Health is a recognised necessity, both as a human right and a crucial factor in the alleviation of poverty. [1] It has served as the basis for overseas interventions in various contexts, with its interpretation and subsequent consequences evolving through history. In the 19th and early 20th century, it contributed to the moral justification of colonialism. Imperialist activities were condoned through the provision of the supposedly superior Western lifestyle, sanitation, and medicine. [2] Following the liberation of colonised nations, developmental aid became a new avenue for the pursuit of neo-colonial agendas. [3] An increased awareness of the iatrogenic harm international volunteers often inflict has led to a paradigm shift in humanitarian medicine. The volunteer is no longer the omnipotent centre but should aim to support indigenous staff with cultural humility.

This article explores the harms of previous models of global health, the movement towards decolonised humanitarianism, and reflections on the role of the medical student through a personal experience in rural Eswatini, formerly known as Swaziland.

Previous models of voluntourism: The harms and unintended consequences
The negative consequences of voluntourism as a commercial enterprise have become extensively recognised in both literature and legislation. A poignant example was when Australia became the first country to declare orphanage trafficking a form of modern-day slavery in 2018. [4] This is because it involves the use of children living in poverty to secure volunteer placements and donations from foreign tourists. [4] Medical overseas volunteering is not free of these abhorrent outcomes. [5] Foreign medical practitioners working in under-resourced countries can cause the undermining and hindrance of local health systems. [5] The lack of continuity of care can result in poor treatment outcomes and higher complication rates. [6] Western evidence-based medicine is less applicable when practiced in communities that differ vastly from the ones in which the guidelines were developed. [7] These can lead to inappropriate and incorrect diagnoses and treatments. [7] Health inequity is intrinsically linked to the social and economic factors that sustain poverty, and volunteers do little to address these. The assumption that well-meaning medical students can remedy the complex and structural factors of poverty and health in a week-long trip is unquestionably naïve. We cannot perpetuate harmful consequences in the name of our learning and education. The desire for medical students to be involved in the health care of those in under-resourced health systems should not be abandoned, but it does need to be drastically transformed.

A new approach: Experience in Eswatini (formerly known as Swaziland)
The highest prevalence of HIV/AIDS in the world is found in Eswatini. Almost a third of the country lives with the virus and over half live below the national poverty line. [8, 9] Possible Dreams International (PDI) is an NGO which works with rural families in Eswatini, many of whom are in constant combat against endemic disease and pervasive poverty. PDI has an Australian and a Swazi team. The Australian team is purely supportive. It is the local team that drives the creation and implementation of projects, which primarily address the social determinants of health. As a member of the Australian team, I travelled to Eswatini with three other medical students in 2019. There is an increasing body of literature that advises on how to conduct ethical and sustainable medical volunteering; constantly emerging key factors include working within pre-existing local systems, pre-departure education, and the creation of long-term partnerships with local organisations. [5] Through intensive planning, education, and collaboration with the indigenous team, we aimed to be involved in a trip that was culturally appropriate and competent.

The following is quote from Thobela Sibusiso, a PDI leader, explaining this different approach.

“We teach our volunteers on the PDI approach to help our communities. This is to empower and support our clients, rather than imposing ideas that will not work or have not been tested. Most of the time, the people in need have ideas on how they can improve their lives; with the proper guidance, they are able to make the most of their ideas. Other volunteers come into the country with ideas which are not known to the communities and, once they leave, all the projects are likely to collapse.”

The Amandala Sewing Project became the primary focus of our trip. Communities refer families to PDI, and the team proceeds to evaluate their health, as well as any social and economic barriers. In one community where we conducted this field work, we found that it was continuously women who were...
the sole income providers for their families. A lack of education, employment opportunities, and the injustice that accompanies their gender means that transactional sex is often the only available means of doing this. This income avenue poses several threats to the women’s health and security, further perpetuating poverty and illness. We aimed to assist PDI in providing an alternative income source that was both empowering and sustainable. To ensure that we did not impose our own values or goals, we organised a community meeting between the relevant women and local female leaders. They discussed the kind of change they would like to make and began plans to form an enterprise. PDI found teachers for sewing and business skills with the intention of making uniforms for local groups. We worked with them to create a budget of $2000AUD and fundraised this money. Six months later, the Amandala Sewing Project brought ten women together, made school uniform deliveries to two schools, and is now seeking ways to expand their market. The medical student group gained an intricate understanding of the interplay between poverty and health and had a purely supportive role in the formation of the initiative.

New challenges: Difficulties of the new approach
Changes in the perspective and manner of overseas volunteering are on route towards minimising the harm that foreign intervenors cause, but this does present a new set of challenges. A significant challenge our team faced was fundraising. During our field work we identified a need for income generation projects and the construction of safe housing. Fundraising is most effective when individuals can donate to specific projects and individuals. For example, child sponsorship programs became popular due to the personal connection a donor can form. [10] However, this can create an enormous gap in time between the community need being identified and the program coming into effect. Projects can become stagnant whilst they wait for funds and communities can lose trust in the organisation. When there is a direct link between donations and particular programs, a cultural bias may be placed on the eventual spending of the funds. The paradigm of aid must shift away from donors assuming they know best and allow the funds to support the intentions of indigenous leaders who have a far better understanding.

Conclusion
The human right to health is essential for every facet of life and, thus, we must continue doing everything we can to actualise it for all. As medical students, this can involve taking part in global health initiatives and volunteering our time. However, we must continue working to decolonise global health so that it places local communities at the centre and our desires and inevitable bias in the periphery.

About the Author
Ishka de Silva is a third-year student at Monash University. She is interested in many areas of public health, particularly the relationship between socioeconomic policy and health.

Conflicts of Interest
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