It is the responsibility of the nursing team to ensure that the correct fluids are given over the correct period of time according to the prescription. The following

¹⁶¹ Appropriate prescription and administration of intravenous fluids is an ongoing debate, a reflection of the complexities of the human body and its response to pathologies and fluid resuscitation (Gnanasampanthan et al., 2014; Silversides and Perner, 2019).

equation demonstrates how the drip rate is calculated. To demonstrate this equation, if an adult patient required one litre of fluid over eight hours, the drip rate (ggtts)¹⁶² would be as follows;

$$\frac{(\text{volume to be infused ml}) 1000}{(\text{time in minutes}) 480} \times (\text{drop factor}) 20 = 42 \text{ ggtts}$$

Once the system is prepared and primed, the flow rate is regulated by rolling the wheel of the roller clamp to increase or decrease compression on the lumen of the line, and the health care professional counting the drops as visualised in the transparent drip counter. A common way to do this is to divide the number of drops per minute (gtts) required by four and monitor the drip rate within a 15 second window, altering the flow using the wheel clamp as required. For the above equation that would be approximately 11 drops per 15 seconds. As the infusion is facilitated by gravity, there are many factors that can affect its flow. Movement of the patient and of the limb which is cannulated can occlude the line. Patients may detach the line so that they can leave the ward i.e. for toileting needs. Different positions of the patient can cause the infusion to slow down or speed up.

Managing IV fluids in IPD, Agok

IPD is the ward with the highest number of beds. It is a long single-story building with thick white concrete walls that exhibit regular cracks, an indication of the logistical difficulties of building in Agok.¹⁶³ The northern side of the building forms part of the

¹⁶² From the Latin *guttae* meaning drops.

¹⁶³ The geographical location of Agok causes distinct challenges for building. The soil is alluvial across this region, the historic flood plain of the Nile and its tributaries. In the region of Agok, the soil is known as 'black cotton soil'. Black cotton soil is highly plastic, meaning it is predominantly clay. This soil has the

hospital parameter boundary, running parallel with the wide dust road that extends the length of the site. On this far side of the building, the bright blue framed windows that run its length look out onto the kiosks and coffee shops that have set up opposite the hospital grounds, each window covered with netting, an essential prophylactic for malaria. The building is divided roughly in three. Entering through the blue metal door halfway down southern length, you step on to ward one of IPD. The beds run perpendicular to the walls in two rows down the building length, 14 in total. Looking to the far left, a large arch in the partition wall separates ward 1 from ward 2. Ward 2 has another 12 beds. There are two sinks on IPD, one at the central partition and one at the far end of ward two. Looking in the opposite direction to the right, a smaller open doorway is the entrance to the Critical Monitoring Unit (CMU), an 8-bedded unit reserved for the most critical patients. Back outside, three large tents breach the space between IPD and ITFC, the canvas doorways at each end rolled high to encourage coolness. Each tent has 10-12 beds, also managed by the same IPD staff. When required, additional beds are brought in to the IPD building and fill the walkway down the centre of the ward, the patients in a line head-to-toe. In addition to this, the staff on IPD have the responsibility for patients in general isolation. The isolation tent is a 2-minute walk from IPD, on the other side of the hospital grounds past the maternity ward and towards the ID ward.

In IPD children, adults, male and female are mixed on the wards, and each patient has one caretaker with them. In theory, ward one is used for paediatrics, but capacity challenges this in practice. Beds 1 -3 are used for the most unstable patients, adult and

properties of high swelling in rainy season, and shrinkage in dry season, attributed to the presence of the mineral montmorillonite. This shifting causes instability for constructions, often seen as cracks in the buildings as seen in IPD (Khalid, 2014; Srikanth et al., 2018).

child. These beds are opposite the nurse's station and therefore most observable, and close to CMU¹⁶⁴. The nursing station consists of a small raised worktop situated under one of the windows. On the nursing station work top are small quantities of the related paraphernalia: a range of needles, syringes, gauze, hand sanitiser and tape. Under the work top, the shelves house the ward paperwork, admissions and discharge books and an array of guidelines. The large red metal shelving unit that sits flush against the wall dividing ward 1 and CMU is stacked with big cardboard boxes of medical stock and equipment. Dust sits on all the surfaces and shelves, blown in through the windows and walked in through the doors. Three to four plastic chairs sit in two rows facing each other, parallel to the shelving unit and the length of bed 14. Staff sit here to write in the admissions book, or to rest during their shift. Cleaning the shelves, the nursing station, the wheeled silver trolleys and the monitoring equipment is part of the daily routine for those on shift, as the environment and activities of the ward make dusk and clutter a constant feature.

Looking down the ward from the nursing station, takes the view through the centre of the whole IPD unit. Metal drip stands are dotted around the ward whose white rusting paint matches the bed frames. Thick grey blankets cover the thin white plastic-coated mattresses on the bed, a visual signal that the bed is occupied. The bright colours of the ward come from the additional belongings and clothes of patients and the bright dresses and shawls worn by the staff, partially covered by the white coat of the ward uniform. String lines run parallel with the head and foot of each bed, occasioned with clothes pegs and bits of tied plastic. The strings are used to facilitate a variety of

¹⁶⁴ Patients are moved from IPD to CMU if they require a higher level of care. The nurse-to-patient ratio in CMU is much higher at 1 nurse and 1 nurse aid to 4 patients.

materials around individual bed spaces: to hang or dry pieces of clothing during the day; to support malaria nets from dusk till dawn; to afford some privacy and dignity from the white opaque sheets during an intimate procedure or emergency; and when preparing the deceased. When all the available drip stands are in use, the strings provide a place to hang the paediatric giving set, the plastic tubing and chamber that connects to the patient when administering fluid. The ward is staffed with two nurses and two nursing assistants, and frequently operates above the full bed occupancy rate (Médecins Sans Frontières, 2018a). The average bed occupancy rate of IPD over the year 2017 was 167% (Médecins Sans Frontières, 2018a), however this figure is taken with caution as the beds in the tents are not classed as permanent beds within these figures.

Patient files are kept in a plastic pocket at the end of each bed. Fluid is prescribed by the clinical officer or doctor on a fluid chart. The fluid chart has a simple format. A table with 24 boxes fills one side of an A4 sheet, each box represents an hour of the 24 hour period in a day. The number of millilitres per hour required is documented in each hourly box, or a single volume is scribed across a number of boxes with arrows delimiting the timeliness. The fluid chart acts as both the prescription and the monitoring chart. The CO or doctor prescribes the fluid along with the times, and the nursing staff indicate when the fluid has been given by putting a diagonal line through the box for each accorded hour.

Taken together the above section contrasts the banality of the IV infusion procedure and technique with the lively movement of the IPD. An acute eye may already be anticipating some tensions, the patient to nurse ratio, the dust of the ward and the

negotiable accuracy of monitoring. To draw out the tensions of this contrast the following section focuses on three materials chosen because of the debate they attracted during my fieldwork.

The sheathed needle

Every Monday morning a meeting is held in the ER room for the nursing staff, led by the nurse supervisors. Staff file in through the opposing doors on the left and right of the room, siding up on the wooden benches, plastic chairs and patient trolleys. The meeting is opened by the night supervisor, who gives an overview of the night and the current status of the hospital; overall capacity, deaths, births. Following this, one or two of the day supervisors speak, along with the deputy head nurse, passing information, guidance and news. The last person to speak in the meeting was often the training nurse supervisor, to spread awareness of the weekly training sessions and relate any specific training points or updates about practice. In one meeting the incorrect use of needles was discussed. It had come to his attention that sheathed needles were being used to cap IV line circuits when they were not in use. He emphasised that this was not correct practice and it must stop. Hands were raised to ask what the staff should use instead. The first response given was to suggest using a small plastic re-sealable bag, the sort used primarily to bag medications for patients amongst other things, and seal it around the end of the line.

All IV lines are single patient use, but the evidence is unclear on the safety of intermittent line use, that is the period of time over which the same line can be used with the same patient for the same infusion fluid. The literature around the intermittent use of IV lines is varied and there is a lack of evidence on the levels of organisms that

may accumulate (O'Grady et al., 2011; Raad et al., 2001). As a demonstration of the uncertainty regarding best practice, the recommendations of the Centre for Disease Control and Prevention (CDC) on the use of intermittent IV administration lines is categorised as an 'unresolved issue'¹⁶⁵ (O'Grady et al., 2011). This is in relation to the infusion of the same intravenous fluid. Specific guidelines exist for changing lines of certain infusions, for example blood products. According to MSF Nursing guidelines, tubing should be changed every 96 hours unless contraindicated (Médecins Sans Frontières, 2014).

Intermittent use of lines is a common practice in Agok hospital. Paediatric giving sets provide accurate measures for delivering three times daily infusions of antibiotics, the lines disconnected and hung over the string in-between infusions to keep them out of the way. Maintenance fluids are required IV fluid therapy for many patients, based on achieving daily fluid and electrolyte requirements. Maintenance fluid consisted of Ringer Lactate and 5% glucose alternatively, prescribed according to body weight. Where replacement and redistribution therapy is required, this is done by adding or subtracting from routine maintenance, depending on the patients status. For example, in children under 12 with severe burns, the MSF protocol prescribes 2ml per kilogram (kg) multiplied by the body surface area (BSA)¹⁶⁶ of Ringer Lactate, plus maintenance fluid per hour for eight hours. Depending on the patient's condition maintenance fluids

¹⁶⁵ Recommendations are ranked according to research. No recommendation, as in the case of intermittent IV line use, 'represents an unresolved issue for which evidence is insufficient or no consensus regarding efficacy exists.' (O'Grady et al., 2011, p 7).

¹⁶⁶ Different systems are used to measure the amount of body surface area (BSA) covered by burns, expressed as percentage. The system recommended in the MSF clinical guidelines is the Lund-Browder table (Lundin and Alsbjørn, 2012; Médecins Sans Frontières, 2018b) which gives a numerical value to part of the body dependent on age of the patients. The number for each effected part is added to give a final total.

may be required for infusion over the initial 12 to 24 hour period following admission. Maintenance fluids as calculated for burns are as follows; 4ml/kg/hour for the first 10kg of body weight plus 2ml/kg/hour for next 10kg plus 1ml/kg/h for each additional kg (over 20kg, up to 30kg), alternating between glucose 5% and Ringer Lactate (Médecins Sans Frontières, 2018c, p 291). The following example will demonstrate this protocol.

Fluid protocol for the first 8 hours for a child under 12 years old weighing 12 kg with 10% BSA.

Maintenance fluid

4ml per kg per hour (for the first 10kg) = $4 \times 10 = 40\text{ml/hr}$

+ 2ml/kg/hour (for next 10kg) = $2 \times 2 = 4$

Total maintenance fluid = 44ml per hour. Alternating normal saline and glucose 5% four hourly¹⁶⁷.

Replacement fluid

2ml per kg x BSA = $2 \times 12 \times 10 = 240\text{ml}$.

The management of IV lines is an everyday practice. The fluid therapy for burns is an example that demonstrates the complexities of correct fluid maintenance and monitoring. Alternating fluids, a requirement of providing maintenance fluids, means that the IV line must be disconnected, capped and the subsequent fluid attached, making obvious the need for sterile bungs to close the circuit from microorganisms. Once an IV line is detached from the patient the sealed circuit is open to microorganisms. The line

¹⁶⁷ This is not specified in the guidelines.

may be detached once an IV infusion is finished, or if the infusion needs to be interrupted for some reason. The proximal end must be capped with a new sterile cap to avoid exposure to potential contaminants and ensure a closed circuit (Grissinger, 2011). A sheathed needle is both sterile and closes the circuit.

On the ward after the meeting, the ward supervisor, my bedside training colleague, and I were discussing the issue. The supervisor supported the position that the practice of using the needle must be stopped, as has been said in the meeting. The bedside trainer was pursuing the argument that without a current alternative, it was the only available option. Bungs were on the international stock order but would not arrive for some time. In the meantime, the options would be to discard the lines after each use, which would mean an increase in the use of IV lines, and waste; or an increased risk of hospital acquired infections if a suitable alternative is not given to the staff.

Sterile gauze

A balance between the economy of materials and understandings of safe practice was evident in many instances and is a valid interpretation of points of tensions in practice. As per MSF protocol and as supported on the ward by the bedside training team, on removal, the cap of the cannula must be held in sterile gauze soaked in antiseptic as per MSF Nursing Guidelines (Médecins Sans Frontières, 2014). Gauze, is a common and essential medical material. Characterised by a loose open weave which gives it stability and good absorption of fluids, it comes in a number of different sizes and is packaged according to sterile or non-sterile conditions. Sterile gauze, as may be obvious to the reader, are packed in sterile conditions and therefore remain sterile until contaminated by touch, fluid or dust once the package is opened. The process of manufacturing the

gauze means that in its closed packet it is free from microorganisms. Sterile gauzes are therefore essential for some procedures, for example during surgery and cleaning wounds.

One of the training program components was 'a.m trainings'. These trainings took place on weekday mornings in the training room. The topics ranged from physiology such as the basics of shock, to management of symptoms, such as the management of seizures, to practical skills and drug preparation. One week the training was on cannula insertion. Enforcing the above protocol, the training insisted that sterile gauze be used. On returning to the ward after training, one of the nurses spoke to me about the training. The nurse had worked at Agok hospital for two years, and prior to that had worked at the Ministry of Health hospital and also an 'emergency mission' with MSF. We talked about the training he had just attended, he stated that he disagreed with the use of sterile gauze saying it should be a clean procedure, not a sterile one, and that using sterile gauze is a 'waste of resources, we will run out'¹⁶⁸. The opinion of the bedside trainers was fractious on this issue. Compounding the issue of waste was the fact that sterile gauzes came in packets of five, therefore losing the sterility of the other four items on opening the packet.

Use of paediatric giving sets

The third point of tension noted from my observations was the use of paediatric giving sets. As disseminated by the bedside training team and in staff meetings, paediatric giving sets should be only used for children. According to the ICRC, the paediatric giving

¹⁶⁸ Fieldnotes. 12 November 2017.

sets are nearly four times as expensive as an adult set. The key difference between the two sets is that the paediatric set has a 150ml graduated chamber; administration is therefore more accurate, more easily monitored, with a reduced risk of error. From my observations it was apparent that staff used the paediatric sets as an aid, both for safety for the patient through accuracy, and time efficiency for their workload. To demonstrate the value and necessity of using these sets for the administration of medication we can look to the treatment of snakebite. As a neglected tropical disease with under resourced research and development, it is also important to give the reader an insight into the vital work that has been put into making treatment for snakebite available.

Snake bite is a common presentation in Agok hospital. Labelled a disease of poverty, disability and death from envenomation from snake bite disproportionately affects people living in the most poorly developed, impoverished, and politically marginalised communities (Gutiérrez et al., 2017; Harrison et al., 2009; Williams, 2015). Worldwide, annual mortality is estimated between 81,000 to 138,000 with a further estimated 400,000 suffering permanent disability (Williams et al., 2019). Estimates for Sub-Sahara Africa suggest between 435,000 and 580,000 envenomings, with an annual mortality rate of between 20,000 and 32,000 (Potet et al., 2019). Accurate numbers are difficult due to the lack of comprehensive and reliable epidemiological data in the affected countries (Segura et al., 2010), and the inadequate knowledge, training and practice of treatment (Avau et al., 2016; Mahmood et al., 2019; Taieb et al., 2018).

To avoid death and disability, envenoming requires the availability, access and effective administration of antivenom. In May 2014 a high number of snake bite presentations was recorded in Agok hospital, numbering 90 admissions in one month. This sparked

alarm and prompted further analysis of snakebite data. Data was collected from June 2014 – March 2015 on patient demographics, circumstances of snake bite, clinical presentation and outcomes (Alcoba et al., 2015). In this period 119 patients were admitted due to snake bite. Twelve of the patients (10%) required antivenom due to severe cytotoxic or haemotoxic envenoming. Two of these patients, a 4 year old and a 12 year old died in the first hour following admission prior to being given the antivenom. The cause of death is recorded as massive cytotoxicity and necrosis of the lower abdomen, and rapid hemotoxic syndrome including spontaneous bleeding for the eyes. The 10 patients who received the antivenom made a full recovery (Alcoba et al., 2015, p 235). The data analysis highlighted the necessity of rapid transport and access to antivenom, and the recognition of snake bite as a public health emergency.

The study prompted a larger epidemiology study to be conducted (Haidar et al., 2016). In 2015, an epidemiology study of snakebite incidence and case fatality was carried out by MSF in Agok. (Haidar et al., 2016; Médecins Sans Frontières, 2016d). The research identified a large variety of snakes from the families Elapida (characterised by fixed fangs) and Viperidae (hinged fangs). Snakes identified included *Bitis arietans* (puff adder), *Naja nigricollis* (Black-necked spitting cobra), *Echis pyramidum* (North east African carpet viper), *Naja haje* (Egyptian cobra), and *Dendroaspis* spp (mambas). The case fatality rate for those not accessing treatment was high, demonstrating the burden and magnitude of envenomation in the Agok area. The large variety of venomous snakes highlighted the need for a polyvalent antivenom. At that time, the antivenom Fav-Afrique, produced by French company Sanofi, was the only safe and effective antivenom to treat envenoming in Sub-Saharan Africa. In 2014 Sanofi had announced it was ceasing

production, with the last batch produced due to expire in 2016 (Medecins Sans Frontiers, 2015; Sánchez et al., 2017).

MSF as an international organisation played an essential role in advocating for producers to share the technology for the serum and putting pressure on the international community to act in the face of inefficient antivenom supplies. The lack of anti-venom is a consequence of the worldwide neglect of research, development and availability of immunotherapeutic products for the treatment of snakebite (Alirol et al., 2015; Brown, 2012). Following research, the MSF medical department identified two new appropriate anti-venoms, SAMIR Polyvalent and Echitab-ICP Plus (Potet et al., 2019; Segura et al., 2010; Sánchez et al., 2017). Using the weight of the findings from the research conducted in Agok, MSF gained the agreement of the MOH to pilot the new antivenoms in Agok hospital and in September 2017 they were registered under the South Sudan Drug and Food Control Agency. In addition, the South Sudanese Ethics Review board approved MSF-OCG to conduct a 2-year study; “Use of antivenoms for snakebite with envenoming in routine program conditions: an observational study”. In December 2017, following the registration for the antivenoms, a 5 day training workshop was held in Agok for MOH doctors from across South Sudan on the treatment of snakebite and the use of antivenom, to disseminate training and skills across the country (Médecins Sans Frontières, 2018a). In 2017 snake bite envenoming was reinstated by the WHO to the list of category A neglected tropical diseases (NTD), a welcome move hoped to boost investor funding and add impetus to research and development of antivenom (*The Lancet* editorial, 2017). This demonstrates the concerted and consistent efforts of MSF to advocate for the importance of snake bite as a neglected disease.

In August 2017, 28 cases of snakebite were reported to Agok hospital ten of which required antivenom. The amount of antivenom is given according to the severity of the condition and the response to the antivenom. Of the 10 cases, 5 patients received 1 x 3 vials, 4 patients received 2 x 3 vials and 1 patient 3 x 3 vials totalling 48 vials (Medecins Sans Frontieres, 2017). Once reconstituted, the antivenom is given intravenously. It can be given by slow intravenous injection at a rate of 2ml- 5ml/minute or diluted in isotonic solution and infused over 60 minutes (Ahmed et al., 2008). Infusion is the common method of administration. Although intravenous injection is credited for having the medical professional there to observe for reactions, further dilution and intravenous infusion frees the nurse to also continue with other tasks. The paediatric giving set allows for the infusion of fluid and medication amounting to less than 150ml and provides the best opportunity for administering the required amount safely.

In the above sections I have detailed the process and materials of intravenous fluid administration and illustrated some aspects of the ward setting of the inpatient department in Agok hospital. As explained in the introduction of this chapter, bringing the focus to the minutia of a process provides a lens for the recognition and analysis of the complexities of the humanitarian setting. This lens can then be broadened to raise wide questions of what elements or understandings of quality are valued and pursued, what is compromised or neglected, situating the analysis within the wider quality narratives.

Strict fluid administration and monitoring is the gold standard for many conditions and for severe illness appropriate fluid resuscitation is one of the main determinants in patient survival (Klein et al., 2007; Kraft et al., 2013). Patient mortality reviews were

organised in Agok by the Medical activity Manager, the clinical management of a patient expressed by powerpoint on a large screen in dark training room. I attended these sessions when I could and noticed fluid management always stood out. In some cases, this was because of poor documentation, a question mark on the powerpoint indicating that the fluid prescription meant it was illegible to be commented on in the case review; more often because poor fluid management had contributed to the cause of death. A woman who was treated for query Stephens Johnson Syndrome was the subject of one of the reviews SJS is characterised by extensive necrosis and detachment of the epidermis. The skin and mucous surfaces blister and peel, causing loss of bodily fluid and a bringing a high risk of infection and pain. I remembered the patient being on the ward, bandages covering her body, the mosquito net permanently down.

In stable health systems with contemporary technological support and machinery and improved (although still deficient) resources including staff, errors in fluid management and monitoring are also common (Alani, 2018; Ferenczi et al., 2007; Han et al., 2005). In the UK, it is agreed that complications of intravenous fluid therapy including the monitoring and documentation of fluid therapy are frequent yet underreported and under researched (National Institute for Health and Care Excellence (NICE), 2013).

From my own research studying sepsis in an emergency department in the UK, accurate monitoring of fluid resuscitation was the most poorly completed aspect for staff in managing patient care, a result that is not uncommon (Pinnington et al., 2016). In further support of this argument, numerous studies from the literature in high income countries show the omission of elements of a procedure by nursing staff as common behaviour (Garnerin et al., 2008; Tubbs-Cooley et al., 2015), and demonstrate the

additional challenges of managing interruptions whilst performing tasks (Mitchell et al., 2006).

From my observations in Agok, accurate IV administration is severely challenging. Despite being a daily practice the administration and monitoring of IV fluids is a complex task. It is a time heavy task, and therefore challenging for wards like IPD where the staff ratio is 2 nurses and 2 nurse assistants to over 50 patients. The method of administration, via gravity infusion, leaves much room for error, and has long been recognised as a method with a high occurrence of inaccuracy (Crass and Vance, 1985; Pierce et al., 2013). With this in mind, one can consider the number of practices and processes required to ensure effective and accurate administration of intravenous infusions. Going back to my field notes, the first point is to highlight that within the process for prescribing and documenting fluids there are no safeguards in place to allow for someone who did not administer the fluid to check on the amount that has or has not been given. Infusions are not labelled consistently, if at all, as there is no standardised labelling system in the hospital. One of the international staff members, whose position was concerned with quality of care in the hospital, told me that they had discussed implementing the labels as standardised by MSF at the beginning of their time in Agok, but this was not supported by the senior management team. In a similar discussion with a colleague regarding labels they laughed, telling me of the system used when he was training in Cambodia where an approximation of a line would be drawn on the fluid bag and the fluids would (hopefully) be stopped when they got down to that line. In contrast to this, in the MSF primary healthcare project in Mayom, a five-hour drive from Agok they used labelling consistently. In the observation unit in Mayom, a small unit with approximately 8 – 10 patients, the paperwork for prescribing and

monitoring fluid allowed for more accuracy, and the labelling of fluid bags ensured safer practice.

Framing quality through a micro process allows for the nuances of practice to be discussed in relation to wider implications and associations. The practice, materials and process of IV infusions is a complex yet daily routine. The specific context, the environment, the layout of the ward, the nurse-to-patient ratio provide significant challenges. Added to this, the absence or scarcity of materials, the knowledge and competency of staff, the prioritising and management of tasks all play their part. A process cannot be understood as purely technique and application, it is connected to and part of the network of the ward and hospital and wider medical landscape (Star and Griesemer, 1989a). In the medical humanitarian landscape, the narrative and practice of quality is fragile to shifts and instability. Viewing the articulation and practice of quality as a network of associations brings a unique and important perspective to the meanings of quality in healthcare. Looking in detail at a process reveals the connections between the elements of the process itself and their association to wider factors of influence. Drawing on the wider debates in fluid administration and snakebite treatment, demonstrates the importance of the everyday processes and also highlights their neglect in the quality debate. In its starkness, focusing on the minutia of a process reveals that some elements are prioritised whilst others are neglected, demonstrating the shifting and contradictory nature of quality in complex setting.

Conclusion

This research set out to answer the question *what are the meanings of quality healthcare in humanitarian settings?* To do this it brought together three project sites of the medical humanitarian organisation Médecins Sans Frontières, to allow for a comparative analysis of how quality in healthcare is practiced and articulated across diverse crisis-affected settings. Moving beyond the measuring and counting as prioritized in the dominant quality debate and applying ethnographic methodology to detail the interactions between staff, patients and materials in the spaces set up for humanitarian medical work, this research brings an important and unresearched dimension to the quality debate in humanitarian settings. In conceptualising quality as a process, mediated by the actors, things and materials in the care assemblage, this approach to quality recognises the instability and diversity of humanitarian settings. The MSF sites in Agok, South Sudan, and in Athens and Chios in Greece, demonstrate this diversity and instability in different ways. Researching what quality healthcare is in humanitarian settings brings a new frame to understanding the asymmetries of medical humanitarian practice, set within a landscape of global inequalities.

The expectation often made of quality assessments and evaluations of quality assurance, is that their conclusions include a list of recommendations based on lessons learnt (ALNAP, 2016; Jeffs et al., 2012; Kerr et al., 2012). This conclusion will not frame quick fixes amongst longer term recommendations within a time frame of associated measurable targets. The methodological approach of this research in recognising the complexities of the humanitarian setting, argues that to look for simple answers, and in doing so simplify the settings, does not recognise the complexity required to move forward and address the reality of what we are talking about when we think of quality

healthcare in humanitarian settings. The complexity of the premise of humanitarian action, and the spaces in which medical humanitarian action takes place, should not be simplified to provide quickly quantifiable answers. There are of course drawbacks to doing slow research in a fast-moving environment, and this study recognises that both projects have changed since my fieldwork took place. That said, I remain confident that the core contribution of this work remains not only significant but integral to making meaningful progress in providing quality healthcare.

By drawing on field research in diverse settings this research has provided a nuanced analysis of how quality healthcare is practiced and articulated in the instability of the humanitarian setting. Three key questions were positioned in the introduction. Firstly, what influence does staffing, particularly the organisation and cohesion of staff groups, have on the care assemblage and the quality of healthcare. Secondly, in what ways is quality constructed by materials in the field? Thirdly what claims does MSF make to quality in healthcare, and what is the significance of these claims in practice. In reflecting on these questions, this chapter will bring together the conclusions of this research.

Quality healthcare in unequal landscapes

To understand the quality debate in humanitarian medicine, chapter one first explored the quality debate as it has developed in high-income countries with stable healthcare systems. This was important because the terminology, measures and governance systems applied by healthcare systems under the umbrella of quality come from this debate (Institute of Medicine, 2001; Kruk et al., 2018a; The National Academies of Sciences Engineering and Medicine, 2018) . Drawing on examples of the UK healthcare

system to reveal the political and economic drivers entwined in the narrative, this study demonstrates how the quality debate has been adopted globally and universalised as the normative debate (Carinci et al., 2015; Schneider, 2006). Quality is a vehicle used to drive reforms in the health sector (Blaize-La Caille, 2018). The literature review framed the quality debates, highlighting the need for both a critical approach and alternative methodology. In global health, healthcare quality is framed as a technical matter and is answered with technical solutions that silence the politics of global inequalities (Schuftan, 2016; Shaw, 2015; Travis et al., 2004; World Health Organisation, 2006). Indicators and audits have a place in understanding, improving and demonstrating accountability for the quality of care provided, but it is important to question whether interpreting quality through quantification goes far enough to capture reality, or to understand the social, organisational and cultural practices that impact care and care practices (Biehl and Petryna, 2013b; Goldenberg, 2012; Mol et al., 2010; Turrini, 2011; Waring et al., 2016). This is particularly important in humanitarian settings where asymmetries in power, knowledge and agency of staff and staff groups are shown to be inherent to its construct (Abimbola, 2019; Owen, 2010). Drawing on literature from sociology, anthropology and science and technology studies, the literature review situated my research amongst these disciplines, making clear its theoretical strength and establishing the gaps in the research to which this study responds.

Weaved throughout the chapters is evidence of how the contextual factors, the landscape, directly effects the health and well-being of the populations. Malaria, malnutrition and neglected tropical disease are common presentations to Agok hospital. Food insecurity in the region meant that the same children discharged from the inpatient therapeutic feeding centre would often return. The resource scarcity of the

region informs MSF's claims to essential quality care. Here, MSF is engaged in saving lives in the provision of secondary healthcare to a neglected population. Within the organisation, resource scarcity is reflected in minimum staff numbers and 'low-tech' equipment and diagnostic capabilities. In Greece the everyday living conditions of many refugee and migrants has detrimental effects on their health, and the prolonged waiting and enforced immobility has resulted in a high need, and an unmet need for mental health support (Ben Farhat et al., 2018; Bjertrup et al., 2021). The target population is framed as having complex needs, made more obvious by the juxtaposition of a vulnerable population with evolving needs in a high-income country with existing health and social care systems. Basic needs of shelter, food and security are not met by the systems in Greece. In response, MSF has designed a holistic approach to healthcare, beyond the remit of a purely medical approach.

The two projects make different claims to quality. The deputy head of mission in Greece referred to the projects there as '*not the traditional MSF model*'. Whilst diversity of MSF projects may not support the existence of a traditional model, the imaginary does so. 'Classic' humanitarianism speaks to the minimalist endeavour of meeting basic needs, and of survival rather than enhancement (Redfield, 2008; Redfield, 2012a). This paradigm of humanitarianism is 'rooted in the notion of exceptionalism' (Hilhorst, 2018), a break from the norm, or liminal space to everyday lives (Smirl, 2008). The exceptionalism is enhanced by the organisational structure, the short-term placements of international management staff and the institutional amnesia encouraged by this pattern.

The two project designs mediate quality in a number of ways. To be able to respond to the needs of the refugee and migrant population the MSF project in Greece is designed around a number of health services including legal and social support. Being one of a number of actors in this setting provides wider opportunity for care and service provision. Insulin pens were provided rather than vials and needles as in the essential medicine guidelines (Médecins Sans Frontières, 2018e). The justification was twofold, firstly because they were safer, and secondly because the population requiring them were 'used to a higher standard of care'. This act of improvement enabled by context emphasises the inequalities across the medical landscape of humanitarian action.

In contrast, low expectations hampered progress in Agok. Short term objectives and the concentration of agency and responsibility within the international staff team resulted in a disconnect between staff groups at a professional level. This research has argued that the nursing staff in Agok hospital were not sufficiently supported or respected in the medical teams, and yet were seen as responsible for the quality of care provided in the hospital. This imbalance was felt by the nursing staff who perceived that their work was not seen or valued. Good teamwork and communication promote quality of care and impacts staff well-being. The lack of effective communication between nursing and medical teams results in ineffective management of patients. This research argued that the imaginary around staff groups, and the reluctance to challenge or investigate this imaginary is a barrier to moving forward to improve care. The snapshots of insight provided in this study are not timeless but are connected to the histories and imaginaries of the setting and its contingencies. Different claims to quality were made within the objectives of the MSF projects. As a comparative study, the contrasts drawn

between these sites have demonstrated just as humanitarianism is not the same humanitarianism all the time, neither is quality (Feldman, 2012).

The ethnographical positioning of the researcher brings an important and unique insight into the project settings. Being present as a team member and both interacting with and observing the daily practices in the clinical spaces brought a rich analysis to the challenges and barriers to pursuing quality healthcare. The rhetoric of quality healthcare ascribes to notions of universalism in its profuse usage, and positive semiotic value. As materials of standardisation, protocols and guidelines support the universal ideals of humanitarianism through implicit and explicit claims. Drawing on the use of protocols and guidelines, and the mundane materials of IV fluid administration this research has demonstrated the challenge of pursuing quality amongst resource scarcity. Focusing on minutia of the process of IV administration brought to light the connections of the care assemblage and the inequalities that challenge its stability. Future research on the mundane objects in the humanitarian setting would provide insight into the hidden cares of negotiating quality care in resource limited settings.

The reflection of global inequalities in the figure of the international staff and that of the nationally employed staff remains an important site of academic concern (Ager et al., 2012; Choudry, 2013; Dijkzeul and Wakenge, 2010; Farah, 2020; Redfield, 2012b; Wagner, 2015). This work has added to this literature by emphasising the importance of connections between staff as essential to understanding the barriers to quality care. In doing so it has also complicated the national/international dichotomy. Contrasting the MSF project sites of Athens/Chois and Agok, and the organisational elements within brings nuance to understanding humanitarian organisations, and therefore offers ways

forward to recognise and respond to what is understood to be an inherent contradiction in humanitarian practice. In bringing together these two different sites this study brings a frame of analysis to the organisational elements of MSF that are pertinent across both sites. In both sites there is a disconnect between the expectations and imaginaries of different staff groups. These sticky tensions are further problematised by a lack of shared objectives and poor communication across staff groups.

In long term projects such as Agok, MSF finds itself trapped between the emergency imaginary of humanitarianism and developmentalism. It can be argued that international staff embody the 'emergency' nature of MSF, where saving lives is paramount. This is personified in the international staff member who due to the responsibility bestowed upon her by the organisation treads the lonely thin line between the immediacy of saving lives and the momentous task of 'building capacity'. In Agok this manifested as individualist objectives, where the responsibility for aspects of the project is taken at a personal level. International doctors 'take their own patients' prioritising and controlling care of selected patients, or conduct wards rounds individually without supporting the clinical officers and the sharing of patient care plans. There is an understanding, even an expectation, that international staff members will enact a change of some sort within the project. Changes imposed were not small. A new care plan proforma was introduced for the nursing staff, '*another piece of paper for us to ignore*' responded of one of the supervisors, and a change in the times of the medications rounds across the whole hospital were two of the hospital wide measures introduced during my stay in Agok.

Despite the numerous differences between South Sudan and Greece, the importance of staff feeling valued in the team was a prominent theme in both settings. This is not an unusual finding for studying teamwork in stressful jobs and specifically healthcare work. As explored in chapter four, burnout amongst healthcare professionals and humanitarian workers is a well-recognised syndrome, demonstrative of the stress encountered in these roles. That said, this research demonstrates that inherent biases remain in the organisational structure that remain unchallenged in the field setting. For national staff in Greece and in Agok, humanitarianism is not the exception, it is the everyday, and yet transient international staff are granted superiority of experience within the culture of MSF in both settings. A contrast to the dynamic in high income settings where transient staff are often regarded as inexperienced.

As implied in the main research question, the meanings of quality are numerous. In taking a qualitative approach to quality, framed in ethnographic methodology, this research recognises the variability in relationships of care giving in the messy context of humanitarian setting. This research has demonstrated how the interplay of people, spaces and materials mediate quality in the unequal landscape of humanitarian settings. In recognising this complexity, the contribution of this study is in demonstrating the value of in-depth qualitative research to understand the different elements that influence how quality is mediated, translated and practiced in humanitarian medical practice.

References

- Abbas, M., Aloudat, T., Bartolomei, J., Carballo, M., Durieux-Paillard, S., Gabus, L., Jablonka, A., Jackson, Y., Kaojaroen, K., Koch, D., Martinez, E., Mendelson, M., Petrova-Benedict, R., Tsiodras, S., Christie, D., Saam, M., Hargreaves, S. & Pittet, D. (2018). 'Migrant and refugee populations: a public health and policy perspective on a continuing global crisis', *Antimicrobial resistance & infection control*, 7(1), pp. 113-113.
- Abbasi, K. (1998). Butchers and grocers. *BMJ* [Online], 317(7172), p. 1599. Available at: <https://doi.org/10.1136/bmj.317.7172.1599b> (Accessed: 23 February 2019).
- Abbott, A. (1995). 'Things of boundaries', *Social research*, 62(4), pp. 857-882.
- Aberese-Ako, M. (2017). 'I won't take part!' : Exploring the multiple identities of the ethnographer in two Ghanaian hospitals', *Ethnography*, 18(3), pp. 300-321.
- Abimbola, S. (2019). The foreign gaze: authorship in academic global health. *BMJ Global Health* [Online], 4(5), p. e002068. Available at: <http://dx.doi.org/10.1136/bmjgh-2019-002068> (Accessed: 5 November 2019).
- Abramowitz, S. A. & Panter-Brick, C. (2015). *Medical humanitarianism : ethnographies of practice*. Philadelphia: University of Pennsylvania Press.
- Abrams, E. M., Akombi, B., Alam, S., Alcalde-Rabanal, J. E., Allebeck, P., Amini-Rarani, M., Atnafu, D. D., Ausloos, M., Ayanore, M. A., Azari, S., Azene, Z. N., Babae, E., Bante, A. B., Bisanzio, D., Bohluli, M., Breitborde, N. J. K., Briant, P. S., Castelpietra, G., Cunningham, M., Das, J. K., das Neves, J., Demsie, D. G., Denova-Gutiérrez, E., Eagan, A. W., Elhabashy, H. R., Emmons-Bell, S., Foroutan, M., Gebreslassie, A. A. A., Ghashghae, A., Ghith, N., Gitimoghaddam, M., Goulart, B. N. G., Gubari, M. I. M., Guled, R. A., Hamagharib Abdullah, K., Hassankhani, H., Hayat, K., Herteliu, C., Hoek, H. W., Holla, R., Househ, M., Islam, M., Jafarinia, M., Jahani, M. A., James, S. L., Jonas, J. B., Kabir, Z., Kalani, H., Kalhor, R., Khundkar, R., Kneib, C. J., Koyanagi, A., Larson, S. L., Ledesma, J. R., Leung, J., Lorkowski, S., Lunevicius, R., McKee, M., Mendoza, W., Mengesha, E. W., Meretoja, T. J., Mestrovic, T., Mihretie, K. M., Momen, N. C., Moradi, G., Morrison, S. D., Mueller, U. O., Muriithi, M. K., Ngunjiri, J. W., Olusanya, B. O., Otstavnov, N., P A, M., Palladino, R., Park, E.-K., Pereira, A., Pham, H. Q., Plana-Ripoll, O., Pourshams, A., Prada, S. I., Rao, P. C., Rathi, P., Riahi, S. M., Salem, M. R. R., Sanabria, J., Shamsizadeh, M., Shannawaz, M., Shiferaw, W. S., Shigematsu, M., Shiri, R., Sokhan, A., Sorrie, M. B., Sreeramareddy, C. T., Steiner, C., Sudaryanto, A., Ward, J. L., Wei, J., Weiss, J., Xu, R., Yaya, S. & Yip, P. (2020). 'Global burden of 369 diseases and injuries in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019', *The Lancet (British edition)*, 396(10258), pp. 1204-1222.
- Abu Sa'Da, C. (2012). *In the eyes of others : how people in crises perceive humanitarian aid*: [United States] : MSF-USA.
- Achoki, R., Opiyo, N. & English, M. (2010). 'Mini-review: Management of Hypoglycaemia in Children Aged 0–59 Months', *Journal of Tropical Pediatrics*, 56(4), pp. 227-234.
- Adams, T. E. (2015). *Autoethnography*. Oxford: Oxford University Press.
- Adams, T. E., Holman Jones, S. & Ellis, C. (2015). *Autoethnography*. Oxford: Oxford University Press.
- Adams, V. (2013). 'Evidence-based global public health. Subjects, profits, erasures.', in Biehl, J. & Petryna, A. (eds.) *When people come first. Critical studies in global health*. New Jersey: Princeton University Presspp. 54-90.
- Adler, P. A. & Adler, P. (1987). *Membership roles in field research*. California: Sage.

- Adler, P. A. & Adler, P. (2002). 'Do university lawyers and the police define research values?', in van den Hoonaard, W. C. (ed.) *Walking the tightrope: ethical issues for qualitative researchers*. Toronto: University of Toronto Press, pp. 34-42.
- Adriaenssens, J., De Gucht, V. & Maes, S. (2015). 'Determinants and prevalence of burnout in emergency nurses: A systematic review of 25 years of research', *International journal of nursing studies*, 52(2), pp. 649-661.
- Agamben, G. (1998). *Homo Sacer : sovereign power and bare life*. Stanford, Calif: Stanford University Press.
- Agar, M. H. (1980a). *The professional stranger : an informal introduction to ethnography*. New York ;: Academic Press.
- Agar, M. H. (1980b). *The professional stranger: an informal introduction to ethnography*. New York: Academic Press.
- Ager, A. & Iacovou, M. (2014). 'The co-construction of medical humanitarianism: Analysis of personal, organizationally condoned narratives from an agency website', *Social science & medicine (1982)*, 120, pp. 430-438.
- Ager, A., Pasha, E., Yu, G., Duke, T., Eriksson, C. & Cardozo, B. L. (2012). 'Stress, Mental Health, and Burnout in National Humanitarian Aid Workers in Gulu, Northern Uganda', *Journal of traumatic stress*, 25(6), pp. 713-720.
- Ahmed, S. M., Ahmed, M., Nadeem, A., Mahajan, J., Choudhary, A. & Pal, J. (2008). 'Emergency treatment of a snake bite: Pearls from literature', *Journal of emergencies, trauma, and shock*, 1(2), pp. 97-105.
- Ahmed Suleiman, M. M., Sahal, N., Sodemann, M., El Sony, A. & Aro, A. R. (2013). 'Tuberculosis stigma in Gezira State, Sudan: a case-control study', *The international journal of tuberculosis and lung disease*, 17(3), pp. 388-393.
- Aiken, L. H., Sermeus, W., Van Den Heede, K., Sloane, D. M., Busse, R., McKee, M., Bruyneel, L., Rafferty, A. M., Griffiths, P., Moreno-Casbas, M. T., Tishelman, C., Scott, A., Brzostek, T., Kinnunen, J., Schwendimann, R., Heinen, M., Zikos, D., Sjetne, I. S., Smith, H. L. & Kutney-Lee, A. (2012). Patient safety, satisfaction, and quality of hospital care: Cross sectional surveys of nurses and patients in 12 countries in Europe and the United States. *BMJ* [Online]. Available at: <https://doi.org/10.1136/bmj.e1717> (Accessed: 24 October 2019).
- Ain Ibrahim, N., Makmor Bakry, M., Mohd Tahir, N. A., Mohd Zaini, N. R. & Mohamed Shah, N. (2020). 'A Prospective Cohort Study of Factors Associated with Empiric Antibiotic De-escalation in Neonates Suspected with Early Onset Sepsis (EOS)', *Paediatric drugs*, 22(3), pp. 321-330.
- Akpan-Idiok, P. A. & Anarado, A. N. (2014). 'Perceptions of burden of caregiving by informal caregivers of cancer patients attending University of Calabar Teaching Hospital, Calabar, Nigeria', *The Pan African medical journal*, 18(159), pp. 159-159.
- Alani, D. (2018). An Audit of Fluid Balance Monitoring in Patients Admitted due to an Exacerbation of Congestive Heart Failure. *Age and Ageing* [Online], 47(suppl_5), pp. v13-v60. Available at: <https://doi.org/10.1093/ageing/afy140.191> (Accessed: 27 November 2019).
- Alatinga, K. & Williams, J. (2014). 'Community perceptions on the provision of quality health care in Ghana: the case of Kassena- Nankana Mutual Health Insurance Scheme', *Ghana journal of development studies*, 11(2), pp. 83-99.
- Albahari, M. (2016). 'After the Shipwreck: Mourning and Citizenship in the Mediterranean, Our Sea', *Social research*, 83(2), pp. 275-294.

- Albuquerque, S., Eriksson, A. & Alvesson, H. M. (2018). 'The rite of passage of becoming a humanitarian health worker: experiences of retention in Sweden', *Global health action*, 11(1), pp. 1417522-1417522.
- Alcoba, G., Sterk, E., Powell, K., Rusch, B., Tamannai, M., Rull, M., Ciglenecki, I., Potet, J., Kuch, U. & Chappuis, F. (2015). 'Snakebite envenoming in South Sudan: a true public health emergency', *Tropical Medicine & International Health*, 20, pp. 234-235.
- Alirol, E., Lechevalier, P., Zamatto, F., Chappuis, F., Alcoba, G. & Potet, J. (2015). Antivenoms for Snakebite Envenoming: What Is in the Research Pipeline? 9(9), p. e0003896. Available at: <https://doi.org/10.1371/journal.pntd.0003896> (Accessed: 21 September 2017).
- Allen, D. (2004). 'Ethnomethodological insights into insider–outsider relationships in nursing ethnographies of healthcare settings', *Nursing Inquiry*, 11(1), pp. 14-24.
- Allen, D. (2009). 'From boundary concept to boundary object: The practice and politics of care pathway development', *Social science & medicine (1982)*, 69(3), pp. 354-361.
- Allen, D. (2015). *The invisible work of nurses : hospitals, organisation and healthcare*. Abingdon, Oxon: Routledge.
- Allen, D., Braithwaite, J., Sandall, J. & Waring, J. (2016). *The sociology of healthcare safety and quality*. Malden, MA: Wiley Blackwell.
- Allen, T. (2015). 'Life beyond bubbles: Cognitive dissonance and humanitarian impunity in Northern Uganda.', in Abramowitz, S. A. & Panterbrick, C. (eds.) *Medical humanitarianism : ethnographies of practice*. Philadelphia: University of Pennsylvania Press.
- Almeida, C., Braveman, P., Gold, M. R., Szwarcwald, C. L., Ribeiro, J. M., Miglionico, A., Millar, J. S., Porto, S., Costa, N. d. R., Rubio, V. O., Segall, M., Starfield, B., Travassos, C., Uga, A., Valente, J. & Viacava, F. (2001). Methodological concerns and recommendations on policy consequences of the World Health Report 2000. *The Lancet (British edition)* [Online], 357(9269), pp. 1692-1697. Available at: [https://doi.org/10.1016/S0140-6736\(00\)04825-X](https://doi.org/10.1016/S0140-6736(00)04825-X) (Accessed: 2 November 2016).
- ALNAP (2016). Evaluation of Humanitarian Action guide. Available at: <https://www.betterevaluation.org/en/themes/evaluating-humanitarian-action> (Accessed: 20 November 2019).
- Aloudat, T. & Smith, J. (2020). 'Changing contexts in humanitarianism. A challenge for anthropology', in Véran, J. F. o. (ed.) *Médecins Sans Frontières and humanitarian situations : an anthropological exploration*. Milton Park, Abingdon, Oxon: Routledgepp. 27-38.
- Alvarado, O., Trelles, M., Tayler-Smith, K., Joseph, H., Gesline, R., Wilna, T., Mohammad Omar, M., Faiz Mohammad, N., Muhima Mastaki, J., Chingumwa Buhu, R., Caluwaerts, A. & Dominguez, L. (2015). 'Orthopaedic surgery in natural disaster and conflict settings: how can quality care be ensured?', *International Orthopaedics (SICOT)*, 39(10), pp. 1901-1908.
- Amnesty International (2016). *EU-Turkey deal a historic blow to rights*. Available at: <https://www.amnesty.org/en/latest/news/2016/03/eu-turkey-refugee-deal-a-historic-blow-to-rights/> (Accessed: 28 July 2019).
- Ansbro, É. M., Biringanine, M., Caleo, G., Prieto-Merino, D., Sadique, Z., Perel, P., Jobanputra, K. & Roberts, B. (2019). Management of diabetes and associated costs in a complex humanitarian setting in the Democratic Republic of Congo: a

- retrospective cohort study. *BMJ open* [Online], 9(11), pp. e030176-e030176. Available at: <https://doi.org/10.1136/bmjopen-2019-030176> (Accessed: 12 February 2020).
- Anspach, R. & Mizrahi, N. (2006). 'The field worker's fields: ethics, ethnography and medical sociology', *Sociology of health and illness*, 28(1), pp. 713-731.
- Anthwal, P., Kumar, N., Manchanda, A. & Garg, B. (2018). 'Six-Hour Sepsis Bundle Decreases Mortality: Truth or Illusion - A Prospective Observational Study', *Indian journal of critical care medicine : peer-reviewed, official publication of Indian Society of Critical Care Medicine*, 22(12), pp. 852-857.
- Antonopoulos, G. A. & Winterdyk, J. (2006). 'The Smuggling of Migrants in Greece: An Examination of its Social Organization', *European journal of criminology*, 3(4), pp. 439-461.
- Apthorpe, R. (2014). 'Anthropology and humanitarisms across borders: A growing field of study', *Journal of the Royal Anthropological Institute*, 20(2), pp. 357-361.
- Arabian-Hoseynabadi, H., Oraee, H. & Tavner, P. J. (2010). 'Failure Modes and Effects Analysis (FMEA) for wind turbines', *International journal of electrical power & energy systems*, 32(7), pp. 817-824.
- Aranaz-Andrés, J. M., Aibar-Remón, C., Vitaller-Murillo, J., Ruiz-López, P., Limón-Ramírez, R. & Terol-García, E. (2008). 'Incidence of adverse events related to health care in Spain: results of the Spanish National Study of Adverse Events', *Journal of epidemiology and community health* (1979), 62(12), pp. 1022-1029.
- Araujo, M. T., Velloso, I. S. C., Ceci, C. & Purkis, M. E. (2019). The significance of overlooked objects: Materiality and care at home for people with dementia. *Nursing inquiry* [Online], 27(1), pp. e12306-n/a. Available at: <https://doi-org.manchester.idm.oclc.org/10.1111/nin.12306> (Accessed: 20 June 2020).
- Armstrong, L., Lauder, W. & Shepherd, A. (2015). 'An evaluation of methods used to teach quality improvement to undergraduate healthcare students to inform curriculum development within preregistration nurse education: a protocol for systematic review and narrative synthesis', *Systematic reviews*, 4, p. 8.
- Asgary, R. & Lawrence, K. (2014). Characteristics, determinants and perspectives of experienced medical humanitarians: a qualitative approach. *BMJ Open* [Online], 4(12), p. e006460. Available at: <https://doi.org/10.1136/bmjopen-2014-006460> (Accessed: 12 September 2018).
- Asgary, R. & Price, J. T. (2018). 'Socio-Cultural Challenges of Family Planning Initiatives for Displaced Populations in Conflict Situations and Humanitarian Settings', *Disaster medicine and public health preparedness*, 12(6), pp. 670-674.
- Atkinson, P. (1997). Narrative Turn or Blind Alley? *Qualitative health research* [Online], 7(3), pp. 325-344. Available at: <https://doi-org.manchester.idm.oclc.org/10.1177/104973239700700302> (Accessed: 13 December 2019).
- Attree, M. (2001). 'Patients' and relatives' experiences and perspectives of 'Good' and 'Not so Good' quality care', *Journal of advanced nursing*, 33(4), pp. 456-466.
- Australian Commission on Safety and Quality in Health Care (2017). National Model Clinical Governance Framework. Available at: <https://www.safetyandquality.gov.au/sites/default/files/migrated/National-Model-Clinical-Governance-Framework.pdf> (Accessed: 20 June 2019).
- Avau, B., Borra, V., Vandekerckhove, P. & De Buck, E. (2016). The Treatment of Snake Bites in a First Aid Setting: A Systematic Review. *PLoS Neglected Tropical*

- Diseases* [Online], 10(10), p. e0005079. Available at: <https://doi.org/10.1371/journal.pntd.0005079> (Accessed: 21 September 2017).
- Awais, S., Saeed, A. & Ch, A. (2014). 'Use of external fixators for damage- control orthopaedics in natural disasters like the 2005 Pakistan earthquake', *International Orthopaedics (SICOT)*, 38(8), pp. 1563-1568.
- Aynsley-Green, A. & Pickering, P. (1975). Tepid Sponging In Pyrexia. *British medical journal* [Online], 2(5967), pp. 393-393. Available at: <https://www.jstor.org/stable/20473088> (Accessed: 17 March 2021).
- Bae, S. H., Mark, B. & Fried, B. (2010). 'Impact of Nursing Unit Turnover on Patient Outcomes in Hospitals', *Journal of nursing scholarship*, 42(1), pp. 40-49.
- Baker, G. R., Norton, P. G., Flintoft, V., Blais, R., Brown, A., Cox, J., Etchells, E., Ghali, W. A., Hébert, P., Majumdar, S. R., O'Beirne, M., Palacios-Derflingher, L., Reid, R. J., Sheps, S. & Tamblyn, R. (2004). 'The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada', *CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne*, 170(11), p. 1678.
- Baker, M. (2010). Interpreters and translators in the war zone: narrated and narrators. *Translator (Manchester, England)* [Online], 16(2), pp. 197-222. Available at: <https://doi.org/10.1080/13556509.2010.10799469> (Accessed: 24 July 2017).
- Bakker, A. B., Killmer, C. H., Siegrist, J. & Schaufeli, W. B. (2000). 'Effort-reward imbalance and burnout among nurses', *Journal of advanced nursing*, 31(4), pp. 884-891.
- Balampanidis, D. & Polyzos, I. (2016). 'Migrants' settlement in two central neighborhoods of Athens: An analytical framework for urban transformations and interethnic coexistence', *City (London, England)*, 20(1), pp. 75-90.
- Balinska, M. A. (2019). A humanitarian approach to travel medicine? *Forced Migration Review* [Online], (61). Available at: <https://www.fmreview.org/ethics/balinska> (Accessed: 22 September 2019).
- Balinska, M. A., Nesbitt, R., Ghantous, Z., Ciglenecki, I. & Staderini, N. (2019). 'Reproductive health in humanitarian settings in Lebanon and Iraq: results from four cross-sectional studies, 2014-2015', *Conflict and health*, 13(1), pp. 24-24.
- Ballangrud, R., Husebø, S. E., Aase, K., Aaberg, O. R., Vifladt, A., Berg, G. V. & Hall-Lord, M. L. (2017). "'Teamwork in hospitals": a quasi-experimental study protocol applying a human factors approach', *BMC nursing*, 16(1), pp. 34-34.
- Bank Muñoz, C. (2008). *Transnational tortillas : race, gender, and shop-floor politics in Mexico and the United States*. Ithaca: ILR Press.
- Barnett, H. (2018). The patient perspective of quality of care: A review of the literature., pp. 1-27. Available at: <https://www.msf-crash.org/en/publications/medicine-and-public-health/literature-review-evaluation-quality-care-patients> (Accessed: 10 October 2020).
- Barnett, M. N. (2011). *The empire of humanity : a history of humanitarianism*. Ithaca: Cornell University Press.
- Barnett, M. N. (2012). 'Faith in the machine? Humanitarianism in an age of Bureaucratization', in Barnett, M. N. & Stein, J. G. (eds.) *Sacred aid : faith and humanitarianism*. Oxford: Oxford University Presspp. 188-210.
- Barsky, R. F. (1996). 'The Interpreter as Intercultural Agent in Convention Refugee Hearings', *Translator (Manchester, England)*, 2(1), pp. 45-63.

- Bateman, C. (2013). MSF again paves the way with ART. *South African medical journal* [Online], 103(2), pp. 71-73. Available at: <https://doi.org/10.7196/samj.6666> (Accessed: 22 September 2018).
- Baudouin, S. V. (2008). *Sepsis*. London: Springer.
- Baum, F. (2007). Health for All Now! Reviving the spirit of Alma Ata in the Twenty-first century: An Introduction to the Alma Ata Declaration. *Social medicine (Social Medicine Publication Group)* [Online], 2(1), pp. 34-41. Available at: <https://www.socialmedicine.info/index.php/socialmedicine/article/view/76/187> (Accessed: 2 June 2018).
- Beer, N., Ali, A. S., Eskilsson, H., Jansson, A., Abdul-Kadir, F. M., Rotllant-Estelrich, G., Abass, A. K., Wabwire-Mangen, F., Björkman, A. & Källander, K. (2012). 'A qualitative study on caretakers' perceived need of bed-nets after reduced malaria transmission in Zanzibar, Tanzania', *BMC public health*, 12(1), pp. 606-606.
- Behzadifar, M., Bragazzi, N. L., Arab-Zozani, M., Bakhtiari, A., Behzadifar, M., Beyranvand, T., Yousefzadeh, N., Azari, S., Sajadi, H. S., Saki, M., Saran, M. & Gorji, H. A. (2019). 'The challenges of implementation of clinical governance in Iran: a meta-synthesis of qualitative studies', *Health research policy and systems*, 17(1), pp. 3-14.
- Belanteri, R. A., Hinderaker, S. G., Wilkinson, E., Episkopou, M., Timire, C., De Plecker, E., Mabhala, M., Takarinda, K. C., Van den Bergh, R., Stark, L. & Sar, V. (2020). Sexual violence against migrants and asylum seekers. The experience of the MSF clinic on Lesbos Island, Greece. *PLoS one* [Online], 15(9), pp. e0239187-e0239187. Available at: <https://doi.org/10.1371/journal.pone.0239187> (Accessed: 21 January 2021).
- Ben Abdelahfidh, L., Huber, J., Rojas López, F., Glorie, C., Vanden Bussche, I., Coiret, C., Spoel, E., Pignard, A. L., Heymans, S. & De Bethune, X. (2019). Access to abortion of undocumented migrants seen by Médecins du Monde in the Humanitarian Hub. *European Journal of Public Health* [Online], 29(Supplement_4). Available at: <https://doi.org/10.1093/eurpub/ckz186.042> (Accessed: 12 March 2020).
- Ben Farhat, J., Blanchet, K., Juul Bjertrup, P., Veizis, A., Perrin, C., Coulborn, R. M., Mayaud, P. & Cohuet, S. (2018). Syrian refugees in Greece: experience with violence, mental health status, and access to information during the journey and while in Greece. *BMC medicine* [Online], 16(1), pp. 40-40. Available at: <https://doi.org/10.1186/s12916-018-1028-4> (Accessed: 24 April 2019).
- Berendes, S., Heywood, P., Oliver, S. & Garner, P. (2011). Quality of Private and Public Ambulatory Health Care in Low and Middle Income Countries: Systematic Review of Comparative Studies (Quality of Private Versus Public Care). *PLoS Medicine* [Online], 8(4), p. e1000433. Available at: <https://doi.org/10.1371/journal.pmed.1000433> (Accessed: 17 January 2020).
- Berry, N. S. (2014). 'Did we do good? NGOs, conflicts of interest and the evaluation of short-term medical missions in Sololá, Guatemala', *Social Science & Medicine*, 120, pp. 344-351.
- Bertol, M., Van den Bergh, R., Trelles Centurion, M., Kenslor Ralph D, H., Basimuoneye Kahutsi, J.-P., Qayeum Qasemy, A., Jean, J., Majuste, A., Kubuya Hangi, T. & Safi, S. (2014). 'Saving life and limb: limb salvage using external fixation, a multi-centre review of orthopaedic surgical activities in Médecins Sans Frontières', *International Orthopaedics (SICOT)*, 38(8), pp. 1555-1561.

- Berwick, D., Snair, M. & Nishtar, S. (2018). Crossing the Global Health Care Quality Chasm: A Key Component of Universal Health Coverage. *JAMA : the journal of the American Medical Association* [Online], 320(13), p. 1317. Available at: <https://jamanetwork-com.manchester.idm.oclc.org/journals/jama/fullarticle/2701790> (Accessed: 5 August 2019).
- Beswick, S. (2004). *Sudan's blood memory : the legacy of war, ethnicity, and slavery in early South Sudan*. Rochester, NY: University of Rochester Press.
- Bevan, G. & Cornwell, J. (2006). 'Structure and logic of regulation and governance of quality of health care: was OFSTED a model for the Commission for Health Improvement?', *Health economics, policy and law*, 1(4), pp. 343-370.
- Bhutta, Z. A. & Black, R. E. (2013). 'Global Maternal, Newborn, and Child Health — So Near and Yet So Far', *The New England Journal of Medicine*, 369(23), pp. 2226-2235.
- Biehl, J. & Petryna, A. (eds.) (2013a). *When People Come First - Critical Studies in Global Health*, New Jersey: Princeton University Press.
- Biehl, J. & Petryna, A. (eds.) (2013b). *When people come first. Critical studies in global health*, New Jersey: Princeton University Press.
- Binet, L. & Saulnier, M. (2019). Médecins Sans Frontières, Evolution of an International Movement: Associative History 1971-2011. Available at: http://associativehistory.msf.org/sites/default/files/Histoire_Assoc_MS_F_VAng.pdf (Accessed: 22 January 2020).
- Binns, C. & Lee, M. K. (2015). 'Health for All: A Fundamental Goal of Public Health in Our Region', *Asia-Pacific journal of public health*, 27(1), pp. 11-14.
- Bjertrup, P. J., Ben Farhat, J., Bouhenia, M., Neuman, M., Mayaud, P. & Blanchet, K. (2021). 'Being Stuck': Refugees' Experiences of Enforced Waiting in Greece', in *Immobility and Medicine: Exploring Stillness, Waiting and the In-Between*. pp. 39-59 [Online]. Version. Available at: https://doi.org/10.1007/978-981-15-4976-2_3.
- Bjertrup, P. J., Bouhenia, M., Mayaud, P., Perrin, C., Ben Farhat, J. & Blanchet, K. (2018). 'A life in waiting: Refugees' mental health and narratives of social suffering after European Union border closures in March 2016', *Social science & medicine* (1982), 215, pp. 53-60.
- Blackburn, P. (2006). 'National staff: Towards advancement?', *TAG, Internal magazine of MSF Switzerland*, (no. 9), p. 2.
- Blaize-La Caille, C. E. (2018). *Labouring for quality : crossing the chasm in maternal health care in Trinidad and Tobago*. ProQuest Dissertations Publishing.
- Boillot, F. & Herard, P. (2014). 'External fixators and sudden-onset disasters: Médecins Sans Frontières experience', *International Orthopaedics (SICOT)*, 38(8), pp. 1551-1554.
- Bolton, S. C., Charalampopoulos, V. & Skountridaki, L. (2019). 'Selective Consent and Dissent: Professional Response to Reform in the Post-Crisis Greek NHS', *Work, employment and society*, 33(2), pp. 262-279.
- Bompart, F., Kiechel, J.-R., Sebbag, R. & Pecoul, B. (2011). 'Innovative public-private partnerships to maximize the delivery of anti-malarial medicines: lessons learned from the ASAQ Winthrop experience', *Malaria journal*, 10(1), pp. 143-143.
- Borton, J., Brusset, E., Hallam, A. & Millwood, D. (1996). *The international response to conflict and genocide : lessons from the Rwanda experience Study 3, Humanitarian*

- aid and effects ; by John Borton, Emery Brusset and Alistair Hallam. London: Overseas Development Institute.*
- Bourgeois, N., Boutet, A., Bousquet, P. J., Basset, D., Douard-Enault, C., Charachon, S. & Lachaud, L. (2010). 'Comparison of three real-time PCR methods with blood smears and rapid diagnostic test in Plasmodium sp. infection', *Clinical microbiology and infection*, 16(8), pp. 1305-1311.
- Boyce, M. R. & O'Meara, W. P. (2017). 'Use of malaria RDTs in various health contexts across sub-Saharan Africa: a systematic review', *BMC public health*, 17(1), pp. 470-470.
- Bradby, H., Lebano, A., Hamed, S., Gil-Salmerón, A., Durá-Ferrandis, E., Garcés-Ferrer, J., Sherlaw, W., Christova, I., Karnaki, P., Zota, D. & Riza, E. (2020). Policy Makers', NGO, and Healthcare Workers' Accounts of Migrants' and Refugees' Healthcare Access Across Europe—Human Rights and Citizenship Based Claims. *Frontiers in sociology* [Online], 5. Available at: <https://doi.org/10.3389/fsoc.2020.00016> (Accessed: 21 January 2021).
- Bradfield, O. M. (2010). 'Ward Rounds: The Next Focus for Quality Improvement?', *Australian health review*, 34(2), pp. 193-196.
- Bradol, J.-H. & Szumilin, E. (2017). 'AIDS. A new pandemic leading to new medical and political practices', in *Medical innovations in humanitarian situations*. pp. 178-199 [Online]. Version. Available at: https://msfaccess.org/sites/default/files/MSF_assets/Innovation/Docs/MedInovBookMedInovinHumanitarian_ENG_2011.pdf.
- Bradol, J.-H. & Vidal, C. (eds.) (2011). *Medical Innovations in Humanitarian Situations. The work of Médecins Sans Frontières.*, United States: MSF-USA.
- Bradol, J.-H. & Vidal, C. (2011). *Medical Innovations in Humanitarian Solutions*. [Online]. CRASH. Available at: <https://www.msf-crash.org/en/publications/medicine-and-public-health/medical-innovations-humanitarian-situations>.
- Brauman, R. & Beck, M. (2017). Médecins Sans Frontières and medical quality. Available at: <https://www.msf-crash.org/en/publications/medicine-and-public-health/medecins-sans-frontieres-and-medical-quality> (Accessed: 10 October 2020).
- Brennan, T. A., Leape, L. L., Laird, N. M., Hebert, L., Localio, A. R., Lawthers, A. G., Newhouse, J. P., Weiler, P. C. & Hiatt, H. H. (1991). 'Incidence of Adverse Events and Negligence in Hospitalized Patients : Results of the Harvard Medical Practice Study I', *The New England Journal of Medicine*, 324(6), pp. 370-376.
- Brick, T. & Peters, M. (2014). 'Risks and benefits of transfusion for children with severe anemia in Africa', *BMC Medicine*, 12(1), p. 68.
- Brown, N. I. (2012). Consequences of Neglect: Analysis of the Sub-Saharan African Snake Antivenom Market and the Global Context (The African and Global Snake Antivenom Markets). *PLoS Neglected Tropical Diseases* [Online], 6(6), p. e1670. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3367979/> (Accessed: 10 October 2020).
- Buekens, P., Keusch, G., Belizan, J. & Bhutta, Z. A. (2004). 'Evidence-Based Global Health', *JAMA : the journal of the American Medical Association*, 291(21), pp. 2639-2641.
- Burhans, L. M. & Alligood, M. R. (2010). 'Quality nursing care in the words of nurses', *Journal of advanced nursing*, 66(8), pp. 1689-1697.
- Burki, T. (2018). 'End of a cholera epidemic in South Sudan declared', *The Lancet (British edition)*, 391(10121), pp. 647-647.

- Burrows, J. N., Elliott, R. L., Kaneko, T., Mowbray, C. E. & Waterson, D. (2014). 'The role of modern drug discovery in the fight against neglected and tropical diseases', *MedChemComm*, 5(6), pp. 688-7.
- Busby, A. & Gilchrist, B. (1992). 'The role of the nurse in the medical ward round', *Journal of advanced nursing*, 17(3), pp. 339-346.
- Cabot, H. (2014). *On the doorstep of Europe : asylum and citizenship in Greece*. Philadelphia, Pennsylvania: University of Pennsylvania Press.
- Calhoun, C. (2008). 'The Imperative to Reduce Suffering:: Charity, Progress, and Emergencies in the Field of Humanitarian Action', in Barnett, M. & Weiss, T. G. (eds.) *Humanitarianism in Question: Power, politics, ethics*. Ithaca: Cornell University Press, p. 73.
- Calhoun, C. (2013). 'The idea of emergency: Humanitarianism and Global (dis) order', in Fassin, D. & Pandolfi, M. (eds.) *Contemporary states of emergency : the politics of military and humanitarian interventions*. First paperback edition. ed. New York: Zone Books pp. 29 - 58.
- Callaghan, M., Ford, N. & Schneider, H. (2010). 'A systematic review of task- shifting for HIV treatment and care in Africa', *Human resources for health*, 8(1), pp. 8-8.
- Camilli, A. & Paynter, E. (2021). Death on the Central Mediterranean: 2013-2020. *The New Humanitarian* [Online]. Available at: <https://www.thenewhumanitarian.org/news-feature/2021/01/12/migration-central-mediterranean-timeline-rescue> (Accessed: 12 January 2021).
- Campani, G. & Lapov, Z. (2015). 'What Survival Strategies for Sub-Saharan Migrant Women? Networking Competences in a Gender-Aware Perspective', *Studi sulla formazione*, 18(1), p. 7.
- Campbell, S. M., Roland, M. O. & Buetow, S. A. (2000). 'Defining quality of care', *Social Science & Medicine*, 51(11), pp. 1611-1625.
- Carayon, P., Wetterneck, T. B., Rivera-Rodriguez, A. J., Hundt, A. S., Hoonakker, P., Holden, R. & Gurses, A. P. (2014). 'Human factors systems approach to healthcare quality and patient safety', *Applied ergonomics*, 45(1), pp. 14-25.
- Cardozo, B. L., Talley, L., Burton, A. & Crawford, C. (2004). 'Karen refugee living in Thai-Burmese border camps: traumatic experiences, mental health outcomes, and social functioning', *Social science & medicine (1982)*, 58(12), pp. 2637-2644.
- Carinci, F., van Gool, K., Mainz, J., Veillard, J., Pichora, E. C., Januel, J. M., Arispe, I., Kim, S. M. & Klazinga, N. S. (2015). 'Towards actionable international comparisons of health system performance: expert revision of the OECD framework and quality indicators', *International journal for quality in health care*, 27(2), pp. 137-146.
- Carlson, J. D. & Rubenfeld, D. G. (2007). 'Barriers to implementing protocol-based sepsis resuscitation in the emergency department—Results of a national survey', *Critical Care Medicine*, 35(11), pp. 2525-2532.
- Carpi, E. (2019). 'The 'need to be there'. North-South encounters and imaginations in the humanitarian economy.', in Fiddian-Qasmiyeh, E. & Daley, P. (eds.) *Routledge handbook of South-South relations*. Abingdon, Oxon ;: Routledge pp. 296 - 308.
- Carruth, L. (2014). 'Camel milk, amoxicillin, and a prayer: Medical pluralism and medical humanitarian aid in the Somali Region of Ethiopia', *Social science & medicine*, 120, pp. 405-412.
- Carruth, L. & Mendenhall, E. (2019). "'Wasting away": Diabetes, food insecurity, and medical insecurity in the Somali Region of Ethiopia', *Social science & medicine (1982)*, 228, pp. 155-163.

- Castellanos-Ortega, A., Suberviola, B., Garcia-Astudillo, L. A., Holanda, M. S., Ortiz, F., Llorca, J. & Delgado-Rodriguez, M. (2010). 'Impact of the Surviving Sepsis Campaign Protocols on Hospital Length of Stay and Mortality in Septic Shock Patients: Results of a Three-year Follow-up Quasi-experimental Study: Castellanos-Ortega A, Suberviola B, Garcia-Astudillo LA, et al. *Crit Care Med* 2010;38:1039-43', *Critical Care Medicine*, 38(4), pp. 1036-1043.
- Chang, S. H. & Cataldo, J. K. (2014). 'A systematic review of global cultural variations in knowledge, attitudes and health responses to tuberculosis stigma', *The international journal of tuberculosis and lung disease*, 18(2), pp. 168-173.
- Chatelain, E. & Ioset, J.-R. (2011). 'Drug discovery and development for neglected diseases: the DNDi model', *Drug design, development and therapy*, 5, pp. 175-181.
- Chen, Y., Meinecke, J. & Sivey, P. (2016). 'A Theory of Waiting Time Reporting and Quality Signaling', *Health economics*, 25(11), pp. 1355-1371.
- Cheng, A. C., West, T. E., Limmathurotsakul, D. & Peacock, S. J. (2008). Strategies to Reduce Mortality from Bacterial Sepsis in Adults in Developing Countries (Neglected Diseases). *PLoS Medicine* [Online], 5(8), p. e175. Available at: <https://doi.org/10.1371/journal.pmed.0050175> (Accessed: 23 February 2020).
- Chirac, P. & Torreele, E. (2006). 'Global framework on essential health R&D', *The Lancet (British edition)*, 367(9522), pp. 1560-1561.
- Choudry, A. (2013). *NGOization : Complicity, Contradictions and Prospects* (1 ed.). London: Zed Books.
- Chouliaraki, L. & Stolic, T. (2017). 'Rethinking media responsibility in the refugee 'crisis': a visual typology of European news', *Media, culture & society*, 39(8), pp. 1162-1177.
- Choumanivong, C., Poole, G. E. & Cooper, A. (2014). 'Refugee family reunification and mental health in resettlement', *Kōtuitui*, 9(2), pp. 89-100.
- Christmas, D. M. B. & Sweeney, A. (2016). 'Service user, patient, survivor or client ... has the time come to return to 'patient'?', *British journal of psychiatry*, 209(1), pp. 9-13.
- Chu, K., Stokes, C., Trelles, M. & Ford, N. (2011). 'Improving Effective Surgical Delivery in Humanitarian Disasters: Lessons from Haiti', *PLoS Medicine*, 8(4), p. e1001025.
- Chu, K. M., Ford, N. & Trelles, M. (2010). 'Operative mortality in resource-limited settings: the experience of Medecins Sans Frontieres in 13 countries', *Archives of surgery*, 145(8), p. 721.
- Chuah, F. L. H., Tan, S. T., Yeo, J. & Legido-Quigley, H. (2018). 'The health needs and access barriers among refugees and asylum-seekers in Malaysia: a qualitative study', *International journal for equity in health*, 17(1), pp. 120-120.
- Claeyé, F. & Jackson, T. (2011). 'Project delivery in HIV/AIDS and TB in Southern Africa: the cross-cultural management imperative', *Journal of health organization and management*, 25(4), pp. 469-486.
- Cohen, J. (2005). 'UNICEF: suggestions for change', *The Lancet (British edition)*, 365(9456), pp. 291-291.
- Collins, R. O. (2008). *A history of modern Sudan*. Cambridge: Cambridge University Press.
- Collinson, J. A. & Hockey, J. (2005). 'Autoethnography: self indulgence or rigorous methodology?', in McNamee, M. J. (ed.) *Philosophy and the sciences of exercise, health and sport : critical perspectives on research methods*. London: Routledgepp. 177-191.
- Conde, K. A. P., Silva, E., Silva, C. O., Ferreira, E., Freitas, F. G. R., Castro, I., Rea-Neto, A., Grion, C. M. C., Moura, A. D., Lobo, S. M., Azevedo, L. C. P., Machado, F. R. & Salluh,

- J. I. F. (2013). Differences in Sepsis Treatment and Outcomes between Public and Private Hospitals in Brazil: A Multicenter Observational Study. *PLoS ONE* [Online], 8(6). Available at: <https://doi.org/10.1371/journal.pone.0064790> (Accessed: 22 October 2019).
- Conde-Agudelo, A., Diaz-Rossello, J. L. & Belizan, J. M. (2003). 'Kangaroo Mother Care To Reduce Morbidity and Mortality in Low Birthweight Infants', *Birth (Berkeley, Calif.)*, 30(2), pp. 133-134.
- Cooper, Z., Gibbons, S., Jones, S. & McGuire, A. (2011). 'Does Hospital Competition Save Lives? Evidence From The English NHS Patient Choice Reforms', *Economic Journal*, 121(554), pp. F228-F260.
- Copnall, J. (2013). *A poisonous thorn in our hearts : Sudan and South Sudan's bitter and incomplete divorce*. London: Hurst & Company.
- Cosgrove, J. (2007). *Synthesis Report: expanded Summary. Joint evaluation of the international response to the Indian Ocean tsunami*, London: Tsunami Evaluation Coalition.
- Costa, D. S. J., Mercieca-Bebber, R., Tesson, S., Seidler, Z. & Lopez, A.-L. (2019). Patient, client, consumer, survivor or other alternatives? A scoping review of preferred terms for labelling individuals who access healthcare across settings. *BMJ Open* [Online], 9(3), pp. e025166-e025166. Available at: <https://doi.org/10.1136/bmjopen-2018-025166> (Accessed: 12 March 2020).
- Coy, P. G. (2001). 'Shared Risks and Research Dilemmas on a Peace Brigades International Team in Sri Lanka', *Journal of Contemporary Ethnography*, 30(5), pp. 575-606.
- Cross, V. J., Parker, J. T., Law Min, M.-C. Y. L. & Bourne, R. S. (2018). Pharmacist prescribing in critical care: an evaluation of the introduction of pharmacist prescribing in a single large UK teaching hospital. *European journal of hospital pharmacy. Science and practice* [Online], 25(e1), pp. e2-e6. Available at: <http://dx.doi.org/manchester.idm.oclc.org/10.1136/ejhpharm-2017-001267> (Accessed: 21 February 2021).
- Cuadra, C. B. (2012). 'Right of access to health care for undocumented migrants in EU: a comparative study of national policies', *European journal of public health*, 22(2), pp. 267-271.
- Cueto, M. (2004). 'The origins of primary health care and selective primary health care', *American Journal of Public Health*, 94(11), pp. 1864-1874.
- D'Amour, D., Ferrada-Videla, M., San Martin Rodriguez, L. & Beaulieu, M.-D. (2005). 'The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks', *Journal of interprofessional care*, 19(S1), pp. 116-131.
- Danish Refugee Council (2017). Fundamental Rights and the EU Hotspot approach. Available at: <https://reliefweb.int/report/world/fundamental-rights-and-eu-hotspot-approach-october-2017> (Accessed: 22 December 2017).
- Darzi, A., Health, D. o. (2008). *High quality care for all: NHS next stage review final report*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/228836/7432.pdf (Accessed: 2 February 2020).
- Dator, W., Abunab, H. & Dao-Ayen, N. (2018). Health challenges and access to health care among Syrian refugees in Jordan: a review. *Eastern Mediterranean health journal* [Online], 24(7), pp. 680-686. Available at: <https://link.gale.com/apps/doc/A556466288/AONE?u=jrycal5&sid=AONE&xid=063e4432> (Accessed: 15 March 2021).

- Daubman, B. R., Cranmer, H., Black, L. & Goodman, A. (2019). 'How to talk with dying patients and their families after disasters and humanitarian crises: a review of available tools and guides for disaster responders', *Journal of international humanitarian action*, 4(1), pp. 1-12.
- Davey, E. (2014). 'French adventures in solidarity: revolutionary tourists and radical humanitarians', *European Review of History: Revue européenne d'histoire*, 21(4), pp. 577-595.
- Davies, H. T. O., Nutley, S. M. & Mannion, R. (2000). 'Organisational culture and quality of health care', *Quality Health Care*, 9(2), p. 111.
- Ddungu, H. (2011). 'Palliative care: what approaches are suitable in developing countries?', *British journal of haematology*, 154(6), pp. 728-735.
- De Paoli, L. (2018). 'Access to health services for the refugee community in Greece: lessons learned', *Public Health*, 157, p. 104.
- de Vries, E. N., Ramrattan, M. A., Smorenburg, S. M., Gouma, D. J. & Boermeester, M. A. (2008). 'The incidence and nature of in-hospital adverse events: a systematic review', *Quality and Safety in Health Care*, 17(3), p. 216.
- De Waal, A. (2015). *The real politics of the Horn of Africa : money, war and the business of power*. Cambridge: Polity Press.
- Dean, E. (2014). 'Would you let your family stay here?: Despite its flaws, the Friends and Family Test allows patients to give valuable feedback, writes Erin Dean', *Nursing standard*, 29(2), pp. 22-23.
- Deblonde, J., Sasse, A., Del Amo, J., Burns, F., Delpéch, V., Cowan, S., Levoy, M., Keith, L., Pharris, A., Amato-Gauci, A. & Noori, T. (2015). Restricted access to antiretroviral treatment for undocumented migrants: a bottle neck to control the HIV epidemic in the EU/EEA. *BMC public health* [Online], 15(1), pp. 1228-1228. Available at: <https://doi.org/10.1186/s12889-015-2571-y> (Accessed: 22 June 2018).
- Dechaine, D. R. (2002). 'Humanitarian Space and the Social Imaginary: Médecins Sans Frontières/Doctors Without Borders and the Rhetoric of Global Community', *Journal of Communication Inquiry*, 26(4), pp. 354-369.
- DeJong, J., Ghattas, H., Bashour, H., Mourtada, R., Akik, C. & Reese-Masterson, A. (2017). Reproductive, maternal, neonatal and child health in conflict: a case study on Syria using Countdown indicators. *BMJ global health* [Online], 2(3), pp. e000302-e000302. Available at: <https://doi.org/10.1136/bmjgh-2017-000302> (Accessed: 23 July 2018).
- Dellinger, P. R., Levy, M. M., Rhodes, M. A., Annane, E. D., Gerlach, L. H., Opal, S. S., Sevransky, M. J., Sprung, E. C., Douglas, R. I., Jaeschke, M. R., Osborn, C. T., Nunnally, S. M., Townsend, R. S., Reinhart, D. K., Kleinpell, A. R., Angus, J. D., Deutschman, J. C., Machado, J. F., Rubenfeld, J. G., Webb, J. S., Beale, J. R., Vincent, J. J.-L. & Moreno, J. R. (2013). 'Surviving Sepsis Campaign: International Guidelines for Management of Severe Sepsis and Septic Shock: 2012', *Critical Care Medicine*, 41(2), pp. 580-637.
- Deng, B. K. & Logan, S. (2019). *The struggle for South Sudan : challenges of security and state formation*. London: I.B. Tauris.
- Deng, F. M. (1972). *The Dinka of the Sudan*. New York ;: Holt, Rinehart and Winston.
- Deng, L. B. (2010). 'Justice in Sudan: will the award of the international Abyei Arbitration Tribunal be honoured?', *Journal of Eastern African Studies*, 4(2), pp. 298-313.
- Department of Health (1998). A First class service : quality in the new NHS. *The new NHS* [Online]. Available at:

- https://webarchive.nationalarchives.gov.uk/20110322225724/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006902 (Accessed: 22 August 2018).
- Department of Health (2002). Learning from Bristol: The Department of Health's response to the Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995. London: The Stationary Office Limited
- Department of Health and Social Care and National Institute for Health and Care Excellence (2018). *Framework Agreement between the Department of Health and Social Care and the National Institute for Health and Care Excellence*. Available at: <https://www.nice.org.uk/Media/Default/About/Who-we-are/NICE-framework-agreement.pdf> (Accessed: February 7th 2020).
- Deribew, A., Abebe, G., Apers, L., Abdissa, A., Deribe, F., Woldemichael, K., Jira, C., Tesfaye, M., Shiffa, J., Aseffa, A., Bezabih, M., Abeje, T. & Colebunders, R. (2012). 'Prevalence of pulmonary TB and spoligotype pattern of Mycobacterium tuberculosis among TB suspects in a rural community in Southwest Ethiopia', *BMC Infectious Diseases*, 12(1), p. 54.
- Devi, S. (2020). 'Greece "deliberately depriving" care to child refugees', *The Lancet (British edition)*, 395(10221), pp. 323-323.
- DHSS, G. B. W. O. (1979). Patients come first: consultative paper on the structure and management of the National Health Service in England and Wales. London: HMSO.
- Dias, S., Gama, A., Tavares, A. M., Reigado, V., Simões, D., Carreiras, E., Mora, C. & Pinto Ferreira, A. (2019). 'Are Opportunities Being Missed? Burden of HIV, STI and TB, and Unawareness of HIV among African Migrants', *International journal of environmental research and public health*, 16(15), p. 2710.
- Dicocco-Bloom, B. & Crabtree, B. F. (2006). 'Making Sense of Qualitative Research: The Qualitative Research Interview', *Medical Education*, 40(4), pp. 314-321.
- Dijkzeul, D. & Wakenge, C. I. (2010). 'Doing good, but looking bad? Local perceptions of two humanitarian organisations in eastern Democratic Republic of the Congo', *Disasters*, 34(4), pp. 1139-1170.
- DiMeglio, L. A., Evans-Molina, C. & Oram, R. A. (2018). 'Type 1 diabetes', *The Lancet (British edition)*, 391(10138), pp. 2449-2462.
- Dinala, H., Sambo, J., Nyambe, S. & Yamauchi, T. (2020). 'A Comparative Report on Health and Water, Sanitation and Hygiene in Malawi, Tanzania and Zambia', *Sanitation Value Chain*, 4(3), pp. 37-60.
- Dixon, A., Foot, C. & Harrison, T. (2012). Preparing for the Francis report. How to assure quality in the NHS. Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/preparing-for-the-francis-report-jul2012.pdf (Accessed: 13 June 2021).
- Dlamini-Simelane, T. & Moyer, E. (2017). Task shifting or shifting care practices?: The impact of task shifting on patients' experiences and health care arrangements in Swaziland. *BMC health services research* [Online], 17(1), pp. 20-20. Available at: <https://doi.org/10.1186/s12913-016-1960-y> (Accessed: 22 March 2018).
- Doloriert, C. & Sambrook, S. (2012). 'Organisational autoethnography', *Journal of organizational ethnography*, 1(1), pp. 83-95.
- Donabedian, A. (2005). Evaluating the quality of medical care. *The Milbank Memorial Fund quarterly* [Online], 83(4), pp. 691-729. Available at: <https://doi.org/10.1111/j.1468-0009.2005.00397.x> (Accessed: 22 September 2017).

- Donaldson, L. J. (2000). *An Organisation with a memory : report of an expert group on learning from adverse events in the NHS*. London: Stationery Office.
- Dopfer, C., Vakilzadeh, A., Happle, C., Kleinert, E., Müller, F., Ernst, D., Schmidt, R., Behrens, G., Merkesdal, S., Wetzke, M. & Jablonka, A. (2018). 'Pregnancy Related Health Care Needs in Refugees—A Current Three Center Experience in Europe', *International journal of environmental research and public health*, 15(9), p. 1934.
- Dougherty, M. C. & Tripp-Reimer, T. (1985). 'The Interface of Nursing and Anthropology', *Annual Review of Anthropology*, 14, pp. 219-241.
- Downing, J., Gwyther, L. & Mwangi-Powell, F. (2012). 'Public health and palliative care. A perspective from Africa', in Sallnow, L., Kumar, S. & Kellehear, A. (eds.) *International perspectives on public health and palliative care*. Abingdon, Oxon ;; Routledgepp. 69-84.
- Doyle, C., Lennox, L. & Bell, D. (2013). A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *BMJ Open* [Online], 3(1), p. e001570. Available at: <https://doi.org/10.1136/bmjopen-2012-001570> (Accessed: 10 September 2020).
- Dubey, R., Gunasekaran, A., Altay, N., Childe, S. J. & Papadopoulos, T. (2016). 'Understanding employee turnover in humanitarian organizations', *Industrial and commercial training*, 48(4), pp. 208-214.
- Dufour, C., Geoffroy, V., Maury, H. & Grünewald, F. (2004). 'Rights, Standards and Quality in a Complex Humanitarian Space: Is Sphere the Right Tool?', *Disasters*, 28(2), pp. 124-141.
- Duggirala, M., Rajendran, C. & Anantharaman, R. N. (2008). 'Patient-perceived dimensions of total quality service in healthcare', *Benchmarking : an international journal*, 15(5), pp. 560-583.
- Dwyer, S. C. & Buckle, J. L. (2009). 'The Space Between: On Being an Insider- Outsider in Qualitative Research', *International Journal of Qualitative Methods*, 8(1), pp. 54-63.
- Dörnemann, J., van den Boogaard, W., Van den Bergh, R., Takarinda, K. C., Martinez, P., Bekouanebandi, J. G., Javed, I., Ndelema, B., Lefèvre, A., Khalid, G. G. & Zuniga, I. (2017). 'Where technology does not go: specialised neonatal care in resource-poor and conflict-affected contexts', *Public health action*, 7(2), pp. 168-174.
- ECDC (2013). Migrant health: Sexual transmission of HIV within migrant groups in the EU/EEA and implications for effective interventions. Available at: <https://www.ecdc.europa.eu/sites/default/files/media/en/publications/Publications/Migrant-health-sexual-transmission.pdf> (Accessed: 22 November 2018).
- ECDC (2017). Special report. HIV and migrants. Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia: 2017 progress report. Available at: <https://www.ecdc.europa.eu/sites/default/files/documents/HIV%20and%20migrants.pdf> (Accessed: 20 January 2021).
- El-Nawawy, A., Moustafa, A. A., Antonios, M. A. M. & Atta, M. M. (2019). Clinical Outcomes Associated with Fluid Overload in Critically Ill Pediatric Patients. *Journal of tropical pediatrics* [Online], pp. 152-162. Available at: <https://doi.org/10.1093/tropej/fmz045> (Accessed: 3 February 2020).
- Eleftherakos, C., van den Boogaard, W., Barry, D., Severy, N., Kotsioni, I. & Roland-Gosselin, L. (2018). "I prefer dying fast than dying slowly", how institutional abuse worsens the mental health of stranded Syrian, Afghan and Congolese migrants on Lesbos island following the implementation of EU-Turkey deal.

- Conflict and health* [Online], 12(1), pp. 38-38. Available at: <https://doi.org/10.1186/s13031-018-0172-y> (Accessed: 22 January 2019).
- Ellis, C., Adams, T. E. & Bochner, A., P. (2011a). Autoethnography: An Overview. *Historical social research (Köln)* [Online], 36(4 (138)), pp. 273-290. (Accessed: 2017).
- Ellis, C., Adams, T. E. & Bochner, A., P. (2011b). Autoethnography: An Overview. *Historical social research* [Online], 36(4 (138)), pp. 273-290. Available at: <https://www.jstor.org/stable/23032294> (Accessed: 3 October 2017).
- Emerson, R. M. (1995). *Writing ethnographic fieldnotes*. Chicago: University of Chicago Press.
- Emmerich, N., Swinglehurst, D., Maybin, J., Park, S. & Quilligan, S. (2015). Caring for quality of care: symbolic violence and the bureaucracies of audit. *BMC medical ethics* [Online], 16(1), pp. 1 - 12. Available at: <https://doi.org/10.1186/s12910-015-0006-z> (Accessed: 14 November 2020).
- English, M. (2000). 'Life threatening severe anaemia', *Transactions of the Society of Tropical Medicine and Hygiene.*, 94(6), pp. 585-588.
- English, M., Ahmed, M., Ngando, C., Berkley, J. & Ross, A. (2002). 'Blood transfusion for severe anaemia in children in a Kenyan hospital', *The Lancet*, 359(9305), pp. 494-495.
- Epstein, R. M. & Street, R. L. (2011). 'The values and value of patient- centered care', *Annals of family medicine*, 9(2), p. 100.
- European Council (2016). EU-Turkey statement, 18 March 2016.
- Fakoya, I., Álvarez-del Arco, D., Woode-Owusu, M., Monge, S., Rivero-Montesdeoca, Y., Delpech, V., Rice, B., Noori, T., Pharris, A., Amato-Gauci, A. J., del Amo, J. & Burns, F. M. (2015). 'A systematic review of post-migration acquisition of HIV among migrants from countries with generalised HIV epidemics living in Europe: mplications for effectively managing HIV prevention programmes and policy', *BMC public health*, 15(1), pp. 561-561.
- Farah, R. (2020). Expat, Local, and Refugee. *Migration and society : advances in research* [Online], 3(1), pp. 130-144. Available at: <https://doi.org/10.3167/arms.2020.030111> (Accessed: 10 October 2020).
- Farley, R., Askew, D. & Kay, M. (2014). 'Caring for refugees in general practice: perspectives from the coalface', *Australian journal of primary health*, 20(1), pp. 85-91.
- Farmer, P. (1992). *AIDS and accusation: Haiti and the geography of blame*. Berkeley: University of California Press.
- Farmer, P. (2003). *Pathologies of power : health, human rights, and the new war on the poor*. Berkeley, California: University of California Press.
- Fassin, D. (2008). The elementary forms of care. an empirical approach to ethics in a South African hospital. *Social Science and Medicine* [Online], 67(2), pp. 262-270. Available at: <https://doi.org/10.1016/j.socscimed.2008.03.044> (Accessed: 6 October 2020).
- Fassin, D. (2010a). 'Inequalities of lives, hierarchies of humanity: moral commitments and ethical dilemmas of humanitarianism.', in Feldman, L. & Ticktin, M. (eds.) *In the name of humanity. The Government of threat and care*. Durham and London: Duke University Presspp. 238-255.
- Fassin, D. (2010b). 'Inequalities of lives, hierarchies of humanity: moral commitments and ethical dilemmas of humanitarianism.', in Feldman, L. & Ticktin, M. (eds.) *In the name of humanity. The Government of threat and care*. Durham and London: Duke University Presspp. 238-255.

- Fassin, D. (2012). *Companion to Moral Anthropology* (1 ed.). Somerset: Wiley.
- FEANTSA (2020). Migration cluster study visit: reception and housing conditions for asylum seekers residing in Greece (Lesvos and Athens, 2nd - 4th March 2020) Available at: https://www.feantsa.org/public/user/Resources/Fin_Report_studyvisit_Greece.pdf (Accessed: 22 July 2020).
- Feili, H. R., Akar, N., Lotfizadeh, H., Bairampour, M. & Nasiri, S. (2013). 'Risk analysis of geothermal power plants using Failure Modes and Effects Analysis (FMEA) technique', *Energy conversion and management*, 72, pp. 69-76.
- Feldman, I. (2012). The Humanitarian Condition: Palestinian Refugees and the Politics of Living. *Humanity* [Online], 3(2), pp. 155-172. Available at: <https://muse-jhu-edu.manchester.idm.oclc.org/article/477662> (Accessed: 21 July 2019).
- Feldman, I. & Ticktin, M. I. (eds.) (2010). *In the name of humanity : the government of threat and care*, Durham, N.C: Duke University Press.
- Ferenczi, E., Datta, S. S. J. & Chopada, A. (2007). 'Intravenous fluid administration in elderly patients at a London hospital: A two-part audit encompassing ward-based fluid monitoring and prescribing practice by doctors', *International Journal of Surgery*, 5(6), pp. 408-412.
- Ferreira, C., O'Brien, D., Alonso, B., Al-Zomour, A. & Ford, N. (2018). 'Provision and continuation of antiretroviral therapy during acute conflict: the experience of MSF in Central African Republic and Yemen', *Conflict and health*, 12(1), pp. 30-30.
- Firth-Cozens, J. (2001). 'Multidisciplinary teamwork: the good, bad, and everything in between', *Quality in Health Care*, 10(2), pp. 65-66.
- Fitzpatrick, J. (2009). 'NICE celebrates 10th anniversary amid renal cancer drug controversy', *BJU International*, 103(8), pp. ii-v.
- Fonseca, B. d. P., Albuquerque, P. C. & Zicker, F. (2020). 'Neglected tropical diseases in Brazil: lack of correlation between disease burden, research funding and output', *Tropical medicine & international health*, 25(11), pp. 1373-1384.
- Ford, S. R., Visram, A., Ribeiro, C. T., Delgado, A. F., de Carvalho, W. B., Berend, K., Joyner, B. L., Boyd, J. M., Kocis, K. C., Kissoon, N., Carcillo, J. A., Scott, H., Melendez, E., Cruz, A. T., Maitland, K., Akech, S. O. & Russell, E. C. (2011). Mortality after Fluid Bolus in African Children with Sepsis. *The New England Journal of Medicine* [Online], 365(14), pp. 1348-1353. Available at: <https://doi.org/10.1056/NEJMoa1101549> (Accessed: 15 February 2020).
- Fotakis, E. A., Giantsis, I. A., Castells Sierra, J., Tanti, F., Balaska, S., Mavridis, K., Kourtidis, S., Vontas, J. & Chaskopoulou, A. (2020). 'Population dynamics, pathogen detection and insecticide resistance of mosquito and sand fly in refugee camps, Greece', *Infectious diseases of poverty*, 9(1), pp. 30-30.
- Fox, R. & Goemaere, E. (2006). 'They Call It "Patient Selection" in Khayelitsha: The Experience of Medecins Sans Frontieres--South Africa in Enrolling Patients to Receive Antiretroviral Treatment for HIV/AIDS', *Cambridge Quarterly of Healthcare Ethics*, 15(3), pp. 302-12.
- Fox, R. C. (1995). 'Medical humanitarianism and human rights: Reflections on Doctors Without Borders and Doctors of the World', *Social Science and Medicine*, 41(12), pp. 1607-1616.
- Fox, R. C. (1995). 'Medical humanitarianism and human rights: Reflections on Doctors Without Borders and Doctors of the World', *Social Science & Medicine*, 41(12), pp. 1607-1616.

- Fox, R. e. C. (2014). *Doctors without borders : humanitarian quests, impossible dreams of Médecins sans frontières*. Baltimore: Johns Hopkins University Press.
- FRA. European Union Agency for Fundamental Rights (2019). *Update of the 2016 opinion of the European Union Agency for Fundamental Rights on fundamental rights in the 'hotspots' set up in Greece and Italy.* , Luxembourg: European Union Agency for Fundamental Rights. Available at: https://fra.europa.eu/sites/default/files/fra_uploads/fra-2019-opinion-hotspots-update-03-2019_en.pdf (Accessed: 18 August 2019).
- Frampton, S. B. (2013). *The putting patients first field guide : global lessons in designing and implementing patient-centered care*. Somerset, New Jersey: Wiley.
- Freccero, J., Biswas, D., Whiting, A., Alrabe, K. & Seelinger, K. T. (2017). Sexual exploitation of unaccompanied migrant and refugee boys in Greece: Approaches to prevention. *PLoS medicine* [Online], 14(11), pp. e1002438-e1002438. Available at: <https://doi.org/10.1371/journal.pmed.1002438> (Accessed: 18 June 2018).
- Freedman, J. (2016). 'Sexual and gender-based violence against refugee women: a hidden aspect of the refugee "crisis"', *Reproductive health matters*, 24(47), pp. 18-26.
- Freedman, L. P. & Kruk, M. E. (2014). Disrespect and abuse of women in childbirth: challenging the global quality and accountability agendas. *The Lancet* [Online], 384(9948), pp. e42-e44. Available at: [https://doi.org/10.1016/S0140-6736\(14\)60859-X](https://doi.org/10.1016/S0140-6736(14)60859-X) (Accessed: 31 January 2017).
- Fuchs, A., Bielicki, J., Mathur, S., Sharland, M. & Van Den Anker, J. N. (2018). 'Reviewing the WHO guidelines for antibiotic use for sepsis in neonates and children', *Paediatrics and international child health*, 38(sup1), pp. S3-S15.
- Fund for Peace (2019). *Fragile States Index Annual Report 2019*. Available at: <http://fundforpeace.org/wp-content/uploads/2019/04/9511904-fragilestatesindex.pdf> (Accessed: 7th August 2019).
- Garnerin, P., Arès, M., Huchet, A. & Clergue, F. (2008). Verifying patient identity and site of surgery: improving compliance with protocol by audit and feedback. *Quality and Safety in Health Care* [Online], 17(6), pp. 454-458. Available at: <https://doi.org/10.1136/qshc.2007.022301> (Accessed: 25 January 2020).
- Gawande, A. A., Thomas, E. J., Zinner, M. J. & Brennan, T. A. (1999). 'The incidence and nature of surgical adverse events in Colorado and Utah in 1992', *Surgery*, 126(1), pp. 66-75.
- Gay y Blasco, P. & Wardle, H. (2007). *How to read ethnography*. London: Routledge.
- Gennep, A. v. (1960). *The rites of passage*. Chicago: University of Chicago Press.
- Gennep, A. v. (2019). *The rites of passage* (2nd ed.). London: The University of Chicago Press.
- Giambrone, G. P., Smith, M. C., Wu, X., Gaber-Baylis, L. K., Bhat, A. U., Zabih, R., Altorki, N. K., Fleischut, P. M. & Stiles, B. M. (2016). 'Variability in length of stay after uncomplicated pulmonary lobectomy: is length of stay a quality metric or a patient metric?', *European journal of cardio-thoracic surgery*, 49(4), pp. e65-e71.
- Giguère, K., Eaton, J. W., Marsh, K., Johnson, L. F., Johnson, C. C., Ehui, E., Jahn, A., Wanyeki, I., Mbofana, F., Bakiono, F., Mahy, M. & Maheu-Giroux, M. (2021). Trends in knowledge of HIV status and efficiency of HIV testing services in sub-Saharan Africa, 2000-20: a modelling study using survey and HIV testing programme data. *The Lancet HIV* [Online]. Available at: [https://doi.org/10.1016/S2352-3018\(20\)30315-5](https://doi.org/10.1016/S2352-3018(20)30315-5) (Accessed: 12 March 2021).

- Gill, G. V., Mbanya, J. C., Ramaiya, K. L. & Tesfaye, S. (2009). 'A sub-Saharan African perspective of diabetes', *Diabetologia*, 52(1), pp. 8-16.
- Gilles, H. M. (1986). 'Schistosomiasis. The St. Lucia Project', *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 80(2), p. 225.
- Gillies, R. (2006). 'From here to the La Mancha Agreement', *TAG. Internal publication*, (no. 9), pp. 26-27.
- Girgis, M. (2007). 'The Capacity-building Paradox: using friendship to build capacity in the South', *Development in Practice*, 17(3), pp. 353-366.
- Glasman, J. I. (2020). *Humanitarianism and the quantification of human needs minimal humanity*. Abingdon, Oxon ;: Routledge.
- Gnanasampanthan, V., Porten, L. & Bissett, I. (2014). 'Improving surgical intravenous fluid management: a controlled educational study', *ANZ Journal of Surgery*, 84(12), pp. 932-936.
- Gold, R. (1958). 'Roles in sociological field observations', *Social forces*, 36(3), pp. 217-223.
- Goldenberg, M. J. (2012). 'Defining "quality of care" persuasively', *Theoretical medicine and bioethics*, 33(4), pp. 243-261.
- Graffigna, G. (2015). *Patient Engagement : a Consumer-Centered Model to Innovate Healthcare* [Online]. Warsaw: De Gruyter Open.
- Greek Council for Refugees (2018). Reports of systematic pushbacks in the Evros region. Available at: <https://www.gcr.gr/en/ekdoseis-media/reports/reports/item/790-reports-of-systematic-pushbacks-in-the-evros-region> (Accessed: 14 September 2018).
- Greek Ombudsman Independent Authority (2017). *Special Report. Migration flows and refugee protection. Administrative challenges and human rights issues*. Available at: https://www.synigoros.gr/resources/docs/greek_ombudsman_migrants_refugees_2017_en.pdf (Accessed: 1st July 2018).
- Greene, A. (2020). 'Mobiles and 'making do': Exploring the affective, digital practices of refugee women waiting in Greece', *European journal of cultural studies*, 23(5), pp. 731-748.
- Griffiths, A., Beaussier, A.-L., Demeritt, D. & Rothstein, H. (2017). 'Intelligent Monitoring? Assessing the ability of the Care Quality Commission's statistical surveillance tool to predict quality and prioritise NHS hospital inspections', *BMJ quality & safety*, 26(2), p. 120.
- Grissinger, M. (2011). 'Capping intravenous tubing and disinfecting intravenous ports reduce risks of infection', *P & T : a peer-reviewed journal for formulary management*, 36(2), pp. 62-76.
- Gunst, M., Jarman, K., Yarwood, V., Rokadiya, S., Capsaskis, L., Orcutt, M. & Abbara, A. (2019). 'Healthcare access for refugees in Greece: Challenges and opportunities', *Health policy (Amsterdam)*, 123(9), pp. 818-824.
- Gutiérrez, J. M., Calvete, J. J., Habib, A. G., Harrison, R. A., Williams, D. J. & Warrell, D. A. (2017). 'Snakebite envenoming', *Nature Reviews Disease Primers*, 3.
- Gwatkin, D. R. (2017). Trends in health inequalities in developing countries. *The Lancet Global Health* [Online], 5(4), pp. e371-e372. Available at: [https://doi.org/10.1016/S2214-109X\(17\)30080-3](https://doi.org/10.1016/S2214-109X(17)30080-3) (Accessed: 12 January 2018).
- Hadaway, C. L. (2009). 'Preventing and managing peripheral extravasation', *Nursing*, 39(10), pp. 26-27.

- Hadley, M., Blum, L., Mujaddid, S., Parveen, S., Nuremowla, S., Haque, M. E. & Ullah, M. (2007). Why Bangladeshi nurses avoid 'nursing': Social and structural factors on hospital wards in Bangladesh. *Social Science and Medicine* [Online], 64(6), pp. 1166-1177. Available at: <https://doi.org/10.1016/j.socscimed.2006.06.030> (Accessed: 28 November 2020).
- Hadley, M. B. & Roques, A. (2007). 'Nursing in Bangladesh: Rhetoric and reality', *Social science & medicine* (1982), 64(6), pp. 1153-1165.
- Haidar, M., Cignoux, E., Newport, T., Neira, L. F., Ciglencecki, I., Rusch, B., Rumunu, J., Porten, K. & Alcoba, G. (2016). Snakebite incidence and case fatality rate in Agok, South Sudan: a cross-sectional survey using two sampling methods. *MSF Scientific Day South Asia 2016* [Online]. Available at: https://www.msf.org.uk/sites/uk/files/5.076_HAIDAR_Other_OCG_final.pdf (Accessed: 26 February 2020).
- Haj-Ali, W., Karroum, L. B., Natafqi, N. & Kassak, K. (2014). 'Exploring the relationship between accreditation and patient satisfaction-the case of selected Lebanese hospitals', *International Journal of Health Policy and Management*, 3(6), pp. 341-346.
- Hall, J. J. & Taylor, R. (2003). Health for All beyond 2000: the demise of the Alma-Ata Declaration and primary health care in developing countries. *Medical Journal of Australia* [Online], 178(1), pp. 17-20. Available at: <https://doi.org/10.5694/j.1326-5377.2003.tb05033.x> (Accessed: 20 November 2020).
- Han, P. Y., Coombes, I. D. & Green, B. (2005). Factors predictive of intravenous fluid administration errors in Australian surgical care wards. *Quality and Safety in Health Care* [Online], 14(3), p. 179. Available at: <https://doi.org/10.1136/qshc.2004.010728> (Accessed: 13 January 2020).
- Hannerz, U. (1998). 'Other Transnationals: Perspectives Gained from Studying Sideways', *Paideuma*, 44, pp. 109-123.
- Hannerz, U. (2006). 'Studying down, up, sideways, through, backwards, forwards, away and at home: Reflections on the field of worries of an expansive discipline', in Coleman, S. & Collins, P. (eds.) *Locating the field : space, place and context in anthropology*. Oxford: Routledgepp. 23-42.
- Hansen, K., Boyle, A., Holroyd, B., Phillips, G., Bengler, J., Chartier, L. B., Lecky, F., Vaillancourt, S., Cameron, P., Waligora, G., Kurland, L. & Truesdale, M. (2020). 'Updated framework on quality and safety in emergency medicine', *Emergency medicine journal*, 37(7), pp. 437-442.
- Harrison, R., Cohen, A. W. S. & Walton, M. (2015). 'Patient safety and quality of care in developing countries in Southeast Asia: a systematic literature review', *International journal for quality in health care*, 27(4), pp. 240-254.
- Harrison, R. A., Hargreaves, A., Wagstaff, S. C., Faragher, B. & Lalloo, D. G. (2009). Snake Envenoming: A Disease of Poverty. *PLoS Neglected Tropical Diseases* [Online], 3(12), p. e569. Available at: <https://doi.org/10.1371/journal.pntd.0000569> (Accessed: 2 February 2020).
- Haviland, W., Prins, H., E. L., McBride, B. & Walrath, D. (2014). *Cultural Anthropology: The Human Challenge*. (14 ed.). Wadsworth, USA.: Cengage Learning.
- Hedt-Gauthier, B. L., Jeufack, H. M., Neufeld, N. H., Alem, A., Sauer, S., Odhiambo, J., Boum, Y., Shuchman, M. & Volmink, J. (2019). Stuck in the middle: a systematic review of authorship in collaborative health research in Africa, 2014–2016. *BMJ Global*

- Health* [Online], 4(5), p. e001853. Available at: <https://doi.org/10.1136/bmjgh-2019-001853> (Accessed: 2 January 2020).
- Hermans, M., Kooistra, J., Cannegieter, S., Rosendaal, F., Mook-Kanamori, D. & Nemeth, B. (2017). 'Healthcare and disease burden among refugees in long-stay refugee camps at Lesbos, Greece', *European Journal of Epidemiology*, 32(9), pp. 851-854.
- Herring, R., Richardson, T. & Caldwell, G. (2013). 'Ward rounds: what goes around comes around', *The Lancet (British edition)*, 381(9864), pp. 373-374.
- Hilhorst (2002). 'Being Good at Doing Good? Quality and Accountability of Humanitarian NGOs', *Disasters*, 26(3), pp. 193-212.
- Hilhorst, D. (2018). 'Classical humanitarianism and resilience humanitarianism: making sense of two brands of humanitarian action', *Journal of international humanitarian action*, 3(1), pp. 1-12.
- Hilhorst, D. & van Leeuwen, M. (2005). 'Grounding local peace organisations: a case study of southern Sudan', *The Journal of modern African studies*, 43(4), pp. 537-563.
- Hilhorst, D. J. M. (2005). 'Dead letter or living document? Ten years Code of Conduct for Disaster Relief', *Disasters*, 29(4), pp. 351-369.
- Ho, T. K. & Baker, D. M. (2012). 'Appraisal and revalidation', *Surgery*, 30(9), pp. 447-454.
- Hoffman, M., Mofolo, I., Salima, C., Hoffman, I., Zadrozny, S., Martinson, F. & Van Der Horst, C. (2012). 'Utilization of family members to provide hospital care in Malawi: the role of Hospital Guardians', *Malawi medical journal*, 24(4), pp. 74-78.
- Holland, C. K. (1993). 'An ethnographic study of nursing culture as an exploration for determining the existence of a system of ritual', *Journal of Advanced Nursing*, 18(9), pp. 1461-1470.
- Home Secretary and the Secretary of State for Health (2007). Learning from Tragedy, keeping patients safe. Overview of the Government's action programme in response to the recommendations of the Shipman Inquiry. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/228886/7014.pdf (Accessed: 2 September 2020).
- Hommel, I., van Gurp, P. J., Tack, C. J., Wollersheim, H. & Hulscher, M. E. J. L. (2016). 'Perioperative diabetes care: development and validation of quality indicators throughout the entire hospital care pathway', *BMJ quality & safety*, 25(7), pp. 525-534.
- Hui, A., Latif, A., Hinsliff-Smith, K. & Chen, T. (2020). 'Exploring the impacts of organisational structure, policy and practice on the health inequalities of marginalised communities: Illustrative cases from the UK healthcare system', *Health policy (Amsterdam)*, 124(3), pp. 298-302.
- Human Rights Watch (2008). Abandoning Abyei. Destruction and displacement, May 2008. Available at: <https://www.hrw.org/report/2008/07/21/abandoning-abyei/destruction-and-displacement-may-2008> (Accessed: 2nd August 2019).
- Human Rights Watch (2011). Sudan: Stop Abyei abuses, hold forces accountable. Available at: <https://www.hrw.org/news/2011/05/26/sudan-stop-abyei-abuses-hold-forces-accountable> (Accessed: 2nd August 2019).
- Human Rights Watch (2019). Human Rights Watch world report. Events of 2018. *Human Rights Watch world report*. [Online], pp. 1-674. Available at: https://www.hrw.org/sites/default/files/world_report_download/hrw_world_report_2019.pdf (Accessed: 30th July 2019).
- Humphreys, M. (2016). 'Getting Personal: Reflexivity and Autoethnographic Vignettes', *Qualitative inquiry*, 11(6), pp. 840-860.

- Hunt, M., Nouvet, E., Chenier, A., Krishnaraj, G., Bernard, C., Bezanson, K., de Laat, S. & Schwartz, L. (2020). 'Addressing obstacles to the inclusion of palliative care in humanitarian health projects: a qualitative study of humanitarian health professionals' and policy makers' perceptions', *Conflict and health*, 14(1), pp. 70-70.
- Hutchinson, A., Coster, J. E., Cooper, K. L., Pearson, M., McIntosh, A. & Bath, P. A. (2013). 'A structured judgement method to enhance mortality case note review: development and evaluation', *BMJ quality & safety*, 22(12), pp. 1032-1040.
- Hörbst, V. & Wolf, A. (2014). 'ARVs and ARTs: Medicoscapes and the Unequal Place-making for Biomedical Treatments in sub-Saharan Africa', *Medical Anthropology Quarterly*, 28(2), pp. 182-202.
- Iedema, R. A. M., Jorm, C., Long, D., Braithwaite, J., Travaglia, J. & Westbrook, M. (2006). 'Turning the medical gaze in upon itself: Root cause analysis and the investigation of clinical error', *Social science & medicine* (1982), 62(7), pp. 1605-1615.
- Iliffe, S., Davies, N., Manthorpe, J., Crome, P., Ahmedzai, S. H., Vernooij-Dassen, M. J. F. J. & Engels, Y. (2016). 'Improving palliative care in selected settings in England using quality indicators: a realist evaluation', *BMC palliative care*, 15(1), pp. 69-69.
- Impedovo, M. A., Andreucci, C. & Ginestí, J. (2017). 'Mediation of artefacts, tools and technical objects: an international and french perspective', *International Journal of Technology and Design Education*, 27(1), pp. 19-30.
- Impey, A. (2013). 'Keeping in touch via cassette: tracing Dinka songs from cattle camp to transnational audio-letter', *Journal of African Cultural Studies*, 25(2), pp. 197-210.
- Institute of Medicine (2000). *To err is human : building a safer health system*. Washington, D.C: National Academy Press.
- Institute of Medicine (2001). *Crossing the quality chasm : a new health system for the 21st century*. Washington, D.C: National Academy Press.
- Inter-Agency Standing Committee (2011). Global Health Cluster. Coordination and registration of providers of foreign medical teams in the humanitarian response to sudden onset disasters: A health cluster concept paper. Available at: https://www.who.int/hac/global_health_cluster/about/policy_strategy/fmt_concept_paper_27_May.pdf (Accessed: 8 September 2020).
- International Crisis Group (2007). *Sudan: Breaking the Abyei deadlock*, Nairobi/Brussels. Available at: <https://d2071andvip0wj.cloudfront.net/b47-sudan-breaking-the-abyei-deadlock.pdf> (Accessed: 6th August 2019).
- International Diabetes Federation (2019). IDF Diabetes Atlas. Available at: https://diabetesatlas.org/upload/resources/material/20200302_133351_IDFA_TLAS9e-final-web.pdf (Accessed: 22 February 2020).
- International Organization for Migration (2021). Who is a migrant. Available at: <https://www.iom.int/who-is-a-migrant> (Accessed: 12 March 2021).
- Jachens, L., Houdmont, J. & Thomas, R. (2019). 'Effort–reward imbalance and burnout among humanitarian aid workers', *Disasters*, 43(1), pp. 67-87.
- Jachetti, A., Massénat, R. B., Edema, N., Woolley, S. C., Benedetti, G., Van Den Bergh, R. & Trelles, M. (2019). Introduction of a standardised protocol, including systematic use of tranexamic acid, for management of severe adult trauma patients in a low-resource setting: the MSF experience from Port-au-Prince, Haiti. *BMC emergency medicine* [Online], 19(1), pp. 56-9. Available at: <https://doi.org/10.1186/s12873-019-0266-x> (Accessed: 10 October 2020).

- Jafar, A. J. N., Norton, I., Lecky, F. & Redmond, A. D. (2015). 'A literature review of medical record keeping by foreign medical teams in sudden onset disasters', *Prehospital and disaster medicine*, 30(2), p. 216.
- Jardien-Baboo, S., van Rooyen, D., Ricks, E. & Jordan, P. (2016). 'Perceptions of patient-centred care at public hospitals in Nelson Mandela Bay', *Health SA Gesondheid*, 21(1), pp. 397-405.
- Jeffs, L., Berta, W., Lingard, L. & Baker, G. R. (2012). 'Learning from near misses: from quick fixes to closing off the Swiss-cheese holes', *BMJ quality & safety*, 21(4), pp. 287-294.
- Johns, N. E. B. A., Lozano, R. P. & Wulf, S. M. P. H. (2013). 'What's killing mothers and what's killing women? Contextualising maternal conditions in the post-MDG era using the Global Burden of Disease (GBD) Study 2010', *The Lancet (British edition)*, 381, pp. S68-S68.
- Johnson, D. H. (2007). *The Abyei Protocol Demystified*. The Sudan Tribune. Paris. Available at: <http://www.sudantribune.com/The-Abyei-Protocol-Demystified,25125> (Accessed: 2nd August 2019).
- Johnson, D. H. (2008). 'Why abyei matters: The breaking point of sudan's comprehensive peace agreement?', *African Affairs*, 107(426), pp. 1-19.
- Johnson, D. H. (2016). *The root causes of Sudan's civil wars : old wars & new wars* (Expanded 3rd edition. ed.). Woodbridge: James Currey.
- Johnson, J., De Souza, C. & Glasby, J. (eds.) (2008). *Understanding health and social care : an introductory reader*, Los Angeles: SAGE.
- Johnston, M. & Magnan, M. A. (2019). 'Using a Fall Prevention Checklist to Reduce Hospital Falls: Results of a Quality Improvement Project', *The American journal of nursing*, 119(3), pp. 43-49.
- Jones, A. (2018). 'Safe transfusion of blood components', *Nursing standard*, 32(25), pp. 50-63.
- Jones, B., Kwong, E. & Warburton, W. (2021). Quality improvement made simple. What everyone should know about health care quality improvement. *The Health Foundation* [Online]. Available at: <https://www.health.org.uk/publications/quality-improvement-made-simple> (Accessed: 1 May 2021).
- Jones, J. & Smith, J. (2017). 'Ethnography: challenges and opportunities', *Evidence - Based Nursing*, 20(4), p. 98.
- Joseph, J. A. (2013). 'The "Right to Know" or "Know Your Rights"?: Human Rights and a People-Centered Approach to Health Policy', in Biehl, J. & Petryna, A. (eds.) *When People Come First: Critical Studies in Global Health*. STU - Student edition ed. Princeton: Princeton University Presspp. 91-108.
- Joseph, L., Ismail, S., Prior, D., Gunst, M., Jarman, K., Harris, M. & Abbara, A. (2018). Barriers to healthcare access for refugees in Greece. *European journal of public health* [Online], 28(suppl_4). Available at: <https://doi.org/10.1093/eurpub/cky214.285> (Accessed: 20 March 2019).
- Joseph, M. (2011). 'Liminality', in Nel, P. & Paul, L. (eds.) *Key words for childrens literature*. New York; London: NYU Presspp. 138-141.
- Jull, A. & Griffiths, P. (2010). 'Is pressure sore prevention a sensitive indicator of the quality of nursing care? A cautionary note', *International journal of nursing studies*, 47(5), pp. 531-533.
- Jumbert, M. G. (2018). 'Control or rescue at sea? Aims and limits of border surveillance technologies in the Mediterranean Sea', *Disasters*, 42(4), pp. 674-696.

- Juris, J. & Khasnabish, A. (2014). 'Immanent Accounts: Ethnography, Engagement, and Social Movement Practices', in Porta, D. D. & Diani, M. (eds.) *The Oxford handbook of social movements Oxford Handbooks in Politics & International Relations*: Oxford University Press.
- Jézéquel, J.-H. (2015). 'Staging a "Medical coup"? Médecins Sans Frontières and the 2005 food crisis in Niger', in Abramowitz, S. A. & Panter-Brick, C. (eds.) *Medical humanitarianism: ethnographies of practice*. Philadelphia: University of Pennsylvania Press pp. 119 - 143.
- Kakalou, E., Riza, E., Chalikias, M., Voudouri, N., Vetsika, A., Tsiamis, C., Choursoglou, S., Terzidis, A., Karamagioli, E., Antypas, T. & Pikoulis, E. (2018). Demographic and clinical characteristics of refugees seeking primary healthcare services in Greece in the period 2015-2016: a descriptive study. *International health* [Online], 10(6), pp. 421-429. Available at: <https://doi.org/10.1093/inthealth/ihy042> (Accessed: 12 August 2019).
- Kalil, A. C., Gilbert, D. N., Winslow, D. L., Masur, H. & Klompas, M. (2018). 'Infectious Diseases Society of America (IDSA) POSITION STATEMENT: Why IDSA Did Not Endorse the Surviving Sepsis Campaign Guidelines', *Clinical Infectious Diseases*, 66(10), pp. 1631-1635.
- Karantinos, D. (2016). Labour market integration of asylum seekers and refugees. Greece. Available at: <http://ec.europa.eu/social/BlobServlet?docId=15909&langId=en> (Accessed: 16 May 2017).
- Kasperek, B. (2016). Routes, corridors, and spaces of exception: Governing migration and Europe. *Near futures online* [Online], 1. Available at: http://nearfuturesonline.org/wp-content/uploads/2016/01/Kasperek_Final_PDF.pdf (Accessed: 21 October 2018).
- Kaufman, M. R., Levy, E., Da Costa, R., Joelsons, P., Skoko, M. & Gvaram, M. (2020). Abortion Services in Humanitarian Contexts. *Journal of health care for the poor and underserved* [Online], 31(4), pp. 1569-1572. Available at: <https://doi.org/10.1353/hpu.2020.0118> (Accessed: 13 January 2021).
- Kayali, M., Moussally, K., Lakis, C., Sawan, C., Reid, A. & Edwards, J. (2019). Treating Syrian refugees with diabetes and hypertension in Shatila refugee camp, Lebanon: Médecins Sans Frontières model of care and treatment outcomes. *Conflict and Health* [Online], 13(1). Available at: <https://doi.org/manchester.idm.oclc.org/10.1186/s13031-019-0191-3> (Accessed: 4 June 2019).
- Kentikelenis, A. E. & Shriwise, A. (2016). International organisations and migrant health in Europe. *Public Health Reviews* [Online], 37(1). Available at: <https://doi.org/10.1186/s40985-016-0033-4> (Accessed: 22 June 2018).
- Keogh, B. (2013). Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. Available at: <https://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf> (Accessed: 20 October 2019).
- Kerr, C. A., Neeman, N., Davis, R. B., Schulze, J., Libman, H., Markson, L., Aronson, M. & Bell, S. K. (2012). 'HIV Quality of Care Assessment at an Academic Hospital: Outcomes and Lessons Learned', *American journal of medical quality*, 27(4), pp. 321-328.

- Kersten, R., Bosse, G., Dorner, F., Slavuckij, A., Fernandez, G. & Marx, M. (2013a). Too complicated for the field? Measuring quality of care in humanitarian aid settings. *Global Health Action* [Online], 6(1), pp. 1-7. Available at: <https://doi-org.manchester.idm.oclc.org/10.3402/gha.v6i0.20311> (Accessed: 14 October 2017).
- Kersten, R., Bosse, G., Dorner, F., Slavuckij, A., Fernandez, G. & Marx, M. (2013b). Too complicated for the field? Measuring quality of care in humanitarian aid settings. *Global Health Action* [Online], 6(1). Available at: <https://doi-org.manchester.idm.oclc.org/10.3402/gha.v6i0.20311> (Accessed: 14 October 2017).
- Khalid, A. H. (2014). *Mechanical response of two plastic clay soils from Sudan*. Doctoral, Imperial College London., Imperial College London. [Online] Available at: <https://hdl.handle.net/10044/1/23918>.
- Kirk, K. & Edgley, A. (2021). Insights into nurses' precarious emotional labour in the emergency department. *Emergency nurse* [Online], 29(1), pp. 22-26. Available at: <https://journals-rcni-com.manchester.idm.oclc.org/emergency-nurse/evidence-and-practice/insights-into-nurses-precarious-emotional-labour-in-the-emergency-department-en.2020.e2039/full#R2> (Accessed: 15 March 2021).
- Kitson, A., Marshall, A., Bassett, K. & Zeitz, K. (2013). What are the core elements of patient- centred care? A narrative review and synthesis of the literature from health policy, medicine and nursing. Oxford, UK.
- Klarkowski, D. B., Wazome, J. M., Lokuge, K. M., Shanks, L., Mills, C. F. & O'Brien, D. P. (2009). The evaluation of a rapid in situ HIV confirmation test in a programme with a high failure rate of the WHO HIV two-test diagnostic algorithm. *PloS one* [Online], 4(2), pp. e4351-e4351. Available at: <https://doi.org/10.1371/journal.pone.0004351> (Accessed: 12 June 2019).
- Klein, B. M., Hayden, B. D., Elson, L. C., Nathens, S. A., Gamelli, N. R., Gibran, G. N., Herndon, G. D., Arnoldo, G. B., Silver, G. G., Schoenfeld, G. D. & Tompkins, G. R. (2007). 'The Association Between Fluid Administration and Outcome Following Major Burn: A Multicenter Study', *Annals of Surgery*, 245(4), pp. 622-628.
- Knaul, F. M., Farmer, P. E., Krakauer, E. L., De Lima, L., Bhadelia, A., Jiang Kwete, X., Arreola-Ornelas, H., Gómez-Dantés, O., Rodriguez, N. M., Alleyne, G. A. O., Connor, S. R., Hunter, D. J., Lohman, D., Radbruch, L., del Rocío Sáenz Madrigal, M., Atun, R., Foley, K. M., Frenk, J., Jamison, D. T., Rajagopal, M. R., Abu-Saad Huijjer, H., Binagwaho, A., Bošnjak, S. M., Clark, D., Cleary, J. F., Cossío Díaz, J. R., Goh, C., Goldschmidt-Clermont, P. J., Gospodarowicz, M., Gwyther, L., Higginson, I. J., Hughes-Hallett, T., Luyirika, E. B. K., Medina Mora, M. E., Mwangi-Powell, F. N., Nishtar, S., O'Brien, M. E., Reddy, K. S., Salerno, J. A., Allende, S., Bhadelia, N., Calderon, M., Fan, V. Y., Jiménez, J., Ntizimira, C. R., Perez-Cruz, P. E., Salas-Herrera, I. G., Spence, D., Steedman, M. R., Verguet, S., Downing, J. D., Paudel, B. D., Elsner, M., Gillespie, J. A., Hofman, K. J., Khanh, Q. T., Lorenz, K. A., Méndez Carniado, O., Nugent, R., Wroe, E. B. & Zimmerman, C. (2018). 'Alleviating the access abyss in palliative care and pain relief—an imperative of universal health coverage: the Lancet Commission report', *The Lancet (British edition)*, 391(10128), pp. 1391-1454.
- Kofman, E. (2019). 'Gendered mobilities and vulnerabilities: refugee journeys to and in Europe', *Journal of Ethnic and Migration Studies*, 45(12), pp. 2185-2199.

- Kolyva, K. (2013). 'NMC: robust revalidation for public protection', *British Journal of Nursing*, 22(19), pp. 1100-1100.
- Kondilis, E., Giannakopoulos, S., Gavana, M., Ierodiakonou, I., Waitzkin, H. & Benos, A. (2013). 'Economic Crisis, Restrictive Policies, and the Population's Health and Health Care: The Greek Case', *American Journal of Public Health*, 103(6), pp. 973-980.
- Kondo, D. K. (1990). *Crafting selves : power, gender, and discourses of identity in a Japanese workplace*. Chicago: University of Chicago Press.
- Korff, V. P., Balbo, N., Mills, M., Heyse, L. & Wittek, R. (2015). 'The impact of humanitarian context conditions and individual characteristics on aid worker retention', *Disasters*, 39(3), pp. 522-545.
- Kotronaki, L., Lafazani, O. & Maniatis, G. (2018). 'Living Resistance: Experiences from Refugee Housing Squats in Athens', *The South Atlantic quarterly*, 117(4), pp. 892-895.
- Kotsiou, O., Kotsios, P., Srivastava, D. S., Kotsios, V., Gourgoulisanis, K. I. & Exadaktylos, A. K. (2018). Impact of the Refugee Crisis on the Greek Healthcare System: A Long Road to Ithaca. *International journal of environmental research and public health* [Online], 15(8). Available at: <https://doi.org/10.3390/ijerph15081790> (Accessed: 19 May 2019).
- Kourachanis, N. (2019). 'From camps to social integration? Social housing interventions for asylum seekers in Greece', *International journal of sociology and social policy*, 39(3/4), pp. 221-234.
- Kousoulis, A. A., Ioakeim-Ioannidou, M. & Economopoulos, K. P. (2016). 'Access to health for refugees in Greece: lessons in inequalities', *International journal for equity in health*, 15(1), pp. 122-122.
- Kovner, B., Zehavi, A. & Golan, D. (2021). 'Unaccompanied asylum-seeking youth in Greece: protection, liberation and criminalisation', *The international journal of human rights*, pp. 1-24.
- Kraft, R., Herndon, D. N., Branski, L. K., Finnerty, C. C., Leonard, K. R. & Jeschke, M. G. (2013). 'Optimized fluid management improves outcomes of pediatric burn patients', *Journal of Surgical Research*, 181(1), pp. 121-128.
- Kruk, M. E., Gage, A. D., Arsenault, C., Jordan, K., Leslie, H. H., Roder-DeWan, S., Adeyi, O., Barker, P., Daelmans, B., Doubova, S. V., English, M., Elorrio, E. G., Guanais, F., Gureje, O., Hirschhorn, L. R., Jiang, L., Kelley, E., Lemango, E. T., Liljestrand, J., Malata, A., Marchant, T., Matsoso, M. P., Meara, J. G., Mohanan, M., Ndiaye, Y., Norheim, O. F., Reddy, K. S., Rowe, A. K., Salomon, J. A., Thapa, G., Twum-Danso, N. A. Y. & Pate, M. (2018a). High-quality health systems in the Sustainable Development Goals era: time for a revolution. *The Lancet global health* [Online], 6(11), pp. e1196-e1252. Available at: <https://www.sciencedirect.com/manchester.idm.oclc.org/science/article/pii/S2214109X18303863> (Accessed: 10 September 2020).
- Kruk, M. E., Gage, A. D., Joseph, N. T., Danaei, G., García-Saisó, S. & Salomon, J. A. (2018b). Mortality due to low-quality health systems in the universal health coverage era: a systematic analysis of amenable deaths in 137 countries. *The Lancet (British edition)* [Online], 392(10160), pp. 2203-2212. Available at: [https://doi.org/10.1016/S0140-6736\(18\)31668-4](https://doi.org/10.1016/S0140-6736(18)31668-4) (Accessed: 22 September 2019).
- Kruk, M. E. & Pate, M. (2020). The Lancet Global Health Commission on High Quality Health Systems 1 year on: progress on a global imperative. *The Lancet global*

- health* [Online], 8(1), pp. e30-e32. Available at: [https://doi.org/10.1016/S2214-109X\(19\)30485-1](https://doi.org/10.1016/S2214-109X(19)30485-1) (Accessed: 20 September 2020).
- Kvale, S. (1996). *InterViews : an introduction to qualitative research interviewing*. Thousand Oaks, California: Sage.
- Kvarnström, S. (2008). 'Difficulties in collaboration: A critical incident study of interprofessional healthcare teamwork', *Journal of interprofessional care*, 22(2), pp. 191-203.
- Labhardt, N. D., Balo, J.-R., Ndam, M., Grimm, J.-J. & Manga, E. (2010). 'Task shifting to non-physician clinicians for integrated management of hypertension and diabetes in rural Cameroon: a programme assessment at two years', *BMC health services research*, 10(1), pp. 339-339.
- Lackritz, E., Hightower, A., Zucker, J., Ruebush, T., Onudi, C., Steketee, R., Were, J., Patrick, E. & Campbell, C. (1997). 'Longitudinal evaluation of severely anemic children in Kenya: The effect of transfusion on mortality and hematologic recovery', *AIDS*, 11(12), pp. 1487-1494.
- Lal, S. & Spence, D. (2016). 'Humanitarian Nursing in Developing Countries: A Phenomenological Analysis', *Journal of transcultural nursing*, 27(1), pp. 18-24.
- Lamb, I. A. (2016). 'The Gates of Greece: Refugees and Policy Choices', *Mediterranean quarterly*, 27(2), pp. 67-88.
- Laqueur, T. W. (1989). 'Bodies, Details, and the Humanitarian Narrative', *The New Cultural History*. Berkeley: University of California Presspp. 176-204.
- Laszlo, E., Baker, R. & Eisenberg, E. (1978). *The Objectives of the New International Economic Order* [Online]. New York: Pergamon.
- Latour, B. (1986). *Laboratory life : the construction of scientific facts*. Princeton: Princeton University Press.
- Latour, B. (2005). *Reassembling the social an introduction to actor-network-theory*. Oxford: Oxford University Press.
- LaVeist, T. A., Isaac, L. A. & Williams, K. P. (2009). 'Mistrust of Health Care Organizations Is Associated with Underutilization of Health Services', *Health services research*, 44(6), pp. 2093-2105.
- Le Roux, C. S. (2016). 'Exploring rigour in autoethnographic research', *International journal of social research methodology*, 20(2), pp. 195-207.
- Leape, L. L., Brennan, T. A., Laird, N., Lawthers, A. G., Localio, A. R., Barnes, B. A., Hebert, L., Newhouse, J. P., Weiler, P. C. & Hiatt, H. (1991). 'The Nature of Adverse Events in Hospitalized Patients: Results of the Harvard Medical Practice Study II', *The New England journal of medicine*, 324(6), pp. 377-384.
- Leatherman, S., Ferris, T. G., Berwick, D., Omaswa, F. & Crisp, N. (2010). 'The role of quality improvement in strengthening health systems in developing countries', *International Journal for Quality in Health Care*, 22(4), pp. 237-243.
- Lecky, F., Benger, J., Mason, S., Cameron, P. & Walsh, C. (2014). 'The International Federation for Emergency Medicine framework for quality and safety in the emergency department', *Emergency medicine journal*, 31(11), pp. 926-929.
- Lee, J., Louw, E., Niemi, M., Nelson, R., Mark, R. G., Celi, L. A., Mukamal, K. J. & Danziger, J. (2015). 'Association between fluid balance and survival in critically ill patients', *Journal of Internal Medicine*, 277(4), pp. 468-477.
- Leidman, E., Couture, A., Hullah, E. & Bilukha, O. (2019). 'Concordance between estimates of acute malnutrition measured by weight-for-height and by mid-upper arm circumference after age adjustment: population-representative surveys from humanitarian settings', *BMC nutrition*, 5(1), pp. 39-39.

- Lewis, D. & Mosse, D. (2006). *Development brokers and translators : the ethnography of aid and agencies*. Bloomfield, Conn: Kumarian Press.
- Li, S. & Zeng, W. (2016). 'Risk analysis for the supplier selection problem using failure modes and effects analysis (FMEA)', *Journal of intelligent manufacturing*, 27(6), pp. 1309-1321.
- Liaropoulos, L. (2012). 'Greek economic crisis: not a tragedy for health', *BMJ : British Medical Journal*, 345(7885), pp. 24-25.
- Lim, J., Kim, J., Moon, B. & Kim, G. (2018). Trepid massage for febrile children: A systematic review and meta-analysis. *International journal of nursing practice* [Online], 24(5), pp. e12649-n/a. Available at: <https://doi.org/10.1111/ijn.12649> (Accessed: 22 December 2018).
- Lines, L., M., Lepore, M. & Wiener, J., M. (2015). Patient-centered, Person-centered, and Person-directed Care: They are Not the Same. *Medical care* [Online], 53(7), pp. 561-563. Available at: <https://www.jstor.org/stable/26418011> (Accessed: 12 October 2020).
- Littlejohns, P., Knight, A., Littlejohns, A., Poole, T. L. & Kieslich, K. (2017). Setting standards and monitoring quality in the NHS 1999–2013: a classic case of goal conflict. *The International journal of health planning and management* [Online], 32(2), pp. e185-e205. Available at: [https://doi-org.manchester.idm.oclc.org/10.1002/hpm.2365](https://doi.org/manchester.idm.oclc.org/10.1002/hpm.2365) (Accessed: 22 April 2018).
- Liu, J. & Male, R. (2005). 'Quality of care: The medical imperative, the quality imperative.', in Medecins Sans Frontieres (ed.) *My sweet La Mancha*. Geneva: Medecins Sans Frontieres International.
- Liu, L. D., Oza, S. M., Hogan, D. P., Chu, Y. M., Perin, J. P., Zhu, J. P., Lawn, J. E. P., Cousens, S. P., Mathers, C. P. & Black, R. E. P. (2016). 'Global, regional, and national causes of under-5 mortality in 2000–15: an updated systematic analysis with implications for the Sustainable Development Goals', *The Lancet (British edition)*, 388(10063), pp. 3027-3035.
- Liu, Y., Kong, Z. & Zhang, Q. (2018). 'Failure modes and effects analysis (FMEA) for the security of the supply chain system of the gas station in China', *Ecotoxicology and environmental safety*, 164, pp. 325-330.
- Loquercio, D. (2006). *Understanding and addressing staff turnover in humanitarian agencies*. London: Overseas Development Institute.
- LoVerde, P. T. (2019). 'Schistosomiasis', *Digenetic Trematodes*, pp. 45-70.
- Lundin, K. & Alsbjörn, B. (2012). The 101 percent in Lund-Browder charts – A commentary. *Burns* [Online], 39(4), pp. 819-820. Available at: <https://doi.org/10.1016/j.burns.2012.08.016> (Accessed: 22 February 2020).
- Luzuriaga, K. & Mofenson, L. M. (2016). 'Challenges in the Elimination of Pediatric HIV-1 Infection', *The New England journal of medicine*, 374(8), pp. 761-770.
- Macarayan, E. K., Gage, A. D., Doubova, S. V., Guanais, F., Lemango, E. T., Ndiaye, Y., Waiswa, P. & Kruk, M. E. (2018). Assessment of quality of primary care with facility surveys: a descriptive analysis in ten low-income and middle-income countries. *The Lancet global health* [Online], 6(11), pp. e1176-e1185. Available at: [https://doi.org/10.1016/S2214-109X\(18\)30440-6](https://doi.org/10.1016/S2214-109X(18)30440-6) (Accessed: 3 January 2019).
- Macfarlane, A. J. R. (2019). 'What is clinical governance?', *BJA education*, 19(6), pp. 174-175.
- MacKichan, F., Brangan, E., Wye, L., Checkland, K., Lasserson, D., Huntley, A., Morris, R., Tammes, P., Salisbury, C. & Purdy, S. (2017). Why do patients seek primary

- medical care in emergency departments? An ethnographic exploration of access to general practice. *BMJ open* [Online], 7(4), pp. e013816-e013816. Available at: <https://doi.org/10.1136/bmjopen-2016-013816> (Accessed: 22 October 2020).
- Mackinlay, E. (2019). *Critical writing for embodied approaches : autoethnography, feminism and decoloniality*. Cham: Palgrave Macmillan.
- Mackintosh, C. (2000). 'Is there a place for "care" within nursing?', *International journal of nursing studies*, 37(4), pp. 321-327.
- MacNeil, A., Glaziou, P., Sismanidis, C., Date, A., Maloney, S. & Floyd, K. (2020). 'Global Epidemiology of Tuberculosis and Progress Toward Meeting Global Targets - Worldwide, 2018', *MMWR. Morbidity and mortality weekly report*, 69(11), pp. 281-285.
- Madianou, M., Ong, J. C., Longboan, L. & Cornelio, J. S. (2016). 'The Appearance of Accountability: Communication Technologies and Power Asymmetries in Humanitarian Aid and Disaster Recovery', *Journal of communication*, 66(6), pp. 960-981.
- Magnussen, L., Ehiri, J. & Jolly, P. (2004). 'Comprehensive Versus Selective Primary Health Care: Lessons For Global Health Policy', *Health Affairs*, 23(3), pp. 167-176.
- Mahmood, M. A., Halliday, D., Cumming, R., Thwin, K. T., Myitzu, M., White, J., Alfred, S., Warrell, D. A., Bacon, D., Naing, W., Aung, H., Thein, M. M., Chit, N. N., Serhal, S., Nwe, M. T., Aung, P. P. & Peh, C. A. (2019). Inadequate knowledge about snakebite envenoming symptoms and application of harmful first aid methods in the community in high snakebite incidence areas of Myanmar. *PLoS neglected tropical diseases* [Online], 13(2), pp. e0007171-e0007171. Available at: <https://doi.org/10.1371/journal.pntd.0007171> (Accessed: 21 February 2020).
- Maitland, K. (2015). 'Management of severe paediatric malaria in resource-limited settings', *BMC Medicine*, 13(1).
- Maitland, K. (2019). Emergency fluid bolus therapy studies: first do no harm. *Archives of Disease in Childhood* [Online], 104(5), p. 409. Available at: <https://doi.org/10.1136/archdischild-2018-315885> (Accessed: 23 February 2020).
- Maitland, K., Kiguli, S., Opoka, R. O., Engoru, C., Olupot-Olupot, P., Akech, S. O., Nyeko, R., Mtove, G., Reyburn, H., Lang, T., Brent, B., Evans, J. A., Tibenderana, J. K., Crawley, J., Russell, E. C., Levin, M., Babiker, A. G. & Gibb, D. M. (2009). Protocol. Feast trial. Available at: https://www.nejm.org/doi/suppl/10.1056/NEJMoa1101549/suppl_file/nejmoa1101549_protocol.pdf (Accessed: 15 February 2020).
- Maitland, K., Kiguli, S., Opoka, R. O., Engoru, C., Olupot-Olupot, P., Akech, S. O., Nyeko, R., Mtove, G., Reyburn, H., Lang, T., Brent, B., Evans, J. A., Tibenderana, J. K., Crawley, J., Russell, E. C., Levin, M., Babiker, A. G. & Gibb, D. M. (2011). 'Mortality after Fluid Bolus in African Children with Severe Infection', *The New England Journal of Medicine*, 364(26), pp. 2483-2495.
- Maitland, K. & South, A. (2012). BMJ win for a surprising trial. Available at: <https://mrc.ukri.org/news/blog/bmj-win-for-a-surprising-trial/> (Accessed: 22 February 2020).
- Malbrain, M., Regenmortel, N., Saugel, B., Tavernier, B., Gaal, P.-J., Joannes-Boyau, O., Teboul, J.-L., Rice, T., Mythen, M. & Monnet, X. (2018). 'Principles of fluid management and stewardship in septic shock: it is time to consider the four D's and the four phases of fluid therapy', *Annals of Intensive Care*, 8(1), pp. 1-16.

- Manias, E. & Street, A. (2001). 'Nurse–doctor interactions during critical care ward rounds', *Journal of clinical nursing*, 10(4), pp. 442-450.
- Mannion, R. & Davies, H. T. O. (2008). 'Payment for performance in health care', *BMJ*, 336(7639), pp. 306-308.
- Maphosa, T. P., Mulqueeney, D. M., Osei, E., Kuupiel, D. & Mashamba-Thompson, T. P. (2020). Mapping evidence on malnutrition screening tools for children under 5 years in sub-Saharan Africa: a scoping review protocol. *Systematic reviews* [Online], 9(1), pp. 52-52. Available at: <https://doi.org/10.1186/s13643-020-01309-6> (Accessed: 29 January 2021).
- Marcus, G. E. (1986). *Anthropology as cultural critique : an experimental moment in the human sciences*. Chicago: University of Chicago Press.
- Marriage, Z. (2004). *Not Breaking the Rules, Not Playing the Game: International Assistance to Countries at War (1997-2001)*. PhD Thesis, London School of Economics and Political Science, London, United Kingdom [Online] Available at: <http://etheses.lse.ac.uk/2301/>.
- Marriage, Z. (2006). 'The Comfort of Denial: External Assistance in Southern Sudan', *Development and change*, 37(3), pp. 479-500.
- Marshall, A., Kitson, A. & Zeitz, K. (2012). 'Patients' views of patient- centred care: a phenomenological case study in one surgical unit', *Journal of Advanced Nursing*, 68(12), pp. 2664-2673.
- Martin, D., Nettleton, S., Buse, C., Prior, L. & Twigg, J. (2015). 'Architecture and health care: a place for sociology', *Sociology of Health & Illness*, 37(7), pp. 1007-1022.
- Mason, P. H., Kerridge, I. & Lipworth, W. (2017). 'The global in global health is not a given', *American Journal of Tropical Medicine and Hygiene*, 96(4), pp. 767-769.
- Massoud, M. R., Mensah-Abrampah, N., Sax, S., Leatherman, S., Agins, B., Barker, P., Kelley, E., Heiby, J. R. & Lotherington, J. (2012). 'Charting the way forward to better quality health care: how do we get there and what are the next steps? Recommendations from the Salzburg Global Seminar on making health care better in low- and middle-income economies', *International Journal for Quality in Health Care*, 24(6), pp. 558-563.
- Maxwell, R. J. (1984). Quality assessment in health. *British Medical Journal* [Online], 288(6428), pp. 1470-1472. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1441041/> (Accessed: 30 November 2020).
- Mbanya, J. C. N. P., Motala, A. A. P., Sobngwi, E. M. D., Assah, F. K. M. D. & Enoru, S. T. M. D. (2010). 'Diabetes in sub-Saharan Africa', *The Lancet (British edition)*, 375(9733), pp. 2254-2266.
- Mbaye, R., Gebeyehu, R., Hossmann, S., Mbarga, N., Bih-Neh, E., Eteki, L., Thelma, O.-A., Oyerinde, A., Kiti, G., Mburu, Y., Haberer, J., Siedner, M., Okeke, I. & Boum, Y. (2019). Who is telling the story? A systematic review of authorship for infectious disease research conducted in Africa, 1980–2016. *BMJ Global Health* [Online], 4(5), p. e001855. Available at: <https://doi.org/10.1136/bmjgh-2019-001855> (Accessed: 20 September 2020).
- Mbuthia, G. W., Nyamogoba, H. D. N., Chiang, S. S. & McGarvey, S. T. (2020). Burden of stigma among tuberculosis patients in a pastoralist community in Kenya: A mixed methods study. *PloS one* [Online], 15(10), pp. e0240457-e0240457. Available at: <https://doi.org/10.1371/journal.pone.0240457> (Accessed: 15 January 2021).

- McCarthy, J. & Rose, P. (2010). *Values-based health & social care beyond evidence-based practice*. Los Angeles: SAGE.
- McCarty, C. A., Woehrle, T. A., Waring, S. C., Taran, A. M. & Kitch, L. A. (2018). 'Implementation of the MEDFRAT to Promote Quality Care and Decrease Falls in Community Hospital Emergency Rooms', *Journal of emergency nursing*, 44(3), pp. 280-284.
- McKee, M., Karanikolos, M., Belcher, P. & Stuckler, D. (2012). 'Austerity: a failed experiment on the people of Europe', *Clinical medicine (London, England)*, 12(4), pp. 346-350.
- Medecins Sans Frontieres (2017). *SitRep, Agok. July 2017.*, Internal document.
- Medecins Sans Frontieres (2015). Snakebite. Global health community slithers away from snakebite crisis as antivenom runs out.: Medecins Sans Frontieres.
- Medecins Sans Frontieres (2018). *Mission strategy paper South Sudan. Pluri - annual strategy: 2016-2018*, Internal document.: Médecins Sans Frontières.
- Medécins Sans Frontières (2015). *Advanced neonatal care. Clinical and therapeutic guideline.*: MSF OCG and OCBA (Internal use).
- Medécins Sans Frontières (2019). 'Essential Obstetric and newborn care.'
- Melvin, J. (2015). 'P-169 Listening to the voice of the user: friends and family test in a hospice setting', *BMJ supportive & palliative care*, 5(Suppl 3), pp. A61-A61.
- Mendes, W., Martins, M., Rozenfeld, S. & Travassos, C. (2009). 'The assessment of adverse events in hospitals in Brazil', *International journal for quality in health care*, 21(4), pp. 279-284.
- Mengesha, Z. B., Perz, J., Dune, T. & Ussher, J. (2018). Preparedness of Health Care Professionals for Delivering Sexual and Reproductive Health Care to Refugee and Migrant Women: A Mixed Methods Study. *International journal of environmental research and public health* [Online], 15(1), p. 174. Available at: <https://doi.org/10.3390/ijerph15010174> (Accessed: 23 June 2018).
- Metusela, C., Ussher, J., Perz, J., Hawkey, A., Morrow, M., Narchal, R., Estoesta, J. & Monteiro, M. (2017). "'In My Culture, We Don't Know Anything About That": Sexual and Reproductive Health of Migrant and Refugee Women', *International journal of behavioral medicine*, 24(6), pp. 836-845.
- Migliori, G., Sotgiu, G., Lange, C. & Centis, R. (2010). 'Extensively drug-resistant tuberculosis: back to the future', *European Respiratory Journal*, 36(3), pp. 475-477.
- Mijatović, D. (2018). *Report of the Commissioner for Human Rights of the Council of Europe following her visit to Greece from 35 to 29 June 2018.*: Council of Europe. Available at: <https://rm.coe.int/report-on-the-visit-to-greece-from-25-to-29-june-2018-by-dunja-mijatov/16808ea5bd> (Accessed: 1st July 2019).
- Mitchell, P., Nicholson, C. L. & Jenkins, A. (2006). 'Side errors in neurosurgery', *Acta Neurochirurgica*, 148(12), pp. 1289-1292.
- Mobile Info Team (2019). Illegal pushbacks in Evros: Evidence of human rights abuses at the Greece/Turkey border. *Annual Report 2018-19* [Online]. Available at: <https://www.statewatch.org/media/documents/news/2019/dec/gr-tu-mobile-info-team-pushbacks-report-11-19.pdf> (Accessed: 21 February 2020).
- Moeran, B. (2007). From participant observation to observational participation: Anthropology, fieldwork and organisational ethnography. *Creative Encounters*. [Online]. Available at: <https://openarchive.cbs.dk/bitstream/handle/10398/7038/wp%202007-2.pdf> (Accessed: 19 December 2019).

- Mohamed Moctar Mouliom, M., Frédéric, M., Jane-Francis Tatah Kihla, A., Nnode Herman, O.-N., Nabilah Pemi, M., Valentine Ngum, N., Abel, W., Félicité Flore, D.-T., Dorine Godelive Tseuko, T., Henri René, Z., Jean Marc Kameni, F., Matthew, L. & Julius, A.-N. (2019). 'Antimicrobial resistance from a one health perspective in Cameroon: a systematic review and meta-analysis', *BMC public health*, 19(1), pp. 1-20.
- Mol, A., Moser, I. & Pols, J. (2010). *Care in practice : on tinkering in clinics, homes and farms*. Bielefeld: Transcript.
- Moris, D. & Kousoulis, A. (2017). 'Refugee crisis in Greece: healthcare and integration as current challenges', *Perspectives in Public Health*, 137(6), pp. 309-310.
- Morris, S., Sutton, M. & Gravelle, H. (2005). 'Inequity and inequality in the use of health care in England: an empirical investigation', *Social science & medicine*, 60(6), pp. 1251-1266.
- Moucheraud, C., Owen, H., Singh, N. S., Ng, C. K., Requejo, J., Lawn, J. E. & Berman, P. (2016). 'Countdown to 2015 country case studies: what have we learned about processes and progress towards MDGs 4 and 5?', *BMC public health*, 16 Suppl 2(S2), pp. 794-794.
- Mugusi, F., Villamor, E., Urassa, W., Saathoff, E., Bosch, R. J. & Fawzi, W. W. (2006). 'HIV co-infection, CD4 cell counts and clinical correlates of bacillary density in pulmonary tuberculosis', *The international journal of tuberculosis and lung disease : the official journal of the International Union against Tuberculosis and Lung Disease*, 10(6), pp. 663-669.
- Muhammad, M., Wallerstein, N., Sussman, A. L., Avila, M., Belone, L. & Duran, B. (2015). 'Reflections on Researcher Identity and Power: The Impact of Positionality on Community Based Participatory Research (CBPR) Processes and Outcomes', *Critical Sociology*, 41(7-8), pp. 1045-1063.
- Mukhtar, H. M. E. & Elnimeiri, M. K. (2014). 'Physical methods used by Sudanese mothers in rural settings to manage a child with fever', *Sudanese journal of paediatrics*, 14(1), pp. 59-64.
- Mulhall, A., Le May, A. & Alexander, C. (1999). 'Bridging the research-practice gap: A reflective account of research work', *Nursing Times Research*, 4(2), pp. 119-130.
- Muliira, J. K. & Kizza, I. B. (2019). The other untold burden of cancer in sub-Saharan Africa: Anxiety and depressive symptoms among family caregivers of adult cancer patients. *International journal of Africa nursing sciences* [Online], 11, p. 100166. Available at: <https://doi.org/10.1016/j.ijans.2019.100166> (Accessed: 20 May 2020).
- Mullan, F. P. & Frehywot, S. M. D. (2007). 'Non-physician clinicians in 47 sub-Saharan African countries', *The Lancet (British edition)*, 370(9605), pp. 2158-2163.
- Muneer, S. E. T. (2011). 'Transfer of knowledge through expatriates nationals (TOKTEN) as a gender sensitive development assistance modality in patriarchal societies: An example from Kassala State, Eastern Sudan', *Journal of the Saudi Society of Agricultural Sciences*, 10(2), pp. 89-94.
- Murphy, A., Biringanine, M., Roberts, B., Stringer, B., Perel, P. & Jobanputra, K. (2017). 'Diabetes care in a complex humanitarian emergency setting: a qualitative evaluation', *BMC health services research*, 17(1), pp. 431-431.
- Murphy, E. & Dingwall, R. (2007). 'Informed consent, anticipatory regulation and ethnographic practice', *Social science & medicine (1982)*, 65(11), pp. 2223-2234.

- Murri, R., Taccari, F., Palazzolo, C., Fantoni, M. & Cauda, R. (2018). 'IDSA Did Not Endorse the Surviving Sepsis Campaign Guidelines', *Clinical Infectious Diseases*, 66(11), pp. 1815-1816.
- Murthy, S. & Kissoon, N. (2013). 'After the FEAST—Fluid Resuscitation in Pediatric Sepsis', *The Indian Journal of Pediatrics*, 80(2), pp. 151-154.
- Médecins Sans Frontières (2016). *9 month Program report. Agok*, Internal document.: Médecins Sans Frontières.
- Médecins Sans Frontières (2018). *SitRep. Greece. Athens. April 2018.*, Internal document. : Médecins Sans Frontières.
- Médecins Sans Frontières (2014). *Nursing Guidelines. MSF OCP. July 2014.* Internal document.: MSF OCP.
- Médecins Sans Frontières (1995). The Chantilly Principles. Who are the Médecins Sans Frontières. Available at: <http://association.msf.org/sites/default/files/documents/Principles%20Chantilly%20EN.pdf> (Accessed: June 1 2019).
- Médecins Sans Frontières (2006a). *La Mancha Agreement*, Athens. Available at: <http://association.msf.org/sites/default/files/documents/La%20Mancha%20Agreement%20EN.pdf> (Accessed: June 1 2019).
- Médecins Sans Frontières (2006b). Whose standards? Standards and accountability in humanitarian aid. Available at: https://www.msf.org.uk/sites/uk/files/DialoguesWhose_Standards_201205092947.pdf (Accessed: 10 January 2016).
- Médecins Sans Frontières (2011). In Abyei Sudan, women and children pay the heaviest price of the lack of healthcare. Available at: <https://msf-seasia.org/news/10522> (Accessed: August 2nd 2019).
- Médecins Sans Frontières (2014). *Nursing Guidelines*. Internal document.: MSF OCP.
- Médecins Sans Frontières (2015). *Advanced neonatal care. Clinical and therapeutic guideline.*: MSF OCG (Internal use).
- Médecins Sans Frontières (2016a). *9 month Program report. Agok*, Internal document.: Médecins Sans Frontières.
- Médecins Sans Frontières (2016b). 'MSF Neonatal Care Policy'. Internal document.
- Médecins Sans Frontières (2016c). *Operational Centre Geneva Strategic Plan 2016 - 2019.*, Internal document.
- Médecins Sans Frontières (2016d). Snakebite incidence and case fatality rate in Agok, South Sudan. *MSF Scientific Day. South Asia* [Online]. Available at: https://www.youtube.com/watch?v=PK-N_8x2Mas [YouTube] (Accessed: 25 February 2019).
- Médecins Sans Frontières (2017a). *SitRep. South Sudan. Agok. December 2017*, Internal document.: Médecins Sans Frontières.
- Médecins Sans Frontières (2017b). *SitRep. South Sudan. Agok. March 2017*, Internal document.: Médecins Sans Frontières.
- Médecins Sans Frontières (2018a). *Annual program report. South Sudan 2018.*, Internal document.: Médecins Sans Frontières.
- Médecins Sans Frontières (2018b). *Clinical Guidelines. Diagnosis and Treatment Manual* [Online]. Médecins Sans Frontières. Available at: <https://medicalguidelines.msf.org/viewport/MG/en/guidelines-16681097.html>.
- Médecins Sans Frontières (2018c). *Clinical Guidelines. Diagnosis and Treatment Manual*.

- Médecins Sans Frontières (2018d). 'Diabetes', in Médecins Sans Frontières (ed.) *Non-communicable diseases. Programmatic and clinical guidelines*. Draft for Intersectional use: Médecins Sans Frontièrespp. 41-58.
- Médecins Sans Frontières (2018e). *Essential drugs - practical guidelines* [Online]. Médecins Sans Frontières. Available at: <https://medicalguidelines.msf.org/viewport/EssDr/english/essential-drugs-16682376.html>.
- Médecins Sans Frontières (2018f). MSF in Greece. Report on Activities 2018. Available at: https://msf.gr/sites/default/files/msfpublications/eng_msf_greece_annual_activity_report_2018_eng_final_lowresspreads.pdf (Accessed: 22 September 2019).
- Médecins Sans Frontières (2018g). *Project document. 2017. Country: South Sudan*.
- Médecins Sans Frontières (2018h). *Project document. Year 2018/2019. Country: Greece., Internal document.: Médecins Sans Frontières.*
- Médecins Sans Frontières (2018i). *Project document. Year: 2018. Country: South Sudan.*
- Médecins Sans Frontières (2018j). *Sitrep Athens Project. May 2018., Internal document: Médecins Sans Frontières.*
- Médecins Sans Frontières (2018k). *Sitrep Chios Project. July 2018, Internal document: Médecins Sans Frontières.*
- Médecins Sans Frontières (2018l). *SitRep. Athens. April 2018, Internal document.: Médecins Sans Frontières.*
- Médecins Sans Frontières (2018m). *Sitrep. Chios Project. June 2018., Internal document.: Médecins Sans Frontières.*
- Médecins Sans Frontières (2018). *Mission Strategy Paper. OCG. Country: Greece. Year: 2018., Internal document.: Médecins Sans Frontières.*
- Médecins Sans Frontières (2019). *International Activity Report 2019*. Available at: <https://www.msf.org/sites/msf.org/files/2020-08/international-activity-report-2019.pdf> (Accessed: 3 May 2018).
- Médecins Sans Frontières (2020). *International Activity Report 2019*, Geneva: Médecins Sans Frontières. Available at: <https://www.msf.org/sites/msf.org/files/2020-08/msf-international-activity-report-2019.pdf>.
- Nader, L. (1972). 'Up the anthropologist: perspectives gained from studying up', in Hymes, D. (ed.) *Reinventing Anthropology*. New York: Pantheon Bookspp. 284-311.
- National Institute for Health and Care Excellence (NICE) (2013). *Intravenous fluid therapy in adults in hospital (CG174)*. London: NICE.
- Navarro, V. (2000). 'Assessment of the World Health Report 2000', *The Lancet (British edition)*, 356(9241), pp. 1598-1601.
- Ndelema, B., Van den Bergh, R., Manzi, M., van den Boogaard, W., Kosgei, R. J., Zuniga, I., Juvenal, M. & Reid, A. (2016). 'Low-tech, high impact: care for premature neonates in a district hospital in Burundi. A way forward to decrease neonatal mortality', *BMC research notes*, 9(1), pp. 28-28.
- Ngatia, P. M. & Kimotho, V. (2010). *Retention of Clinical Officers in Southern Sudan: A Tracer Study of Maridi National Health Training Institute Graduates. African Medical and research Foundation* [Online]. Available at: <https://www.hrresourcecenter.org/node/3951.html> (Accessed: 3 May 2018).
- Nguyen, B. H., Corbett, W. S., Steele, T. R., Banta, R. J., Clark, W. R., Hayes, A. S., Edwards, A. J., Cho, A. T. & Wittlake, A. W. (2007). 'Implementation of a bundle of quality indicators for the early management of severe sepsis and septic shock is

- associated with decreased mortality', *Critical Care Medicine*, 35(4), pp. 1105-1112.
- Nguyen, V.-K. (2010). *The Republic of Therapy Triage and Sovereignty in West Africa's Time of AIDS*. North Carolina: Duke University Press.
- Nicholls, S., Cullen, R., O'Neill, S. & Halligan, A. (2000). 'Clinical governance: its origins and its foundations', *British Journal of Clinical Governance*, 5(3), pp. 172-178.
- Njunge, J. M., Oyaro, I. N., Kibinge, N. K., Rono, M. K., Kariuki, S. M., Newton, C. R., Berkley, J. A. & Gitau, E. N. (2017). Cerebrospinal fluid markers to distinguish bacterial meningitis from cerebral malaria in children. *Wellcome open research* [Online], 2, pp. 47-47. Available at: <https://doi.org/10.12688/wellcomeopenres.11958.2> (Accessed: 20 April 2018).
- Nouvet, E., Sivaram, M., Bezanson, K., Krishnaraj, G., Hunt, M., de Laat, S., Sanger, S., Banfield, L., Rodriguez, P. F. E. & Schwartz, L. J. (2018). 'Palliative care in humanitarian crises: a review of the literature', *Journal of international humanitarian action*, 3(1), pp. 1-14.
- Nowaskie, D., Carvell, C. A., Alder, C. A., LaMantia, M. A., Gao, S., Brown, S., Boustani, M. A. & Austrom, M. G. (2020). 'Care coordinator assistants: Job satisfaction and the importance of teamwork in delivering person-centered dementia care', *Dementia (London, England)*, 19(5), pp. 1560-1572.
- Nugus, P., Greenfield, D., Travaglia, J., Westbrook, J. & Braithwaite, J. (2010). 'How and where clinicians exercise power: Interprofessional relations in health care', *Social science & medicine* (1982), 71(5), pp. 898-909.
- Nwosu, C., Spears, C. A., Pate, C., Gold, D. T., Bennett, G., Haglund, M. & Fuller, A. (2020). Influence of Caretakers' Health Literacy on Delays to Traumatic Brain Injury Care in Uganda. *Annals of global health* [Online], 86(1), pp. 127-127. Available at: <https://doi.org/10.5334/aogh.2978> (Accessed: 18 January 2021).
- Nyaba, P. A. (2019a). *South Sudan : elites, ethnicity, endless wars and the stunted state*. Dar es Salaam, Tanzania: Mkuki na Nyota.
- Nyaba, P. A. (2019b). *South Sudan: elites, ethnicity, endless wars and the stunted state* [Online]. Dar es Salaam, Tanzania: Mkuki na Nyota.
- Nyamtema, A., Mwakatundu, N., Dominico, S., Hamed, M., Pemba, S., Rumanyika, R., Kairuki, C., Kassiga, I., Shayo, A., Nzabuhakwa, C. & Lyimo, C. (2016). Enhancing Maternal and Perinatal Health in Under-Served Remote Areas in Sub-Saharan Africa: A Tanzanian Model. *PLoS One* [Online], 11(3), p. e0151419. Available at: <https://doi.org/10.1371/journal.pone.0151419> (Accessed: 23 September 2017).
- O'Grady, N. P., Alexander, M., Burns, L. A., Dellinger, E. P., Garland, J., Heard, S. O., Lipsett, P. A., Masur, H., Mermel, L. A., Pearson, M. L., Raad, I. I., Randolph, A. G., Rupp, M. E. & Saint, S. (2011). 'Guidelines for the prevention of intravascular catheter-related infections', *AJIC: American Journal of Infection Control*, 39(4), pp. S1-S34.
- O'Hare, J. A. (2007). 'Anatomy of the ward round', *European journal of internal medicine*, 19(5), pp. 309-313.
- O'Neil, D. S., Prigerson, H. G., Mmoledi, K., Sobekwa, M., Ratshikana-Moloko, M., Tsitsi, J. M., Cubasch, H., Wong, M. L., Omoshoro-Jones, J. A. O., Sackstein, P. E., Blinderman, C. D., Jacobson, J. S., Joffe, M., Ruff, P., Neugut, A. I. & Blanchard, C. L. (2018). 'Informal Caregiver Challenges for Advanced Cancer Patients During End-of-Life Care in Johannesburg, South Africa and Distinctions Based on Place of Death', *Journal of pain and symptom management*, 56(1), pp. 98-106.
- O'Neill, P. (2002). 'Good intentions and awkward outcomes: Ethical gatekeeping in field research.', in van den Hoonaard, W. C. (ed.) *Walking the tightrope : ethical*

- issues for qualitative researchers*. Toronto, Canada: University of Toronto Press pp. 17-25.
- Oakley, J. (1996). 'Anthropology and autobiography. Participatory experience and embodied knowledge.', in Oakley, J. & Calloway, H. (eds.) *Anthropology and Autobiography*. London: Routledge.
- Ockenden, D. (2020). Ockenden report. Emerging findings and recommendations from the Independent Review of maternity services at the Shrewsbury and Telford Hospital NHS Trust. Available at: <https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf> (Accessed: 10 December 2020).
- Ogle, G. D., Abdullah, M., Mason, D., Januszewski, A. S. & Besançon, S. (2016). 'Insulin storage in hot climates without refrigeration: temperature reduction efficacy of clay pots and other techniques', *Diabetic medicine*, 33(11), pp. 1544-1553.
- Oikonomou, N. & Mariolis, A. (2010). 'How is Greece conforming to Alma-Ata's principles in the middle of its biggest financial crisis?', *British journal of general practice*, 60(575), pp. 456-457.
- Oleribe, O. O., Crossey, M. M. E. & Taylor-Robinson, S. D. (2015). 'Sustainable Health Development Goals (SHDG): breaking down the walls', *The Pan African medical journal*, 22(306), pp. 306-306.
- Olujide, A. (2016). 'Quality in Primary Health Care Services in Sub-Sahara Africa: Right or Privilege?', *Journal of Community Medicine and Primary Health care*, 28(1), pp. 25-30.
- Olupot-Olupot, P., Engoru, C., Thompson, J., Nteziyaremye, J., Chebet, M., Ssenyondo, T., Dambisya, C., Okuuny, V., Wokulira, R., Amorut, D., Ongodia, P., Mpoya, A., Williams, T., Uyoga, S., Macharia, A., Gibb, D., Walker, A. & Maitland, K. (2014). Phase II trial of standard versus increased transfusion volume in Ugandan children with acute severe anemia. *BMC Medicine* [Online], 12(1), p. 67. Available at: <https://doi.org/10.1186/1741-7015-12-67> (Accessed: 22 February 2020).
- Ong, J. C. & Combinido, P. (2018). Local aid workers in the digital humanitarian project: between "second class citizens" and "entrepreneurial survivors". *Critical Asian Studies* [Online], 50(1), pp. 86-102. Available at: <https://doi.org/10.1080/14672715.2017.1401937> (Accessed: 14 May 2019).
- Opiyo, N., Molyneux, E., Sinclair, D., Garner, P. & English, M. (2014). 'Immediate fluid management of children with severe febrile illness and signs of impaired circulation in low-income settings: a contextualised systematic review', *BMJ Open*, 4(4).
- Orbinski, J. (1998). On the meaning of SPHERE standards to States and other humanitarian actors. Available at: <https://www.msf.fr/sites/default/files/1998-12-03-Orbinski.pdf> (Accessed: 25 February 2021).
- Orcutt, M., Mussa, R., Hiam, L., Veizis, A., McCann, S., Papadimitriou, E., Ponthieu, A. & Knipper, M. (2020). 'EU migration policies drive health crisis on Greek islands', *The Lancet (British edition)*, 395(10225), pp. 668-670.
- Orlikowski, W. J. (2002). 'Knowing in Practice: Enacting a Collective Capability in Distributed Organizing', *Organization science (Providence, R.I.)*, 13(3), pp. 249-273.
- Ostrander (1993). 'Surely You're Not in This Just to Be Helpful': Access, Rapport, and Interviews in Three Studies of Elites', *Journal of contemporary ethnography*, 22, p. 1.

- Owen, J. R. (2010). 'Listening to the rice grow': the local–expat interface in Lao-based international NGOs', *Development in Practice*, 20(1), pp. 99-112.
- Oxfam (2017). A dangerous 'game'. The pushback of migrants, including refugees at Europe's borders. Available at: https://www-cdn.oxfam.org/s3fs-public/file_attachments/bp-dangerous-game-pushback-migrants-refugees-060417-en_0.pdf (Accessed: 17 June 2019).
- Packard, R. M. (2016). *A history of global health : interventions into the lives of other peoples*. Baltimore: Johns Hopkins University Press.
- Padmapriyadarsini, C., Narendran, G. & Swaminathan, S. (2011). 'Diagnosis & treatment of tuberculosis in HIV co-infected patients', *The Indian journal of medical research*, 134(6), pp. 850-865.
- Pandey, K. R. (2018). 'From health for all to universal health coverage: Alma Ata is still relevant', *Globalization and health*, 14(1), pp. 62-62.
- Pandolfi, M. & Corbet, A. (2011). De l'humanitaire imparfait. *Ethnologie française* [Online], 41(3), pp. 465-472. Available at: <https://doi.org/10.3917/ethn.113.0465> (Accessed: 17 June 2019).
- Papatzani, E. (2021). 'Encountering Everyday Racist Practices: Sociospatial Negotiations of Immigrant Settlement in Athens, Greece', *International journal of urban and regional research*, 45(1), pp. 61-79.
- Papoutsis, A., Painter, J., Papada, E. & Vradis, A. (2019). 'The EC hotspot approach in Greece: creating liminal EU territory', *Journal of ethnic and migration studies*, 45(12), pp. 2200-2212.
- Paraskevis, D., Nikolopoulos, G., Fotiou, A., Tsiara, C., Paraskeva, D., Sypsa, V., Lazanas, M., Gargalianos, P., Psychogiou, M., Skoutelis, A., Wiessing, L., Friedman, S. R., Jarlais, D. C. D. E. S., Terzidou, M., Kremastinou, J., Malliori, M. & Hatzakis, A. (2013). Economic recession and emergence of an HIV-1 outbreak among drug injectors in Athens metropolitan area: a longitudinal study. *PloS one* [Online], 8(11), pp. e78941-e78941. Available at: <https://doi.org/10.1371/journal.pone.0078941> (Accessed: 14 June 2017).
- Parkinson, S. E. & Behrouzan, O. (2015). 'Negotiating health and life: Syrian refugees and the politics of access in Lebanon', *Social science & medicine (1982)*, 146, pp. 324-331.
- Pascucci, E. (2018). 'The local labour building the international community: Precarious work within humanitarian spaces', *Environment and planning. A*, 51(3), pp. 743-760.
- Paton, L. (2017). 'The importance of revalidation in the eyes of the CQC', *Nursing And Residential Care*, 19(5), pp. 291-293.
- Patterson, L. J. & Lilburne, C. (2003). 'What is the Commission for Health Improvement?', *Postgraduate Medical Journal*, 79(932), pp. 303-305.
- Patton, M. Q. (2015). *Qualitative research & evaluation methods : integrating theory and practice* (Fourth edition. ed.). Thousand Oaks, California: SAGE Publications, Inc.
- Peak, M., Burke, R., Ryan, S., Wratten, K., Turnock, R. & Vellenoweth, C. (2005). 'Clinical governance - the turn of continuous improvement?', *Clinical Governance: An International Journal*, 10(2), pp. 98-105.
- Pellatt, G. (2003). 'Ethnography and reflexivity: emotions and feelings in fieldwork.', *Nurse Researcher*, 10, pp. 28 - 37.
- Perkins, M. D. & Cunningham, J. (2007). 'Facing the crisis: Improving the diagnosis of tuberculosis in the HIV era', *Journal Of Infectious Diseases*, 196(s1), pp. S15-S27.

- Pfeiffer, J. & Chapman, R. (2015). 'An anthropology of aid in Africa', *The Lancet (British edition)*, 385(9983), pp. 2144-2145.
- Pflueger, D. (2015). 'Accounting for quality: on the relationship between accounting and quality improvement in healthcare', *BMC health services research*, 15(1), pp. 178-178.
- PharmacoEcon. Outcomes News (2007). A real NICE controversy over QALY in the UK. *PharmacoEconomics & Outcomes News* [Online], 536(1), p. 2. Available at: <https://doi-org.manchester.idm.oclc.org/10.2165/00151234-200705360-00003> (Accessed: 7 Feb 2020).
- Pink, S., Morgan, J. & Dainty, A. (2014). 'The safe hand: Gels, water, gloves and the materiality of tactile knowing', *Journal of Material Culture*, 19(4), pp. 425-442.
- Pinnington, S., Atterton, B. & Ingleby, S. (2016). 'Making the journey safe: recognising and responding to severe sepsis in accident and emergency', *BMJ quality improvement reports*, 5(1).
- Plankey-Videla, N. (2012a). 'Informed Consent as Process: Problematizing Informed Consent in Organizational Ethnographies', *Qualitative sociology*, 35(1), pp. 1-21.
- Plankey-Videla, N. (2012b). *We Are in This Dance Together : Gender, Power, and Globalization at a Mexican Garment Firm*. Piscataway: Rutgers University Press.
- Plows, A. & Moeller, N. (2018). *Messy ethnographies in action*. Wilmington, Delaware: Vernon Press.
- Potet, J., Smith, J. & McIver, L. (2019). 'Reviewing evidence of the clinical effectiveness of commercially available antivenoms in sub-Saharan Africa identifies the need for a multi-centre, multi-antivenom clinical trial', *PLoS neglected tropical diseases*, 13(6), p. e0007551.
- Powell, M. & Mannion, R. (2016). 'Groundhog Day': the Coalition government's quality and safety reforms', in Exworthy, M., Mannion, R. & Powell, M. A. (eds.) *Dismantling the NHS? : evaluating the impact of health reforms*. Bristol, UK: Policy Presspp. 323 - 342.
- Powell, R. A., Ali, Z., Luyirika, E., Harding, R., Radbruch, L. & Mwangi-Powell, F. N. (2017). 'Out of the shadows: non-communicable diseases and palliative care in Africa', *BMJ supportive & palliative care*, 7(2), pp. 128-132.
- Prasad, A. (2019). *Autoethnography and organization research : reflections from fieldwork in Palestine*. Cham, Switzerland: Palgrave Macmillan.
- Purssell, E. (2000). 'Physical treatment of fever', *Archives of disease in childhood*, 82(3), pp. 238-239.
- Puskarich, M. A., Illich, B. M. & Jones, A. E. (2014). Prognosis of emergency department patients with suspected infection and intermediate lactate levels: A systematic review. *Journal of Critical Care* [Online], 29(3). Available at: <https://doi.org/10.1016/j.jcrc.2013.12.017> (Accessed: 22 February 2020).
- Pécoul, B. (2004). New drugs for neglected diseases: from pipeline to patients. *PLoS medicine* [Online], 1(1), pp. e6-e6. Available at: <https://doi.org/10.1371/journal.pmed.0010006> (Accessed: 14 January 2020).
- Raad, I., Hanna, H. A., Awad, A., Alrahwan, A., Bivins, C., Khan, A., Richardson, D., Umphrey, J. L., Whimbey, E. & Mansour, G. (2001). Optimal Frequency of Changing Intravenous Administration Sets: Is It Safe to Prolong Use Beyond 72 Hours? *Infection Control and Hospital Epidemiology* [Online], 22(3), pp. 136-139. Available at: <https://doi.org/10.1086/501879> (Accessed: 27 January 2020).
- Rade, D. A., Crawford, G., Lobo, R., Gray, C. & Brown, G. (2018). Sexual Health Help-Seeking Behavior among Migrants from Sub-Saharan Africa and South East Asia

- living in High Income Countries: A Systematic Review. *International journal of environmental research and public health* [Online], 15(7), p. 1311. Available at: <https://doi.org/10.3390/ijerph15071311> (Accessed: 12 June 2019).
- Rafferty, A. M., Ball, J. & Aiken, L. H. (2001). Are teamwork and professional autonomy compatible, and do they result in improved hospital care? *Quality in health care* [Online], 10 Suppl 2(Supplement 2), pp. ii32-ii37. Available at: <https://doi.org/10.1136/qhc.0100032> (Accessed: 12 September 2020).
- Rafter, N., Hickey, A., Conroy, R. M., Condell, S., O'Connor, P., Vaughan, D., Walsh, G. & Williams, D. J. (2017). 'The Irish National Adverse Events Study (INAES): the frequency and nature of adverse events in Irish hospitals—a retrospective record review study', *BMJ quality & safety*, 26(2), pp. 111-119.
- Raleigh, V. & Foot, C. (2010). Getting the measure of quality. Opportunities and challenges. Available at: <https://www.kingsfund.org.uk/sites/default/files/Getting-the-measure-of-quality-Veena-Raleigh-Catherine-Foot-The-Kings-Fund-January-2010.pdf> (Accessed: 10 September 2020).
- Rannan-Eliya, R., Wijemanne, N., Liyanage, I., Dalpatadu, S., de Alwis, S., Amarasinghe, S. & Shanthikumar, S. (2015). Quality of inpatient care in public and private hospitals in Sri Lanka. *Health Policy and Planning* [Online], 30, pp. i46-i58. Available at: <https://doi.org/10.1093/heapol/czu062> (Accessed: 31 January 2017).
- Rapport, N. (2002). 'Post-cultural anthropology. the ironization of values in a world of movement.', in Amit, V. (ed.) *Realizing Community: Concepts, Social Relationships and Sentiments*. London: Routledgepp. 146 - 164.
- Ravaghi, H., Mohseni, M., Rafiei, S., Zadeh, N. S., Mostofian, F. & Heidarpoor, P. (2014). 'Clinical Governance in Iran: Theory to Practice', *Procedia, social and behavioral sciences*, 109, pp. 1174-1179.
- Redditt, V. J., Graziano, D., Janakiram, P. & Rashid, M. (2015). Health status of newly arrived refugees in Toronto, Ont: Part 2: chronic diseases. *Canadian family physician Medecin de famille canadien* [Online], 61(7), pp. e310-e315. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4501621/> (Accessed: 4 June 2019).
- Redfield, P. (2005). 'Doctors, Borders, and Life in Crisis', *Cultural Anthropology*, 20(3), pp. 328-361.
- Redfield, P. (2008). 'Vital Mobility and the Humanitarian Kit', in Lakoff, A. & Collier, S. J. (eds.) *Biosecurity Interventions: Global Health and Security in Question*. NEW YORK: Columbia University Press,p. 147.
- Redfield, P. (2012a). 'Bioexpectations: life technologies as humanitarian goods', *Public Culture*, 24(1 66), p. 157.
- Redfield, P. (2012b). 'The unbearable lightness of expats: Double Binds of Humanitarian Mobility', *Cultural Anthropology*, 27(2), pp. 358-382.
- Redfield, P. (2013). *Life in Crisis The Ethical Journey of Doctors Without Borders*. Berkeley: University of California Press.
- Reid-Henry, S. M. (2014). Humanitarianism as liberal diagnostic: humanitarian reason and the political rationalities of the liberal will-to-care. *Transactions - Institute of British Geographers (1965)* [Online], 39(3), pp. 418-431. Available at: <https://doi-org.manchester.idm.oclc.org/10.1111/tran.12029> (Accessed: 12 September 2020).

- Remion, S. & Powell, K. (2015). 'Agok Paradise - an unforgettable experience (full board and return travel included)', *TAG. Internal Magazine*.
- Rieff, D. (2002). *A bed for the night : humanitarianism in crisis*. London: Vintage.
- Rieff, D. (2019). Humanitarian Politics and the Spectre of Illegitimacy. *Journal of Humanitarian Affairs* [Online], 1(1), pp. 46-48. Available at: <https://doi.org/10.7227/JHA.006> (Accessed: 12 January 2020).
- Ringberg, T. & Reihlen, M. (2008). 'Towards a Socio-Cognitive Approach to Knowledge Transfer', *Journal of management studies*, 45(5), pp. 912-935.
- Roberfroid, D., Huybregts, L., Lachat, C., Vrijens, F., Kolsteren, P. & Guesdon, B. (2015). 'Inconsistent diagnosis of acute malnutrition by weight-for-height and mid-upper arm circumference: contributors in 16 cross-sectional surveys from South Sudan, the Philippines, Chad, and Bangladesh', *Nutrition journal*, 14(1), pp. 86-86.
- Robert, G., Cornwell, J. & Black, N. (2018). 'Friends and family test should no longer be mandatory', *BMJ (Clinical research ed.)*, 360, pp. k367-k367.
- Robertshaw, L., Dhesi, S. & Jones, L. L. (2017). Challenges and facilitators for health professionals providing primary healthcare for refugees and asylum seekers in high-income countries: a systematic review and thematic synthesis of qualitative research. *BMJ open* [Online], 7(8), pp. e015981-e015981. Available at: <https://doi.org/10.1136/bmjopen-2017-015981> (Accessed: 12 April 2018).
- Robinson, D. (2016). EU border force flags concerns over charities' interaction with migrant smugglers. *The Financial Times* [Online]. Available at: <https://www.ft.com/content/3e6b6450-c1f7-11e6-9bca-2b93a6856354?segmentId=a7371401-027d-d8bf-8a7f-2a746e767d56> (Accessed: 16 December 2016).
- Rosa, W. E. & Davidson, P. M. (2020). 'Coronavirus disease 2019 (COVID-19): strengthening our resolve to achieve universal palliative care', *International nursing review*, 67(2), pp. 160-163.
- Roth, S. (2012). 'Professionalisation Trends and Inequality: experiences and practices in aid relationships', *Third World Quarterly*, 33(8), pp. 1459-1474.
- Roumelioti, M.-E., Glew, R. H., Khitan, Z. J., Rondon-Berrios, H., Argyropoulos, C. P., Malhotra, D., Raj, D. S., Agaba, E. I., Rohrscheib, M., Murata, G. H., Shapiro, J. I. & Tzamaloukas, A. H. (2018). 'Fluid balance concepts in medicine: Principles and practice', *World journal of nephrology*, 7(1), pp. 1-28.
- Ruelas, E., Gómez-Dantés, O., Leatherman, S., Fortune, T. & Gay-Molina, J. G. (2012). 'Strengthening the quality agenda in health care in low- and middle-income countries: questions to consider', *International Journal for Quality in Health Care*, 24(6), pp. 553-557.
- Ruger, J. P. (2005). 'The Changing Role of the World Bank in Global Health', *American journal of public health*, 95(1), pp. 60-70.
- Sacks-Davis, R., Chibo, D., Peach, E., Aleksic, E., Crowe, S. M., El Hayek, C., Marukutira, T., Higgins, N., Stooove, M. & Hellard, M. (2020). Phylogenetic clustering networks among heterosexual migrants with new HIV diagnoses post-migration in Australia. *PloS one* [Online], 15(9), pp. e0237469-e0237469. Available at: <https://doi.org/10.1371/journal.pone.0237469> (Accessed: 21 January 2021).
- Sadeghi-Bazargani, H., Tabrizi, J. S., Saadati, M., Hassanzadeh, R. & Alizadeh, G. (2015). 'Nursing experiences of clinical governance implementation: a qualitative study', *Clinical governance*, 20(4), pp. 183-190.

- Saleh, A. S. (2018). Is early goal-directed therapy associated with a higher risk of adverse events? *Journal of Intensive Care* [Online], 6(1). Available at: <https://doi.org/10.1186/s40560-018-0345-1> (Accessed: 23 February 2020).
- Saleh, S., Farah, A., Dimassi, H., El Arnaut, N., Constantin, J., Osman, M., El Morr, C. & Alameddine, M. (2018). Using Mobile Health to Enhance Outcomes of Noncommunicable Diseases Care in Rural Settings and Refugee Camps: Randomized Controlled Trial. *JMIR mHealth and uHealth* [Online], 6(7), pp. e137-e137. Available at: <https://doi.org/10.2196/mhealth.8146> (Accessed: 12 February 2019).
- Santana, M.-J., Manalili, K., Zelinsky, S., Brien, S., Gibbons, E., King, J., Frank, L., Wallström, S., Fairie, P., Leeb, K., Quan, H. & Sawatzky, R. (2020). Improving the quality of person-centred healthcare from the patient perspective: development of person-centred quality indicators. *BMJ open* [Online], 10(10), pp. e037323-e037323. Available at: <http://dx.doi.org/manchester.idm.oclc.org/10.1136/bmjopen-2020-037323> (Accessed: 6 January 2021).
- Sausman, C. (2001). 'New roles and responsibilities of NHS chief executives in relation to quality and clinical governance', *Quality & safety in health care*, 10(Supplement 2), pp. ii13-ii20.
- Scally, G. & Donaldson, L. J. (1998). 'Clinical governance and the drive for quality improvement in the new NHS in England', *BMJ*, 317(7150), p. 61.
- Schapendonk, J. & Steel, G. (2014). 'Following Migrant Trajectories: The Im/Mobility of Sub-Saharan Africans en Route to the European Union', *Annals of the Association of American Geographers*, 104(2), pp. 262-270.
- Scheel, S. & Ratfisch, P. (2014). 'Refugee Protection Meets Migration Management: UNHCR as a Global Police of Populations', *Journal of ethnic and migration studies*, 40(6), pp. 924-941.
- Schmitt, M. L., Clatworthy, D., Ratnayake, R., Klaesener-Metzner, N., Roesch, E., Wheeler, E. & Sommer, M. (2017). Understanding the menstrual hygiene management challenges facing displaced girls and women: findings from qualitative assessments in Myanmar and Lebanon. *Conflict and health* [Online], 11, p. 19. Available at: <https://doi.org/10.1186/s13031-017-0121-1> (Accessed: 12 June 2018).
- Schnall, J., Hayden, D. & Wilkinson, D. (2019). 'Newborns in crisis: An outline of neonatal ethical dilemmas in humanitarian medicine', *Developing world bioethics*, 19(4), pp. 196-205.
- Schneider, A. (2006). 'How quality improvement in health care can help to achieve the Millennium Development Goals', *Bulletin of the World Health Organization*, 84(4), pp. 259-259.
- Schneider, M., Chappuis, F. & Pautex, S. (2018). 'How do expatriate health workers cope with needs to provide palliative care in humanitarian emergency assistance? A qualitative study with in-depth interviews', *Palliative medicine*, 32(10), pp. 1567-1574.
- Schuftan, C. (2016). How is the human rights based approach to change the ethics and praxis of achieving universal health coverage? *Social Medicine* [Online]. Available at: <http://www.socialmedicine.info/index.php/socialmedicine/article/view/886> (Accessed: 9 October 216).
- Schuster, M. A., Onorato, S. E. & Meltzer, D. O. (2017). 'Measuring the Cost of Quality Measurement: A Missing Link in Quality Strategy', *JAMA : the journal of the American Medical Association*, 318(13), pp. 1219-1220.

- Schwartzman, H. B. (1993). *Ethnography in organizations*. Newbury Park, California: SAGE.
- Schöpke-Gonzalez, A., Thomer, A. & Conway, P. (2020). 'Identity Navigation During Refugee Experiences: Between Individual Agency and Systemic Architectures of Control', *The International journal of information, diversity, & inclusion*, 4(2), pp. 36-67.
- Sciruba, A. (2017). Misrecognizing Asylum: Causes, Modalities, and Consequences of the Crisis of a Fundamental Human Right. *Rivista di filosofia del diritto, Journal of Legal Philosophy* [Online], 1, pp. 141-164. Available at: [https://www.academia.edu/33566841/Misrecognizing Asylum Causes Modalities and Consequences of the Crisis of a Fundamental Human Right 1](https://www.academia.edu/33566841/Misrecognizing_Asylum_Causes Modalities and Consequences of the Crisis of a Fundamental Human Right 1) (Accessed: 16 January 2021).
- Sciruba, A. (2017). Categorizing migrants by undermining the right to asylum. The implementation of the «hotspot approach» in Sicily. *Etnografia e ricerca qualitativa, Rivista quadrimestrale* [Online], 1, pp. 97-120. Available at: https://www.academia.edu/33922608/Categorizing_migrants_by_undermining_the_right_to_asylum_The_implementation_of_the_Hotspot_approach_in_Sicily (Accessed: 16 January 2021).
- Segura, Á., Villalta, M., Herrera, M., León, G., Harrison, R., Durfa, N., Nasidi, A., Calvete, J. J., Theakston, R. D. G., Warrell, D. A. & Gutiérrez, J. M. (2010). 'Preclinical assessment of the efficacy of a new antivenom (EchiTAb-Plus-ICP ®) for the treatment of viper envenoming in sub-Saharan Africa', *Toxicon*, 55(2-3), pp. 369-374.
- Seymour, J. & Clark, D. (2018). 'The Liverpool Care Pathway for the Dying Patient: a critical analysis of its rise, demise and legacy in England', *Wellcome open research*, 3, pp. 15-15.
- Shankar, E. M., Vignesh, R., Ellegård, R., Barathan, M., Chong, Y. K., Bador, M. K., Rukumani, D. V., Sabet, N. S., Kamarulzaman, A., Velu, V. & Larsson, M. (2014). HIV– Mycobacterium tuberculosis co-infection: a 'danger-couple model' of disease pathogenesis. Blackwell Publishing Ltd.
- Sharma, N. (2014). 'ProCESS Investigators. A Randomized Trial of Protocol-based Care for Early Septic Shock', *American Journal of Respiratory and Critical Care Medicine*, 190(7), p. 827.
- Shaw, C. (2015). Accreditation is not a stand-alone solution. *Eastern Mediterranean Health Journal* [Online], 21(3), pp. 226-231. Available at: <http://www.emro.who.int/emhj-volume-21-2015/volume-21-issue-3/accreditation-is-not-a-stand-alone-solution.html#:~:text=In%20practice%2C%20UHC%20tends%20to,safety%2C%20clinical%20effectiveness%20and%20accreditation>. (Accessed: 22 September 2018).
- Sheingold, B. H. & Hahn, J. A. (2014). 'The history of healthcare quality: The first 100 years 1860–1960', *International Journal of Africa Nursing Sciences*, 1(C), pp. 18-22.
- Shen, Y., King, C. H., Binder, S., Zhang, F., Whalen, C. C., Evan Secor, W., Montgomery, S. P., Mwinzi, P. N. M., Olsen, A., Magnussen, P., Kinung'hi, S., Phillips, A. E., Nalá, R., Ferro, J., Aurelio, H. O., Fleming, F., Garba, A., Hamidou, A., Fenwick, A., Campbell, C. H. & Colley, D. G. (2017). 'Protocol and baseline data for a multi-year cohort study of the effects of different mass drug treatment approaches on functional

- morbidity from schistosomiasis in four African countries', *BMC infectious diseases*, 17(1), pp. 652-652.
- Shevchenko, O. & Fox, R. C. (2008). "Nationals" and "Expatriates": Challenges of Fulfilling "Sans Frontières" ("Without Borders") Ideals in International Humanitarian Action', *Health and Human Rights*, 10(1), pp. 109-122.
- Shinn, D. H. (2004a). Addis Ababa Agreement: was it destined to fail and are there lessons for the Current Sudan Peace Process? *Annales d'Ethiopie* [Online], 20. Available at: <https://www.cmi.no/file/1867-Addis-Ababa-agreement.pdf> (Accessed: 5th August 2019).
- Shinn, D. H. (2004b). Addis Ababa Agreement: was it destined to fail and are there lessons for the current Sudan Peace Process? *Annales d'Ethiopie* [Online], 20. Available at: <https://www.cmi.no/file/1867-Addis-Ababa-agreement.pdf> (Accessed: 5th August 2019).
- Shipman, K. E., Stammers, J., Doyle, A. & Gittoes, N. (2016). 'Delivering a quality-assured fracture liaison service in a UK teaching hospital—is it achievable?', *Osteoporosis international*, 27(10), pp. 3049-3056.
- Shoman, H., Karafillakis, E. & Rawaf, S. (2017). 'The link between the West African Ebola outbreak and health systems in Guinea, Liberia and Sierra Leone: a systematic review', *Globalization and health*, 13(1), pp. 1-1.
- Silversides, J. & Perner, A. (2019). 'Liberal versus restrictive fluid therapy in critically ill patients', *Intensive Care Medicine*, 45(10), pp. 1440-1442.
- Simmons, P., Hawley, C. J., Gale, T. M. & Sivakumaran, T. (2010). 'Service user, patient, client, user or survivor: describing recipients of mental health services', *The psychiatrist*, 34(1), pp. 20-23.
- Simou, E. & Koutsogeorgou, E. (2014). 'Effects of the economic crisis on health and healthcare in Greece in the literature from 2009 to 2013: A systematic review', *Health policy (Amsterdam)*, 115(2), pp. 111-119.
- Sims Sanyahumbi, A., Sable, C. A., Karlsten, M., Hosseinipour, M. C., Kazembe, P. N., Minard, C. G. & Penny, D. J. (2017). Task shifting to clinical officer-led echocardiography screening for detecting rheumatic heart disease in Malawi, Africa. *Cardiology in the young* [Online], 27(6), p. 1133. Available at: <https://doi.org/10.1017/S1047951116002511> (Accessed: 24 April 2018).
- Singer, K., Schulze-Sturm, U., Alba-Alejandre, I., Hollwitz, B., Nguyen, T. T. T., Sollinger, F., Eberle, J., Hübner, J., Kobbe, R., Genzel-Boroviczeny, O. & von Both, U. (2019). 'Impact of refugee influx on the epidemiology of late-presenting HIV-infected pregnant women and mother-to-child transmission: comparing a southern and northern medical centre in Germany', *Infection*, 47(5), pp. 847-852.
- Skull, S. A. & Murray, S. B. (2005). 'Hurdles to health: immigrant and refugee health care in Australia', *Australian health review*, 29(1), pp. 25-9.
- Smirl, L. (2008). 'Building the Other, Constructing Ourselves: Spatial Dimensions of International Humanitarian Response', *International Political Sociology*, 2(3), pp. 236-253.
- Smirl, L. (2015). *Spaces of aid : how cars, compounds and hotels shape humanitarianism*. London: Zed Books.
- Smith, J. & Aloudat, T. (2017). 'Palliative care in humanitarian medicine', *Palliative medicine*, 31(2), pp. 99-101.
- Smith, J. & Taylor, E. M. (2013). MDGs and NTDs: reshaping the global health agenda. *PLoS neglected tropical diseases* [Online], 7(12), pp. e2529-e2529. Available at: <https://doi.org/10.1371/journal.pntd.0002529> (Accessed: 18 September 2017).

- Smith, K. E., Bambra, C. & Hill, S. E. (2016). *Health Inequalities: Critical Perspectives*. Oxford: Oxford University Press, Incorporated.
- Soop, M., Fryksmark, U., Koster, M. & Haglund, B. (2009). 'The incidence of adverse events in Swedish hospitals: a retrospective medical record review study', *International journal for quality in health care*, 21(4), pp. 285-291.
- Sousa, P., Uva, A. S., Serranheira, F., Nunes, C. & Leite, E. S. (2014). 'Estimating the incidence of adverse events in Portuguese hospitals: a contribution to improving quality and patient safety', *BMC health services research*, 14(1), pp. 311-311.
- Southall, A. (1976). Nuer and Dinka Are People: Ecology, Ethnicity and Logical Possibility. *Man* [Online], 11(4), pp. 463-491. Available at: <https://doi.org/10.2307/2800433> (Accessed: 23 March 2017).
- Spall, K. (2009). 'NICE is making life difficult for cancer patients', *British Journal of Nursing*, 18(6), p. 344.
- Spanou, C. (2008). 'State reform in Greece: responding to old and new challenges', *The International journal of public sector management*, 21(2), pp. 150-173.
- Spathopoulou, A., Carastathis, A. & Tsilimpounidi, M. (2020). 'Vulnerable Refugees' and 'Voluntary Deportations': Performing the Hotspot, Embodying Its Violence', *Geopolitics*, pp. 1-27.
- Spetz, J., Dudley, N., Trupin, L., Rogers, M., Meier, D. E. & Dumanovsky, T. (2016). 'Few Hospital Palliative Care Programs Meet National Staffing Recommendations', *Health affairs (Project Hope)*, 35(9), pp. 1690-1697.
- Spicer, N. (2008). 'Places of Exclusion and Inclusion: Asylum-Seeker and Refugee Experiences of Neighbourhoods in the UK', *Journal of ethnic and migration studies*, 34(3), pp. 491-510.
- Spiegel, P. B. & Qassim, M. (2003). 'Forgotten refugees and other displaced populations', *The Lancet (British edition)*, 362(9377), pp. 72-74.
- Spradley, J. P. (1980). *Participant observation*. Fort Worth: Harcourt Brace Jovanovich.
- Spurgeon, P., Sujan, M.-A., Cross, S. & Flanagan, H. (2019). *An Outline of the Evolution and Conduct of the Safer Clinical Systems Programme: Background to the Approach* [Online]. Cham: Springer International Publishing. Available at: https://doi.org/10.1007/978-3-030-18244-1_5.
- Srikanth, R., S., Prasad, A. C. S. V. & Vamsi, K., N. (2018). Lime-Stabilized Black Cotton Soil and Brick Powder Mixture as Subbase Material. *Advances in Civil Engineering* [Online], 2018, pp. 1-5. Available at: <https://doi.org/10.1155/2018/5834685> (Accessed: 29 September 2019).
- Srikanth Reddy, S., Prasad, A. C. S. V. & Vamsi Krishna, N. (2018). 'Lime-Stabilized Black Cotton Soil and Brick Powder Mixture as Subbase Material', *Advances in Civil Engineering*, 2018.
- Ssemugabo, C., Nalinya, S., Halage, A. A., Neebye, R. M., Musoke, D. & Jørs, E. (2020). 'Doctors experiences on the quality of care for pesticide poisoning patients in hospitals in Kampala, Uganda: a qualitative exploration using donabedian's model', *BMC health services research*, 20(1), pp. 30-30.
- Ssonko, C., Gonzalez, L., Mesic, A., da Fonseca, M. S., Achar, J., Safar, N., Martin, B., Wong, S. & Casas, E. C. (2017). Delivering HIV care in challenging operating environments: the MSF experience towards differentiated models of care for settings with multiple basic health care needs. *Journal of the International AIDS Society* [Online], 20(Suppl 4), pp. 21654-n/a. Available at: <https://doi.org/10.7448/IAS.20.5.21654> (Accessed: 12 July 2018).

- Stanley, L. (1991). 'Feminist autobiography and feminist epistemology', in Aaron, J. & Walby, S. (eds.) *Out of the margins : women's studies in the nineties*. London: Farmer Press.
- Star, S. L. & Griesemer, J. R. (1989a). Institutional Ecology, 'Translations' and Boundary Objects: Amateurs and Professionals in Berkeley's Museum of Vertebrate Zoology. *Social Studies of Science* [Online], 19(3), pp. 1907-39. Available at: <https://www.jstor.org/stable/285080> (Accessed: 2 August 2019).
- Star, S. L. & Griesemer, J. R. (1989b). Institutional Ecology, 'Translations' and Boundary Objects: Amateurs and Professionals in Berkeley's Museum of Vertebrate Zoology, 1907-39. *Social Studies of Science* [Online], 19(3). Available at: <https://www.jstor.org/stable/285080> (Accessed: 2 August 2019).
- Steinke, A. (2020). 'Professionalization', in De Lauri, A. (ed.) *Humanitarianism: Keywords*: Brillpp. 167-169.
- Stewart, D. W. (2009). 'Casualties of war: compassion fatigue and health care providers', *Medsurg nursing*, 18(2), p. 91.
- Street, A. (2012). 'Affective infrastructure: Hospital Landscapes of hope and failure', *Space and Culture*, 15(1), pp. 44-56.
- Strickland, P. (2018). *Refugee advocates blast arrests of rescue workers in Greece*: Aljazeera News. Available at: <https://www.aljazeera.com/news/2018/9/16/refugee-advocates-blast-arrests-of-rescue-workers-in-greece> (Accessed: 16 September 2018).
- Strudwick, R. (2014). *Participant observation : an ethnographic study of the culture in a diagnostic imaging department*. London: SAGE Publications.
- Stubbs, T., Kentikelenis, A., Stuckler, D., McKee, M. & King, L. (2017). 'The impact of IMF conditionality on government health expenditure: A cross-national analysis of 16 West African nations', *Social science & medicine* (1982), 174, pp. 220-227.
- Stumpfenhorst, M., Stumpfenhorst, R. & Razum, O. (2011). The UN OCHA cluster approach: gaps between theory and practice. *Journal of public health* [Online], 19(6), pp. 587-592. Available at: <https://doi-org.manchester.idm.oclc.org/10.1007/s10389-011-0417-3> (Accessed: 20 November 2017).
- Sufrin, C. (2015). "'Doctor, Why Didn't You Adopt My Baby?' Observant Participation, Care, and the Simultaneous Practice of Medicine and Anthropology', *Culture, Medicine, and Psychiatry*, 39(4), pp. 614-633.
- Suhonen, R., Stolt, M., Berg, A., Katajisto, J., Lemonidou, C., Patiraki, E., Sjövall, K. & Charalambous, A. (2018). 'Cancer patients' perceptions of quality-of-care attributes—Associations with age, perceived health status, gender and education', *Journal of clinical nursing*, 27(1-2), pp. 306-316.
- Sweet, S. J. & Norman, I. J. (1995). 'The nurse-doctor relationship: a selective literature review', *Journal of advanced nursing*, 22(1), pp. 165-170.
- Swenne, C. L. & Skytt, B. (2014). 'The ward round – patient experiences and barriers to participation', *Scandinavian journal of caring sciences*, 28(2), pp. 297-304.
- Swinglehurst, D., Emmerich, N., Maybin, J., Park, S. & Quilligan, S. (2015). 'Confronting the quality paradox: towards new characterisations of 'quality' in contemporary healthcare', *BMC health services research*, 15(1), p. 240.
- Swinglehurst, D., Greenhalgh, T., Russell, J. & Myall, M. (2011). 'Receptionist input to quality and safety in repeat prescribing in UK general practice: ethnographic case study', *BMJ*, 343(7831), pp. 983-983.

- Sánchez, A., Segura, Á., Vargas, M., Herrera, M., Villalta, M., Estrada, R., Wu, F., Litschka-Koen, T., Perry, M. A., Alape-Girón, A. & León, G. (2017). 'Expanding the neutralization scope of the EchiTAB-plus-ICP antivenom to include venoms of elapids from Southern Africa', *Toxicon*, 125, pp. 59-64.
- Söderbäck, M. & Christensson, K. (2008). 'Family involvement in the care of a hospitalised child: A questionnaire survey of Mozambican family caregivers', *International journal of nursing studies*, 45(12), pp. 1778-1788.
- Tadesse, B. T., Ashley, E. A., Ongarello, S., Havumaki, J., Wijegoonewardena, M., González, I. J. & Dittrich, S. (2017). 'Antimicrobial resistance in Africa: a systematic review', *BMC infectious diseases*, 17(1), pp. 616-616.
- Taieb, F., Dub, T., Madec, Y., Tondeur, L., Chippaux, J. P., Lebreton, M., Medang, R., Foute, F. N. N., Tchoffo, D., Potet, J., Alcoba, G., Comte, E., Einterz, E., M. & Nkwescheu, A., S. (2018). Knowledge, attitude and practices of snakebite management amongst health workers in Cameroon: Need for continuous training and capacity building. *PLoS Neglected Tropical Diseases* [Online], 12(10), p. e0006716. Available at: <https://doi.org/10.1371/journal.pntd.0006716> (Accessed: 26 February 2020).
- Taithe, B. (2004). 'Reinventing (French) universalism: religion, humanitarianism and the 'French doctors'', *Modern & Contemporary France*, 12(2), pp. 147-158.
- Taithe, B. (2019). 'Compassion fatigue: the changing nature of humanitarian emotions', in Martin-Moruno, D. & Pichel, B. (eds.) *Emotional bodies. The historical performativity of emotions*. Urbana: University of Illinois Press pp. 242-262.
- Tantchou, J. C. (2018). The Materiality of Care and Nurses' "Attitude Problem". *Science, Technology, & Human Values* [Online], 43(2), pp. 270-301. Available at: <https://doi-org.manchester.idm.oclc.org/10.1177/0162243917714868> (Accessed: 10 October 2020).
- Tassell, N. & Flett, R. (2007). 'Obsessive Passion as an Explanation for Burnout: An Alternative Theoretical Perspective Applied to Humanitarian Work', *The Australian journal of rehabilitation counselling*, 13(2), pp. 101-114.
- Taylor, S. (2018). "Global health': meaning what?', *BMJ Global Health*, 3(2).
- Tazzioli, M. (2018). 'Containment through mobility: migrants' spatial disobediences and the reshaping of control through the hotspot system', *Journal of ethnic and migration studies*, 44(16), pp. 2764-2779.
- Tazzioli, M. & Garelli, G. (2020). 'Containment beyond detention: The hotspot system and disrupted migration movements across Europe', *Environment and planning. D, Society & space*, 38(6), pp. 1009-1027.
- Tedlock, B. (1991). 'From Participant Observation to the Observation of Participation: The Emergence of Narrative Ethnography', *Journal of Anthropological Research*, 47(1), pp. 69-94.
- Teicher, C. L., Alberti, K., Porten, K., Elder, G., Baron, E. & Herard, P. (2014). 'Médecins sans frontières experience in orthopedic surgery in postearthquake Haiti in 2010', *Prehospital and disaster medicine*, 29(1), p. 21.
- Terry, F. (2002). *Condemned to repeat? : the paradox of humanitarian action*. Ithaca: Cornell University Press.
- The Abyei Protocol (2005). The Comprehensive Peace Agreement between the Government of The Republic of The Sudan and and The Sudan People's Liberation Movement/Sudan People's Liberation Army. Available at: https://unmis.unmissions.org/sites/default/files/old_dnn/cpa-en.pdf (Accessed: 30th July 2019).

- The Health Foundation (2013). Quality improvement made simple. What everyone should know about health care quality improvement. Available at: <https://www.health.org.uk/publications/quality-improvement-made-simple> (Accessed: January 16 2020).
- The Health Foundation (2016). Person-centred care made simple. What everyone should know about person-centred care. *Quick Guide January 2016* [Online], pp. 1-45. Available at: <https://www.health.org.uk/sites/default/files/PersonCentredCareMadeSimple.pdf> (Accessed: 28 May 2019).
- The National Academics of Sciences Engineering and Medicine (2018). Crossing the Global Quality Chasm. Improving Healthcare Worldwide. Available at: <https://www.nap.edu/catalog/25152/crossing-the-global-quality-chasm-improving-health-care-worldwide> (Accessed: 10 August 2019).
- The New Humanitarian (2005). President swears in new government of national unity. *The New Humanitarian* [Online]. Available at: <http://www.thenewhumanitarian.org/news/2005/09/22/president-swears-new-government-national-unity> (Accessed: 28th July 2019).
- The Sphere Association (2018). *The Sphere handbook : humanitarian charter and minimum standards in disaster response* (4th ed.): Sphere Project.
- The World Health Organisation (2015). *People-centred and integrated health services: an overview of the evidence. Interim report.*, Geneva: world Health Organisation. Available at: <https://www.who.int/servicedeliverysafety/areas/people-centred-care/evidence-overview/en/> (Accessed: 28 August 2020).
- Thode, R. (1999). 'Do we need a new word for patients?. "Users" isn't an appropriate alternative', *BMJ. British medical journal (Clinical research ed.)*, 319(7222), pp. 1436-1436.
- Thomas, E. (2015). *South Sudan : a slow liberation*. London, England: Zed Books.
- Thomas, M., Burt, M. & Parkes, J. (2010). 'The emergence of evidence-based practice', in McCarthy, J. & Rose, P. (eds.) *Values-based health and social care beyond evidence-based practice*. Los Angeles: Sage.
- Thompson, D. R. & Stewart, S. (2006). 'Handmaiden or right-hand man: Is the relationship between doctors and nurses still therapeutic?', *International journal of cardiology*, 118(2), pp. 139-140.
- Thomson, J., Schaefer, M., Caminoa, B., Kahindi, D. & Hurtado, N. (2017). 'Improved Neonatal Mortality at a District Hospital in Aweil, South Sudan', *Journal of tropical pediatrics (1980)*, 63(3), pp. 189-195.
- Thow, A. M., Apprey, C., Winters, J., Stellmach, D., Alders, R., Aduku, L. N. E., Mulcahy, G. & Annan, R. (2020). Understanding the Impact of Historical Policy Legacies on Nutrition Policy Space: Economic Policy Agendas and Current Food Policy Paradigms in Ghana. *International journal of health policy and management* [Online]. Available at: <https://www.ijhpm.com/article 3953.html> (Accessed: 2 December 2020).
- Ticktin, M. (2006). 'Where ethics and politics meet', *American Ethnologist*, 33(1), pp. 33-49.
- Ticktin, M. (2011). *Casualties of Care. Immigration and the Politics of Humanitarianism in France* (1. ed.). Berkeley: University of California Press.
- Ticktin, M. (2014). 'Transnational Humanitarianism', *Annual review of anthropology*, 43(1), pp. 273-289.

- Ticktin, M. I. (2011). *Casualties of Care. Immigration and the Politics of Humanitarianism in France* (1. ed.). Berkeley: University of California Press.
- Timmermans, S. & Berg, M. (1997). Standardization in Action: Achieving Local Universality through Medical Protocols. *Social studies of science* [Online], 27(2), pp. 273-305. Available at: [https://doi-org.manchester.idm.oclc.org/10.1177/030631297027002003](https://doi.org/manchester.idm.oclc.org/10.1177/030631297027002003) (Accessed: 3 June 2019).
- Timmermans, S. & Berg, M. (2003). *The gold standard : the challenge of evidence-based medicine and standardization in health care*. Philadelphia: Temple University Press.
- Tjoflåt, I., Karlsen, B. & Sætre Hansen, B. (2016). 'Working with local nurses to promote hospital-nursing care during humanitarian assignments overseas: experiences from the perspectives of nurses', *Journal of Clinical Nursing*, 25(11-12), pp. 1654-1662.
- Toffolutti, V., McKee, M. & Stuckler, D. (2017). 'Evidence Points To 'Gaming' At Hospitals Subject To National Health Service Cleanliness Inspections', *Health affairs Web exclusive*, 36(2), pp. 355-361.
- Toor, J., Truscott, J. E., Werkman, M., Turner, H. C., Phillips, A. E., King, C. H., Medley, G. F. & Anderson, R. M. (2019). 'Determining post-treatment surveillance criteria for predicting the elimination of *Schistosoma mansoni* transmission', *Parasites & vectors*, 12(1), pp. 437-437.
- Topp, S. M. (2017). The Lancet Global Health Commission on High Quality Health Systems—where's the complexity? *Lancet Global Health* [Online], 5(6), pp. e571-e571. Available at: [https://doi.org/10.1016/S2214-109X\(17\)30176-6](https://doi.org/10.1016/S2214-109X(17)30176-6) (Accessed: 18 September 2019).
- Tountas, Y., Karnaki, P. & Pavi, E. (2002). 'Reforming the reform: the greek national health system in transition', *Health policy (Amsterdam)*, 62(1), pp. 15-29.
- Tountas, Y., Karnaki, P., Pavi, E. & Souliotis, K. (2005). 'The "unexpected" growth of the private health sector in Greece', *Health policy (Amsterdam)*, 74(2), pp. 167-180.
- Travaglia, J. (2009). *Locating vulnerability in the field of patient safety*. Doctor of Philosophy, University of New South Wales [Online] Available at: <http://handle.unsw.edu.au/1959.4/54571>.
- Travaglia, J. F., Debono, D., Spigelman, A. D. & Braithwaite, J. (2011). 'Clinical governance: a review of key concepts in the literature', *Clinical Governance: An International Journal*, 16(1), pp. 62-77.
- Travis, P., Bennett, S., Haines, A., Pang, T., Bhutta, Z., Hyder, A. A., Pielemeier, N. R., Mills, A. & Evans, T. (2004). 'Overcoming health-systems constraints to achieve the Millennium Development Goals', *The Lancet (British edition)*, 364(9437), pp. 900-906.
- Trompette, P. & Vinck, D. (2009). Retour sur la notion d'objet-frontière. *Revue d'anthropologie des connaissances* [Online], 3-1(1), pp. 3-25. Available at: <https://www.cairn.info/revue-anthropologie-des-connaissances-2009-1-page-3.htm> (Accessed: 30 October 2020).
- Tsimtsiou, Z., Kokkali, S., Tatsioni, A., Birka, S., Papaioannou, A., Dislian, V., Andreou, M., Haidich, A. & Oikonomidou, E. (2020). Identifying patient-related barriers in hypertension control: a multi-centered, mixed-method study in Greek rural practices. *Rural and remote health* [Online], 20. Available at: <https://www.rrh.org.au/journal/article/5710> (Accessed: 15 March 2021).

- Tsing, A. L. (2005). *Friction : an ethnography of global connection*. Princeton, N.J: Princeton University Press.
- Tsoni, I. (2013). 'African Border-Crossings in a 'City of Others': Constellations of Irregular Im/Mobility and In/Equality in the Everyday Urban Environment of Athens', *Journal of Mediterranean studies*, 22(1), pp. 141-169.
- Tsoukas, H. (2005). *Complex knowledge : studies in organizational epistemology*. Oxford: Oxford University Press.
- Tubbs-Cooley, H. L., Pickler, R. H., Younger, J. B. & Mark, B. A. (2015). 'A descriptive study of nurse-reported missed care in neonatal intensive care units', *Journal of Advanced Nursing*, 71(4), pp. 813-824.
- Turi, S. K. & Von Ah, D. (2013). 'Implementation of Early Goal-directed Therapy for Septic Patients in the Emergency Department: A Review of the Literature', *Journal of Emergency Nursing*, 39(1), pp. 13-19.
- Turnbull, E., Flabouris, A. & Iedema, R. (2005). 'An outside perspective on the lifeworld of ICU', *Australian critical care*, 18(2), pp. 71-75.
- Turner, L. (2015). On encampment and gendered vulnerabilities: A critical analysis of the UK's vulnerable persons relocation scheme for Syrian refugees. *Oxford Monitor of Forced Migration* [Online], 5, pp. 21-25. Available at: https://764cab94-a9b5-43c3-a608-3aca9e914cb0.filesusr.com/ugd/701039_ee88bbae48604aa685f5c69ad7ee7b16.pdf (Accessed: 14 January 2021).
- Turrini, M. (2011). Debate: Care in Practice. On Normativity, Concepts, and Boundaries. The normativity of care. *Italian Journal of Science and Technology Studies* [Online], 2(1), pp. 73-79. Available at: <http://www.tecnoscienza.net/index.php/tsj/article/view/67/48> (Accessed: 20 October 2020).
- Turse, N. (2016). *Next time they'll come to count the dead : war and survival in South Sudan*. Chicago, Illinois: Haymarket Books.
- Twigt, M. A. (2018). The mediation of hope: Digital technologies and affective affordances within Iraqi refugee households in Jordan. *Social media + society* [Online]. Available at: <https://journals.sagepub.com/doi/pdf/10.1177/2056305118764426> (Accessed: 14 January 2021).
- Tyndall, J. A., Ndiaye, K., Weli, C., Dejene, E., Ume, N., Inyang, V., Okere, C., Sandberg, J. & Waldman, R. J. (2020). 'The relationship between armed conflict and reproductive, maternal, newborn and child health and nutrition status and services in northeastern Nigeria: a mixed-methods case study', *Conflict and health*, 14(1), pp. 75-75.
- UNEP (2002). Capacity building for sustainable development: an overview of UNEP environmental capacity development activities. Available at: <https://www.unep.org/resources/report/capacity-building-sustainable-development-overview-unep-environmental-capacity> (Accessed: 23 December 2020).
- UNESCO (2017). *Glossary of migration related terms*. Available at: <https://wayback.archive-it.org/10611/20171126022403/http://www.unesco.org/new/en/social-and-human-sciences/themes/international-migration/glossary/asylum-seeker/>.
- UNHCR (2010). Convention and protocol relating to the status of refugees. Available at: <https://www.unhcr.org/3b66c2aa10.html> (Accessed: 11 June 2017).

- UNHCR (2016). Refugees and migrants sea arrivals in Europe. Monthly data update: December 2016.
- UNHCR (2017). UNHCR Global Report 2017 - Europe regional summary. Available at: <https://www.unhcr.org/uk/publications/fundraising/5b30bb837/unhcr-global-report-2017-europe-regional-summary.html?query=europe%20sea%20arrivals%202017> (Accessed: 23 March 2018).
- UNHCR (2018). *Global Trends.Forced Displacement in 2017*, Geneva, Switzerland: United Nations High Commissioner for refugees. Available at: <https://www.unhcr.org/5b27be547>.
- United Nations Emergency Relief Fund (2005). *Humanitarian Response Review. August 2005.*, New York and Geneva.: United Nations. Available at: https://interagencystandingcommittee.org/system/files/legacy_files/Humanitarian%20Response%20Review%202005.pdf (Accessed: 8 September 2020).
- United Nations High Commissioner for Refugees (2017). South Sudan Situation 2017. Available at: <https://www.unhcr.org/593e9e9b7.pdf> (Accessed: 31st July 2019).
- United Nations Office for the Coordination of Humanitarian Affairs (2017). Crisis in South Sudan. Available at: http://interactive.unocha.org/emergency/2017_south_sudan/#situationposition (Accessed: 31st July 2019).
- United Nations Office for the Coordination of Humanitarian Affairs (2018). South Sudan: Humanitarian Needs Overview 2018. Available at: https://reliefweb.int/sites/reliefweb.int/files/resources/South_Sudan_2018_Humanitarian_Needs_Overview.pdf (Accessed: 30th July 2019).
- van der Walt, H. M. & Swartz, L. (2002). 'Task orientated nursing in a tuberculosis control programme in South Africa:: where does it come from and what keeps it going?', *Social science & medicine* (1982), 54(7), pp. 1001-1009.
- van Dishoeck, A.-M., Looman, C. W. N., Steyerberg, E. W., Halfens, R. J. G. & Mackenbach, J. P. (2016). 'Performance indicators; the association between the quality of preventive care and the prevalence of hospital-acquired skin lesions in adult hospital patients', *Journal of advanced nursing*, 72(11), pp. 2818-2830.
- Van Dyke, M. & Waldman, R. (2004). *The Sphere Project evaluation report.*, Mailman school of public health. Columbia University.: Center for Global Health and Economic Development. Available at: http://www.unscn.org/layout/modules/resources/files/Evaluation_report.pdf.
- Vanderelst, D. & Speybroeck, N. (2010). Quantifying the lack of scientific interest in neglected tropical diseases. *PLoS neglected tropical diseases* [Online], 4(1), pp. e576-e576. Available at: <https://doi.org/10.1371/journal.pntd.0000576> (Accessed: 21 February 2021).
- Vasilopoulos, A. (2020). 'European Policies for the Inclusion of Refugees in Higher Education: The Case of Greece', *Open Journal for Anthropological Studies*, 4(2), pp. 61-74.
- Vatne, A., Klingenberg, C., Øymar, K., Rønnestad, A. E., Manzoni, P. & Rettedal, S. (2020). 'Reduced Antibiotic Exposure by Serial Physical Examinations in Term Neonates at Risk of Early-onset Sepsis', *The Pediatric infectious disease journal*, 39(5), pp. 438-443.
- Veillard, J., Kelley, E., Nejad, S. B., Colombo, F. & Evans, T., Niek (2018). Universal quality healthcare coverage - a commitment to building a healthier and more productive society. . *BMJ Opinion* [Online]. Available at:

<https://blogs.bmj.com/bmj/2018/07/05/universal-quality-healthcare-coverage-a-commitment-to-building-a-healthier-and-more-productive-society/> (Accessed: 20 September 2020).

- Vernon, A., Deriche, K. & Eisenhauer, S. (2016). Connecting Refugees. How internet and mobile connectivity can improve refugee well-being and transform humanitarian action. Available at: <https://www.unhcr.org/5770d43c4.pdf> (Accessed: 28 September 2020).
- Véran, J. F. (2020). *Médecins Sans Frontières and humanitarian situations : an anthropological exploration*. Milton Park, Abingdon, Oxon: Routledge.
- Vidal, C. & Pinel, J. (2011). 'MSF "Satellites" A strategy underlying different medical practices.', in Bradol, J.-H. & Vidal, C. (eds.) *Medical Innovations in Humanitarian Situations. The work of Médecins Sans frontières*. United States of America: MSF-USA.
- Vincent, C., Neale, G. & Woloshynowych, M. (2001). 'Adverse events in British hospitals: preliminary retrospective record review', *BMJ*, 322(7285), p. 517.
- von Philipsborn, P., Steinbeis, F., Bender, M. E., Regmi, S. & Tinnemann, P. (2015). 'Poverty-related and neglected diseases - an economic and epidemiological analysis of poverty relatedness and neglect in research and development', *Global health action*, 8(1), pp. 25818-25818.
- Wagner, L. (2015). 'Compassion and care at the limits of privilege: Haitian doctors amid the influx of foreign humanitarian volunteers.', in Abramowitz, S. A. & Panter-Brick, C. (eds.) *Medical humanitarianism: ethnographies of practice Pennsylvania studies in human rights*. Philadelphia: University of Pennsylvania Press pp. 41- 57.
- Waldman, E. & Glass, M. (eds.) (2020). *A field manual for palliative care in humanitarian crisis*, Oxford: Oxford University Press.
- Walker, P. (2005). 'Cracking the code: the genesis, use and future of the Code of Conduct', *Disasters*, 29(4), pp. 323-336.
- Walsh, J. A. & Warren, K. S. (1980). 'Selective primary health care: An interim strategy for disease control in developing countries', *Social science & medicine. Medical economics*, 14(2), pp. 145-163.
- Walshe, K., Boyd, A., Bryce, M., Luscombe, K., Tazzyman, A., Tredinnick-Rowe, J. & Archer, J. (2017). 'Implementing medical revalidation in the United Kingdom: Findings about organisational changes and impacts from a survey of Responsible Officers', *Journal of the Royal Society of Medicine*, 110(1), pp. 23-30.
- Walton, V., Hogden, A., Johnson, J. & Greenfield, D. (2016). 'Ward rounds, participants, roles and perceptions: literature review', *International journal of health care quality assurance*, 29(4), pp. 364-379.
- Wang, K. Y., Chou, C. C. & Lai, J. C. Y. (2019). 'A structural model of total quality management, work values, job satisfaction and patient-safety-culture attitude among nurses', *Journal of nursing management*, 27(2), pp. 225-232.
- Wanyenze, R. K., Hahn, J. A., Liechty, C. A., Ragland, K., Ronald, A., Mayanja-Kizza, H., Coates, T., Kanya, M. R. & Bangsberg, D. R. (2011). 'Linkage to HIV Care and Survival Following Inpatient HIV Counseling and Testing', *AIDS and behavior*, 15(4), pp. 751-760.
- Waring, J., Allen, D., Braithwaite, J. & Sandall, J. (2016). 'Healthcare quality and safety: a review of policy, practice and research.', in Allen, D., Braithwaite, J., Sandall, J. & Waring, J. (eds.) *Sociology of health and illness monograph series*. Malden, MA: Wiley Blackwell.

- Waskiewicz, A., Alexis, O. & Cross, D. (2019). 'Supporting patients with long-term catheterisation to reduce risk of catheter-associated urinary tract infection', *British journal of nursing (Mark Allen Publishing)*, 28(9), pp. S4-S17.
- Weber, H., Stöckli, M., Nübling, M. & Langewitz, W. A. (2007). 'Communication during ward rounds in internal medicine. An analysis of patient-nurse-physician interactions using RIAS', *Patient education and counseling*, 67(3), pp. 343-348.
- Wei, L., Elizabeth, M. & Marie, G. (2013). 'Medication communication during ward rounds on medical wards: Power relations and spatial practices', *Health (London, England : 1997)*, 17(2), pp. 113-134.
- Weisskoppel, C. (2005). 'Moving across: Looking at Multi- Sited- Ethnography in Theory and Practice', *Zeitschrift fur Ethnologie*, 130(1), pp. 45-68.
- Wells, S., Diap, G. & Kiechel, J.-R. (2013). 'The story of artesunate-mefloquine (ASMQ), innovative partnerships in drug development: case study', *Malaria journal*, 12(1), pp. 68-68.
- Wensley, C., Botti, M., McKillop, A. & Merry, A. F. (2017). 'A framework of comfort for practice: An integrative review identifying the multiple influences on patients' experience of comfort in healthcare settings', *International journal for quality in health care*, 29(2), pp. 151-162.
- Whitmarsh, I. (2013). 'The ascetic subject of compliance. The turn to chronic disease in global health.', in Biehl, J. & Petryna, A. (eds.) *When people come first. Critical studies in global health*. New Jersey: Princeton University Press pp. 302-324.
- WHO - OECD - World Bank (2018). Delivering Quality Health Services. A global imperative for universal health coverage. Available at: <https://www.who.int/servicedeliverysafety/quality-report/en/> (Accessed: 10 August 2019).
- Widge (2015). *Permanent Court of Arbitration makes ruling on Abyei border*. I dream of billboards burning. Striking a match between social justice activism and oppositional cultural practice. Available at: <http://burningbillboard.org/2009/07/22/permanent-court-of-arbitration-makes-ruling-on-abyei-border/> (Accessed: 5th August 2019).
- Wiig, S., Robert, G., Anderson, J. E., Pietikainen, E., Reiman, T., Macchi, L. & Aase, K. (2014). 'Applying different quality and safety models in healthcare improvement work: Boundary objects and system thinking', *Reliability engineering & system safety*, 125, pp. 134-144.
- Wilhoit, E. D. (2018). 'Space, Place, and the Communicative Constitution of Organizations: A Constitutive Model of Organizational Space', *Communication Theory*, 28(3), pp. 311-331.
- Williams, D. J. (2015). Snake bite: a global failure to act costs thousands of lives each year. *BMJ : British Medical Journal (Online)* [Online], 351. Available at: <https://doi.org/10.1136/bmj.h5378> (Accessed: 12 January 2020).
- Williams, D. J., Faiz, M. A., Abela-Ridder, B., Ainsworth, S., Bulfone, T. C., Nickerson, A. D., Habib, A. G., Junghanss, T., Fan, H. u. W., Turner, M., Harrison, R. A. & Warrell, D. A. (2019). 'Strategy for a globally coordinated response to a priority neglected tropical disease: Snakebite envenoming', *PLoS Neglected Tropical Diseases*, 13(2), p. e0007059.
- Wilson, R. M., Michel, P., Olsen, S., Gibberd, R. W., Vincent, C., El-Assady, R., Rasslan, O., Qsous, S., Macharia, W. M., Sahel, A., Whittaker, S., Abdo-Ali, M., Letaief, M., Ahmed, N. A., Abdellatif, A. & Larizgoitia, I. (2012a). 'Patient safety in developing

- countries: retrospective estimation of scale and nature of harm to patients in hospital', *BMJ*, 344(7850).
- Wilson, R. M., Michel, P., Olsen, S., Gibberd, R. W., Vincent, C., El-Assady, R., Rasslan, O., Qsous, S., Macharia, W. M., Sahel, A., Whittaker, S., Abdo-Ali, M., Letaief, M., Ahmed, N. A., Abdellatif, A. & Larizgoitia, I. (2012b). 'Patient safety in developing countries: retrospective estimation of scale and nature of harm to patients in hospital', *BMJ*, 344(7850), p. 20.
- Wilson, R. M., Runciman, W. B. & Gibberd, R. W. (1995). 'The Quality in Australian Health Care Study', *Medical Journal of Australia*, 163, pp. 458-71.
- Wisner, B. (1988). 'Gobi versus PHC? Some dangers of selective primary health care', *Social science & medicine* (1982), 26(9), pp. 963-969.
- Wong, E. G., Trelles, M., Dominguez, L., Gupta, S., Burnham, G. & Kushner, A. L. (2014). 'Surgical skills needed for humanitarian missions in resource- limited settings: Common operative procedures performed at Médecins Sans Frontières facilities', *Surgery*, 156(3), pp. 642-649.
- World Health Assembly (1979). Thirty Second World Health Assembly. Formulating strategies for Health for All by the Year 2000. *Resolution of the World Health Assembly. WHA32.30* [Online]. Available at: https://apps.who.int/iris/bitstream/handle/10665/154334/WHA32_R30_eng.pdf?sequence=1&isAllowed=y (Accessed: 25 September 2020).
- World Health Organisation (1990). Cancer pain relief and palliative care. *report of a WHO Expert Committee* [Online]. Available at: <https://apps.who.int/iris/handle/10665/39524> (Accessed: 19 February 2021).
- World Health Organisation (2000a). 'Severe falciparum malaria. World Health Organization, Communicable Diseases Cluster', *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 94 suppl 1, pp. S1-90.
- World Health Organisation (2000b). The World Health Report 2000 - Health systems: improving performance. Available at: <https://www.who.int/whr/2000/en/> (Accessed: 20 November 2020).
- World Health Organisation (2002). World Health Report: Reducing Risks, Promoting Healthy Life. Available at: <https://www.who.int/whr/2002/en/> (Accessed: 20 January 2019).
- World Health Organisation (2006). Quality of care : a process for making strategic choices in health systems. Available at: https://www.who.int/management/quality/assurance/QualityCare_B.Def.pdf (Accessed: 27 January 2017).
- World Health Organisation (2008). Task shifting: global recommendations and guidelines. Available at: <https://www.who.int/healthsystems/TTR-TaskShifting.pdf> (Accessed: 14 October 2018).
- World Health Organisation (2019). 'The Global Health Observatory. South Sudan'. Available at: <https://apps.who.int/gho/data/node.main?lang=en> (Accessed 19 March 2021).
- World Health Organization Regional Office for Africa (2020). Child Health. Available at: <https://www.afro.who.int/health-topics/child-health> (Accessed: 22nd February 2020).
- World Health Organisation (2018). Integrating palliative care and symptom relief into the response to humanitarian emergencies and crisis. Available at: <https://apps.who.int/iris/bitstream/handle/10665/274565/9789241514460-eng.pdf?ua=1> (Accessed: 19 February 2021).

- World Health Organisation (1981). Global Health Strategy for Health for All by the year 2000. Available at: https://iris.wpro.who.int/bitstream/handle/10665.1/6967/WPR_RC032_Global_Strategy_1981_en.pdf (Accessed: 25 September 2020).
- Yamey, G. (2002). 'The World's Most Neglected Diseases: Ignored By The Pharmaceutical Industry And By Public-Private Partnerships', *BMJ: British Medical Journal*, 325(7357), pp. 176-177.
- Yamey, G. & Feachem, R. (2011). 'Evidence-based policymaking in global health – the payoffs and pitfalls', *Evidence-based medicine (English ed.)*, 16(4), pp. 97-99.
- Yanow, D., Ybema, S. & van Hulst, M. (2012). 'Practising Organisational Ethnography', in Symon, G. & Cassell, C. (eds.) *Qualitative Organizational Research Core Methods and Current Challenges*. London: SAGE Publicationspp. 331-350.
- Ybema, S. & Kamsteeg, F. (2009). 'Making the familiar strange: A case for organisational ethnography', in Ybema, S., Yanow, D., Wels, H. & Kamsteeg, F. (eds.) *Organizational Ethnography. Studying the complexities of everyday life*. Los Angeles: Sagepp. 97 -113.
- Yealy, D. M., Kellum, J. A., Huang, D. T., Barnato, A. E., Weissfeld, L. A., Pike, F., Terndrup, T., Wang, H. E., Hou, P. C., Lovecchio, F., Filbin, M. R., Shapiro, N. I. & Angus, D. C. (2014). 'A Randomized Trial of Protocol-Based Care for Early Septic Shock', *The New England Journal of Medicine*, 370(18), pp. 1683-1693.
- Yun, K., Hebrank, K., Graber, L., Sullivan, M.-C., Chen, I. & Gupta, J. (2012). 'High Prevalence of Chronic Non-Communicable Conditions Among Adult Refugees: Implications for Practice and Policy', *Journal of Community Health*, 37(5), pp. 1110-1118.
- Zaheer, S., Ginsburg, L. R., Wong, H. J., Thomson, K. & Bain, L. (2018). Importance of safety climate, teamwork climate and demographics: understanding nurses, allied health professionals and clerical staff perceptions of patient safety. *BMJ Open Quality* [Online], 7(4), pp. e000433-e000433. Available at: <http://dx.doi.org/10.1136/bmj-oq-2018-000433> (Accessed: 15 March 2021).
- Zaman, T. (2020). Neighbourliness, conviviality, and the sacred in Athens' refugee squats. *Transactions - Institute of British Geographers (1965)* [Online], 45(3), pp. 529-541. Available at: <https://doi.org/10.1111/tran.12360> (Accessed: 16 January 2021).
- Zimmermann, K. (2016). *Improving Health Care. Global program plan of action for 2017*, Internal document: Médecins Sans Frontières - Switzerland/OCG - Medical department.