Universität Bielefeld
Fakultät für Gesundheitswissenschaften
School of Public Health

TRANSNATIONAL ENGAGEMENT IN THE AREA OF HEALTH, A GHANAIAN - GERMAN CASE STUDY

Dissertationsschrift

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Dissertationsschrift
zur Erlangung des akademischen Grades
Doctor of Philosophy (PhD)

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Köln, 28. July 2018

Gedruckt auf alterungsbeständigem Papier °°ISO 9706

Summary

Introduction

Transnational Health Projects (TNHPs) are a form of planned engagement of a diaspora community for their country of origin in the area of health. International organizations and governments of northern countries point out that diaspora communities can positively contribute to the development of their countries of origin by remittances and transfer of know-how. The Ghanaian community is a diaspora of particular relevance in Germany. People with a Ghanaian migration background account for the largest group of immigrants from Sub-Sahara Africa (approx. 40,000). They form a socially and economically active community that has developed extensive transnational networks over the years. The motives as well as the thematic focus of commitment vary; areas of interest are for example health, education or infrastructure. However, activities in the health sector (e.g. establishing healthcare centers, sending medical equipment, etc.) account for one of the main areas of engagement.

Aim of the Study

The study aims at exploring the social phenomenon of TNHPs. For this purpose, respective interactions between Ghanaians living in Germany and relevant actors in Ghana are investigated and analyzed. This includes the identification of the projects' topics, actors involved, activities, resources and motivations. In addition, strategies (logic of action) as well as factors inherent in the transnational setting are examined. The projects' possible effects on availability, access and perception of health services in Ghana as well as the potential influence on transnational networks are evaluated and discussed.

Methods

A qualitative research design was chosen to pursue the objectives stated above. The transnational character of the research topic is reflected in the fact that, over a period of almost two years, a total of 50 semi-structured interviews were conducted in Ghana as well as Germany. The sampling followed the network structures of the projects, covering donors, recipients and supporters as well as actors holding knowledge about the processes of transnational engagement, e.g. representatives of institutions and organizations. Five TNHPs were identified and served as the basis for developing a typology of transnational engagement in the area of health.

Results

TNHPs are characterized by constellations of actors in Ghana and Germany who bring in their interests from donors', recipients' and supporters' perspective. Depending on the topic of the TNHPs, different resources are needed. Monetary resources and funding were often explicitly described as a prerequisite of a TNHP. While the resources that individuals provide for a project can be very beneficial for the development of a project, the dependence on a singular person also poses high risks: his or her withdrawal can have a hampering impact on the development of the project. By contextualizing the characteristics identified, the motivation of actors and the availability of resources, three different types of engagement have evolved, namely "continuous engagement" (Type I), "single action" (Type II) and "planning" (Type III). Type I is characterized by a pragmatic approach that, in combination with available resources, results in the realization of projects. With new ideas and the perspective of further development evolving, actors are encouraged to stay involved and maintain or advance their engagement. Type II is characterized by a fixed goal and the limitation to one project, which is completed under difficult circumstances. A lack of resources is the major factor for discontinuation. Type III is characterized by a project idea that develops over time. The engagement is motivated by an optimistic attitude, and even if the conditions to accomplish a project are not supportive, the actors remain optimistic and stick to their commitment.

Discussion/ Conclusion

TNHPs have been identified from the literature as a part of civil society and of the (transnational) community that has the potential to take an active role in the context of health sector development (Primary Health Care and Universal Health Coverage). The TNHPs accumulate different forms of resources and take shape in heterogeneous forms of engagement (Type I-III). The study has shown how difficult it is for researchers to identify strategies and to demonstrate how they contribute to the development of the Ghanaian health system. However, the examples show that TNHPs, within the limits of their resources, do contribute to the availability, accessibility and quality of Ghanaian health services. While the projects cannot compete with or substitute activities of other actors (e.g. Ghanaian government, non-governmental organizations, private for profit providers), the current development of guidelines and policies (e.g. National Migration Policy, Sustainable Development Goals) are meant to strengthen the TNHP's contribution as civil society actors. In order to better understand the potential of transnational engagement, further research on the phenomenon of TNHPs is needed, e.g. collecting data on a larger scale to quantify the phenomenon for Ghana and internationally, or applying a participatory research approach. This holds the

opportunity to increase the actors' agency and to strengthen their role in a competitive field and to reaffirm the importance of community engagement for health in times of global migration.

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Acronyms and Abbreviations

BMZ	=	Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung
CD4D	=	Connecting Diaspora for Development
CEO	=	Chief Executive Officer
CHAG	=	Christian Health Association of Ghana
CHC	=	Community Health Center
CHPS	=	Community-based Health Planning and Services
CIM	=	Centre for International Migration and Development
CSO	=	Civil Society Organization (here: Civil Society Platform on SDG)
DAAD	=	German Academic Exchange Service (Deutscher Akademischer Austauschdienst e. V)
DAB/DSU	=	Diaspora Affairs Bureau / Diaspora Support Unit
DCG	=	Donation Contact Group
DGE e.V.	=	Deutsch-Ghanaischer-Entwicklungsverein
GDEP	=	Ghanaian Diaspora Engagement Policy
GDP	=	Gross Domestic Product
GHS	=	Ghana Health Service
HTA	=	Home town associations
GIPC	=	Ghana Investment Promotion Centre
GIZ/GTZ	=	Gesellschaft für Internationale/Technische Zusammenarbeit
GNCM	=	Ghana National Commission of Migration
GSS	=	Ghana Statistical Service
HIV/AIDS	=	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
HRH	=	Human Resources for Health
IOM	=	International Organization for Migration
MDG	=	Millennium Development Goal
MIDA	=	Migration for Development in Africa
MMR	=	Maternal Mortality Ratio
MoH	=	Ministry of Health
MoFA	=	Ministry of Foreign Affairs
NCD	=	Non-Communicable Disease
NGO	=	Non-Governmental Organization
NHIS	=	National Health Insurance Scheme
NMP	=	National Migration Policy
NRW	=	North Rhine-Westphalia

OECD	=	Organization for Economic Co-operation and Development
PHC	=	Primary Health Care
PMD	=	Migration for Development program
PPPs	=	Public-private partnerships
PQMD	=	Partnership for Quality Medical Donations
SDG	=	Sustainable Development Goals
TNHPs	=	Transnational health projects
TRQN	=	Temporary Return of Qualified Nationals
UGAG	=	Union of Ghanaian Associations in Germany
UHC	=	Universal Health Coverage
UNCG	=	UN Communications Group
UNICEF	=	United Nations Children's Fund
WHO	=	World Health Organization

Acknowledgements

Nobody said it was easy – and certainly writing this PhD thesis has challenged me in so many ways. Sometimes it has been a bumpy ride literally, while travelling on Ghanaian roads, and metaphorically, when facing the challenges that writing a PhD thesis brings. However, when thinking about the journey in retrospect, not the potholes come to mind, but all the support and encouragement, the personal and academic encounters, and people, so many people, who brought me here eventually. Especially without my interview partners in Ghana and Germany, who took time to answer all my questions and trusted me to share their experiences and opinions generously, this work would not have been possible.

I would like to express my sincere gratitude to Professor Oliver Razum, my supervisor, for his guidance and encouragement to pursue my passion for transnational engagement throughout the long process of completing this project.

The ACBRIDGE–Program provided the framework and the resources especially for the field research in Ghana. I would like to thank Dr. Michael Käser, Professor Richard Adanu, Jaswinder Kaur as well as Edith Tetteh for their coordination and support. I would also like to thank my colleagues Adolf, Harriet and Nathaniel for precious advice on anything “Ghanaian” and Melanie for being the best company I could have wished for in Ghana and for being a friend beyond.

Without Maren, Clara and Linda, who offered their advice, listened to my concerns, always discussed with me and just kept it “pragmatic”, this thesis probably would not have been completed. Thank you for being the awesome friends you are!

Bielefeld University has been a real home base for me during the time of field research in Ghana and afterwards. This is especially due to the very special colleagues from “AG3 Epidemiologie & International Public Health”, who included me seamlessly and always had open ears, advice as well as time for coffee and cake. A heartfelt thank you goes to Ilona, Yüce, Anne, Patrick, Melina, Lisa, Odile, Seven, Thomas, Jürgen and all the others! I would also like to thank Prof. Thomas Faist from the department of Sociology and the participants of the research seminar “Transnational Studies” for giving me the opportunity to participate in their group for a while.

During the “second half” of the project my colleagues from BZgA have always been encouraging and sympathetic. My thank you goes especially to Heike, Christina, Michaela, Phillip, Christoph, Judith S., Sabine H., Ursula, Till, Martin W., Martin S., Alexander H., Boris, Wolfgang and Dr. Lehmann.

And there are so many friends, near and far, who were just there, knew the right words at the right time and also when it was better not to say anything: Katja, Arnaud, Leo, Rosalyn, Nele, Lesley, Dimitri, Angelika, Miriam, Kati, Matthias, Veit, Dominik, Annamarie, Laura, Alena, Ikumi, Tabea, Wolle, Sebastian, Karen, Sandra, the entire family Dehne, Frank, Ulf, Kate, Kerstin, family Gonska, Christopher, Gunther, Kaya, Stepan (for adding a whole new dimension to transnationality) and all the others – thank you from the bottom of my heart – you made (and make) all the difference!

Bei meinen Eltern bedanke ich mich für ALLES und besonders dafür, dass sie immer einfach da sind, mich unterstützen, alles leicht und möglich machen. Ich danke Kathrin, die mich manchmal besser kennt, als ich mich selbst, und auf diesem Weg keinen Schritt von meiner Seite gewichen ist. Für unerschütterliches Vertrauen und Geduld danke ich im Besonderen meinen Großeltern, Cord, Doti, Pauli sowie dem gesamten Rest der Familie!

1 Introduction and Background

In an age of globalization, even seemingly local services such as health care and national health systems are influenced by transnational networks that affect individuals as much as structures and processes. International migration implies challenges and opportunities for individuals and communities in the countries of origin and in the host countries. The potential benefits are widely discussed and emphasized. International organizations and governments of northern countries point out that diasporas can positively contribute to the development of their countries of origin by remittances and transfer of know-how (Castles & Delgado Wise 2008). At the same time in the countries of origin the development of diaspora institutions on governmental and non-governmental level indicates their interest to engage the diasporas with programs and policies (Agunias & Newland 2012, Faist 2008).

Many countries have an active diaspora, which stays in contact and supports family, friends, communities and development in their countries of origin on different levels and topics (e.g. Dominican Republic (Levitt 2001), Mexico (Agunias & Newland 2012)). The networks of migration often extend to many countries (IOM 2017)[1] and the activities reflect a multitude of professional and personal interests.

With Ghanaians being the group of migrants that account for the biggest group of immigrants from Sub-Sahara Africa in Germany (DESTATIS 2017) and Germany being among the favourite destination countries of Ghanaians (WB 2016:129) provides opportunities for exchange between the two countries. The Ghanaian diaspora in Germany is active for their home country and since one of the main areas of engagement is directed towards health (Schmelz 2009) the focus of this study is on transnational engagement between Ghana and Germany, in particular with regard to health.

Existing transnational health projects (TNHPs) in this context can generally be described as activities that are initiated by Ghanaian immigrants, embedded in different kinds of transnational network structures and aim for effects in Ghana. However, the transfer is not unidirectional but is strongly affected by reciprocal processes. Even though the different approaches may vary significantly in size and set-up conditions

[1] The movement of migrants into and out of countries is illustrated with an application by IOM (https://www.iom.int/world-migration), which is based on Data of United Nations, Department of Economic and Social Affairs (2015) Trends in International Migrant Stock: Migrants by Destination and Origin (United Nations database, POP/DB/MIG/Stock/Rev.2015).
http://www.un.org/en/development/desa/population/migration/data/estimates2/estimates15.shtml

(e.g. with respect to actors involved, structural and organizational differences (Schmelz 2009)) they all have in common that they operate in a transnational social space.

Projects and activities of Ghanaians living in Germany that aim to contribute to the health of the Ghanaian population have been numerous (Schmelz 2009, Mörath 2015). But so far there has been no adequate analysis of interaction patterns that would allow for an estimation of the influence that TNHPs might have on the development of the Ghanaian health sector. The present study explores the potential of transnational engagement as a resource that can contribute to individual and structural development. In order to do so, it is crucial to understand the social, economical and political context in which these projects take place. The explorative study aims to identify relevant actors, networks and patterns of interaction and motives in order to analyze transnational engagement in the Ghanaian health sector. The results of the study can help to categorize the variety of TNHPs and to derive factors that promote or hamper the effects from the constellations.

The first Chapter aims to put transnational engagement for health into the Ghanaian context. Information on Ghana, the Ghanaian health system and peoples' health status is provided and illustrates the framework conditions. In addition, the Ghanaian diaspora, their structures in Germany and Ghana as well as governmental programs in Germany and Ghana are described. The chapter also gives a comprehensive account of the activities and networks that the Ghanaian diaspora maintains in Germany and Ghana.

The second chapter gives an overview of theories and current research that characterize the phenomenon of transnational engagement of migrants for their countries of origin. In order to present the different facets of transnational engagement, the introduced theories focus on individual actors as well as community aspects. Furthermore, the concepts of health system development (primary health care (PHC) and universal health coverage (UHC)) are introduced and provide the framework to contextualize TNHPs as community activities that aim to improve health care in Ghana. An example of the attempt to regulate transnational activities in a health facility in Ghana illustrates practical challenges. Based on the practical and theoretical insights into the field of research aim and objectives of the study are outlined.

In Chapter 3 the research setting and conditions of data collection are described. The qualitative research methods and tools of data collection that were applied in order to explore the phenomenon of transnational health projects are presented.

Furthermore, in Chapter 4 the findings from the interview material are analyzed. On the basis of five TNHPs, the activities, ideas, interests and motives of the actors involved are examined. The analysis gives a detailed account of the Ghanaian and German conditions that influence the planning and implementation process of TNHPs.

In Chapter 5 the analytical framework that supports the identification of relevant topics, systems, strategies and ultimately the construction of a typology is illustrated and applied. The typology refers to the development of TNHPs over time and focuses on the realization of goals and ideas set by the different actors. Positive and negative influential factors are outlined and described.

In Chapter 6 the phenomenon of TNHPs is evaluated by contextualizing outcomes of Chapter 4 and 5 with the theoretical findings (Chapter 2). The typology of TNHPs and its relevance for transnational interaction and cooperation in practice as well as influential factors and the dynamics of TNHPs are discussed. The listing of limitations and strengths of the study then concludes with an outlook and recommendations for the different stakeholders of TNHPs (donors and recipients) and policy development. Needs for future research are identified.

1.1 Ghana – Country Profile

Ghana is a West African country with a coastline to the Atlantic Ocean of 539 km in the South and three neighbouring countries (North: Burkina Faso, West: Cote d'Ivoire, East: Togo), that spans an area of 238.537 km^2 (CIA 2018). The country is administered in ten regions[2] under which metropolitan areas (6), municipalities (49) and districts (261) are defined (GRA 2018). It is estimated that 54 percent of the total population (28,033,000) live in urban areas (UNdata 2018)[3]. Densely populated areas are concentrated in the southern half of the country and along the coast (Ashanti: 5,406,209; Greater Accra: 4,613,637) (GSS 2016).

A north south-disparity is also reflected in the access to infrastructure (e.g. roads, water, electricity, internet, schools, health facilities) (Osei-Assibey 2014, WB 2011).

As a country with a stable democracy since 1960, Ghana has constantly improved its socio-economic indicators (e.g. income, education) over the years and is doing better than most of the countries within the region (Molini & Paci 2015).

[2] Ashanti, Brong Ahafo, Central, Eastern, Greater Accra, Northern, Upper East, Upper West, Volta and Western (http://www.gra.gov.gh/docs/info/all_mmdas_in_ghana.pdf)

[3] According to Ghana Statistical Service (2010) "Population and House Census" the proportion of urban population (15 largest towns) was 50,9 percent of a total population of 24,658,823.

Migration, internal and international, has always been prevalent in Ghana (Nieswand 2009). Influenced by political and economic developments in the country, the western African region and the global context, migration patterns changed over time: in the 1970s-1980s emigration initially increased, triggered by economic crisis in Ghana and the demand of skilled workers in neighboring countries. In the 1980s-1990s further economic decline (evident e.g. in the fall of real wages, shortage of basic goods and services, and high inflation) as well as the political situation that led Ghanaians to seek political asylum abroad (IOM 2011:24ff) influenced the development of the Ghanaian society and economy. While emigration flows within the West African region still account for the biggest proportion of movements of people, the emigration, especially of skilled professionals, to destinations all over the world has increased over the years (IOM 2009:13). It is estimated that between 5.6 percent and 11.1 percent of Ghanaians live outside Ghana (Mörath 2015). At the same time, based on data provided by the Bank of Ghana, remittances from abroad to Ghana „increased from USD$1.5 billion in 2005 to USD$2.1 billion in 2010 and then almost USD$5.0 billion in 2015“ (Teye et al. 2017:10, IOM 2009:14).

Development of technology (e.g. internet, mobile phones) and affordable air travel “make movement and communication between large distances possible with much greater frequency, speed, and regularity, and in larger numbers than even just fifty years ago” (Mazzucato 2008:71). Therefore, staying in touch and organizing activities from abroad has become easier and have intensified. The Ghanaian government launched programs with (international) partners and implemented policies that aim to reduce the negative effects of emigration (e.g. brain drain) and improve the positive effects (e.g. benefits from knowledge transfer, increased investment) e.g. by allowing small-minimum-deposit foreign-currency bank accounts (MOI 2016, Gamlen 2006).

1.2 The Ghanaian Health System

Health Situation

Data provided by the Ghana Health Service (GHS) (GHS 2018:13) as well as reports from international organizations (WHO 2018) point out the constant improvement of health status indicators in Ghana (e.g. infant mortality rate, under-five mortality rate and life expectancy at birth) over the past decades: under-five mortality rate (per 1,000 live births) decreased from 128 (1990) to 62 (2015) and maternal mortality ratio (per 100,000 live births) decreased from 760 (1990) to 319 (2015) (WHO 2017a, WHO 2015). But while the situation is constantly improving it stays behind the expected

progress (WHO 2017b). The MDG target set for reducing the maternal mortality ratio (MMR) was not met by the year 2015 (Fenny et al. 2018:226). The country's physician density of 0.1/ 1,000 population (2010) and hospital bed density of 0,9/ 1,000 population (2011) and specialists as well as specific equipment and treatments are concentrated in the biggest cities, Accra and Kumasi, where the teaching hospitals are located. (Drislane et al. 2014, CIA 2018, Sulemana & Dinye 2014) The distribution of physicians also shows the disparities between urban and rural locations, when in 2011 "Ashanti and Greater regions, with 35% of the population had about 70% of the country's physicians" (Abdulai et al. 2017:2). Communicable diseases (lower respiratory infections, malaria, HIV/ AIDS) are with almost 25 percent (2013) the leading causes of death followed by stroke (8.7 percent) and birth related complications (preterm birth, asphyxia and birth trauma) (7.2 percent) (WHO 2015, GSS et al. 2015). Over the years the increase in non-communicable diseases (e.g. cancers, diabetes, cardiovascular diseases and chronic respiratory diseases) has put another challenge on the health system (WHO 2014, de-Graft Aikins et al. 2014).

The Ministry of Health (MOH) regulates the health system and administers health care on national, regional and district level with its agencies and regulatory bodies (e.g. the Ghana Health Service[4], the Medical and Dental Council[5]) (Escribano-Ferrer et al. 2016). While institutions of the government provide most of the curative, preventive and promotive services (Boom et al. 2004, MOH 2007a) health care in Ghana is also delivered by private-for-profit, private-not-for-profit, and traditional structures (Abor et al. 2008). With the launch of the government's health policy in 1997, „fostering ‚partnerships' and ‚collaborations' with NGOs and civil society in service provision has been recognised as means of achieving national health goals" (Hushie 2016: 2). In 2013 the Private Health Sector Development Policy form 2003 was replaced by a new policy, with the aim to strengthen the private health sector and to „increase opportunity for the poor to access private health care services." (GHS 2013:vi)

Faith based health services account for up to 40 percent of available health care (Olivier et al. 2012), with the Christian Health Association of Ghana (CHAG) as the main actor (GHS 2015), and the role of private providers of health care services and public-private partnerships is increasing (Saleh 2013, Netherlands Enterprise Agency 2015)[6].

[4] The Ghana Health Service (GHS), for example, is responsible for the implementation of policies for health delivery, strives to increase access to quality health services, and the management of available resources.http://www.ghanahealthservice.org/ghs-category.php?cid=2

[5] The Medical and Dental Council is for example in charge of professional standards and the examinations and registration of foreign trained medical and dental practitioners. http://mdcghana.org

[6] „The health sector in Ghana is in transition from a mainly government managed public sector to greater diversity of health services providers. The public sector faces many challenges in terms of financing and the resulting diminishing quality of basic services. The National Health Insurance (NHIS) is a national

In 2014 the total health expenditure in Ghana accounted for 3.5 percent of the GDP (2.1 public, 1.4 private) (WB 2018a). With the implementation of the National Health Insurance Scheme (NHIS) in 2003 the out-of-pocket health expenditure of the total expenditure on health constantly decreased from 31.9 percent in 2003 to 16.1 percent in 2011 (WB 2018b). Since then the challenges to the NHIS have grown (e.g. increasing numbers of subscribers, exemptions for the poor, control of health care provider costs, increase of NCD burden) (de-Graft Aikins et al. 2014, Atuoye et al. 2016) and the percentage for out-of-pocket payments of the total health expenditure increases (WB 2018a, Fusheini 2016). Of the total health expenditure another 15.4 percent are external resources for health (Indexmundi 2018)[7]. While international development aid played an important role since the late 1980s and has been constantly growing in number of donor organizations and volume of health aid, it has changed from project funding to health-sector-wide approaches (Escribano-Ferrer et al. 2016, Wood Pallas 2015). A study to assess medical donation practices in Ghana that was done by the Partnership for Quality Medical Donations (PQMD) in 2008 (Wiafe et al. 2008). This study found that donations were mostly directed to the urban south of the country. The donating agencies at that time were mainly Non-Governmental Organizations (NGOs), more than half of which were faith based.

The regulation of donations in the area of health and voluntary medical outreach programmes are a good example for the challenges of a sector wide as well as intersectoral approach in the health sector. It shows the multitude of actors, the dynamics of policy making and challenges of implementation (ANNEX A - GUIDELINES).

The Ghanaian health sector is also affected by migration of health professionals out of the country (Campbell et al. 2013). The emigration of health personnel trained in Ghana (24 percent of nurses and 56 percent of doctors (Clemens & Pettersson 2008)) is still high and poses a challenge to the health system (IOM 2009). In the human resources strategic plan (2007-2011) (MOH 2007b:44) the Ghanaian government formulates a strategy to managed migration in order to encourage health professionals to work in the Ghanaian health sector. In the strategic plan outward migration of medical staff is recognized as a factor that contributes to the shortage of human

service that finances the sector but while effective it faces serious challenges for financial sustainability and efficiency.“ (Netherlands Enterprise Agency 2015:4)

[7] “External resources for health are funds or services in kind that are provided by entities not part of the country in question. The resources may come from international organizations, other countries through bilateral arrangements, or foreign nongovernmental organizations. These resources are part of total health expenditure.” (Indexmundi 2018)

resources for health and the MIDA program, the “Brain Gain” project, is described as a strategy to engage Ghanaian health professionals that work in Europe (MOH 2007b:17).

With regard to the ‘Health for all’ approach, that was coined in context of the 1978 Alma Ata Conference and influenced policy globally (→ 2.2.1 Primary Health Care and Community Participation), activities of the Ghanaian government and development cooperation started to consider to improve peoples health (Nyonator et al. 2005). Over the years the government implemented programs that were supposed to make health care more accessible and affordable for the Ghanaian population (e.g. GSS/GHS et al. 2009). The Community-Based Health Planning and Services (CHPS), a reform strategy that was developed based on a study from Navrongo in the north of the country (Binka et. al. 1995), seeks “to improve the accessibility, efficiency and quality of health and family planning care“ (Nyonator et al. 2005) to achieve universal health coverage, aims to make essential primary health services available. The pilot phase of the program started in 1999 (de Graft Akins et al. 2014) and grew from 30 districts that had stated the program in 2000 to 104 districts in 2003 (Nyonator et al. 2005). In 2016 a revised National CHPS Policy was launched to increase the programs coverage (GHS 2016).

Accessibility of health service is one of the major challenges of the health situation in Ghana. The number and distribution of facilities (hospitals/ clinics) (MOH 2015) as well as the poor infrastructure (e.g. vehicles, roads, electricity) and a shortage of qualified medical personnel[8] – especially in the rural areas – create a situation where the need for efficient community-based approaches is still high. (MOH 2011, MOH 2014, Saleh 2013)

1.3 The Ghanaian Diaspora in Germany and Ghana

For Ghanaian migrants, Germany is among the favourite destination countries (WB 2016:129). The number of Ghanaian citizens in Germany has increased over the years from around 3,000 in the 1970s to almost 15,000 in the 1980s with a maximum of 26,000 in the 1990s, when also the number of asylum-seekers from Ghana peaked (Schmelz 2009:8). Since then the Ghanaian community is constantly growing (up to 32,870 in 2016 (DESTATIS 2017)). The majority of people who have a temporary residence status (in total 12,140) are in Germany for family reasons (Castles & Miller

[8] While over a period of three years (2005 - 2008) the number of physician per 1000 population decreased, over the same period of time the number of nurses and midwives per 1000 population. http://www.hrh-observatory.afro.who.int/countries/ghana-2/ [Accessed 24.02.2018]

2003:27ff). The biggest communities have settled in economically strong federal states North Rhine-Westphalia (11,250), Hamburg (5,745), Bremen (4,160), Hesse (with Frankfurt am Main) (2,810) and Berlin (2,215) (Castles & Miller 2003:25f). In 2016 women accounted for 46,6 percent of the community and the average age of Ghanaians, male and female, is 34,6 years. While almost half of the Ghanaians (12,835) stay between one to four years in Germany, the average length of stay is 11,1 years (DESTATIS 2017).

The reasons why Ghanaians come to Germany have changed over time and can be summarized as educational migration (students and professionals who come to Germany to study or for further professional training), asylum-seeking migration (especially during the 1980s and 1990s) and family reunification (as a form of chain migration) (Schmelz 2009:9, BAMF 2014:257). Even though the language barrier initially makes English-speaking countries more attractive, Germany attracts skilled and unskilled migrants alike (Schmelz 2009:9). Nevertheless it is assumed that the majority of Ghanaians living in Germany are employed as low- or unskilled workers. A study from 2005 points out that in Germany 30 percent of the Ghanaians earn less than 10,000 Euro per year (Orozco 2005:8).

The socioeconomic figures given above are based on data by the German Federal Statistical Office and the Central Register of Foreigners (DESTATIS). They only include Ghanaian citizens living in Germany. Neither naturalized persons born in Ghana nor their children born in Germany, or the children from bi-national partnerships are taking into account (Mörath 2015:10). Based on estimates the group of people with a Ghanaian migration background (approx. 70,000) account for the biggest group of immigrants from Sub-Sahara Africa (DESTATIS 2017). They build a socially and economically active community, also described as diaspora[9], that has developed extensive transnational networks over the years. While individuals describe their strong connection and continuous involvement with family and friends in Ghana, activities and engagement for Ghana are also organized within groups and formal structures of clubs and associations (Schmelz 2009:24, Mörath 2015:17). The organizations set different priorities for activities in Germany (e.g. mutual support for leading a life Germany, topics of integration into the German society) and Ghana:

[9] In the context of this study the term diaspora is used according to the IOM definition that refers to "migrants or descendants of migrants, whose identity and sense of belonging have been shaped by their migration experience and background" and who „are connected to more than a single country". While the concept has been criticized (e.g. for focusing on the nationality and not doing justice to the diverse group of people it refers to or the lack of a clear definition and therefore a comparable data base), IOM uses an approach to enable, engage and empower transnational communities as agents for development.
IOM (2017) World Migration Report 2018. 305.
http://publications.iom.int/system/files/pdf/wmr_2018_en.pdf [Accessed 19.02.2018]

- Home town associations (HTA) usually focus on one place or the region of origin of its members. There are no figures on the exact number of associations or their respective members available, but Mörath reports numbers between 10 and 100 members (Mörath 2015:17). The biggest ethnic group of Ghanaians in Germany is from the Ashanti region while hardly any migrants come from the North of the country (Schmelz 2009:10f).
- Clubs e.g. Deutsch-Ghanaischer-Entwicklungsverein (DGE e.V.) that was founded in 1993 by a Ghanaian nurse, are mostly focused on one project and are often supported not exclusively by Ghanaians (Mörath 2015:17).
- Umbrella organizations e.g. the Union of Ghanaian Associations in Germany (UGAG), that was founded in 2003 and has 12 Ghana Unions as members (2015). It was initiated to assist Ghanaians in Germany, initiate development projects in Ghana, and strengthen cooperation with Ghana Unions in other European countries. It also aims to build a link between Ghanaians in Germany and the Ghanaian embassy (Mörath 2015:17, Schmelz 2009:16, UGAG 2018). The Ghana Council NRW was founded in 2009. As of 2015 it is comprised of 22 clubs, associations, businesses and individual members. It aims to link Ghanaians to the Federal State Government of NRW (Mörath 2015:17, Sieveking et al. 2008).
- Religious associations or religious communities have a central role for the social life of many Ghanaians in Germany, it is estimated that 90 percent belong to a church. Sometimes they cooperate with other organizations (e.g. Ghana Council NRW). Their engagement is often directed towards partner church communities in Ghana (Mörath 2015:22f).

In contrast to other migrant communities (e.g. from Cameroon) it is striking, that the Ghanaian diaspora is not organized according to professional qualifications and interests (e.g. engineers, doctors). Due to a lack of organizational structures (e.g. in formalized membership (GTZ 2010:14)), limited resources and competence to create and update a web presence, insufficient documentation and research it is not easy to gain an overview of active actors in the field. The Ghanaian government as well as potential cooperation partners (e.g. German development cooperation or the Ghanaian Government) already took measures to gain an overview by commissioning studies (e.g. Schmelz (2009), Mörath (2015) funded by GTZ/GIZ) and strengthen certain actors (e.g. UGAG by the Ghanaian by the embassy).

Some of the organizations's websites mentioned by Mörath (2015) are no longer accessible (13.03.2018). This can be interpreted as an indicator for their inactivity. New organizations emerge frequently but often do not survive for a long time. Other

organizations have been active for more than 10 or 20 years. In most of the cases there is no cooperation between different associations and sometimes even competition and rivalry about resources and members (Mörath 2015:39).

Areas of engagement in Ghana are mainly health (e.g. supporting health facilities with equipment, services and, building of health facilities, payment of insurance fees), education (e.g. school fees, building schools) and infrastructure (e.g. water, roads). Of the nine examples of organizations described by Mörath (2015), seven explicitly mentioned health related development activities as their core activities. Since in Germany Ghanaians mostly work in the low-income sector, for them it is often not easy to mobilize the necessary financial resources to (constantly) fund the described projects (Schmelz 2009:26).

The official and informal transfers of money (remittances) are another important contribution of Ghanaian migrants to their home country. Even though there have been many studies and articles on the topic (WB 2008, 2016, GTZ 2010), relevant data is difficult to acquire for different reasons (e.g. comparison of different national statistics, high percentage of informal transactions). For Ghana the remittances over the years steadily grew (in 2008 more than one sixth of the national GDP) (MOI 2016:viii) and are an important factor to the development of the country. Remittances have also been an important topic in the development of the national policy on migration (Nieswand 2008:34). While they are not the in focus of this study, knowledge about its impact on development will serve as an important indicator when it comes to accessing the impact of contributions and engagement in the area of health.

Activities of the Ghanaian Government

With the change of the political regime in 2000 the diaspora community was seen as "economic and political resource" (Schmelz 2009) and measures to approach Ghanaians abroad were introduced. Besides organizing a homecoming summit in 2001 to promote investment in Ghana, laws were passed to make it easier for the diaspora to stay involved with Ghana and increase investments[10]. Over the years different contact points within the governmental structure were established: the Ghana Investment Promotion Centre (GIPC) (2001), Non-Resident Ghanaian Secretariat (as part of GIPC) (2003). In 2006 the Ministry of Tourism was renamed Ministry of Tourism and Diaspora Relations (which is changed back in 2009) and the Migration Bureau/Unit and a Migration Commission was established in the Ministry for the Interior to coordinate national institutions/ministries. (Mörath 2015). The embassies (especially in

[10] E.g.: Dual Citizenship Act of 2001 (Act 591) and the Citizenship Regulations to permit dual citizenship, the right to vote for the Ghanaian diaspora (registered in Ghana) through the enactment of the Representation of the Peoples (Amendment) Act of 2006 (Mörath 2015).

the United Kingdom and in the USA) tried to build contacts with Ghanaians abroad. In the Growth and Poverty Reduction Strategy (GPRS II) from 2005 remittances are included and with the expansion of rural banks it was tried to formalize financial flows from abroad. In a second Homecoming summit in 2007 hampering factors for investment and needs were addressed (e.g. corruption and bureaucracy) (Mörath 2015:35f.).

Since 2006 the Ghanaian government has been working with national and international development policy - actors and new programs were launched[11]. In 2012 an internet platform (www.ghanaiandiaspora.com) was launched. The Ministry of Foreign Affairs established a Diaspora Support Unit (DSU), that was renamed Diaspora Affairs Bureau (DAB) in 2013 (IOM 2014). Another Homecoming summit was held in 2013 and with the involvement of actors from the field (national and international) an action plan for a Ghanaian Diaspora Engagement Policy (GDEP) was developed and established (Mörath 2015:36). While the activities of the Ghanaian Government increased over the years and measures were taken, the progress on policy development on migration and diaspora has been not comprehensive enough[12] and was too slow. But in 2016 Ghana launched its National Migration policy (MOI 2016, IOM 2016), which includes a chapter on diaspora, dual citizenship and transnationalism (MOI 2016:69ff.) and also recognizes the health sector as an area that has been affected by migration ("brain drain" and "brain circulation") in the past. It makes suggestions to approach problems (e.g. the shortages of qualified personnel) in the future.

Over the years the Ghanaian government has been cooperating with international organizations and governments. Looking at the development of the health sector WHO has extensively published reports on the effects of the mobility of health personnel (WHO 2004) and the IOM has conducted special programs.

- The Migration for development in Africa (MIDA) initiative started in 2003. It "aims to build a bridge between available resources of the Ghanaian diaspora and needs, opportunities and policies in the health sector in Ghana" for example by initiating contacts between the diaspora and actors in Ghana and by "building capacity of stakeholders in countries of origin" (IOM 2012a). In the second phase of the program (MIDA Ghana Health II, 2005-2008) 67

[11] 2011: Diaspora Engagement Project (DEP) by IOM that involves cooperation with different Ministries (Foreign Ministry, the Ministry for the Interior and the Ghana Immigration Service) and starts mapping the Ghanaian diaspora in different countries. (Mörath 2015)

[12] In Mörath (2015) 'While Ghana has robust laws which seek to facilitate the participation of the diaspora in development, many of the laws limit their full involvement in some aspects of socioeconomic development of the country. It is recommended that the State hastens the process for the passage of the national migration policy, which will comprehensively deal with migration in its entirety' (Awumbila/Teye 2014: Preface).

assignments were carried out. In the third phase (MIDA Ghana Health III, 2008-2012) 215 assignments and 15 internships were carried out. The program was funded by the Dutch Embassy in Ghana (IOM 2012a).

- The Temporary Return of Qualified Nationals Project (TRQN) was done in three phases (I: 2006-2008, II: 2008-2012, III: 2012-2015) and aims to place highly qualified migrants, migrant organizations in the Netherlands and other EU countries, with public and private sector institutions in their countries of origins, for short-term assignments. In Ghana, one of nine target countries that participated in the program, the focus of activities was on health. The project was funded by the Directorate of Consular Affairs and Migration Policy, Ministry of Foreign Affairs (MoFA) of the Netherlands. (Leith & Rivas 2015)
- Connecting Diaspora for Development (CD4D) is the continuation of TRQN project. Ghana was a target country but was phased out of the project in September 2017.[13]

Programs of the German Government

The German government considers migration as an important approach to facilitate sustainable development in developing countries (Bührer 2011). Ghana has been a partner country for Germany for over 30 years and the topic of migration has become of particular interest. Therefore, studies on the Ghanaian diaspora in Germany were conducted and cooperation and programs were implemented over the years (Schmelz 2009, Mörath 2015).

Since the 1980s the "returning experts" program funded by the German Federal Ministry for Economic Cooperation and Development (BMZ)/ Centre for International Migration and Development (CIM)[14] has been an approach of cooperating of the German with the Ghanaian government and to support development. It focuses on giving information and financial support to Ghanaians in Germany and facilitated network building, creation of jobs and provision of equipment in Ghana (Schmelz 2009).[15]

"Migration for Development" (PMD) (GIZ 2018) is a five-year (2015 to 2020) program on behalf of the BMZ and is implemented by CIM. The program is active in a total of 24 countries, of which Ghana is one. In two modules it aims to support activities of migrants in Germany and Ghana in order to facilitate development in the country of

[13] www.connectingdiaspora.org
[14] CIM is run by the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH and the Federal Employment Agency's International Placement Services.
[15] As a current example serves the establishment of an employment office in Accra, which is supposed to prevent migration to Germany and encourage development cooperation (Blasberg 2018).

origin (e.g. by cooperating with the diaspora, transfer of knowledge through returning experts, measures in Germany to help returnees prepare for reintegration). In Ghana the Ministry of Employment and Labour Relations is an important partner (Hujer 2018).

2 Theory

The aim of the chapter is to provide information from two major fields: the field of transnational studies in order to concretise the social phenomenon of TNHPs and the field of developments in international public health in order to understand the current status of health care and the strategic approach of the Ghanaian government or international organizations operating in Ghana respectively.

Attention is drawn to insights from the social sciences (sociology, public health) that build a theoretical foundation for the study and help to contextualize the activities of the Ghanaian diaspora in the Ghanaian health system. When available, studies referring to the Ghanaian migrant community are included.

Against this background, research gaps (e.g. the development potential of TNHPs for the Ghanaian health sector) are identified.

Theoretical concepts are operationalized in order to answer the research question of the study, which is explicated at the end of this chapter.

2.1 Transnational Engagement

Migration studies is a field of research that incorporates different disciplines (e.g. sociology, history, anthropology) in order to explore questions around the movement of people from one location to another and its effects on receiving and sending countries. Social, political and economic as well as individual aspects are being explored, taking various perspectives.

2.1.1 Transnationalism

Considering the increased interactions across national borders, the transnational approach has been developed in the field of migration studies from the beginning of the 1990s. As one of the first authors, Glick Schiller et al. (1992) wrote about the concept of transnationalism and described it as a process of connecting sending and receiving societies by establishing social fields. These fields are made of multi-layered relationships at different levels (e.g. economic, social, political, family) (Glick Schiller et al. 1992). But while the attention for the concept of transnationalism was high, social scientists came to the conclusion that it was not a new phenomenon (Schunck 2014:2). Migrants have always been connected to their countries of origin (Pries 2002), but just as the dynamic of migration itself has increased, the interaction between diaspora and

countries of origin has also intensified. Due to interactions that cross national borders on the one hand, and due to factors like economic links, improved communication technology and the possibility of cheaper travelling on the other hand, migrants may lead their lives in a transnational context. (Glick Schiller et al. 1995, Portes 1999, Vertovec 2003) The relevance of the concept was debated (Mahler 2003, Schunck 2014:3) and today, more than twenty years later, an established field of transnational studies is in place. The aspect of "simultaneous embeddedness in more than one society" (Levitt & Jaworsky 2007:131) has become a common perspective to analyze migration and also integration processes. However, it is stated that there is still not enough "reliable data on the scope of transnational involvement among immigrants in Europe" (Schunck 2014:3).

In the context of transnationalism, a recurring critique is directed towards the so-called "methodological nationalism", meaning that the nation state is taken "as the sole and unquestioned unit of analysis or reference" (Faist et al. 2013:16f.). Limitations occur for example when it comes to data collection that refers to the territory of a nation state and is used as a basis for comparison, or when the concepts of nation and ethnicity are equated (Faist et al. 2013:17f.). Paying attention to limitations of the national concept might help to improve studies and analysis in migration studies. However, the critique, which is not only directed towards migration studies but towards sociological theory in general, is not yet based on sufficient data to adapt existing theories accordingly (Schunck 2014:62).

According to Wimmer and Glick Schiller (2002) the growing attention in research for transnational communities reflects a shift away from "methodological nationalism". However, the nation state undeniably still is an actor with responsibilities, interests and expectations (e.g. in the form of laws, policies and programs) that are relevant to migrants and cannot be ignored (Grillo 2018:29). Faist et al. (2013:140) suggest transnational spaces as a "conceptual tool which can serve as a point of departure" to analyse social practice beyond national borders.

Paying attention to limitations of the national concept might help to improve research designs and analysis in migration studies. However, the critique, which is not only directed towards migration studies but towards sociological theory in general, is not yet backed up with sufficient data to adapt existing theories accordingly (Schunck 2014:62).

Studies on activities and structures of Ghanaian migrant communities have also applied a transnational perspective in order to illustrate the relationship networks and

processes that span across national borders. They take activities and relationships across national borders as a starting point and offer analytical frameworks built on models/ concepts of actors and structures. Such frameworks help to contextualize data and contribute to the development of Transnationalism/ Transnational theories and research methods.

Based on multi-sited ethnography at locations in Ghana and in Germany, the study of Nieswand describes the process of transnationalization that Ghanaians go through (Nieswand 2001). He puts a special focus on demographic processes, institution-building and the configurations of identity. The theory of a transnational status paradoxon is illustrated.

Mazzucato (2005, 2006, 2009, 2010), within the scope of an interdisciplinary research program (Ghana TransNet), studied migrants abroad who interact with people in Ghana (e.g. family, friends, colleagues). A simultaneously matched sampling methodology was applied.

Sieveking also applied a transnational perspective in her studies on the commitment of African migrants from North Rhine-Westphalia towards development policies (Sieveking 2009) and on the dynamics of migration and development in West Africa (Sieveking & Fauser 2009).

2.1.2 Transnational Social Space

Since the 1990s, different concepts describing the living conditions of migrants have been coined: transnational social space“ (Faist 2000, Faist et al. 2013), „transnational social field“ (Levitt & Nyberg-Sørensen 2004; Mahler 2003:75f), „Ethnoscape“ (Appadurai 1998) und „transnational communities“ (Castles 2002), only to name a few. Some of the terms are used as a synonym.

Based on Faist et al. (2013:53), the concept of transnational social space will be applied for this study. These authors are working out the multi-layerdness of transnational social spaces by highlighting the different dimensions of linkages. This includes the circulation of monetary /economic capital as well as human capital (e.g. education and skills) and social capital (e.g. networks). The concept of transnational social spaces is offering a useful framework for the research question pursued in this study, since it accounts for the changing conditions under which migration processes occur. It also offers a suitable approach to identifying factors that influence the transfer of knowledge.

Transnational social spaces are described as closely connected to cross-border ties and practices. They are said to be “relatively stable, lasting and dense sets of ties reaching beyond and across borders of sovereigns states” (Faist 2010:13).

Different forms of transnational social spaces can be distinguished by actors’ relationships (e.g. family kinship groups), the character (e.g. common goals in transnational circuits) and degree of interaction (e.g. moral obligation in transnational communities).

The variety of aspects stated by Faist et al. as characterizing transnational social spaces can be operationalized in the context of this study. They are used to identify influential factors from the data that shape TNHPs.

2.1.3 Actors Perspective and Interaction

Transnational social formations are made of “social agents”, which according to Faist et al. (2013:14) can be “individuals, groups or organizations and even states”. They are connected with social and symbolic ties. The networks they form are based on “personal interactions (…) and the institutionalised fields of economy, polity, law, science, and religion” (Faist & Sieveking 2011:6).

Norman Long provides a similar definition of social actors: “individual persons, informal groups or interpersonal networks, organisations, collective groupings, and what are sometimes called ‘macro’ actors (e.g. a particular national government, church or international organisation)”. Social actors are characterised as “active participants who process information and strategize in their dealings with various local actors as well as with outside institutions and personnel” (Long 2001:13). On this basis, the management of interpersonal relationships is described as agency (Long 2001:19). According to Long, the concept of Agency refers to the knowledgeability, experience, desire, capability to command relevant skills. It also means accessing material and non-material resources, engaging in particular organizing practices and social embeddedness “that impact upon or shape one’s own and others’ actions and interpretations” (Long 2001:49 & 240). In contrast to a structural analysis of social life, Long’s actor-oriented approach aims to “elucidate the precise sets of interlocking relationships, actor ‘projects’ and social practices that interpenetrate various social, symbolic and geographical spaces” in order to explain differential responses to similar structural circumstances (Long 2001:13). It offers “valuable insights into these processes of social construction and reconstruction” (Long 2001:49).

In the context of this study, the broad understanding of social actors and the concept of agency provide tools to identify interests/ interpretations (Long 2001:50) and to assess

actors and their characteristics, as well as the activities of TNHPs in a wider social context. The engagement of Ghanaian immigrants in Germany for their home country takes many forms and is determined by a variety of interests and motives. Mechanisms that facilitate cooperation and integration can be altruism and self-interest (Lucas & Stark 1985) as well as obligations, reciprocity and solidarity (Faist 2000). But not only are the motives of this engagement different: the thematic focus of commitment also varies. The areas of interest are for example health, education or infrastructure.

'Migrants', 'diaspora', or the 'transnational community' are particularly important actors in the context of TNHPs[16]. Expectations that have often been ascribed to migration processes over the past are for example:

- transfer of financial and social remittances,
- transformation form brain drain to brain gain,
- stimulation of development by temporary migration.

These points can be summarised under the general expectation that migrants function as development agents (Sinatti & Horst 2015). Faist and Sieveking (2011) aim at exploring the actual relevance and the scope of contributions that migrants are able to make for the development of their countries of origin.

The perception of migrants as development agents, who initiate cooperations based on their experience in and knowledge about the different settings (Faist 2010), becomes apparent in the variety of their projects. With their commitment they aim at contributing to the social and economic structures in Ghana, for instance.

Hometown associations are another collective actor described as important in the transnational social space between Ghana and Germany (Mörath 2015, Schmelz 2009 → 1.3 The Ghanaian Diaspora in Germany and Ghana). Like other organizations drawing on social and cultural values such as village, clan or lineage, religion or ethnicity (Grillo 2018:155), hometown associations form a part of civil society as it is described by Faist et al. (2013:159ff.). The interactions with the actual home towns, however, are said to often resemble "donor – beneficiary relationships rather than a collaboration of partners and equal members of one community" (Faist et al. 2013:79).

2.1.4 Resources and Social Capital

Resources of actors provide the basis of TNHPs, and as such they are central to the research question. They are, or are not, at the disposal of actors, they influence their

[16] Though the underlying concepts of the terms "transnational migration" and "diaspora" are critically discussed because of the political connotations (Grillo 2018:44ff), in the context of this study the terms will be used synonymously.

activities and position and therefore contribute to shape social structures. In order to better understand the processes and the structure of transnational social spaces, researchers from the field of migration studies (Pries 1998: 75; Levitt 1998: 927; Kelly & Lusis 2006, Fauser et al. 2015) point out that Bourdieu's theory of capital and habitus (Bourdieu 1986) can be applied to transnational social spaces, even though Bourdieu did not conduct research in a transnational social space himself.

Bourdieu defines activities of people in the context of social spaces, which are shaped by structures that exist regardless of the consciousness and will of individuals (Diefenbach & Nauck 1997:279). Structures are shaped by rules, norms and the shortage of resources. They determine possible action for social actors. With his concept of habitus Bourdieu offers a tool to connect the individual with the social by stating that "social practices are neither the mechanical imposition of structures nor the outcome of the free intentional pursuit of individuals" (Navarro 2006:16).

The power over specific resources is described as capital (Bourdieu 1986). Bourdieu distinguishes economic capital, cultural capital and social capital. He refers to the capital forms also as power (Bourdieu 1986:47).

Of the three forms *economic capital* is probably the easiest to comprehend and distinguish. It refers to anything "which is immediately and directly convertible to money and may be institutionalized in the form of property rights" (Bourdieu 1986:47). In the context of this study economic capital is often associated with remittances that migrants send back to their countries of origin. The World Bank uses a definition of remittances that refers to personal transfers as „all current transfers between resident and nonresident individuals, independent of the source of income of the sender (irrespective of whether the sender receives income from labor, entrepreneurial or property income, social benefits, or any other types of transfers or disposes of assets) and the relationship between the households (irrespective of whether they are related or unrelated individuals)" (WB 2017:101f). This broad definition, which includes „family members but also to any recipient in their home country", also aims to include social contributions (WB 2016:XVii) and reflects an awareness of the multiple forms of remittances. While this form of remittances is probably the one which has attracted most research interest (WB 2016, IMF 2009), figures on their scale and studies on their effects are still mostly vague due to the availability and quality of the data.

For *cultural capital* three different aspects are defined. The embodied state refers to all cultural forms of knowledge and education which are "linked to the body" (Bourdieu 1986:48). The objectified state of cultural capital refers to "material objects and media, such as writings, paintings, monuments, instruments, etc." (Bourdieu 1986:50).

Whenever cultural capital is legitimized by formal qualifications (e.g. an academic degree, certificates), Bourdieu talks about the institutionalized state.

Social capital is described as “the aggregate of actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition”. It depends on “the membership in a group” (e.g. family, club) (Bourdieu 1986:51). Looking at the network aspect of transnational social spaces, social capital is of special interest in the context of this study. Social practices of migrants include remittances that go beyond monetary resources, which illustrates “that social and cultural ideas and practices are also transmitted and received in transnational settings” (Faist et al. 2013:34). Levitt distinguishes three types of social remittances (normative structures, systems of practice and social capital) and explains how social and cultural resources are transformed into social remittances that contribute, among other things, to the development of communities (Levitt 2001:54ff.).

For the present study it is particularly relevant to understand the interdependence of different forms of capital. While Bourdieu states that “all types of capital can be derived from economic capital” (1986: 53), he also points out that the conversion from one form to another is not always straightforward. Not only can it be time consuming to acquire certain forms of cultural capital, but some forms of capital and power depend on relationships (social capital) “which cannot act instantaneously, at the appropriate moment, unless they have been established and maintained for a long time” (Bourdieu 1986:54). Furthermore, the value of different forms of capital can be very different depending on the context of the respective habitus on the one hand and of the social space on the other hand (Kelly & Lusis 2006).

The three forms of capital “can be regarded as the basis for an individual’s opportunities to partake in certain fields, such as the labor market, education, health or politics” (Fauser et al. 2015). Looking at the different forms of capital allows for the identification of inequalities and to relate them to the social positions and the practices in the transnational social field.

This study is focusing on health activities of migrants in a transnational social space. In terms of their resources, the relevant forms of capital are what Faist (2000:117ff.) labels economic capital (e.g. financial resources), human capital (e.g. education and competences) and social capital (e.g. relationships, network connections). He describes human capital, equivalent to Bourdieu’s cultural capital, as knowledge and skills. Looking at the medical sector, the so-called human capital is also of importance

and has been discussed and researched widely, e.g. within the scope of Human Resources for Health programmes by WHO. While the term suggests a “humanistic connotation” it has been criticized for its economic focus that often ignores the relevance of cultural and social capital forms of capital (Bourdieu 1986: 48).

Bourdieu also never applied his theories with regard to health topics (Pinxten & Lievens 2014: 1097). However, his concepts of capital forms and social space can help to better understand dynamics of health inequalities. Most of the social determinants of health (e.g. unequal distribution of power, income, goods, services, access to health care, schools and education, conditions of work and leisure, homes, communities) (WHO/CSDH 2008) can be associated with the different forms of capital described above. While research on the connection between economic factors like income and health has been extensive (Pickett & Wilkinson 2015) the impact of social capital is more difficult to measure (Abel (2008), Pearce & Smith (2003)).

2.1.5 Development in a Transnational Context

The World Bank estimates that remittances exceed the amount of official aid flows by far (WB 2016) and the potential of migration for the development in African countries has received growing attention on the African continent (Nieswand 2009) and from development partners abroad. In the political context of the Ghana – North-Rhine Westphalia (NRW) partnership the hope was expressed, “to use the precious resources [*of the Ghanaian diaspora*] for development cooperation” (Sieveking 2011:190).

Based on a nationally-representative houshold survey Adams et al. (2008:23) found that internal (from within Ghana) and international remittances “reduce the level, depth, and severity of poverty in Ghana” and that “international remittances have a greater impact on reducing poverty than internal remittances” (Adams et al. 2008:23).

However, attempts to measure the impact of remittances as well as the relation between remittances and development have also been assessed critically.

Faist points out that even though the development nexus is a good starting point “the notion of development is no longer at the centre” (Faist 2011:7) of transnational processes. According to him the transnational social question does not only apply to inequalities that exist between regions and groups, it also considers social inequalities “not mainly as problems faced by so-called developing countries” (Faist 2011:6).

Nieswand points out that „compared to the limited volume of most donations the discourse on diaspora and development often appears ‘oversized’" (Nieswand 2009:28). According to him evaluating the impact of single projects is hardly possible and the “disparity between the rhetoric employed in the diaspora and development discourse and its practical impact highlights the relevance of the symbolic dimension of these activities“ (2009:28).

Phillips (2013) explores the potential of the diaspora for development. He rejects the idea that remittances are “a substitute for development aid” (Phillips 2013:156) that can fund public projects. Phillips comes to the conclusion that “perhaps the most crucial benefit of migration is psychological in character” (Phillips 2013:156) when expectations rise and migrants realizes what they are capable of.

The concept of migrants as development agents has been critically discussed (Faist & Sieveking 2011, Sinatti & Horst 2015, Fauser & Nijenhuis 2016). According to Faist “migration alone cannot remove structural constraints to economic growth and functioning democracy” (Faist 2011:11).

2.2 Concepts of Health System Development

Within the field of international Public Health, the concepts of Primary Health Care (PHC) have been subject of extensive research and political debate. Lately, Universal Health Coverage (UHC) has been named as a concept of linking population health and sustainable human development. In the context of this study, these two will serve as the basis to point out influential factors on people’s health status and approaches to its improvement. Focusing in particular on aspects like

- relevance of the community
- availability, accessibility and quality of health care (for example in the field of Human Resources for Health, HRH)
- activities of NGOs and private providers of health care
- responsibilities of the government

will help to contextualize the status, relevance, potential and constraints of TNHPs in the development of the Ghanaian health system.

2.2.1 Primary Health Care and Community Participation

The international conference on Primary Health Care, which took place in 1978 in Alma-Ata, marks a global starting point of awareness for the importance of health as a human right and the benefits of community-based health services. Community

participation as well as intersectorial cooperation were highlighted in order to achieve better health for everyone in the world. As an outcome of the conference, fundamental and global recommendations were provided, with a special focus on the extreme inequalities in the health status of people in developing countries. (WHO & UNICEF 1978)

The concept of Primary Health Care is a comprehensive approach that takes the sociocultural and economic conditions, the structures and developments of the health sector and other factors into account (ibid.:4f.) and aims at making “essential health care universally accessible to individuals and families in an acceptable and affordable way and with their full participation” (ibid.:38).

The national health system of a given country, with the availability of a qualified health workforce, serves as the basis for further activities. The government is seen as responsible for major funding and creating the political conditions for the Primary Health Care agenda (ibid.:19f, 42f, 51, 75), while the support of different levels of the health system as well as intersectorial cooperation is necessary for its sustainability. (ibid.:39f, 42f)

According to the WHO definition from 1978 “a community consist of people living together in some form of social organization and cohesion. Its members share in varying degrees political, economical, social and cultural characteristics, as well as interests and aspirations, including health. Communities vary widely in size and socioeconomic profile, ranging from clusters of isolated homesteads to more organized villages, towns and city districts” (ibid.:49f). Communities of all formats and the active participation of their members are described as crucial factors in the process of implementation. Primary Health Care is described as an essential care “made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination” (ibid.:16). For one, this is because community participation helps to identify the actual needs and problems of the population, and at the same time communities hold capacities and resources that can contribute to the development and implementation of suitable solutions (ibid.:18, 50).

The declaration of Alma Ata also calls “for strong, coordinated, international solidarity and support” (ibid.:31). This includes international organizations like WHO and UNICEF as well as funding agencies, all health workers and the whole world community (ibid.:6). Because of their work within communities, the activities of (inter-)national non-governmental organizations are described as particularly valuable (ibid.:79).

Moreover, with its potential to improve the health status of people, Primary Health Care is also seen as an indicator for social and economic development of a country (ibid.:44ff).

Looking at the political, economic, demographic and epidemiological developments since 1978, the national and international conditions for health care provision have changed. While in most countries Primary Health Care was prioritized, a lack of policy development, human resources, administrative network and financial capacities often restricted the implementation of the PHC-measures (Dugbatey 1999), Bozorgmehr et al. 2010, Segall 2003). With the developments having been reviewed and having been subjected to research as well as political debate (Gillam 2008), the world health report 2008 (WHO 2008) emphasizes the relevance of the concept of PHC under new conditions. As can be seen in the growing importance of civil society organizations, public-private partnerships and the national diasporas, “power is gravitating from national governments to international organizations” (WHO 2008:108).

The definition of community given in the context of the Alma-Ata Declaration in 1978 describes groups of actors that are residents in a specific location (e.g. village, town). In the face of global migration processes and technical progress (e.g. travel, internet, cellphone), it seems appropriate for the purpose of this study to extend the concept and understand the Ghanaian diaspora as a (transnational) part of the community. The diaspora without doubt shares political, economic, social and cultural characteristics (WHO & UNICEF1978:49). When they assume health-related activities, it often is not directly for their own health but to support family and friends or communities of origin. With the perspective of a (semi)outsider, they have a position that is neither comparable to community members in Ghana nor to external development partners.

2.2.2 Universal Health Coverage and Inequalities

The importance of the concept of PHC was reinforced by the implementation of the Millennium Development Goals in 2000 (Chan 2007) and remains relevant in Sustainable Development Goals (SDG), which became effective in 2016, Pettigrew, L.M. et al. 2015). Goal number 3 carries the title “Ensure healthy lives and promote well-being for all at all ages”. It includes the following target: “Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all” (UN 2018).

Maternal and child health indicators, which have formed part of the Millennium Development Goals before, continue to be part of the monitoring efforts. Throughout

the world, maternal and neonatal health are considered good indicators for the functionality of the health care system of a country. (Campbell et al. 2013:854) While many health indicators are strongly poverty related, data on maternal, under-five and infant mortality are also meant to reflect the availability of basic health services such as antenatal care, emergency obstetrics and vaccinations. (WHO 2006)

The aspiration of universal health coverage (UHC), which focuses on equity and social justice (Ooms et al. 2013, WHO/CSDH 2008) has close historical links with the approach of Primary Health Care. It “aims to ensure that all members of a society can access the health-care services they need without incurring financial hardship” (Campbell et al. 2013:853).

While the obligation to protect the right to health, to provide health services and to regulate all actors in the field lies with governments, actors from the private sector (e.g. public-private partnerships, NGOs) often have a crucial role in providing health care (Hallo de Wolf 2016). In the context of UHC, the fragmentation of health services and the focus on “coverage”, as opposed to a comprehensive concept of “care”, have been criticized in particular (Global Health Watch 2015). As a developing country, Ghana has been strongly affected by (inter-)national policies and programs that play a crucial role in the provision of health care (→ 1.2 The Ghanaian Health System).

Against the background of persisting health inequalities, Graham et al (2013) introduce the term “effective coverage”, defining it as “high and equitable coverage of quality care”. They argue for repositioning quality at the centre of Universal Health Coverage, which is closely linked to the personnel working in the health sector.

The availability of qualified human resources for health is a crucial factor to achieve UHC. With their analysis of human resources for health policy, Campbell et al. (2013:858) come to the conclusion that the successful development of HRH depends on continuous ”political leadership and commitment that is multisectoral, legislated and regulated through governance instruments”, as well as on a multilateral approach that involves actors beyond the health sector (e.g. public and private entities development partners, state and district governments, professional associations, health workers and consumers). Thus, governments and their partners can take their roles to enhance the different dimensions for example by continuous education and training of the workforce and multinational partnerships that build on mutual benefits (availability), measures that address the disparities between urban and rural areas (accessibility), raising awareness of peoples needs depending on sex, age, language, ethnicity etc. (acceptability) and standardisations, monitoring and support through cooperation (quality).

The four dimensions of the workforce (availability, accessibility, acceptability and quality of health care) provide a framework that can be applied to other resources as well (Campbell et al. 2013). The model also draws attention to the gap of essential services that result from forms of supply and the gap between people's needs of services that are not covered.

2.2.3 Attempts to Aid Regulation in the Ghanaian Health Sector

The relations of migrants with their countries of origin have been subject of extensive research in the social sciences.

The engagement of the Ghanaian diaspora, a globally active group of people who support their home country in multiple ways, has also been explored (e.g. in the context of international development cooperation with different European countries, research (e.g. Mazzucato, Nieswand, Sieveking). The relevance of remittances, but also the transfer of social capital is documented for Ghana. And while the quality of available data on remittances and engagement could certainly be improved (Schunck 2014:3), it is commonly described that the area of health is one of the main fields of engagement (e.g. Schmelz 2009, Mörath 2015). Programs of IOM, which are specifically focused on health topics (e.g. MIDA Ghana Health, Connecting Diaspora for Development), confirm the relevance of engagement in the area of health. The Ghanaian government acknowledges the engagement of migrants by developing migration policies. Engagement in the area of health is of particular interest to the government and is met with the development of a specific policy (MoI 2016). But while the potential of migrants' engagement is widely recognized and encouraged, the engagement is also perceived critically (e.g. adherence to standards, complicated bureaucratic requirements). Different measures of regulating the engagement of migrants in the area of health were brought to my attention at the beginning of my field research.

A prominent example are the "Guidelines for Donations and Voluntary Medical Outreach Program in The Health Sector Of Ghana" (MOH (no date, approximately 2010); Annex A), which were highlighted by actors in the medical field. Interview partners from the MoH and related institutions like the GHS mentioned the guidelines during the interviews.[17] They emphasized how important interaction between recipients and donors is.[18] Concerning the distribution of the guidelines, I was told that they were circulated to Ghanaians in the diaspora and to embassies, in order to reach more

[17] 28_01_01(10), 31_01_01(51)
[18] 28_01_01(47)

people and pass on the crucial information. It was stated that they were supposed to explain the donation process, make engagement easier, reduce misunderstandings and improve the quality of donations.[19] In 2012, a representative of the MoH publicly criticized the quality of donated equipment and consumables (Modern Ghana 2012). He pointed out that in order to prevent the negative effects of donations, the MoH had developed policy guidelines and that "the guidelines have been circulated to all embassies, but it is unfortunate that some of such donations still find their way into the country" (Modern Ghana 2012).

In contrast to the proclaimed dissemination of the guidelines, interview partners who are involved in TNHPs in Germany did not mention the guidelines. A representative of the Ghanaian Embassy in Berlin was not aware that the guidelines existed. However, he stated, that "if I'm aware of-, it makes our work easier. If I have this we'll just put it on the notice board. And then people who come see there and then-. (…) Now because if there is a guideline, the guideline is-, is according to a law. So then we all can follow it."[20]

According to an internet search I conducted during my field research among websites addressing the diaspora[21], (as of 04.04.2015) there was no active link available to download the guidelines online, though it used to be available at www.ghanadruginformation.org[22].

The example of the donation policy of a hospital demonstrates that when recipients describe their experiences with donations, they often either mention complications concerning the quality of donated items or of the process itself. Some of them claimed that regulations in the form of guidelines (also called checklist, manual, policy) could have a positive effect on the usability of donations. The donation policy described in the following was therefore developed in a hospital in Ghana.

According to a representative of the hospital management, donations play a significant role in providing and improving health care to patients. Nevertheless, donations are said to not always be beneficial for the hospital. Negative experiences concerning the quality of donated items and difficulties relating to the donation process (e.g. needs assessment, logistics) had motivated the hospital to develop the donation policy. By implementing guidelines, the management of the hospital wanted to improve the quality

[19] "So from that time-, now we are in constant link with people who would want to donate. So we have been able to cut down on demurrages. And again we have been able to cut down on waste" 28_01_01(10)
[20] 33_01_01(51)
[21] http://www.ghanaemberlin.de [Accessed 27.09.2017]
http://www.ghanaiandiaspora.com [Accessed 27.09.2017]
[22] www.ghanadruginformation.org [Accessed 05.01.2013]

of donations and thereby increase the benefits.[23] The donation policy takes into account concerns and problems the hospital experienced in the past. Some donations they received were non-functional or unusable because of the poor quality of used equipment that is near the end of its useful life span. Frequent breakdowns and a lack of necessary spare parts or instruction manuals, expired drugs and items being labelled inadequately or in foreign languages can cause additional costs and problems of disposal for the hospital. In some cases, the practical needs of the hospital were not considered.

The donation policy (also called guidelines and manual) was developed by a nominated committee, chaired by the Medical Director. In 2011, (effective date: 1st May 2011) it was issued by the management of the hospital. The policy has been based on the Guidelines for Drug Donations (WHO 1999) and the Donation Policy of the Ghanaian MoH. The document also provides detailed guidelines on selection criteria (e.g. needs assessment, national and international standards), quality assurance (e.g. sending detailed information about the donation in advance, required approval of hospital management), clearance requirements (e.g. certificates, approval letters and packaging to obtain tax exemptions) and information management (e.g. timely communication between donors and stakeholders). A representative of the hospital management stated about the initial phase of a donation: "… you contact the hospital. Then we give you a copy of the donation policy. Then you go through. If you are happy with it, then you follow the procedure and donate the items to us."[24] The process is based on the assumption that donors initiate a contact with hospitals before they become active.

Different interview partners in the hospital described the donation policy as mandatory[25] and explain that a team of staff members is responsible for its execution[26]. It was striking that almost all the interview partners emphasized the importance of the donation policy, still it was very difficult to obtain a copy of the actual document[27]. When the interviews were conducted, the guidelines had been in place for six months and the effects of the policy had not been assessed yet.

Another example for institutionally regulated engagement is the procedure of "adopting" a hospital ward (Project 2; Annex E2).

These examples from the field show that the Ghanaian diaspora interacts at different levels with the Ghanaian health system. But beside the evaluation from a project/

[23] 03_03_01(42); 03_05_01(47)
[24] 03_03_01(18)
[25] 03_03_01(16); 03_04_01(31); 03_05_01(7); 03_06_01(5)
[26] 03_05_01(8); 03_06_01(37)
[27] 03_08_01(20)

program perspective (e.g. MIDA Ghana Health), at the point of my field research there had been no research on the relevance that TNHPs might have on the Ghanaian health system.

The need for such research was underlined by interview partners from the Ghanaian health system, who described the need to further explore and evaluate the effects of instruments (e.g. donation guideline), while donors wished for more efficiency in the donation process.

2.3 Aim and Objectives

The aim of the study is to analyze interactions of Ghanaians living in Germany who are engaged in transnational health projects with relevant actors on the community level in order to evaluate the projects' possible effects on availability, access and perception of health services in Ghana as well as the potential influence on transnational networks.

The objectives of the study are:

1. To identify and explore the networks and interaction of Ghanaians living in Germany who are engaged in different types of transnational health projects in Ghana.
2. To define interests, motivation and resources of the different actors who are involved in transnational health projects.
3. To assess the logic of action that transnational engagement in the context of health is based on.
4. To identify factors that support or hamper the implementation of transnational health projects.

3 Research Methods and Material

Even though there are studies and reports about the transnational engagement of migrants, especially in terms of financial remittances (Page & Plaza 2006), no data is available on the context and effects of transnational health projects. Therefore, the study is based on a qualitative design, which allows for exploring the phenomenon of transnational engagement in the area of health (Bryant & Charmaz 2007) by analyzing individual cases.

The following chapter gives an overview of the research setting (transnational character of the study), the sampling methods (theoretic sampling) (Przyborski & Wohlrab-Sahr 2009) as well as methods and tools of data collection (problem centered interview) (Witzel 2000). As a next step, the processing and qualitative analysis of the data are described (scope of data) using the MAXQDA software. Since, over the course of the study, the construction of a typology (Kelle & Kluge 2010) became the major approach of data analysis, it is depicted in a separate section. Furthermore ethical considerations that accompanied the research process (informed consent, ethical clearance, role of the researcher) are described.

3.1 Research Setting

The study focuses on transnational engagement in the area of health. It aims at exploring social ties and interactions between different actors as well as the relation of TNHPs to the Ghanaian health system. Therefore, it is necessary to include not only individual, but also institutional actors in the research. The topic of research is characterized by the involvement of a heterogeneous group of actors from different professional backgrounds, who often have expertise and made experiences in Germany and Ghana. Including a large number of actors from different backgrounds in the research reflects the actual setup of TNHPs.

The study focuses especially on Ghanaians (temporarily) living in Germany. It provides insights and offers an opportunity to take the perspective of one subgroup among the heterogeneous Ghanaian diaspora. Yet, some of the findings might be transferable to other groups of Ghanaians (in Europe or other countries).

The data collection focuses not only on actors who are directly involved in projects. By talking to representatives of institutions and organizations in Germany and Ghana the circumstances under which TNHPs develop are also taken into account. By conducting interviews with actors from different backgrounds in Germany and Ghana, it is possible

to build a comprehensive understanding of the research topic. The perceptions of the interview partners are influenced by different national structures and political circumstances.

TNHPs take place in a transnational context that includes places in Germany, Ghana and other countries. While most of the actors move or travel between countries (donors), others (recipients) are stationary in Ghana. The data collection therefore needed to be conducted in Germany as well as Ghana. Conducting the interviews either in a person's professional setting or at the project site creates a comfortable and appreciative context for the interview partner. It also allows for gaining insights in the topic of interest beyond the reported opinion of the interview partners, which may be relevant for the research. Being on-site also creates opportunities to arrange for additional interviews. For the researcher to do justice to the diversity of actors and their specific contexts, travelling between Ghana and Germany as well as within Ghana is essential. The setup of the study thus reflects the transnational character of the research topic.

All interviews were done in English except one, which was done in German.

Research Phases

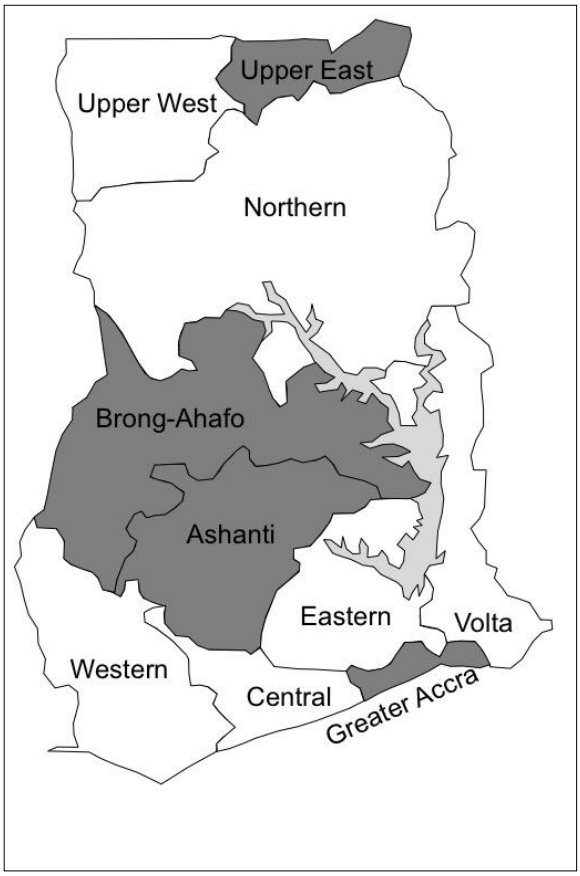
The data was collected over a period of almost two years (from 08/2010 till 07/2012). During the first phase of the research project, contacts with organizations working with Ghanaian migrants were established in Germany (e.g. Union of Ghanaian Associations in Germany, CIM). After having developed an interview guideline, first interviews with representatives of Ghanaian projects and initiatives were conducted in Germany (between August and October 2010). Spending the initial phase of the research project in Germany proved important to collect data and establish contacts with members of the Ghanaian diaspora, who are the main actors of interest for the research. In order to follow their network structures and to assess their engagement in Ghana, the second research phase was carried out in Ghana. The period of October to December 2010 was used for gaining insights into transnational activities in the area of health in Ghana. Thereby, the structural and institutional contexts as well as the engagement in the area of health at the community level were explored. From January until February 2011, besides following-up contacts of the Ghanaian interview partners, new contacts were established through organizations and institutions in Germany. The major phase of data collection took place in Ghana from March until December 2011. Finally, a few follow-up interviews were conducted in Germany up to July 2012. An overview of research phases in Ghana and Germany as well as the conducted interviews is depicted in the Annex C.

Places

In most of the cases, the interviews were conducted at the workplaces of the interviewees or at their homes. The interviews took place in four different cities in Germany, while one interview was conducted in the Netherlands. In Ghana, most of the interviews were conducted in the Greater Accra Region. The other interviews were done at the project sites all over the country.

Figure 1: Map of Ghana with Regions where TNHPs are Located

Source: GeoCurrents Base Map (2017)



The ACBRIDGE-Program

The study was carried out within the scope of the ACBRIDGE-Program[28] funded by the German Academic Exchange Service (Deutscher Akademischer Austauschdienst e. V (DAAD)). The program ran from 2008 to July 2013 and was aimed at finding holistic solutions to major health issues of the West African region. The School of Public Health at the University of Ghana, as one of the program partners, served as a point of reference and a research base during the research activities in Ghana. DAAD funded the logistics and numerous research trips within Germany and Ghana, as well as

[28] https://www.uni-bielefeld.de/gesundhw/ag3/projekte_abgelaufen/acbridge.html [Accessed 27.09.2017]
http://www.ac-bridge.com [Accessed 27.09.2017]
http://www.african-excellence.de/home/ [Accessed 27.09.2017]

between the two countries. The program also funded the transcriptions of the interviews.

3.2 Methods and Tools of Data Collection

Qualitative research design

Depending on the research topic and research interest, the method of analysis needs to be selected from a variety of methods, which can be roughly categorized in theory building or theory testing approaches (Bortz & Döring 1995). Building theories is often shaped by different exploration strategies that are focused on individual cases (Bortz & Döring 1995:333f), while theory testing means analyzing the data against the background of already existing theories (Layder 1993:2).

For empirical research that strives to explore and explain the social rules of a phenomenon, qualitative methods to generate and evaluate data are an appropriate tool (Bortz & Döring 1995:302f). The Grounded Theory methodology by Glaser and Strauss (1998) can be described as the basis for many qualitative research approaches. Its inductive procedure to generate theory exclusively from the research subject has been developed further into methods that also consider theoretical knowledge. Theoretical Sampling for Problem-Centered Interviews and the Construction of a Typology mark such methodological developments. Choosing these methods also meant to take the requirements of the research topic into consideration. The aim is to explore the phenomenon and to gain a broad insight into different aspects of transnational engagement in the context of health. At the same time, the data basis of the study is not large enough to generalize the findings in a quantitative, statistical sense.

Problem-Centered Interviews

The problem-centered interview was developed by Witzel (2000) in order “to gather objective evidence on human behavior as well as subjective perception and ways of processing social reality” (Witzel 2000). The method evolves around semi-structured interviews and follows three principles:

- the interviewer asks the interviewee about his or her knowledge and perceptions regarding the subject of interest (problem-centered),
- different methods are combined, which are necessary to obtain information (object-oriented) and
- the focus is on reconstructing orientations and actions over the course of the research (process-oriented).

The methods can be applied for any interview partner since all people are considered experts “of their orientations and actions”.

Instead of a questionnaire to collect personal data on the interview partners (e.g. age, education), which is suggested by Witzel (2000), these aspects were integrated into the first interview question about the personal background. The other instruments (guideline, recording and postscripts) were applied as follows:

Interview Guidelines

The guidelines structure the interview along central questions and serve as a reminder for the interviewer. They set a framework that helps to follow the same structure for each interview, but at the same time it allows the interview to develop like a conversation, leaving enough space for the interview partner to freely speak about the topics of relevance.

The first version of the guideline was developed on the basis of findings from literature and the assessment of activities on the internet. Information obtained from members of the Ghanaian and other African communities in Germany, as well as from actors in Ghana, was also included. This resulted in two different guidelines: one for actors directly involved in a TNHP (donors, recipients and supporters), the other for experts who have knowledge about the donation process and the structural circumstances in Germany or Ghana. Over the course of the study, with a growing knowledge about the field, the guidelines were continuously developed and questions were added. The final versions with all questions are displayed in the Annex. The interview questions for the experts (Annex D1) were divided into the sections Introduction/ Personal Background and Ghanaian Community. The interview questions for the actors involved with a TNHP (Annex D2) were divided into the sections Introduction/ Personal Background and Projects. In order to find out about transnational engagement in the area of health, both guidelines hold questions about:

- **Who** is engaged?
- **What** is the subject of the engagement?
- **How** is the engagement carried out?
- **Why** are people engaged?
- Future perspectives

In order to keep the setup of the interviews as similar as possible, an outline for briefing/ debriefing the interview partners was also used (Annex D3).

Recording and Postscripts

The recording is an exact documentation of the communication between interviewer and interviewees and serves as a basis for transcribing the interview. The interviewer can thus focus on the development of the conversation.

With the consent of the interview partners, each interview was recorded with a digital recorder. Subsequent to each interview the impressions on atmosphere, dynamics and interactions as well as special occurrences (e.g. interruptions) and ideas on striking topics were documented in the form of a memo. A full transcript of each interview was compiled later.

3.3 Sampling

For a comprehensive analysis of TNHPs, it is crucial to identify individuals who either have personal experience in organizing TNHPs or have knowledge about interaction patterns, networks and structures that build the context for transnational engagement.

A literature search, the assessment of activities on the internet and in the newspapers helped to create an overview of activities of the Ghanaian diaspora in Germany. In addition, key persons provided first contacts to the community. On this basis, the following criteria were established to identify transnational health projects relevant to this research:

- Carried out in Ghana, by Ghanaian migrants who currently live in Germany
- Organized activities that are related to health (e.g. establishing healthcare centers, sending medical equipment, prevention, etc.)
- Set up in a private or public setting
- For profit or non-profit
- Individual efforts as well as group activities

Theoretical sampling (Przyborski & Wohlrab-Sahr 2009:177f) is an adequate method in this context, as there is a lack of theoretical and empirical work on the phenomenon of TNHPs. Hence, the flexibility of the approach allows the concept to be developed in the course of the research. By focusing on the emerging theoretical background of the phenomenon, it becomes possible to get to know the structures of the field. Projects and actors may turn out to be relevant and can be included as the knowledge about the research topic evolves. Findings about the TNHPs therefore influence the selection of further TNHPs.

As an additional approach suitable to the goal of the study, snowball sampling (Przyborski & Wohlrab-Sahr 2009:180f) was applied at certain stages of data

collection. Since TNHPs are not officially registered and even difficult to research on the internet, asking key persons and interview partners helps to find out about projects and relevant actors in the first place. It is also a good way to find out about the complex constellations of actors who are involved with TNHPs and opens up the possibility to get different perspectives on one project.

It soon became obvious that donors, recipients and supporters have different interests and perspectives on TNHPs. One of the main aspects of TNHPs is the transfer of money, equipment, ideas, skills, etc. from one party (donor) to the other (recipient). The donor/ recipient concept reflects an attitude that determines many interactions. Interview partners who support a project describe themselves and their partners as being “in need”[29] or as “helping/ assisting”[30]. However, they do not necessarily describe the recipients as the passive nor the donors as the active party in the exchange. In order to identify the direction of flows, it can still be helpful to distinguish between donor and recipient.

Actors who know about a project or are consulted for advice are defined as supporters in the scope of this study. Their perception of TNHPs is often characterized by a certain distance, because they are not directly affected by the project while usually knowing about the influential factors. It therefore became an additional sampling criterion to include the perspective of all three (donor, recipient and supporter). For four out of the five projects included in this study, it was possible to interview at least one donor, one recipient and one supporter[31].

Another attribute that affected the selection of TNHPs was their location, i.e. where in Ghana the engagement was delivered. Because of the infrastructure such as roads and public transportation, places in the North of the country are more difficult to reach. The healthcare infrastructure is also less developed, as the South of the country is more urban than the North. It makes a logistical difference to support a project in a city or in a rural area, and access to the North of Ghana is especially difficult. The efforts of assessing what can be taken into use are higher in a resource poor environment, and the conditions are more difficult (e.g. electronically powered equipment). In order to avoid bias, projects from different areas throughout Ghana were included in the study (see Figure 1 Map of Ghana with Project Sites).

[29] 18_01_01(6); 22_01_01(78); 28_02_01(2); 29_03_01(20)
[30] 03_06_01(16); 03_08_01 (34); 18_01_02(42); 18_02_01 (29); 22_01_01(50); 23_01_02(44); 26_02_01(51); 29_03_01(26)
[31] Due to practical reasons the donor of P5 was neither contacted nor interviewed.

Finally, the variety of transnational engagement was supposed to be captured by selecting individual donors as well as donor communities, persons with a medical background as well as lay people, and private endeavors as well as engagement for established health facilities in the Ghanaian health system.

3.4 Data Processing and Analysis

Five TNHPs have been identified over the period of the research. Depending on the characteristics of each project (e.g. setup, course and current status) as well as the availability of time resources, information was collected from different sources: interviews (between 2 and 8 per project), observations and documents. (Annex E0-E5)

Over the course of the research, a total of 50 interviews were conducted, not all of which are directly related to one of the five projects under study. Nevertheless, all of the interviews have influenced the development of the study either by contributing information on the process of donations, personal experiences, or by referring me to other interview partners of relevance to the study.

The TNHPs analyzed differ in scale (e.g. number of involved actors, capital, duration) and scope (topic, target group).

While most TNHPs are based on two to three key actors who come up with the idea, feel responsible and organize the activities in Germany and Ghana, the wider context of actors involved ranges from a few personal contacts that give mainly moral support, to extended professional networks and contact persons within governmental and non-governmental structures.[32]

The duration of projects differs and the interviews were conducted at different stages throughout the process of the TNHP. The table depicts the status of each project at the time of the interview and the level of activity described by actors.

[32] See Annex E0-E5 for overview of the actors of TNHPs.

Table 1: Sample Description

Project	Topic	(Main) Location	No. of Interviews	Status of the Project	Involved Actors
P1	Donating beds to a hospital	urban	8	Recently completed	Active
P2	Renovation of a hospital ward	urban	3	Partially completed	Mostly inactive
P3	Engagement of a doctor	rural	5	In Progress/ ongoing	Continuously active
P4	Building a clinic in an urban neighborhood	urban	3	In Progress/ ongoing	Occasionally active
P5	CHC[33] in the north of Ghana	rural	4	Not completed	Mostly inactive

For reasons of anonymity, the names of people and organizations or institutions as well as places are not disclosed. Since the location (urban or rural area) matters in terms of infrastructure and healthcare provision, the projects are categorized as “urban” or “rural” areas.

Within the framework of the study, transnational health projects serve as a unit of analysis to which relevant actors are connected and patterns of interaction might be revealed. For the development of the typology, the individual actors have also served as cases (→ 3.5 Construction of a Typologie).

MAXQDA

A special software for qualitative data analysis was used for organizing and analyzing the data collected. MAXQDA (Version 11) is a program that offers tools for qualitative data analysis (Kuckartz 2007). Grouping the coded text according to categories or subcategories and searching for keywords are functions, which help to gain an overview of the material. Furthermore, its features to directly link text with codes or comments support the structured work with the data. The development of categories can be documented over the course of the project by means of memos, which is also helpful when conducting a thematic analysis (Froschauer & Lueger 2003:165). While software for qualitative data analysis simplifies the practical work with large amounts of

[33] Community Health Center (CHC)

texts, the development of the codes is the sole accomplishment of the researcher (Bohnsack, Marotzki, et. al. 2003:30; Kuckartz 2007:57).

All interviews were transcribed in order to analyze the data. An identification code (e.g. 05_02_01_IV) was assigned to each interview. The first number (05) identifies the project or institution, the second number (02) identifies a person and the third (01) indicates the number of the encounter with this person. The abbreviation at the end (IV) identifies the kind of document (e.g. IV= Interview; M= Memo; REC=Recording).

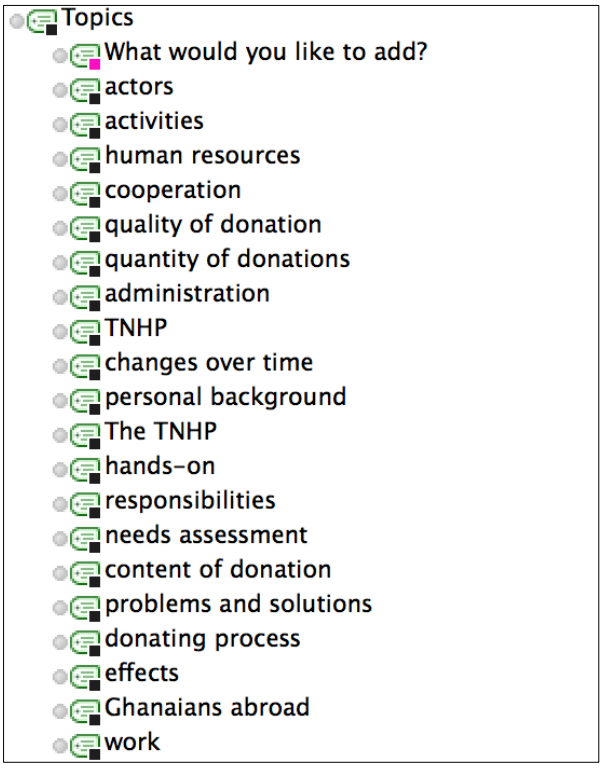
While in Chapter 4 the information are attributed only to interview partners, from Chapter 5 the projects gain more relevance for the analysis of the collected data. Therefore, the information for projects (P1-P5) is added to the identification code in order to give a better orientation to the reader.

Thematic Analysis

The thematic analysis by Froschauer and Lueger (2003) is a method that serves to summarize the data and to identify relevant topics from the text. It looks at the occurrence of topics as well as the chronological order in the narration of an interview partner. Similarities and differences between interviews are identified. The different characteristics of topics are highlighted and put in relation with the research question.

As a first step, the topics were identified from the data:

Figure 2: Topics from the Data



The question “What would you like to add?” was asked at the end of every interview. Since the interview partners often used this answer to repeat the subject that was most relevant to them, the answers are grouped as a separate topic.

The coding of the data then progressed by the development of categories and subcategories (Annex F). The codes of this scheme were summarized under the following topics: Logic/ Region of Engagement, Timeframe/ Duration, Trajectory of the Project, Target Group, Characteristics of Actors, Activities and Interactions, Communication and Cooperation, Documentation and Evaluation, Resources and Motives. These topics provide the structure for the presentation of findings in Chapter 4.

3.5 Construction of a Typology

An additional methodological approach was necessary to develop a better understanding of the complexity of transnational engagement in context of health projects (TNHPs). The development of a typology is based on empirical data as well as theoretical knowledge. Similarly to the thematic analysis described above, Kluge (2000) states that type construction starts from identifying and grouping categories. She defines types as “constructed subgroups with common attributes that can be described by a particular constellation”.

Types are characterized by a high degree of similarity of attributes within a type (internal homogeneity), strong differences between the types (external heterogeneity), empirical correlations between the attributes (“Kausaladaequanz”) and meaningful relationships between the attributes (“Sinnadaequanz”). Kluge (2000) suggests to construct empirically grounded types in four stages:

1. Development of relevant analyzing dimensions
2. Grouping the cases and analyzing empirical regularities
3. Analysis of meaningful relationships and type construction
4. Characterization of the types constructed

The techniques and methods applied depend on the quality of data and can be adjusted throughout the process of qualitative analysis.

TNHPs serve as the research element (“unit of analysis”) in this study. At this point of analysis, or synthesis respectively, the information obtained from the Projects 1 to 5 is being detached from the individual project constellation. The aim is to transfer the information to a more general level that will ultimately allow for developing the typology.

The first stage is to come up with relevant analyzing dimensions. The research question, theoretical knowledge and sampling strategies have guided the process of data collection. As such, they build the basis on which the analyzing dimensions are developed. The results from the Thematic Analysis (→ 3.4 Data Processing and Analysis) (Froschauer & Lueger 2003), which organized the accumulated data in categories and subcategories helped to find the relevant analyzing dimensions.

The following table gives an overview of the (sub)categories that became relevant for the construction of types (see also Annex F):

Table 2: Categories for Construction of Types

Category	Subcategories
Networks	- processes (e.g. course of action, exchange flows) - interactions (e.g. passive/ active, purpose) - relations (e.g. friendship/ family/ professional, frequency) - …
Actors	- motivation - attitude - knowledge/ awareness - experience - qualification - expectations - …
TNHPs	- administration - resources (e.g. money, time, people,…) - background/ development - needs assessment - goal - target group/ beneficiaries - expectations (internal/ external) - formal structures - local structures (integration) - …
Ghanaian/ German System	- assessment - health - Ghanaians abroad - …

The findings from this first stage of building a typology also serve to identify and explore the networks and interaction of Ghanaians living in Germany who are involved in TNHPs (objective 1).

The second stage is to group the cases and identify empirical regularities. Grouping the categories according to striking patterns (e.g. “attitude of actor” combined with “degree of planning” (→ 4.3.3 Communication and Cooperation)) and attributing cases to the categories identified leads to the thematic contextualization of findings. Interests, motivation and resources of the different actors who are involved in transnational health projects (objective 2) are focused upon.

The third stage comprises the analysis of meaningful relationships and type construction. They are based on the identification of strategies and logics of action found in the data (objective 4). By combining the findings, the attribute space is reduced and the categories for the typology emerge. With the categories identified, the cases (interview partners) are assigned to the framework and the typology is constructed.

The fourth and final stage is characterization of the types constructed (→ 5.2 Characterization of Types).

The aim of analyzing empirical regularities and meaningful relationships is to interpret and understand social action. Working systematically through the complex system of categories and subcategories, while comparing different attributes, helps to gain a broad overview of factor combinations. These patterns again can explain activities that constitute the phenomenon of TNHPs. After thorough analysis of data, the construction of a typology reduces, summarizes, concludes and focuses the information collected. It is one of the major outcomes of the study and the basis for the discussion and conclusion.

3.6 Ethical Considerations

Whenever possible, the interview partners were informed well in advance (e.g. via E-Mail) about the topic and interview conditions (Annex G). Before the start of each interview, I introduced myself and the project (again). The interview partners were given the opportunity to put forward their own questions and were asked to sign a consent form (Annex H).

An ethical clearance to conduct the study was obtained from the Ghana Health Service. The official approval of the study was always mentioned in advance to contextualize the study. This information was positively received in health facilities in particular. In a few cases, a copy of the document was presented to the interview partners on request.

The atmosphere of meetings and interviews was characterized by openness, appreciation and a genuine interest in the research topic. Interview partners who

organized their own projects also mentioned the hope to benefit from the attention that the study would generate for their engagement. In a few cases, I was directly asked if I could support their projects financially and if the research program offered any funds to apply for.

4 Analysis: Elaboration of Analyzing Dimensions

The following two chapters present the research findings data and are structured by the objectives (→ 2.3 Aim and Objective) of the study. At the same time the analysis and synthesis represent the successive stages of the construction of types (Kluge 2000).

This first chapter (analysis) gives an overview of factors that potentially influence the development and outcome of TNHPs. Based on the main categories from the interviews (list of codes), strategies mentioned by interview partners and theoretical knowledge about (transnational) engagement, the potential influential factors (attributes) for the development of TNHPs have been identified. The characteristic dimensions are described and possible combinations of attributes and characteristics examined (4.1 – 4.3 (objective 1)). As a next step the attributes "resources" (→ 4.4 Resources) and "motives" (→ 4.5 Motives) are presented, which are crucial to understand the topics addressed in TNHPs (actor's interests), the reasons why actors get involved (motivation) and how they are organizing and implementing their engagement (resources) (objective 2).

The relevant analyzing dimensions (attributes) are the basis to group the different TNHPs according to the specification of their characteristics and by identification of empirical regularities. In the next chapter of the thesis (synthesis), meaningful relationships between the attributes are analyzed and types are constructed (objective 3). By taking all the findings into consideration, the hampering and supporting factors on the development of TNHPs are identified (objective 4).

4.1 Setup of Transnational Health Projects

TNHPs are social phenomena that can take several forms and a complex setup. Based on the existing literature (Gamlen 2006; Chikezie & Thakrar 2005) and information collected from interview partners, the projects under study present relevant facets and forms of diaspora engagement in the health sector. The following section explores the multiple aspects of TNHPs in order to give an overview and identify common and distinguishing characteristics of the different projects.

4.1.1 Location/ Region of Engagement

On the one hand for most interview partners living in Germany makes the engagement for their home country possible in the first place. It is here that they establish the contacts[34], raise funds and earn money[35] to start and continue TNHPs. However, the physical distance comes with multiple challenges that require resources and strategies:

- staying in contact with relatives who are in charge of the projects in Ghana (phone, e-mail)
- seeking advice from friends and acquaintances working in the field of health care and administration[36]
- visiting Ghana regularly to control, continue and handover projects[37]
- supervising contractual agreements with service providers from a distance[38]

Depending on the form of engagement the distance poses different challenges. While for equipment and materials the organization of transport and the resulting costs are a major factor, the supply of services and skills requires time and resources to travel. Transportation of goods and persons within Ghana can be difficult to organize. This usually means that the farther away the destination of goods and services is from the airport or harbor, the more organizational efforts are necessary. Difficulties increase when the selected setting does not have sufficient infrastructure to administrate and receive donations into the system.[39] Therefore, the implementation of TNHPs in Ghana's north is determined by two major factors: first, the shortage of health care infrastructure and personnel creates an obvious need[40]. Second, the lack of infrastructure as well as the distance from economic centers, harbor and airport complicates the logistics of a project and makes certain transactions inappropriate[41]. The difficult conditions often result in delays, increased costs and higher planning efforts.

The experience of my interview partners is that Ghanaians abroad, especially when they come from the northern regions, are keen to help[42]. However, the number of Ghanaians abroad who come from the north of the country is relatively low compared to Ghanaians from the middle and southern regions[43] (Schmelz 2009:11f). While

[34] with fellow country men (03_01_02); through work (32_01_01)
[35] 01_01_01(118)
[36] 28_01_01(32); 32_01_01(24)
[37] 32_01_01(24)
[38] 03_01_02(42)
[39] 28_01_01(11, 32); 18_02_01(33)
[40] 26_02_01(10, 14)
[41] 01_01_02(67); 28_01_01(11); 19_01_02(22)
[42] 19_01_02(16); 22_01_01(68)
[43] 19_01_02(41, 103)

communities come up with their own strategies to attract support from the diaspora[44] (international) Non-governmental Organizations try to increase the motivation of Ghanaians abroad to return and work in the north, e.g. by financially supporting medical personnel[45].

The TNHPs under study show that the location of a project is either determined from the beginning (e.g. based on personal relations with a community (P4; P5) or with an institution (P2; P3)), or it is developed and concretized during the process. The network connections of actors can be valuable resources to acquire information and recommendations (e.g. key person in the national structures of Ghana Health Service (P1) or in Germany e.g. exchange of experiences). The advice and support of a close associate can influence the selection of the location of a facility[46].

4.1.2 Timeframe/ Duration

The time frame can be another characteristic of a project. Whether a project runs long or short term, is primarily determined by the topic (e.g. single donation of equipment, long term partnership such as “adoption of a ward”). While programs (e.g. by IOM) sometimes determine the duration of a project, it more often depends on resources and circumstances[47]. Experience shows that while the time schedule of a project can be meticulously planned, the actual development of a project depends on many factors that cannot always be anticipated. In order to deal with the factor of uncertainty, the interview partners show a high preparedness for spontaneous adjustments and flexibility. The time frame is determined by unexpected occurrences and is adapted according to circumstances throughout the process.

4.1.3 Trajectory of the Project

When interview partners describe TNHPs, they talk about processes and events. Similar to project planning models (Landoni & Corti 2011; BOND 2003; Department for International Development 2003; WHO 1974), the activities mentioned can be grouped into different phases:

[44] 22_01_01(60ff.)
[45] 23_01_02(54)
[46] 28_01_01(11)
[47] 23_01_02(26-28)

Table 3: Characteristics of project phases

Phase	Characteristics
Initiation	idea, opportunity, trigger
Planning	networking, analysis of the situation in Germany/ Ghana, organization of resources, formalities
Implementation	transport, import, installation, handover
Closure/ Prospects	assessment, continuation, sustainability, lessons learned

While TNHPs may have very different timelines, the project phases mostly follow a chronological order. The duration of each phase differs, depending on the project[48]. If the project is part of a program (e.g. MIDA, TRQN) by IOM, the duration of the project might be determined by regulations[49]. Individual timelines depending on personal activities and interests, career (e.g. specialized training for doctors) and responsibilities (e.g. children who are subject to compulsory school attendance) can also determine the planning of TNHPs.

4.1.4 Target Group

By focusing on a target group, the actors can contribute to a special need they have identified. In some cases the donors themselves, or upon agreement with project partners, decide to prioritize one group of people (P2), a community or specific needs because of personal interest (P3), network connections (P4) or material preconditions in the beginning of a project (P5). The focus can also be mandatory or may be recommended by recipients (P1). Due to changes that occur in the course of a project the focus can be adapted, developed or changed.

4.2 Characteristics of Actors

While each of the five TNHPs is set up with a different constellation of actors, the characteristics of actor can be identified in all projects. In the following section, the main characteristics are analyzed.

[48] 01_03_01(44); 01_03_01(90-95)
[49] e.g. from three weeks to a maximum duration of three months for an assignment with MIDA program sponsored by IOM (23_01_02(26))

4.2.1 Classification of Involvement

There are many different ways in which actors are involved with TNHPs. Some contribute with different forms of funding, equipment, services, ideas, moral or spiritual support. Other actors are part of the administrative process[50], represent organizations that impose relevant regulations and conditions[51], or influence the public perception of the project[52]. From an actor's perspective, the involvement can be based on different relationships (e.g. personal or professional). One indicator for the degree of involvement is the investment of resources (as compared to other interests and obligations of the actor, or in relation to the total amount of resources in the project)[53]. Interview partners are aware that donations may create dependency on external support on behalf of the receiving partners. At the project level, it is interesting to consider how dependent the project is on one or more actors, because this can affect the development and sustainability of the endeavor. The donation of materials for day-to-day use as well as equipment for exceptional measures (e.g. to perform special surgeries) complement and expand the recipients' repertoire. But while some forms of support create dependency because the recipients are not in the financial or logistic position to keep up the activities by themselves[54], other arrangements (e.g. training of local staff) are designed to sustainably increase capacities[55].

In some cases, dependency starts already when Ghanaians abroad announce the probable start of a project and promise donations or services, because communities build their hopes on this[56].

When the setup of a TNHP depends on the complex recruitment of personnel, financial support, (medical) knowledge, etc., more organizational effort is required and projects becomes susceptible to delays or come to a standstill.[57]

4.2.2 Individual/ Collective Endeavor

Individual actors often hold a key position within the project (→ 3.2 Methods and Tools of Data Collection). They seem to assume responsibilities and embrace challenges. Donors engage to prove to themselves and to the community in Germany and in Ghana that they can be productive members and contribute. Their personal and professional connections build the basis on which TNHP grow. Groups like hometown

[50] e.g. hospital administration (03_06_01(25f); 18_01_01; GHS (28_01_01(8))
[51] e.g. Ghana Revenue Authority Project Office (25_01_02); IOM (23_01_02)
[52] e.g. district assembly (20_02_02(21)); chief (22_01_01)
[53] "People contribute massively and that-, because contributing 150 Euros wasn't something easy for them." (03_01_02(108))
[54] 03_06_01(30); 19_01_02(16)
[55] 26_02_01(18)
[56] 22_01_01(38)
[57] 01_03_01(74)

organizations and unions, church communities, families and professional networks are described as supportive, resourceful and corrective. Communal decision-making processes and the controlling participation of the whole community are described as a good instrument to prevent the misuse of donated money.[58] Social networks on the one hand provide trustworthy counterparts[59] and, to a certain degree, social control. On the other hand the informal character of social networks also poses risks, since the agreements are not legally binding.[60]

4.3 Activities and Interactions

Actors engage in different kinds of activities and in different ways (e.g. more or less actively). The analysis of activities provides information about their level of involvement in a project. The frequency, occasions, circumstances and intensity of interactions characterize the relationships between different actors.

4.3.1 (Perceived) Effort/ Intensity of Engagement

TNHPs are comprised of phases that demand different forms of engagement of actors (e.g. organization, preparation, presenting ideas, travelling to Ghana,). The duration of engagement, especially the temporary assignments of medical staff in a health facility, is perceived differently. While for the person who provides the service a couple of weeks might equal the annual period of paid leave and are perceived as an extensive effort, representatives of the receiving institutions consider the time of collaboration too short[61]. Depending on the actors' interests and motivation, the activities can be seen from the short/ middle term perspective (reaching a goal, limited to a concrete project) or the long term perspective (interest to help beyond one project, to cause change).

The intensity of engagement (frequency of activities within a certain timeframe) may vary over the course of the project.

Complex relations (e.g. the involvement of many actors), the fact that TNHPs are often subordinated to other responsibilities, and lengthy formal procedures[62] make projects prone to delays. Unplanned and fateful events can also be the cause (e.g. death,

[58] 22_01_01(70)
[59] 01_01_01(61)
[60] "... companies respect contracts and agreements. If he doesn't put it up you can take him to court. But if it's your relative, your friend: you don't have any written agreement with him, if he squanders your money: that's it. It's going to be an argument, you know, and that won't let you get your money back. So I always advice them: get an institution, if you want to do it from there, get into an agreement with the institution, with a witness and you are free." (07_01_03(31)), (see also 04_01_01(75))
[61] 26_01_01(22)
[62] 25_01_02(35)

sickness[63]). Especially when key persons are affected, the whole project can be at stake.

4.3.2 Categories of Activities

When actors describe TNHPs, a major part of the account consists of activities which they plan, perform, have done, consider important, or which they expect from others. While most activities relate to specific phases of the chronological project trajectory (initiation, planning, implementation, closure/ prospects), they are also connected to roles that people assume in the context of the project (donor, recipient, supporter).

Table 4: Identified Activities of Donors, Recipients and Supporters

(note: the table shows neither the intensity nor the frequency of interactions)

	Donor	Recipient	Supporter
Initiation	- have an idea - seize an opportunity - define project identify project aim(s) - contact with recipient/ consultation[64] -	- attract attention for needs[65] - develop and promote guidelines	- promotion of support programs, finding participants[66] - develop and promote guidelines
Planning	- networking - organization of resources - formalities[67] - seek/ give information[68] - convince potential partners[69]	- needs assessment[70] - negotiations with the donor[71] - formalities[72] - connect with community members[73]	- formalities[74] - background checks of program participants[75]
Implementation	- transport/ import/ hand over	- organize handover ceremony[77]	- monitoring (dependent on

[63] 01_03_01(23); 01_01_01(51)
[64] 03_03_01(30)
[65] does not necessarily need to be a recipient, information about needs are also spread by relatives and friends as well as experiences that the donors make themselves.
[66] MIDA (IOM) 03_01_02(38); CIM 07_01_03(33) needs assessment of the country: health sector one of the main areas
[67] e.g. apply for funding
[68] about project, partners, needs, requirements, resources
[69] 03_01_02(104-108)
[70] 03_04_01(9)
[71] 18_01_02(4)
[72] e.g. application for MIDA program, assisting donor with official statements
[73] in some cases the community, in which the project is set up, plays a crucial role in terms of building and supply of manpower, integration and acceptance.
[74] e.g. Customs: approval of exemptions; IOM: organization of project assignments; MoH/ GHS: mediation between donors and recipients.
[75] 23_01_02(22-24)

	donation - render services[76]	- training[78]	resources), monitoring report[79]
Closure/ prospects	- evaluation[80] - planning further steps[81]	- acknowledgment[82] - documentation - handle donation[83] - maintain contact[84]	- evaluation at the country level by MoH[85]

The activities are listed in the order of successive steps that are completed to establish a TNHP (→ 4.1.3 Trajectory of the Project). The interview partners point out crucial phases (e.g. needs assessment) and describe how all the activities contribute to the progression of the projects. It is important to note that projects do not necessarily include all the steps.

Most of the activities involve more than one actor. The interactive character of TNHPs is also reflected in the fact that donors, recipients and supporters uniformly stress the importance of communication at all phases of the project trajectory. The exchange of information between donors and recipients is an interaction that requires the initiative of both sides.[86]

Interview partners state that, over time, recipients have gained more influence on the donations they received. Negative experiences with donations[87] have motivated some institutions (e.g. hospitals, MoH) to develop donation guidelines (→ 2.2.3 Attempts to Aid Regulation in the Ghanaian Health Sector) focusing on the recipients' benefits, usefulness and quality standards. As a result, recipients are in a better position to put forward claims. Nonetheless, recipients are in the difficult situation of having to communicate demands without disregarding the good intentions of donors, who make efforts and provide services voluntarily and sometimes at high personal cost. So while recipients (need to) become more active for their own interests, donors face the challenge to react on demands with limited resources.

[77] e.g. funfair
[76] 03_05_01(7)
[78] e.g. learn how to handle new equipment (03_07_01(58))
[79] 23_01_02(28)
[80] e.g. assignment report (23_01_02(28))
[81] expansion, new projects
[82] e.g. write appreciation letter (03_05_01(73))
[83] can be positive (makes work easier/ services possible) or negative (when items are expired or do not fit into the environment)
[84] 18_01_02(78)
[85] 29_01_02(26-29)
[86] Exchange relationships and the resulting network structures for each project are depicted in project diagrams in the annex.
[87] expired drugs, no manual, instruction leaflet in foreign languages (03_03_01(28))

4.3.3 Communication and Cooperation

Beyond the content and the form of communication, the course/ character of a TNHP is also influenced by the attitude of the actors (rather active/ rather passive approach). At the same time, the development of a TNHP is also strongly influenced by the degree of planning that actors apply.

By cross-tabulating the two attitudes with the planning approach, different types of communication and cooperation can be deducted ("spontaneous", "systematic", "demand driven").

Table 5: Types of Cooperation Derived from Actors' Attitude and Planning

	Degree of Planning	
Attitude of Actor	Not planned	Planned
Active	**Spontaneous**[88]	**Systematic**[89]
Passive	**demand driven**[90]	

The TNHPs (P1 - P5) provide examples for the different types of communication that can have positive and negative effects. P1 is characterized by rather active donors as well as recipients. The mixture of planned and unplanned elements results in a focused endeavor, which at the same time is flexible enough to react to requirements that emerge along the way (e.g. while the item of donation (hospital beds) was clear, the final destination was planned considering the advice of a GHS representative). While P2 also started out actively and followed a plan that was coordinated with the receiving institution, the actors became passive during the course of the project. It stagnated and was eventually demand driven or rather determined by the availability of resources. P3 is another example for a situation where the active attitude of a Germany-based Ghanaian doctor, in connection with well-planned procedures (e.g. agreements with German employer, IOM, receiving hospitals in Ghana), result in a mostly satisfying project for all partners. It is complemented by spontaneous activities that fit into the plan (e.g. the idea to perform teaching during the visits). P4 on the other hand illustrates what can happen when an active attitude (large number of ideas) coincides with a low degree of concrete planning: the activities are not focused and unlikely to be successfully concluded. After the initiation of P5 (activity by potential recipient) all

[88] P1; P3; P4
[89] P1; P2 (initial phase); P3
[90] P2 (implementation); P5

partners became passive. Even though plans exist, the activities depend on circumstances that cannot be influenced by the involved actors.

4.3.4 Documentation and Evaluation

The previously presented logics of action can be mostly attributed to the planning and implementation phase of TNHPs (→ 4.3 Activities and Interactions). Assessing activities at an advanced stage of a project, when interview partners are able to document and evaluate engagement as well as potential future developments, shows what lessons can be learned in the course of a project. The retrospective assessment of a project depends on the role and interests of an actor or, to put it differently, a project can be seen from various angles. The actors also have different ideas of what sustainability means in the context of their engagement.

Actors assess TNHPs retrospectively for different reasons: some programs (e.g. by IOM) require formal reports at different stages of the process (P3). Reports are a monitoring instrument used by the sponsoring organization, which is aimed at delivering relevant information to evaluate the implementation and effects of projects. Adding to the obligatory character of the documentation, the prospect to continue and to receive more funding can motivate the participants to achieve positive results.

The documentation of successfully completed projects is also used in a less formalized but still intentional manner, in order to create a positive public perception and to convince (potential) partners to cooperate. Letters of appreciation and newspaper articles are examples of documenting the trustworthiness, competences and experiences of project partners.[91]

Even if the implementation of TNHPs was not always documented systematically before the interviews, the oral statements show that all interview partners reflect the development of their project, assess it more or less critically and draw conclusions for future planning.

[91] P4; P2

4.4 Resources

Different kinds of resources contribute to the performance of TNHPs. The interview partners describe the following (→ 2.1.4 Resources and Social Capital):

Table 6: Resources of TNHPs

Resources	Examples
Monetary	money in form of donation[92] investment[93] refund[94] co-financing[95] salary[96] personal savings[97]
Material	technical equipment[98] equipment like hospital beds, consumables, medical/ non-medical items purchased in Germany to distribute in Ghana[99] property of land[100]
Structural	infrastructure like harbor, airport, routes of transportation institutional structures legal regulations (regulations, policies)
Social	personal networks (family, friend) professional networks (colleagues, business partners)) good friends[101] family members networking skills (passive (knowledge about structures and actors, personal contacts), active (strategizing, communicating, approaching)[102]
Human	to train medical staff[103] to render services organize the support through medical staff
Immaterial	time, ideas[104] experiences knowledge (cultural, professional, medical, structural, information, advice, instructions[105], knowledge about procedures[106])

[92] regular and exceptional member fees (03_01_02(33, 77))
[93] e.g. buying equipment, medication, consumables (in Ghana or abroad); paying for services, insurance.
[94] e.g. IOM or local facilities who refund program participants for food/ transportation/ accommodation.
[95] e.g. GIZ (Gesellschaft für Internationale Zusammenarbeit) -programme (80% of total costs)
[96] 01_01_01(110)
[97] 01_01_01(110, 118); 01_03_01(45); 22_01_01(4)
[98] incubators (18_02_01(33); 18_01_02(4))
[99] 01_01_01(51); 26_02_01(29)
[100] 01_03_01(29-31)
[101] 01_01_01(114)
[102] Communication (01_01_01(59)); family members (01_03_01(29-31)); project partners (01_03_01(50)); supporters (01_01_01(56))
[103] training to use equipment (26_02_01(14))
[104] 01_01_01(114)
[105] 01_01_01(37)
[106] 01_01_01(59)

Some resources are mainly related to donors (e.g. funding, skills) and others to recipients (e.g. personnel, infrastructure). Most resources can be ascribed to both groups.

Even though a professional medical background can certainly be an advantage to conduct a TNHP, recipients made the experience that laypeople are just as interested and involved in organizing medical donations[107].

Most of the resources can be further categorized by the quality, quantity, frequency, continuity and duration in which they are applied or drawn from.

Table 7: Manifestation of Resources

Manifestations of Resources	Examples
Quality	Private/ community funding, focus on areas of need (e.g. training, services)[108]
Quantity	Sharing of costs between donor and supporter[109], depending on capacity of donors
Frequency	Depending on demand/ needs in Ghana[110]
Continuity	regular supply with medical material[111] reliability of refunds[112] networking (as a process)[113]
Duration	Duration of a program (e.g. MIDA ended in 2012, TRQN runs till the end of 2015), min./ max. period of funding

The combination of resources varies from project to project. While some projects have the tendency to rely on a strong network of personal and professional connections that also generates funds from different sources (P1; P3), other projects are mainly based on ideas and convictions but the networks are not supplying the necessary funds to implement the plans (P2; P4; P5). The projects examined show that, while ideas are the basic precondition for a TNHP, the availability of monetary and human resources is crucial for the implementation of a project.

[107] general interest in hospitals (28_01_01(34)) lay people/ medically trained
[108] 26_01_01(14)
[109] 26_02_01(25)
[110] 26_02_01(31)
[111] “always bring them some medical material” (26_02_01(29))
[112] “The bill is still lying there. From May up to now that I am speaking to you. And nobody is talking about it.” (26_02_01(51)
[113] 26_01_01(5)

4.4.1 Monetary and Material Resources

The scale of TNHPs can also be measured in terms of monetary and material resources. Depending on the projects' objective, the material assets and costs incurred in connection with logistics can be very different.

Table 8: Total costs of TNHPs

Example of Project	Components of Total Costs
Donation of Hospital Beds[114]	value of the used hospital beds[115], costs for cleaning the beds and preparation for the transport, transportation (logistics), travel costs for donors to hand over the donation personally
Provision of Training and Services[116]	travelling costs, time ((unpaid) leave), consumables, time and effort of voluntary work (in Germany and Ghana)[117]
Support of a Hospital Ward[118]	Refurbishment costs (e.g. services and building material), training courses on funding opportunities[119], time and effort of voluntary work (in Germany)

Even though it might be possible to calculate the value of equipment or estimate the costs of time spent, it is not sufficient to add up the figures. In order to account for the actual/ total cost of a project, immaterial and personal factors need to be considered as well.

Contributions are subjectively rated differently[120]. Depending on the financial situation of a person or a group of people, regular contributions (e.g. membership fee[121]) or unexpected costs (e.g. caused by delays regarding the import of goods[122]) can place a burden on the individual person. When the project exceeds the financial means of people involved their livelihood can be affected directly (e.g. by taking up a loan from

[114] P1
[115] "…die Einrichtung-, Betten-, die ganze hat ungefähr 90.000 Euro gekostet" (32_01_01(15))
[116] P3
[117] "So if I stay four weeks, ten days are free from the hospital [in Germany] and ten days are taken from my holiday." (26_02_01(32))
[118] P2; P5
[119] e.g. by "bengo" a consultancy service for NGOs that assists in applying for funds to participate in course costs about 40 Euro. (https://www.engagement-global.de/bengo.html) [Accessed 27.09.2017]
[120] "I send a lot of money" (01_01_01(20)); "…it is costing so much money" (01_01_01(47)); "…we (the hospital) buy huge volumes of consumables, equipments and pharmaceutical products, drugs or products for our operations. So if you compare it into percentage wise (...) it's significant but not that overwhelming". (03_06_01(46))
[121] 03_01_02 (33, 77ff.)
[122] 01_01_02 (67)

the bank[123]). A lack of money also can be the limiting factor that brings the implementation of a project (temporarily) to a halt[124].

(Presumed) responsibilities and running costs (e.g. for the livelihood and wellbeing of other people who work for the project and need to be paid[125]) put pressure on donors and increase the subjectively estimated value of the efforts.

The sources of funding for TNHPs are as different as their content and the actors involved: from institutions, facilities and companies delivering (used) goods and expertise, to organizations and (non) governmental programs contributing partly and proportionally to costs incurred in connection with the project (e.g. IOM that grants daily sustenance, travel and material costs[126]; on behalf of the Federal Ministry for Economic Cooperation and Development Engagement Global has a program that covers 75% of transportation costs[127]; Ghanaian government that grants import duty exemption). Finally friends, group and family members may give according to guidelines (e.g. membership fees), to current need or personal resources and ability.

In order to access monetary sources the actors need to interact with different contact persons (e.g. family and community members, friends, colleagues, representatives of organizations and formal structures). Therefore the knowledge about administrative structures and eligibility criteria is essential to organize funding. Experience helps to navigate the system.

The focus on one source (e.g. support of government, IOM, one group of people) can be enforced by network connections. Since funding has a major impact on the development of a project, it is crucial that funding is stable. In order to achieve continuity in financing actors strive to find reliable partners for their projects that have sufficient means (e.g. (international) organizations and businesses) and shared interests. Drawing support from many sources simultaneously is another common way to set up a TNHP[128]. Actors' strategies for organizing funds depend on their network connections as well as their skills to generate innovative ideas and to convince potential partners.

The procurement of resources is based on different skills, characteristics and preconditions (e.g. communication skills, relationships, patience and time). Hence the required effort to reach the project's goal may vary according to the personal resources of an actor. Depending on the project, the requirements can be different as well.

[123] 01_01_02(65)
[124] 01_03_01(44); 03_01_02(38)
[125] 01_01_01(37, 51, 118)
[126] 23_01_02(25); 26_01_01(25ff.)
[127] http://www.engagement-global.de/tkz-transportkostenzuschuss.html [Accessed 27.09.2017]
[128] P2; P4

The data analyzed shows that unexpected costs[129], delays caused by organizational procedures and unreliable project partners can be challenging factors for the implementation of a project. Contrary to initial ideas and plans, the costs of a TNHP often develop in the course of the project and depend on/ are limited by the available resources.

4.4.2 Structural and Social Resources

Social networks that rely on personal relationships are described by actors as an essential part of TNHPs and an important point of reference. On the one hand, they can be enabling when they encourage and support actors within official structures and help to acquire information about local needs, key persons, official donation procedures and criteria. On the other hand, the personal networks are relationships that are based on reciprocity and require cultivation of contacts, consideration of family responsibilities and duties that at times can also be obstructive[130].

The actors raise support and funding for a TNHP across national borders. They mobilize resources from family members, friends and colleagues who live on different continents[131], are part of international religious communities[132] and connected with international organizations[133]. Mobilizing resources means to organize advice, use infrastructure and raise funds. The degree of organization and structures varies and implies different levels of obligation and therefore reliability (e.g. from loose connections of ideational support[134] to registered unions with membership[135]).

Social networks can influence the actual costs of a project as well. While personal relationships can be a reliable basis that fulfill tasks as a personal favor or in the context of community activities and costs can be saved (e.g. when the hospitals beds in P1 are cleaned by members of the hometown association), the obligations that bind activities to a certain region (e.g. the North of Ghana) can also increase the costs for transportation and lead to less efficient choices.

The TNHPs take place within social, institutional and legal, national and community structures in Germany and Ghana. The actors also establish and strengthen transnational connections, influence framework conditions and create new interdependences with their activities (→ 2.1.2 Transnational Social Spaces).

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[129] 01_01_02(65)
[130] Ghanaians who live and work abroad want to contribute to their home country (33_01_01(3)) sometimes expectations are high (02_01_01(105)) and can lead to the decision not to get involved with Ghana and even break off the contact with family and friends.
[131] 01_03_01
[132] 01_01_01(69, 81); 01_01_02 (25, 31)
[133] 26_02_01
[134] 01_01_01(112)
[135] 03_01_02(73-80)

Structures range from social networks over institutional structures and legal regulations to infrastructure. The observed characteristics of structures are presented according to countries:

Table 9: Characteristics of Structures in Germany

Example	Characteristics of Structure
Social Networks (e.g. family, friends, service organization, Home town associations, Unions, (religious) communities))	- acceptance and support of voluntary commitments[136] - interest for the cause - duties and responsibilities e.g. for (school-aged) children[137] - resourceful members - platform to make new contacts with people of different backgrounds - organize activities that focus on the country of origin - fundraising platform (internal/ external)[138] - concentration/ pooling of resources - informal/ formal (registered organization[139])
Institutional Structures (e.g. working context, (non) governmental institutions and development cooperation (e.g. GIZ, IOM, Ghanaian embassy))	- limited holidays - special arrangements for extra holidays[140] - medical field: access to information and networks[141] terms and conditions of funding[142] - contact point to seek information[143]
Legal Regulations	- Citizenship - Residence status - (export) laws
Infrastructure digital media (phone, internet,…)	- constant exchange of information with home country

[136] 03_01_02(7)
[137] 03_01_03_IV_memo
[138] 22_01_01(33); 03_01_01(38)
[139] “eingetragener Verein”(32_01_01(15)); 03_01_01
[140] 26_02_01(32)
[141] 32_01_01(9)
[142] 32_01_01(17)
[143] 32_01_01(32)

Table 10: Characteristics of Structures in Ghana

Example	Characteristics
Social Networks (e.g. family and friends, local communities, districts[144],…)	- emotionally charged network of duties and expectations by family and friends - close family members supervising TNHPs/ contracts with service providers and reporting back - former fellow students and colleagues (med. field) - decision-making bodies (community chief/ elders, district assembly)[145] - key persons from the field
Institutional Structures Health system (MoH, GHS, hospitals, health centers, Ministry of Finance, Customs	- responsibilities (e.g. committees, departments, key persons)/ regulations - donation policies (institutional) to improve content and procedures of donations
Legal Regulations	- donation policies (national) to improve content and procedures of donations - exemption, waiver of tax
Infrastructure	- access roads - reliable electricity supply

4.4.3 Human and Immaterial Resources

From the data collected, a wide range of qualifications, experiences, values and different forms of knowledge were identified. They contribute to the competence of actors that accounts for their involvement in TNHPs.

Skills of people who contribute to the projects can be acquired through formal education (e.g. qualifications in the medical field), may be learned by experience and practice (e.g. writing applications for funding, bureaucratic processes) or are part of their political/ social/ cultural background and their character (e.g. creativity, persistence, faith).

[144] possibly add information from 20_02_02 and 20_01_03 (experiences from district level)
[145] 22_01_01(58)

Table 11: Types of Competences

Qualification	(medical) education and training[146] additional training (health related topics)[147]
Experiences	(inter) cultural interaction (in Ghana and Germany)[148] administration (e.g. logistics, legal regulations, funding)[149] network connections (personal or professional)
Knowledge	Facts (e.g. about provision of health care, deficits, needs[150]) Processes (e.g. customs, donation guidelines) As a commodity (e.g. give trainings, educate med. students)
(Social/ Political/ Cultural) Background and Values	Family/ community/ society Career, Profession Social status/ Chief, elected politician
Character/ Personality	creativity, persistence, faith, communication skills,…

One of the characteristics of TNHPs is that they involve actors from different countries and cultural backgrounds. Different administrative systems and cultural particularities create a complicated system of requirements and expectations. Interview partners who have been working and living in Ghana and Germany claim to know both systems. They are able to compare, to identify positive and negative characteristics of both systems and develop strategies.[151]

Donors as well as recipients describe institutionalized and organized forms of assistance to TNHPs by governmental and non-governmental actors as helpful. For some projects, they supply important advice and financial support[152]. However, when actors report from practice, it becomes apparent that programs and procedures meant to facilitate the process of TNHPs are not always appreciated or just not known to the actors. The phenomenon of information being difficult to access and a lack of knowledge about regulations and support structures can be found on all levels (e.g. information from customs and hospitals is not available online, representative of

[146] 01_03_01(56, 62); 28_01_01(35)
[147] 01_01_01(63)
[148] 01_01_01(45); 20_02_02(27)
[149] 03_01_02(17); 03_01_02(51)
[150] 03_06_01(60)
[151] 03_02_03(38)
[152] P1; P3

Ghanaian embassy does not know about Guidelines for Donations published by MoH, Ghanaians interview partners in Germany are not aware of policies or guidelines).

Regarding the effect of legal regulations, it can be noticed that the interview partners do not see Ghanaians living abroad as contributing less to their home country if they take up German citizenship or are well integrated in Germany. On the contrary: the interview partners in Germany were all well integrated (e.g. in terms of labor market integration, education, housing and civic engagement) (Organization for Economic Co-operation and Development (OECD) & European Union 2015) and involved with TNHPs.

The donation of medical equipment does not necessarily require medical training or medical knowledge. Very often, lay people are involved in TNHPs.[153] While formal qualifications and work experience are important to fulfill requirements of the Ghanaian health sector (e.g. registration with the regulatory bodies like the Medical and Dental Council for doctors[154]) and international organizations (e.g. MIDA, TRQN[155]), the interview partners describe communication skills and trustworthiness as most important preconditions to set up a successful project.

Most actors, especially donors, are emotionally involved (→ 4.5.2 Motivation) - no matter if they approach the project mainly personally (e.g. links between one's own career and the initiative to help supporting the home community, family and friends) or professionally/ technically (e.g. formal requirements, details about equipment or news coverage). As a result, the experience of frustration and disappointment is an integral part of a TNHP. The interviews show that the actor's resources influence the way in which negative experiences are handled, and what consequences they have on the process of the project.[156]

Communication is one of the basic preconditions for every project. In chapter 4.3.3 communication between different parties (e.g. project partners, colleagues, authorities) and at different stages of a project was identified as a crucial ingredient to run a TNHP.

It can be challenging to exchange information over a long distance and between locations that are characterized by different economic, environmental and cultural circumstances. Through activities in the context of TNHPs, existing interactions are expanded and new arrangements are created: very often, the exchange of information between Ghana and Germany already is an integral part of actors' everyday life. In the transnational context, the actors often communicate virtually via the internet (e.g. Skype, e-mail) and over the phone. They use telephone and internet to stay in contact with family and friends and to follow closely what happens in Ghana. The technology enables Ghanaians in Germany to connect with fellow Ghanaians, to discuss project

[153] "So, yes there might be some medical people within the groups but generally those that come are not-, are not medics. Yeah. Ordinarily lay people who have the interest of hospitals. Hospitals in their areas at heart and they think that they can contribute to-, yeah, building them." (28_01_01(34))
[154] 31_01_01(91)
[155] "...have a professional or university education and at least three years of relevant work experience" (IOM The Netherlands 2012:2)
[156] concrete: 26_02_01(29); vague: 01_01_02(31)

ideas, to join forces, to respond quickly to current projects and to keep track on developments.[157] In order to implement and support TNHPs, (regular) communication about needs is important.

But even when digital media has simplified and increased communication, it does not substitute visits and personal meetings. The necessary mobility requires time and financial resources to organize (regular) visits. These can be done by one person, or can be shared between a group of people[158]. Personal interactions (e.g. during holiday, work stay) are rare and come with a high degree of organizational effort and costs. Communication skills (e.g. to explain the facts of a project to a group of sponsors, showing interest in the concerns of a receiving institution, dealing sensitively with the expectations of actors on a voluntary basis) - all these are critical factors to create personal/ professional relationships on which projects can be built.

Even if the organizers of TNHPs have spent most of their life in Ghana, this does not necessarily mean that they are familiar with the health system, bureaucratic procedures or current needs. For the progress of a project, it is important that actors know or are able to find out who they have to talk to in order to get information or support. Communication is a precondition for and an integral part of cooperation, so competences (e.g. knowledge about structures, procedures and sources) as well as personal relations and networks are equally important to perform TNHPs (→ 4.4.2 Structural and Social Resources; → 4.4.3 Human and Immaterial Resources). Ghanaians abroad often rely on relatives, friends, colleagues, but also on formal structures, as sources of information and support.[159]

4.5 Motives

Interests, motivation and resources are closely connected and at times mutually dependent. In order to explore the phenomenon of TNHPs and to show the different dimensions of engagement, they are considered separately in this section.

Taking into account that donors, recipients and supporters have slightly different perspectives on particular TNHPs, the findings are presented separately for these groups.

4.5.1 Content/ Topic

A TNHP is strongly characterized by its topic/ content. From the data collected, the following forms of engagement can be identified:

[157] 04_01_01(100); 33_01_01(3)
[158] friends and community members can take over/ who ever travels can take over the responsibility (P1; P2)
[159] P4: 01_01_01(20, 59) (daughter), 01_03_01(56) (brother); P2: 03_01_02(15) (sister); P3: colleagues

- ✓ goods (e.g. hospital beds, medical items, drugs, children's cloth [160],
- ✓ services (e.g. medical services, training and teaching of medical staff[161] and
- ✓ funding (e.g. to organize renovation and construction work).

Depending on the project's content, the demands on the actors involved vary. While all projects require certain qualifications of the actors (e.g. organizational skills), the degree of complexity in terms of network connections, knowledge about administrative procedures, medical knowledge, personal time, etc. may differ.

Actors have multiple reasons why they are committed to a certain cause. While some of the projects evolve around one topic, others are based on an initial idea that develops and changes with experience and over time. Other factors that influence the content of a project are individual attributes (e.g. commitment and creativity) of actors and the expectations on all sides (donors, recipients, consulting organizations). The analysis shows that content and destination of transnational engagement in the area of health are closely associated with the donor's personal and professional background (e.g. home community and medical education).

Most of the TNHPs have one clear topic. For example, the actors want to donate equipment to a hospital, open up a clinic or give trainings for medical personal. Furthermore, the activities are described as measures that, in the long run, aim at generally improving access to health care, the delivery of health care, and general human development in Ghana. The interviews showed that the interests described by donors correspond to how the recipients and supporting actors assess the topics and intentions of TNHPs.

Nevertheless, even if TNHPs evolve around one topic, the requirements to reach the goals and the planning that actors need to provide differ for each project.

The decision about which project donors get involved in is influenced by their personal and professional experience, but it does not necessarily depend on a professional background in the medical field.[162]

Interview partners also describe that the interest of donors develops over the course of a project: while some TNHPs stagnate and are not completed, the initial project can also expand (from rendering medical services to training for local staff and the organization of a study visit to Germany (P3 [163]), activities are added and (ideas for) new projects evolve, e.g. from donating equipment to the idea of supporting research

[160] P1: 03_05_01(58)
[161] 26_02_01(10)
[162] 28_01_01(34)
[163] 26_02_01(18)

activities focused on malaria (P1 [164]).

From the recipients' perspective, the supervision of donors (e.g. organization of events for (potential) donors, following up on donations), and the development of guidelines, are also relevant topics to deal with.

Supporters of TNHPs (e.g. governmental institutions and international organizations) often engage in the formalization of the donation process. They develop and implement support programs, and they work on legal conditions and national standards.

Table 12: Interests of Donors, Recipients and Supporters
(see also table 14 Development of Specialization)

	Interest (what?)
Donors (e.g. initiator, Ghanaians in Germany)	- donation of equipment - supply of services[165] - give trainings/ teach[166] - make a change[167] - visibility, publicity, recognition[168] - contribute to development[169] - interest in hospitals[170] - contribute to the medical sector in Ghana [171] - improve access to health care[172] - change health care (access/ delivery) in Ghana (for the better)[173] - directed towards a target group[174] - ambition, power, influence, (political) career) [175]
Recipients (institutions, communities)	- improve health care[176] - build networks (e.g. by the organization of festivals[177]) - ensure standardization of donated products, equipment and services (e.g. by formalizing the implementation process of TNHPs)[178]

[164] 32_01_01(74-88)
[165] e.g. renovation (03_01_02(33))
[166] 26_02_01(21)
[167] "We want to change the way they deliver healthcare", "…learn from the western world" (01_03_01(79))
[168] within the Ghanaian community in Germany, (letter of appreciation, in order to prove success to donors (03_05_01(74)); evidence (18_01_02(26))
[169] e.g. national development (01_03_01(85)); development of a community (22_01_01(97))
[170] 28_01_01(34) general interest in hospitals (lay people/ medically trained)
[171] 28_01_01(34) general interest in hospitals (lay people/ medically trained)
[172] "Everybody who comes here, whether you have money or not, our goal is to treat you." (01_03_01(79)
[173] "…attitudinal change in Ghanaian health workers. I mean-, what I mean by that is there is a lot of lackadaisical attitude in health care in Ghana." (26_02_01(19)
[174] e.g. children (P2 (03_05_01(56); 03_08_01(4)); community of home town (P5)
[175] assume a position that allows to get involved (32_01_01(9))
[176] 22_01_01(97)
[177] 28_01_01(25)
[178] 29_03_01(24-26)

	- enhance standards of living[179] - attract donors[180] - ensure standards/ quality/ continuity
Supporters ((inter-)national organizations, actors from the Ghanaian health sector)	- programs to facilitate engagement of diaspora[181] - development of national guidelines - improve healthcare - ensure that the donation process is formally correct[182] - benefit for Ghanaian tax payer (→ responsible allocation of exemptions)[183]

Connections that exist before the beginning of a project may direct the activities towards a certain group of people, a facility, a community or an area. Examples for target groups from the research are:

- Children of a certain age/ who are sick/ need medical care[184]
- Population of a certain area/ community (home community)[185]
- Collaboration with former colleagues and institutions (e.g. in hospitals or employees of the Ghana Health service), friends and family[186]

Ideas, priorities (demands/ needs) and opportunities (coincidences/ resources) also play an important role in this process to select and pursue a subject.

The data shows that there is no defined order in which the factors come together. The opportunity to procure discarded but functional hospital beds may as well be the starting point for a TNHP as the awareness of deficient health care in the home community or the idea to found a hometown association in Germany. The mutual influence of focused planning and coincidence seems to be a characteristic of TNHPs that should be considered in this analysis.

Types of content

Possible forms of donation are: goods (e.g. hospital beds (P1), medical material (P3[187], P4 (hospital beds, facility), provision of services (P3 training students and hospital

[179] 22_01_01(97)
[180] 28_01_01(25)
[181] e.g. IOM, GIZ, MoH/ GHS, customs
[182] 25_01_02(8)
[183] 29_03_01(24)
[184] P2
[185] P1; P5
[186] P3; P4
[187] 26_02_01(29)

staff) or funding (paying for renovation works (P2), money P5[188]) to a TNHP. The projects show that when actors decide to get engaged, the trigger to do so can be based on different resources (→ 4.4 Resources) (e.g. own competences) and qualifications (e.g. medical qualification or knowledge about bureaucratic procedures, network connections, the ability to generate money and mobilize support) as well as opportunity (e.g. to obtain hospital beds as a donation).

The triggers named above may also influence the process of specialization during the course of a project. Depending on the degree of organizational effort (high/ low) that is necessary to supply the resources required, the availability of content and therefore the specialization of a project will develop.

Table 13: Effects of availability of resources on specialization of TNHP

Resources	Organizational Effort	
	high	**low**
Monetary	P1, P2, P3, P4, P5	
Material	P2, P4	P1 (opportunity), P3 (professional access), P5
Structural	P1, P3 (own car), P4	P2 (no transport), P5
Human	P1, P2, P3	P4, P5
Immaterial	P1, P2, P3, P4, P5 (time)	P1, P2, P3, P4, P5 (experience, ideas, knowledge)
Social	P1, P2, P3, P4, P5	

Even though resources theoretically exist (e.g. knowledge about sources, formal structures, processes and contact persons) utilizing them for projects can still be a complex and labor-intensive process. High organizational effort always implies that more time is required, delays are likely and changes (depending on availability of resources) are common. Some resources (monetary/ social) are associated with a continuous high level of effort to initiate and continue the project. Immaterial resources have different characteristics: while experience, knowledge and ideas are accessible for all analyzed projects, time to contribute to a project is a resource that is scarce and needs to be organized.

[188] 22_01_01(18)

Opportunities occur and are difficult to calculate with. The required effort can be found in the process leading up to an opportunity (e.g. extensive networking activities[189]) and the tasks that result from an opportunity (e.g. organize transportation for donated hospital beds, generate publicity for the donor).

Table 14: Development of Specialization

Basis of Specialization	Development of Specialization	
	predetermined/ from the beginning	**not fixed during the process**
Type of content Goods Funding Services	(available material resources) (competences, skills, qualifications) ((knowledge) about sources, networks)	
Location	P1, P3, P4	P2, P3, P4, P5
Time Frame (certain time, duration)	Some points, determined by organizations	Great majority of events

4.5.2 Motivation

When actors describe why they are engaged with TNHPs and explain diaspora engagement of Ghanaians, it becomes apparent that there are multiple reasons and influential factors that determine the activities.

The main categories of reasons can be related to:

- personal connections and relationships (e.g. relatives, friends, communities,…)
- values (e.g. social norms, cultural background,…)
- expectations (e.g. by others, self-imposed)
- interests (e.g. personal, common)
- resources (e.g. position in a network, financial ability,…)

While almost all TNHPs have the (in)direct goal to improve health care for the people in Ghana (→ 4.5.2 Motivation), other reasons to be involved with TNHPs can be associated with the perspectives of donors, recipients and supporters:

[189] 26_01_01(5)

Table 15: Motivation of Donors, Recipients and Supporters

	Motivation (why?)
Donor (e.g. initiator, Ghanaians in Germany)	Relationships: stay in touch with Ghana[190], intended return to home country[191], sense of belonging (country/ community/ family)[192] Values: faith, religious beliefs, charity[193], altruism, sense of justice[194], concept of reciprocity[195], pity, want to help[196], faith in God (specific) hopes[197] Expectations: contribute (duty, obligation)[198], determination (responsibility)[199], not feeling accepted in Germany[200], success[201], security[202] Resources: capacity, competence, qualification[203]
Recipient (institutions, communities)	Relationships: trust based on personal relationships Expectations: general support[204], good quality equipment and products from Germany[205]
Supporters ((inter-)national organizations, actors from	Expectations: ensure standards/ quality/ continuity[206]; awareness of the potential of TNHPs for national development;

[190] "To see and explore what is happening in the Ghanaian sector as far as their field of experience is concerned." (03_06_01(12)); get involved on a political level (04_01_01(105); 08_04_01(22))
[191] come home to help (01_03_01(85)); to work, to retire (19_01_02(61)); increase personal visibility, future plans of a political career in Ghana (19_01_02(12))
[192] feeling connected "…because they are citizens-, they are citizens of this place" (18_01_02(44); improve health care so that the relatives benefit
[193] 01_01_01(57, 99)
[194] "But I still do because I just know that is how they are, so, lets forget about them. Because if I don't forget about them, if I get angry about their action it is somebody else who is going to suffer." (26_02_01(51))
[195] "…have to give back to the motherland" (03_06_01(12); "…they think that they owe this country something" (03_08_01(8)); "…giving back, you know, to the society" (23_01_02(56))
[196] "Some do it out of pity because of the people they've-, they are suffering, they want to help." (19_01_02(12))
[197] 01_01_01(22, 108); 01_01_01(77); "God will provide, family bonds are very strong, work prompt. More general projects don't generate so much support." (32_01_01(91))
[198] "…want to be of use to the communities" (26_02_01 (10)); "People cannot come home because of the expectation of monetary gains from their relatives, from their friends. They always expect something from you." (26_02_01(53))
[199] leading by example "…if we apply ourselves it will work" (26_02_01(21))
[200] strengthens connections to Ghana (03_01_02(15))
[201] "I haven't had a rest but I'm happy. Because once I get results I get very satisfied." (26_02_01(36))
[202] 01_01_01(57)
[203] "I can do what I can" (01_01_01(57, 99)); being in the position to help, expertise, technical competence, financial resources, physical strength; help (32_01_01(103)); experience in the medical field abroad "…because of our experience over there we want to change things" (01_03_01(79))
[204] 26_02_01(53)
[205] 28_01_01(41)
[206] 29_03_01(20)

the Ghanaian health sector)	Resources: to be in a leadership position to positively influence community development, people's health[207] Relationships: trust based on personal relationships[208]

Usually, a combination of the above-mentioned factors influences engagement of actors. For example, the initiator (donor) of P3 describes a clear interest to change and improve the delivery of health care in Ghana[209] with his activities. At the same time he emphasizes values like altruism and his sense of justice as important factors for continued commitment[210]. Self-imposed duties[211] as well as expectations from family and friends[212] are also mentioned as motivation to become and stay involved. In this case, no main motivation can be identified, all aspects of engagement seem to be equally important. From the recipient's perspective, the motivation to become and stay involved with TNHPs can, for example, be a combination of the expectation to receive good quality support and the long-term perspective to attract donors, and thus resources, for the institution[213]. Trust based relationships are another important aspect of motivation that was mentioned by recipients and supporters[214]. An example of a constellation with one dominating motive is P4. Throughout the interview with the initiator (donor), most of the activities were put in a religious context and the will of God was a recurrent explanation for beginning and continuing the TNHP[215].

On the one hand, most donors describe their engagement in a TNHP as an enriching and fulfilling experience[216]. This, as well as their emotional involvement and strong conviction to implement a specific goal, constitutes an intrinsic motivation to become and stay involved with TNHPs. On the other hand, the activities of donors are strongly determined by expectations, (perceived) pressure and personal/ communal goals, which characterize extrinsic motivation. The mixture of intrinsic and extrinsic motivation reinforces the complex constellation of motivation.

Besides different constellations of motives, most of the activities are genuinely

[207] 22_01_01(97)
[208] 29_02_01(47)
[209] 26_02_01(19)
[210] 26_02_01(51)
[211] 26_02_01(10)
[212] 26_02_01(53)
[213] 28_01_01(41, 25)
[214] 22_01_01(78); 29_02_01(47)
[215] 01_01_01(45, 57, 59)
[216] 03_06_01(12); "I have done something, I feel a little bit fulfilled that next time I should continue to do it." (18_01_02(26)); positive experiences make people want to continue engagement (18_01_02(26)); fulfilment (23_01_02(56)); for the fun of it/ happy/ pleasure/ didn't expect anything in return (26_02_01(21)); joy, "So it is the satisfaction I get from the work I do which gives me the strength to go on." (26_02_01(36))

performed with the intention to support the Ghanaian health system and in particular the receiving institution. However, experience of the customs authority shows that donations in some cases can also serve as a cover-up to import private/ commercial goods tax-free. [217]

From the donors' perspective, the involvement of the Ghanaian government is seen critically. High bureaucratic obstacles, a perceived mentality of entitlement as well as a lack of transparency are factors that are frustrating and discourage engagement.[218] The suspicion of corrupt practices in the context of import can prevent Ghanaians abroad from getting involved in projects.[219]

Another critical point that discourages actors from getting involved lies in the TNHPs themselves. The projects seem to be "too much", meaning that the projects can be complex, the prospective workload and required funding are not predictable, the course of the project is uncertain and therefore the prospect of success does not appear very likely or at least unforeseeable.[220]

Recipients and supporters of TNHPs also mentioned reasons for having changed or stopped their engagement. Negative experiences with donors are for example: longer interruption/ pause of a project[221], and donated items of questionable use for the facilities[222].

The governmental institutions have developed instruments (e.g. Guidelines for Donations and Voluntary Medical Outreach Program in The Health Sector Of Ghana (MOH (no date, approximately 2010)), to ensure the quality of equipment and services and to build policies and structures (e.g. the Diaspora Affairs Bureau) supporting and encouraging the engagement of the diaspora. For many years, international organizations have worked closely with the Ghanaian government and developed programs to attract and support donations and the engagement of medically trained personnel (e.g. IOM). With their work, they aim at bridging the gap of information and understanding between the actors involved.

While the motivation to become and stay involved with TNHPs often results from a combination of different factors, most interview partners describe a personal

[217] 03_08_01(4)
[218] 26_02_01(51); 01_01_01(97)
[219] 01_03_01(87); 01_01_02(25)
[220] 01_01_02(29)
[221] "…they haven't been around for a while" 03_06_01(92); "But when we had agreed on this then there was dead silence." 22_01_01(14)
[222] "Because in the past we have had the experience of donation being dumped on us which were not needed." (29_01_02(11); "Because if the items come and we cannot use them then they become waste." 28_01_01(10)

experience[223], the occurrence of an opportunity[224] (e.g. equipment available) or network connections as the trigger (→ 4.4.2 Structural and Social Resources; → 4.4.3 Human and Immaterial Resources) of their engagement.[225]

[223] identified need they want to meet with their engagement (26_02_01(10))
[224] opportunity, knowledge about equipment in Germany (28_01_01(34))
[225] personal experience/ reported by relatives/ appeal or request by institutions (19_01_02(8))

5 Synthesis: Typology and Influential Factors

As a next step to better understand and explain the complex social phenomenon of TNHPs, the findings from analyzing the data are put into the wider context of transnational engagement.

The contextualization of attributes from Chapter 3 leads to the identification of strategies for Interaction and Communication (5.1.1), Resources (5.1.2) and Motives (5.1.3).

By combining the findings the attribute space is reduced and the categories for the typology emerge (→ 3.5 Constructing of a Typology (Stage 3)). Based on the identified categories the cases (interview partners) are assigned to the framework and the typology is constructed (5.1.4)

Then the characterization of the three types (→ 3.5 Constructing a Typology (Stage 4)) rounds off the process of type construction (5.2).

Based on the typology as well as findings from the analysis the influential factors that shape the outcome of TNHPs are presented (5.3). This is done by summarizing the impact of communication and structural factors under the concept of Dependency (5.3.1), giving an overview of positive and negative developments of TNHPs (5.3.2) and the strategic adaptations that are done by actors (5.3.3) (objective 4 of the study; 1.5)

5.1 Strategies and Logics of Action

The attribute's interaction and communication (→ 4.3 Activities and Interactions), resources (how is a TNHP done?) (→ 4.4 Resources) and motives (why and what is done?) (→ 4.5 Motives) have been identified as key characteristics to explain the development and outcome of TNHPs. By putting the activities of actors into the wider social context of the TNHPs strategies are identified (5.1.1 - 5.1.3). While the findings from 5.1.1 Interaction and Communication are mainly included into the 5.3 Outcomes and Influential Factors the strategies regarding resources (5.1.2) and the strategies regarding motives (5.1.3) provide the basis for the construction of the typology (5.1.4).

5.1.1 Strategies Regarding: Interaction and Communication

Communication between different actors accompanies the whole course of a TNHP. Donors, supporters and recipients follow different communication strategies depending

on their own interests, networks and the types of communication (spontaneous, systematic, demand driven (→ 4.3.3 Communication and Cooperation)).

Everyone involved has their own interests. However, the interview partners representing recipients and also supporters especially mentioned the initiation/ preparation phase (→ 4.1.3 Trajectory of the Project) of a project as being most important for exchanging information, in order to determine needs and requirements, and to ensure usefulness before the activities begin.

From a donor's perspective, communication during the initial phase mainly refers to the mobilization of resources. While it can be helpful to communicate with counterparts "on an equal footing" to create ownership and trust in the project[226], it can also be effective to submit to formal structures and requirements[227] in order to avoid resistance.

Another strategy to further the project is to make use of formal structures and hierarchies for one's own interests, aiming at creating obligations[228]. The approach resembles a top-down-strategy: to contact national authorities, international or subordinate national organizations serves for setting the framework, for clarifying the options of how to proceed and for finding out about formal requirements[229]. By contrast, when actors develop an idea (individually or in a group of people) together with project partners and rely on the process, a bottom/ up-strategy is pursued[230].

The approach is not always to talk exclusively to officials first[231]. It is also possible that loose contact to colleagues and patients/ students of the receiving institutions in Ghana takes place simultaneously with the cooperation with national and international organizations (e.g. IOM, hospital administration)[232].

From the recipient's point of view the collaboration according to formal standards also serves the purpose of ensuring that the donations are suited to the institution's needs[233].

The communication about formalities (e.g. customs requirements) are sometimes addressed right at the beginning of a project[234] or dealt with as they occur in the course of the project[235].

[226] P3_26_02 (donor); P4_01_01 (donor)
[227] P2_03_01 (donor)
[228] P1_32_01_01 (donor) (36ff.): start from the top (MoH) and not from the bottom (institution) → overcome hesitation, contact people you know but even when you do not have a personal contact AND use the system (write to MoH, Ministry of Finance and Ghanaian embassy in Berlin and let everyone know that the others are receiving the same letter)
[229] P1_32_01 (donor); P3_26_02 (donor); P5_22_01 (recipient)
[230] P2_03_01 (donor); P4_01_01 (donor)
[231] e.g. P1_32_01 to GHS, or the donor in P5 to the chief of the village and other representatives of the community
[232] P3_26_02 (donor)
[233] P1_03_06 (recipient)

Experiencing success or blockade, as well as receiving advice from trusted people in the network, may individually influence the development of communication strategies throughout the project. The communication set-up of the projects depends on experiences, attitude and personal resources of the actors involved.

Depending on the resources, both ways of communication (top-down/ bottom-up) can be effective and facilitate the implementation of a project. Actors choose to communicate what they feel most comfortable with, and what they know has worked before. Disappointing experiences (e.g. no response from the embassy[236]) influence the choice of contact partners for future interactions.

It is common to both approaches that people, i.e. representatives of institutions and administration as well as people on the ground, need to be convinced of a project idea before they grant their support. Convincing factors to generate support can be the progress that has already been achieved, a supportive network (e.g. good references and recommendations) as well as a clear idea and goal.

Therefore, the degree to which a project's objective is set and indications for thorough planning can be presented (e.g. knowledge about formal requirements, specialist-knowledge about the subject, specific planning of time and finances) represent additional factors that influence communication and its results. If the objective is already clear, the consultation of authorities and organizations can result in concrete advice and assistance (e.g. the recommendation to donate electronic hospital beds rather to a health facility in a city, because of unstable power supply in rural areas[237], advice to search for appropriate cooperation partners[238], or generating support through an international program[239]). Possible obstacles are identified, and strategies to minimize the formal resistance can be developed. A clear objective is often based on strong personal and institutional connections. A high level of trust and ownership, again, can result in a dynamic development of the TNHP.

If the objective of a TNHP is still open or unclear, authorities and organizations can offer more general information that might help to develop the project, but they often do not contribute with the provision of resources (e.g. asking a person who is related to a village and lives abroad to generally "assist us [village community] with a clinic"[240]). Similar results are achieved with a bottom-up approach (e.g. if the opportunity to donate equipment to a planned health facility leads to organizing the transport

[234] P1_32_01 (donor)
[235] P2_03_01 (donor); P4_01_01 (donor)
[236] P1_32_01
[237] P1_28_01_01(11) (supporter)
[238] P2_03_01_01(45) (donor)
[239] P3_26_02_01(16) (donor)
[240] P5_22_01_01(02)

individually[241]). Unclear and open ideas, while seeming to be more flexible and compatible with different actors' interests, tend to stay vague and easily fade over time.

5.1.2 Strategies Regarding: Resources

The TNHPs analyzed are based on different funding concepts and sources (→ 4.4.1 Monetary and Material Resources). Since most projects are too costly to be sponsored by one single actor, the parties involved develop strategies to mobilize donors and generate money. **Multiple party financing** is a way to share the costs e.g. of training a Ghanaian nurse in Germany (P3: IOM, German hospital, individual key person) or of supplying hospital beds (P1: donor institution in Germany, GIZ, Ghana Union, customs) between different parties. The shared commitment is not only a way to split costs. The actors show genuine interest and engagement, share responsibilities, create ownership and trust among the different partners. At the same time, it reduces the risk that the failure of an important actor (e.g. in case of sickness or death) puts the whole project at stake, because other partners could step in. Interview partners have made the experience that it can be difficult to find trustworthy and reliable partners. In some situations, it is a promising strategy to rather find **many people who contribute a little sum of money**, than to find a few people who make big contributions[242]. Depending on the character of a project, it might either be favorable to collect a **fixed sum of money** from members to fund a concrete activity[243], or to mobilize **regular commitment**, with the aim of creating ownership (e.g. adoption of a ward, membership, partnership) and establishing **long term obligations**.

While funding by a group of people can be beneficial for the continuous development of a project, the efforts to find a common interest and to agree on a strategy, the process of coordination and keeping the support of a group of people are time-consuming. The dynamics of cooperation can be difficult to control and might lead to stagnation of a project. At the same time the involvement of a group of people can serve a body of control that makes sure that the activities are done efficiently and effectively. [244]

Other strategies described by interview partners are to tap **personal financial resources** as a planned contribution, i.e. to "give back"[245], or as an emergency solution in a critical situation, which may go beyond personal capacities[246].

In order to access **formal support structures** (e.g. tax exemption, (inter-) national

[241] P4_01_01_01(57)
[242] "Because my experience is that if you collect small money. Small amounts of money from a lot of people, its-, you get much more than collecting big money from few people. And if it becomes something like an obligation, that I have to do it." (02_01_01(104))
[243] 03_01_02(33)
[244] 03_01_02(141)
[245] P3_03_02_02(73); 03_06_01(12); P3_26_02_01(10)
[246] P4_01_01

funding programs), the actors need to know about requirements and procedures. To fulfill the requirements of a program can be time-consuming and complex, but the framework can also give orientation and security.

The actors have different strategies to attract sponsors and keep them associated with the project: organizing public events[247], positive publicity[248] and showing appreciation e.g. through writing letters[249]. When sponsoring comes from institutions (e.g. IOM), the formal writing of a report might be obligatory[250].

Network strategies are an important factor to influence the availability of resources. Knowledge about the structures in Ghana and Germany, personal relationships and competences to generate monetary resources need to be applied to tackle a TNHP financially. The data provides examples for networks with different numbers of actors. The intensity of ties and interactions between them also varies (→ 4.3 Activities and Interactions). In the following Table 16, the categories “strong network” (many actors, frequent and meaningful interactions, reliable ties) and “weak network” (less actors, interactions are sporadic and superficial, ties without commitment) illustrate the two observed tendencies that impact TNHP.

Another aspect is the actual need, i.e. the amount of investment that is necessary to implement a TNHP (→ 4.4.1 Monetary and Material Resources), which is not limited to material resources but also refers to social and personal costs/ capital (→ 2.1.4 Resources and Social Capital). The needs to implement a TNHP are determined by subjective aspects (e.g. defined by actors, based on their knowledge about medical services and a personal perception of a supply situation in a region or in a facility) as well as objective aspects (e.g. it requires financial resources and knowledge about formalities in order to ship hospital beds to Ghana). In the Table 16, the category “low need” refers to TNHPs that are subjectively rated by the actors as a lower priority, are less costly and require less time. The category “high need” refers to situations in which the TNHP is very important to the involved actors and contributes essentially to the supply situation in Ghana, the implementation is costly and requires a high level of engagement from the actors.

The following table depicts how the presence (respectively, the absence) of network relations in relation to the needed investments can influence the availability of resources.

[247] 03_01_02(92); 25_01_02(26); 28_01_01(33)
[248] 25_01_02(119)
[249] 18_01_02(26); 19_01_02(12)
[250] 23_01_02(31)

Table 16: Availability of Resources for a TNHP

	Low Needs	High Needs (personnel, money)
Strong Network	**easily available** (P2)	**available** (P1; P3)
Weak Network	**(limited) available** (P5)	**lacking/ unavailable** (P4)

When the network connections are strong and the resources needed to implement a TNHP are comparatively low, the chances are high that the resources to implement the project will be **easily available** (e.g. P2, where the renovation of a ward represents a clearly defined project that requires neither any unpredictable transport from Germany to Ghana, nor permanent payment of staff). On the basis of a strong network, it is also likely that the resources for a TNHP with higher costs can be made **available** (e.g. the transport of hospital beds (P1) or the supply of services (P3)). In a constellation where there is no strong network to rely on and the needs of the TNHP are low, it is possible that the resources can be provided by a single person, even though the **availability might be limited** (e.g. P5). If there is no network and the need is high, the chances are high that the resources required to implement a TNHP are **lacking** (e.g. P4).

By focusing on the actual existence/ availability of networks (rather than the kind and quality of the connections), and on the general need for resources (rather than a specific need such as financial means or knowledge), the attribute space is reduced to the basic characteristics. The availability of sufficient resources to make a TNHP work does not only depend on the capacity to make them available (mainly in the context of network connections), but also on the requirements that are set for a TNHP.

It is important to note that over the course of a project the financial situation might changes and that actors may adapt their strategies accordingly.

5.1.3 Strategies Regarding: Motives

As already indicated in the section on motives (→ 4.5 Motives), the different actors of TNHPs are guided by not only one single motivation but by a variety of motives.

The combination of motives is often influenced by positive and negative experiences and expectations.

Looking at the recipients' and supporters' motives to become and stay involved with a TNHP, the influence of positive and negative experiences at the different project phases is interesting to observe. Examples of such experiences have been described

above (→ 4.5.2 Motivation). In combining it with the project phases, the following attitudes can be identified:

Table 17: Change of Recipients' Attitude Over the Development of a TNHP

(influence of positive and negative experiences throughout the different phases of a TNHP from the recipients' point of view)

	Experiences	
Project Phase	Positive	Negative
Initiation Planning	**Openness** *(example: gratitude)*[251]	**Skepticism** *(example: critical examination of enquiries)*[252]
Implementation	**Integration** *(example: Integration of TNHP in routines)*[253]	**Rejection/ Improvement** *(example: Termination*[254]*/ adaptation* [255])
Closure/ Prospects	**Standardization/ Expansion** *(example: Develop strategies to continue TNHP/* *attract more donors))*[256]	**Demarcation/ Regulation** **Resignation** *(example: implementation of rules and standards)*[257]

Usually, the assessment of TNHPs reveals a combination of positive and negative experiences.

On the basis of those experiences, the recipients learn about their needs and develop and adapt their attitude towards TNHPs. While all interview partners were able to distinguish successful from less rewarding or even frustrating TNHPs, not all of them acted upon their assessment by strictly selecting their partners. However, the ability to clearly communicate needs and draw consequences (e.g. by developing donation guidelines) did not depend on the size of an institution, but mostly on the recipients' awareness of the problems, their belief in the usefulness of TNHPs and their

[251] P2_03_06_01 (recipient) → plaque of appreciation was installed at the renovated children's' ward
[252] P1_28_01_01(32) (supporter) → electrical hospital beds cannot go to the district facilities
[253] P1_03_07_01(16) (recipient) → use of hospital beds in the facility; P3_26_01_01(14) (donor) → provision of services and training.
[254] "But when we had agreed on this then there was dead silence." P5_22_01_01(14) (about donor)
[255] P2_03_06_01(92) "they haven't been around for a while" → adoption policy was established to avoid neglect of a project in the future; P5_22_01 (recipient) → looking for new partners
[256] P1; P3
[257] MoH_29_01_02(11) (about recipient) "Because in the past we have had the experience of donation being dumped on us which were not needed."; P1_28_01_01(10) (recipient) "Because if the items come and we cannot use them then they become waste." → development of donation guidelines

willingness to invest resources (e.g. time of personnel) into the improvement. The attitude of recipients can also affect donors (e.g. implementation of donation guidelines that have to be followed (P1)). While clear guidelines and information about formal procedures can support the process of implementing a TNHP, the explicit communication of demands may also be perceived as inappropriate in a situation of voluntary commitment[258].

The data analyzed indicate that especially for donors, the combination of competences (e.g. in the medical sector) and social expectations (e.g. from family, the community of origin) are closely interlinked and affect the degree of motivation.

Table 18: Combinations of Motivational Factors and Effects on Donors' Motivation

	Competences of Donors	
Degree of Expectations	Incompetence	Competence
Obligatory (duty)	**high motivation (extrinsic)** → frustration (optimism, faith/ resignation) *(example: initiator P2; P4)*	**high motivation (intrinsic)** → success/ recognition (strong commitment) *(example: initiator P3)*
Voluntary	**low motivation** → stagnation *(example: P5)*	**high motivation** → success/ recognition *(example: initiator P1; P3)*

Both factors (expectations and competences) can be seen as a continuum with extremes (no expectations from the recipient vs. clear demands; no competences to implement the TNHP vs. all the required competences). These are not very likely to be found in reality. The analysis of TNHPs rather reveals combinations of the two factors that range in the middle, with tendencies into higher or lower competences or expectations respectively.

Within one TNHP, an actor can be competent in one area (e.g. knowledge about the donated equipment) and less competent in others (e.g. awareness of formalities of the donation process).[259] Throughout the process, competences can be developed (e.g.

[258] P3_26_02_01 (53) (donor)
[259] P1_32_01 (donor)

through learning about the requirements for donation[260], development of skills to teach medical personnel[261]), and expectations can change (e.g. recipient who lowers expectations after stagnation of a project[262]).

High expectations (obligations), no matter if they are self-imposed or imposed by others, create (perceived) duties that can put pressure on donors. In combination with adequate competences, it can increase the motivation of donors (e.g. expectations put emphasis on actual needs, donors are encouraged by doing something valuable for the community, the effective support of a TNHP can provoke respect and gratitude). As a consequence, the actor may stay involved, the value of the engagement for the community is emphasized (significance) and liability is created[263]. In order to have a positive impact on motivation, expectations need to be reasonable and realistic.

Negative dynamics occur when expectations are overwhelming, because they are unrealistic or the donor does not have the required competences. As a consequence, the engagement for a TNHP can become frustrating for all actors involved in the TNHP[264]. Coping strategies can be optimism and faith to keep up the activities and stay involved[265]. Especially if expectations are lower and perceived as less obligatory, resignation and stagnation may occur and eventually the TNHP fades out[266].

For the overall development of a TNHP, it becomes clear that motivation and the factors “competence” and “expectations” are mutually dependent: competences can motivate to get involved with a TNHP, and the motivation to get involved with a TNHP encourages the actors to develop their competences. And in a negative way: incompetence prevents actors to become active, and low expectations cause a sense of indifference, with TNHPs appearing insignificant.

Each TNHP has its own dynamic of competence, expectation and motivation; the individual character of donors and his or her ability to deal with the conditions also has an impact on the motivation; certain constellations (as described above) seem to create better conditions for high motivation and therefore a more stable development of a TNHP.

In order to understand the attitudes of actors, the crucial aspects of motivation identified above are combined in the following table. The characteristics of motivation

[260] P1_32_01 (donor)
[261] P3_26_02 (donor)
[262] P5_22_01 (recipient)
[263] e.g. P1; P3
[264] e.g. P2
[265] e.g. P4
[266] e.g. P5

can be crosstabulated with experiences, to illustrate actors' attitudes and their approach to the activities:

Table 19: Attitude of Actors, Influenced by Experience and Motivation

	Degree of Motivation		
Experiences	High Motivation (success)	High Motivation (frustration)	Low Motivation (stagnation)
Positive	**pragmatic**	**optimistic**	**idealistic**
Negative	**pragmatic**	**pessimistic**	**pessimistic**

If the motivation of actors is high (because it is a project that is considered important and the actors possess the necessary competences), the data shows that it is less relevant whether actors make positive or negative experiences over the course of a TNHP. Their competences enable them to act and come up with solutions, despite the situation being difficult. They show a **pragmatic** attitude that is self-determined and solution-oriented.

When actors have made mostly positive experiences throughout the phases of a TNHP (e.g. feedback that their work is important, personal faith/ religious affirmation), they often maintain an **optimistic** attitude because of their high motivation. They are convinced that they are doing important work despite a lack of resources or competences. Their conviction helps to tolerate frustrations and continue with their projects. In situations where projects are stagnating and lacking support by other actors (expectations are low, needs are questionable), some donors in particular develop an **idealistic** approach that focuses on good ideas 'in theory', which are unrealistic to be implemented under given circumstances.

Negative experiences in combination with low motivation (because of competences lacking, and the voluntary character of engagement) or high motivation (because of the obligatory character of the engagement, but still combined with insufficient competences) can lead to frustration and create **pessimistic** attitude (e.g. doubts, critique, skepticism). Insufficient competence is the common feature that causes stagnation and frustration and promotes a pessimistic attitude.

During the dynamic development of a TNHP, and under the influence of experiences during that process, the attitude of actors may change[267]. It is also important to note

[267] e.g. from pragmatic to pessimistic (donor P2); from pragmatic to idealistic (donor P5); from optimistic to pragmatic (recipient P1 and P2)

that, while all facets of the described attitudes were mentioned in the conducted interviews, solely pessimistic attitudes were not found among actors involved with TNHPs.

5.1.4 Type Construction

By combining the findings about availability of resources (5.1.2 Strategies Regarding: Resources) and actors' attitude (5.1.3 Strategies Regarding: Motives), a more comprehensive understanding of the engagement for TNHPs can evolve. The basic characteristics of TNHPs (development over time and outcome, 4.1.3 Trajectory of the Project), as well as the knowledge about the social systems in which TNHPs are conducted (→ 1.2 Ghanaian health system, → 1.3 Ghanaian diaspora), provide orientation to identify similarities within the type (internal homogeneity) and differences between the types (external heterogeneity) (→ 3.5 Construction of a Typology).

The table combines the attributes that define the capacity to make necessary resources available (Table 16, → 5.1.2 Strategies Regarding: Resources) and the attitude of actors towards the TNHP (Table 18, → 5.1.3 Strategies Regarding: Motives). The actors can be allocated to the new categories as follows:

Table 20: Distribution of Cases According to Attitude and Availability of Resources

	Availability of Resources	
Quality of Motivation "Attitude"	Available	Difficult/ Not available
Pragmatic	P1_32_01 (donor)[268] P1_28_01 (supporter)[269] P1_03_03 (recipient)[270] P1_03_04 (recipient) P1_03_05 (recipient) P1_03_06 (recipient)[271] P1_03_07 (recipient) P1_03_08 (recipient) P3_26_02 (donor)[272] P3 _18_01 (recipient) P3_18_02 (recipient) P3_26_01 (recipient)[273]	P2_03_01 (donor) ward P2_03_06 (recipient)[274] P4_01_01) (donor) beds P4_01_03 (recipient)[275] coop with an internat. group of clinics P4_01_02 (supporter)[276]

[268] Once the objects for donation (hospital beds) were identified their usability/ location was checked with officials in Ghana; transport/ financing was organized; top/ down strategy, project realized (positive experience); other activities planned (32_01_01(52)) problem solving strategies (54)
[269] pragmatic advice from within the system, setting up connections (28_01_01(11))
[270] institutionalized involvement, is donation needed: seeking advice from experts (03_03_01(6, 8))
[271] positive report on the successful donation of hospital beds (03_06_01)
[272] "...because once I get results I get very satisfied." (26_02_01(36))
[273] actively involved in the IOM programme
[274] negative experience in context of children's ward, Pragmatic attitude (adoption policy (03_06_01(92))
[275] describe the project very differently from the ideas that Augustina has (03_06_01(83)) pragmatic for their own ideas.
[276] daughter: not very involved in clinic project; has her own project with old people

	P3_23_01 (supporter) P5_22_01 (recipient) gov. program	
Optimistic/ Idealistic	P4_01_01 (donor) clinic P5_19_01 (supporter)[277]	P2_03_01 (donor) big ideas P2_03_02 (supporter)[278] P4_01_01 (donor) opening P5_20_01, P5_ 20_02 (supporter)[279] P5_22_01 (recipient))
Pessimistic		P5 (donor)[280]

The constellation of the ability to make resources available and the attitude to follow a pragmatic approach (segment in the upper left corner of the table) can especially be found with two donors. They started their projects from different positions: a leader of a group of hometown association (medical laymen), who takes the opportunity to transfer a batch of discarded hospital beds and plans to extend the engagement[281], and a doctor, who contributes with his medical skills and personal resources to the delivery of health services and training at different health facilities, and who is supported by an international organization[282]. In both cases, the resources were made available by personal engagement (e.g. spending time to organize the donation, holidays to work in Ghana) and the activation of further actors and support (e.g. in the form of advice on formalities, financial contributions). Problems along the process were handled in a pragmatic and solution-oriented way (e.g. the decision about the allocation of electronic hospital beds was delegated to a representative of the GHS). Recipients and supporters can also be assigned to this category of engagement. With these actors, the availability of resources mainly relates to taking time to advise on the process[283] the capacity of staff to receive and incorporate the donation and services into the respective institution[284] and the willingness to work with the changed situation[285].

[277] not directly involved; generally approving the engagement of diaspora
[278] support is more sporadic/ no actual help/ more like idealistically supporting the idea/ maybe not even that very much/ focused on his own ideas about the development of the Ghanaian health system and what is needed
[279] District Coordinator/ District chief Executive
[280] no interview, was described like this by P5_22_01: started off pragmatic and transformed into idealistic planning/ in the end no contact → looks like pessimism took over
[281] P1_32_01 (donor)
[282] P3_26_02 (donor)
[283] P1_28_01 (supporter); P3_23_01 (supporter)
[284] P1_03_03-07 (recipient)
[285] P1_03_08

The constellation in which it is very difficult to make resources available and actors follow a pragmatic approach (segment in the upper right corner of the table) can be attributed to two donors. They managed to realize their projects even though the donation was difficult to organize from a distance (supervision of renovation work[286] or major difficulties occurred in the course of sending equipment (clearance for hospital beds by customs[287]. The pragmatism of the recipients in a difficult situation, where resources are not available, leads to adaptations in the projects' setup with the potential to find solutions eventually (e.g. introduction of an adoption policy[288] and search for affluent cooperation partners[289].

The combination of available resources and actors who follow an idealistic approach (segment in the center-left of the table) can be found in a supporter[290] who is not directly involved in a TNHP, but generally approves the engagement of diaspora and describes his optimism as a donor. Another example is a donor[291] who started successfully with the delivery of hospital beds, but the actual opening of the clinic was not completed, even though the facility is there. In the same project, the lack of medical staff refers to the combination that resources are not available and actors follow an idealistic approach (segment in the center-right of the table). Also, the donor had optimistic ideas about recruiting medical staff for the facility that were not transferred into practice[292]. The donor and supporter can also be described as optimistic when the lack of resources, that made the completion of P2 so difficult, does not stop them from dreaming about the growth and the establishment of an international organization[293]. The recipient of P5 is thinking about new activities even though there is no contact with the donor.

For the combination of (no) abilities to acquire resources with a pessimistic attitude (lower segments of the table) only one example has been found: The donor of P5 was described as a pragmatic woman who organized herself to support her home community. The development of the project suggests that she chose to end the project when her efforts remained fruitless.

It is not surprising that almost no cases were attributed to the pessimistic attitude. It is unlikely that actors with pessimistic attitudes are actively involved and contribute to the development of TNHPs over a longer period of time. Considering the inclusion criteria of this study (→ 3.3 Sampling) it is therefore likely that actors with a pessimistic attitude

[286] P2_03_01 (donor)
[287] P4_01_01 (donor)
[288] P2_03_06 (recipient)
[289] P4_01_03 (recipient)
[290] P5_19_01
[291] P4_01_01
[292] P4_01_01
[293] P2_03_01_01(82)

were not included in the study. Nevertheless some critical thoughts were mentioned that can be collected in this category. They only refer to very specific scenarios, which the interview partners related not so much to one single TNHP, but to engagement of diaspora in general. The statements were connected to structures and dynamics that were observed in the context of diaspora engagement in the Ghanaian health system.[294] Rather than constructing a fourth type, the pessimistic tendencies will be considered as possible facets of the other types.

While units of analysis (cases) from the beginning have been interview partners, the focus shifted towards the project level as the objectives of the study (objective 3 and 4) became more complex. Table 20 shows that the actors of one project often share a similar attitude and are subject to the same availability of resources.

The projects that seemed to be the most successful in terms of completing a goal or operating constantly over a certain period of time (degree of continuity) (P1; P3) all have actors in the upper left segment.

Projects in the upper right segment (P2; P4) have started off successfully but then experienced difficulties of different sorts (e.g. shortage of money, unreliable network). The pragmatic attitude of the actors leads to the (more or less deliberate) conclusion to not repeat or not further pursue the activities.

The combination of optimism/ idealism and different degrees of availability is characteristic for projects that are pending in a planning situation for an unforeseeable period of time (P4; P5) (often depending on the difficulty to make resources available).

The combination of attributes and the assignment of cases to the six segments of Table 20 reveal different types of engagement that influence the development and outcome of TNHPs.

In the end, the variety of possible combinations can be reduced to three types that correspond to the patterns found in the data collected[295] :

1. The type “continuous engagement” is characterized by a pragmatic approach that, in combination with available resources, results in the realization of projects. In combination with new ideas and the perspective of further development, actors are encouraged to stay involved and maintain or develop the engagement.

[294] P3_02_01(38)
[295] Since the availability of resources rather is of secondary importance in the face of an optimistic attitude, in the construction of the typology these two categories (segments in the center-left and center-right of the table) will be considered as one.

2. The engagement of the "single action" type can be found with actors who have a pragmatic approach, while the resources (from the beginning or over the course of the project) are very difficult to organize or not available at all. Actors who have faced serious challenges during a project, but have come up with a solution, belong to this type. Although they are often highly motivated, the TNHP is not continued.
3. For the third type, "planning", the availability of resources is not as important. The engagement is motivated by an optimistic attitude, so that even when the conditions to accomplish a project seem hopeless, the actors stick to the idea. The lack of success is not considered a reason to quit a project. Motivated by high expectations and strong conviction, the actors stay optimistic and hope for better times.

Table 21: Forms of Engagement for TNHPs Determined by Attitude and Availability of Resources

	Availability of Resources	
Quality of Motivation "Attitude"	(Easily) Available	Difficult/ Not Available
Pragmatic	Continuous engagement	Single action
Optimistic/ Idealistic	planning	
Pessimistic	discontinuance/ no TNHP	

Based on the detailed analysis of actors (→ 4.2. Characteristics of Actors) and the knowledge about the different strategies that are followed in the course of a TNHP, the question now is if there are certain constellations of actors that are characteristic for the three different types of engagement.

Table 20 shows the distribution of actors into the different segments that are later defined as the three types of engagement. All actors of P1 and P3 have been associated with characteristics that resemble continuous engagement (Type I). P2 and P4 have donors and recipients pursuing single action (Type II) and a supporter of P2 in the planning mode (Type III); over the course of the project, donors of both projects develop an idealistic attitude which seems to be a reaction to the difficult experience of organizing a project when resources are not available (not giving up entirely, but surrendering to a less active attitude that somehow fulfills the expectations of being involved with activities for home country, but without the necessary consequences to

complete a project).

P5 was presented as a project with recipients who are very active for the cause of health care for the community. While the TNHPs of interest, and therefore the donor and supporter involved, can be related to Type III (the donor probably even pulled out completely), the recipient seems to be a mixture of Type I (organizing government support) and Type II (taking the engagement as an experience, but since it does not seem to be continued, he comes up with a new approach)

The different factors that influence the communication in the context of TNHPs (hierarchy of communication and objective of TNHP), can be compared with the types developed. Projects with a clear objective (P1; P2; P3) can be related to Type I and Type II. The donors in these projects approached actors at all levels, with a clear idea of what they wanted to do and what kind of support they needed. That does not mean that everything was planned in advance in those projects. On the contrary, many adjustments were made along the way in order to achieve the goal which the donors had defined.

The projects that stayed vague in what they want to achieve and what support they need (P4; P5), can be related to Type III “planning”. Ideas about how to generate and use support often did not work out, no matter if a top-down or a bottom-up-strategy was pursued

5.2 Characterization of Types

The following subsection gives a comprehensive description of the three types. In order to illustrate the three different specifications of engagement, the TNHPs that come closest will serve as an example (prototype). Compared with constructing ideal types, the advantage of this approach is that it is more realistic. At the same time, the small amount of projects under study does not provide enough examples to compare the eventual result with the reality (→ 3.5 Constructing of a Typology). The description of each type follows the same pattern; it is based on the categories from Chapter 4 (characteristics of actors, activities, resources, structures, motives) and focuses on one prototype (TNHPs). Examples from other projects will be used to supplement the description.

5.2.1 Type I: "Continuous Engagement"

The engagement that is described as "continuous engagement" is best represented by P3[296]. The type is characterized by a pragmatic approach that in combination with available resources results in the realization of projects. In combination with new ideas and the perspective of further development, actors are encouraged to stay involved and maintain or further develop the engagement.

Characteristics and constellation of actors

A strong donor is the key person and initiates the project of this type. He has a comprehensive knowledge about the content of the projects (e.g. professional medical background[297]), knows how to navigate the formal requirements and is in the position to contribute with personal resources (e.g. time, money, knowledge). The donor holds a strong position in this constellation. Constant support, as well as the delivery of services and goods, has earned him respect and gratitude on behalf of recipients and supporters. At the same time, the donor relies on a network of actors who support the project at different levels (e.g. granting extra leave, travel fares, financial means, and infrastructure). The recipients of the donations and services also hold an active position. In the first place they are involved because they have a strong self-interest to receive, use and learn from the offer, but their active participation is also a precondition that has been set by the donor and supporter[298]. The expectations of each actor seem to be clear and known by the other actors. All of the actors are focused on the cause and coordinate their activities accordingly.

The fact that one person is in charge creates a strong dependency on the key person; at the same time, this person's relative independence to make decisions helps to shape a clear and convincing project idea.

Activities

All actors shape the project by their own resources and needs. The donor shows a mixture of systematic communication (e.g. in the context of the international program, when planning holidays with German employer) and spontaneous communication (e.g. in order to adjust to the conditions when working on the ground) with recipients and supporters (Table 5; 3.3.3 Communication and Cooperation). Network connections are

[296] P1 (individual donor supported by an international organization, with an extensive network as well as medical competence) it also involves actors who are) would also have been a good example, but the fact that P3 has been going on over many years makes it more continuous and therefore more "typical" for this type

[297] P1 or is highly skilled/ educated

[298] P1 it can also be part of the recipients identification (donation guideline)

activated and established especially in the beginning of the project. Over the course of the project, the interactions are shaped by trustful cooperation. Embedded in continuous exchange of information, the engagement can respond to the current needs. The pragmatic approach is characterized by an open dialogue about feasibility and a solution-oriented approach to deal with problems that arise over the course of the projects (e.g. due to a lack of resources, misunderstandings, expectations).

The donor and the recipients make support structures available. The recipients also participate actively in the project and integrate their ideas and needs.

The range of the activities grows and is constantly adjusted to developments and needs over time[299]. All actors follow a pragmatic approach (e.g. by meeting the requirements for an international program, providing flexible services according to needs). The fact that the engagement is performed continuously and has grown over the time (from services to trainings) points to the commitment of the involved actors as well as to the usefulness of the project. But even though the actors involved evaluate the outcome positively, the process has not always been smooth, and problem-solving strategies have been applied[300]. The ability to react to difficulties along the way is at the heart of the pragmatic approach.

Actors involved do not question the constant engagement, they extend established services and plan new activities. Nevertheless, their experiences make them assess the projects critically.

Resources

The project that serves as an example includes different forms of engagement (e.g. donation of equipment and consumables as well as services like conducting surgeries and trainings). All actors (donor, supporter, recipient) contribute to make the required resources available, e.g. by approving unpaid leave (supporter in Germany), granting travel expenses (international organization), identification of needs (health facility in Ghana), training Ghanaian nurses and teaching students who study to become a medical assistant. Even though the scale of support differs and some actors contribute more than others (in terms of time, money, etc.), the involvement of many people and institutions helps to spread the costs and duties among several actors.

The support is highly appreciated and it contributes in a positive way to the work of the receiving institutions. At the same time, the recipient does not depend on the availability of resources that come from the project.

[299] adjusted to needs: services/ trainings/ consumables
[300] 32_01_01(54)

The high level of medical competences and comprehensive knowledge about the Ghanaian health system (e.g. as a result of years of work experience in health facilities), including formal requirements, forms a good basis to develop the project. The project has undergone the project phases multiple times. The continuity of the engagement is an indicator for the relevance of the project.

The continuous engagement of actors does not equal a constant supply of resources: even when many actors are involved, it is sometimes a challenge to provide the resources required. In this case, the pragmatic approach of actors helps to come up with solutions to continue and develop the project.

In order to increase attention for the project, and thereby generate more support, the active promotion of activities (e.g. through local media in Ghana and Germany) is used to enhance the effect of a successful project. Public recognition contributes to the stabilization of activities. It also serves as a reference for convincing people to become and stay involved.

The experiences of actors and the presentation of a successful performance help to keep supporters in the project and accumulate new sources.

Structures

Personal relationships between the actors, established over a long time, form the basis for a strong network. Each of the partners (donor, supporter, recipient) is committed to the project and contributes to it.

Networks at different levels of social and institutional structures (→ 4.4.2 Structural and Social Resources) are supporting the activities in Germany and Ghana. In Ghana, the engagement is well accepted within the professional community as well as appreciated by laypeople, who benefit from the services.

A combination of professional and personal relationships offers a supportive network that meets all sorts of claims that arise over the course of the project.

Over the course of the project, the experience of continuous engagement has created a sense of trust and reliability. Negative experiences and frustration, which also occur, do not impair the stability/ resilience of the relationships.

Legal requirements and infrastructure issues (e.g. transportation to access the facilities in the North of Ghana) are dealt with, and even though the requirements sometimes are challenging, they do not hamper the project in general.

Motives

The engagement is based on and shaped by a strong intrinsic motivation of the donor. His idea to contribute to the Ghanaian health system is the overall theme, which on the one hand is broad enough to integrate various resources and interests, and is flexible enough to respond to different needs and requirements. On the other hand, it is very clear and sufficiently specific, so that other actors can continuously relate to it.

While the donor describes a strong intrinsic motivation to become and stay engaged with the project, the activities are still performed on a voluntary basis. The involvement of an international program enforces the binding character of the constant collaboration.

Positive experiences over the course of the engagement (e.g. successful outcome of surgeries, positive feedback of patients, staff and students) confirm the project's relevance. Challenges that occur over the course of the project do not affect the actors' fundamental conviction to contribute. Even though the donor describes a strong feeling of duty, he found a way to constructively deal with the high expectations of the Ghanaian community and his own sense of responsibility.

For supporters and recipients, a high level of self-interest (e.g. to improve their work and implement projects) is the reason for their engagement.

While the interests of all actors differ, the common goal to gradually improve the overall situation of health care delivery in Ghana is the connection between all the forms of engagement, which makes it larger than the sum of its parts. A common interest shared by all actors proves useful for focusing the contributions.

The orientation towards feasibility (rather than desire) makes the activities mostly rewarding and encourages actors to stay involved.

5.2.2 Type II: "Single Action"

The engagement described as "single action" can be found mainly in P2[301]. The type is characterized by a fixed goal and the limitation to one project, which is completed under difficult circumstances. Afterwards, the engagement ceases. A lack of resources is the major factor for the discontinuation.

Characteristics and constellation of actors

The donor has a clear idea about the engagement. In P2, the donor is represented by a group of people who decide collectively about the form of contribution they want to

[301] The provision of hospital beds in P4 also fits into Type II, while the rest of the project resembles Type III

make. When challenges occur over the course of the project the group of donors decides about what measures are taken.

On the basis of the initial project idea, the donor selected the recipient. The recipient is not actively integrated into the development of the project and has not formulated any needs or requirements with regard to the project.

While the donor tries to activate support at different levels (e.g. collecting financial contributions in Germany, organizing contractors in Ghana, seeking information from relatives in Ghana), there are no reliable partners to support the project on the basis of a common goal. They follow different interests (e.g. the receiving facility focuses on day-to-day-business, is not integrated into the donation process, does not feel responsible) and the terms of cooperation are not clarified[302].

The relationships are mainly professional and characterized by formal procedures (e.g. renovations being conducted by a contractor, interaction between hospital administration and donor).

The responsibility for the project is shared between many actors (e.g. group of donors, supporters), while the relationships between network partners are weak. This leads to a situation in which commitments are not always reliable.

Activities

In the initial phase, the donor has actively planned the project. While the donor community has discussed and decided systematically which project to support, the recipient is not involved in the process.

The donor does not seek professional advice or support (e.g. from the Ghanaian health system, the facility or other experts) and deals with occurring problems (e.g. shortage of funds) in a pragmatic way.

Personal contacts of the donor do not provide practical advice to facilitate the donation process.

The recipient does not influence the development of the project actively. The receiving institution respects the efforts, but at the same time derives conclusions for future projects (e.g. Adoption Agreement).

The lack of communication creates a situation in which actors do not share the same interest. They have different expectations towards each other and different views regarding the aim of the project.

[302] The adoption agreement was implemented after the project came to a stand still.

Over the course of the project, and due to the lack of resources, the attitude of the donor becomes more passive. The planning of activities still continues, but the engagement comes to halt after the main purpose of the project is reached. The decision not to continue with the project is made due to the lack of resources, which reflects a realistic assessment of the situation by the donor.

Structures

Social networks form the donor's basis of engagement (e.g. hometown association). The engagement is characterized by semi-formal structures that are meant to organize the donation process efficiently and effectively (e.g. by voting for support of a specific project [303]). The relationships in Germany are built on a common goal.

Since the project is aimed at supporting a facility in the Ghanaian health system, it faces a number of requirements that must be adhered to (e.g. communication with the administration). However, the connections to Ghanaian official structures and key actors are only sporadic. The support networks are weak.

The project relies on professional services (e.g. renovations), which put the activities in an official context that is regulated by contracts. This formalization reduces the flexibility of actors. While it offers a certain degree of legal protection and increases the reliability of partners, it also increases the organizational efforts for the donor.

During the planning phase of the project, essential questions concerning the practical implementation of the project remain unclear. Unexpected developments (e.g. higher costs, recruitment of contractors) represent challenges that seriously threaten the progress of the project.

Resources

In the context of this type, the necessary resources are difficult to acquire or not available at all. The constellation of actors and the structures are not reliable and lead to a situation in which the donor needs to put a lot of coordination effort (e.g. time to travel to Ghana, convince people to fund, personal money) into the organization of support for the project. The donor is the only source of funding to the project.

The donor does not have the resources to implement the project at the beginning, nor does he know how to raise them. The lack of experience on behalf of the donor as well as the recipient leads to the rise of unrealistic expectations and creates a situation of frustration for all partners.

[303] 03_01_01(104)

Over the course of the project, and depending on the actual needs, the donor tries to develop a strategy to acquire the necessary funds.

A lack of likeminded partners and a shortage of funding are the main limiting factors that hamper the project's implementation.

When the financial resources are mobilized, the project can be implemented. Since there is no perspective of a reliable long term funding, the continuation of the project is unrealistic.

The donor neither has medical knowledge nor professional experience in the Ghanaian health sector. The interest in organizing a health project is related to personal experience and to reports of relatives and friends, perceiving the delivery of health care in Ghana as insufficient.

A lack of knowledge about local structures in combination with unreliable project partners increases the amount of necessary resources.

Motives

The interest of the donor is very specific and planned down to the last detail. It is based on personal experiences in the Ghanaian health system and motivated by the intention to improve health care delivery for the people in the region of origin. The clear focus (on topic and location) only leaves little scope to take the needs of the future recipient into account. The donor develops new ideas over the course of the project, since reaching the set goal is a strong motivation.

The donor and recipient are not connected by a common idea of implementing a project. They do not have the same understanding of needs but mainly arrange in a working relationship.

For the recipient, the project is an external factor. The engagement from the outside is seen as beneficial to the institution. It is expected that the completed project is organized and implemented by the donor. While not many requirements are made in the first place, it becomes apparent that the engagement from outside needs to follow certain standards in order to sustainably contribute to the performance of the institution.

While the donors are highly motivated (e.g. personal interest to support the home community, a strong sense of duty, to acquire respect within the diaspora community), the project is not continued.

On the one hand, a lack of resources and competences leads to the pragmatic development of creative solutions for the implementation of the project. On the other

hand, a realistic assessment of the situation creates frustration and leads to the rational conclusion that the activities cannot be continued.

5.2.3 Type III: "Planning"

The engagement that is described as "planning" can mainly be found in P4[304]. The type is characterized by a project idea that develops over time. The engagement is motivated by an optimistic attitude, and even if the conditions to accomplish a project are not supportive, the actors remain optimistic and stick to their commitment.

While an optimistic approach keeps the actors attached to the project and can release new forces, it also prevents a critical assessment of the process. The termination of the engagement is not an option, even though the resources are not accumulated and the implementation of the project is not completed.

Characteristics and constellation of actors

The constellation of a highly motivated donor on the one side and ambitious recipients on the other side forms the basis of this project. All actors became involved because of a personal connection to the project.

The donor is a very active person who is involved in many networks and is experienced in social work in Germany and Ghana[305], but she does not have a professional medical background. Besides the project of this study, she plans a wide range of other projects simultaneously. She contributes with the resources that she can mobilize.

On the part of the recipients a crucial incident changed the preconditions of the engagement[306]. The recipient is a group of people with knowledge about the Ghanaian health system. They are in the position to decide about the development of the project.

In order to implement the complex project of opening a clinic, the support of a large number of actors is required. With so many people and institutions involved, the ideas about the scope of the project, the pace and the strategy of implementation differ (e.g. while the donor thinks about recruiting voluntary medical staff to work for the project, the recipients are planning to rent the facility to an international hospital network[307]). The tendency to involve many actors for resource generation does not work out, as the actors do not assume responsibilities. The result is a lack of binding commitments.

[304] P5 is another example
[305] "Because when I-, I worked seventeen years in Ghana with old people, you know. I worked with the social security and I was interviewing old people, you know. To know who gets his right pension, you know." (01_01_02(103))
[306] The key person of the project, a medical doctor from Ghana who worked in the US and planned to retire to Ghana, died before the idea to establish a clinic on the outskirts of Accra, was completed.
[307] 01_03_01(70ff.)

Activities

Many activities have been performed by the actors involved in the project (e.g. delivery of hospital beds, negotiations about the use of the facility).

The planning of further steps and new ideas to implement the project has shaped its development. The actors become creative to adjust their activities and implement the project. At the same time, the constant change of plans makes it difficult to focus and generate resources. The involvement of many actors creates an environment in which many ideas are generated. The focus which is essential to implement the plans is not actively determined.

Different forms of communication (donor: spontaneous; recipient: systematic) illustrate the variety of approaches which the actors follow. While the donor participates actively and comes up with new ideas, the recipient pursues a rather observant approach.

The development of the project is characterized by long phases of waiting.

Resources

The project is resource-intensive (e.g. knowledge about the Ghanaian health system, medical knowledge, management skills, continuous funding to pay staff). The actors involved do not have the necessary competences and resources to implement the project, but need to put a lot of effort into understanding the idea and set-up the project. Most of the time the relevant resources to implement the project are not available.

Over the course of the project, some resources have become available (e.g. building, hospital beds), while others are still lacking and very difficult to get hold of (e.g. medical staff). The dependency on partners to get the project off the ground generates long phases of waiting.

The fixed idea makes it difficult or impossible for the actors to use the available resources for other purposes (e.g. hospital beds are stored in the health facility but not used over a long period of time).

Structures

The donor and the recipient rely on an extensive network of lay and professional people and institutions in Ghana and abroad.

The networks of the donor are characterized by faith-based and welfare organizations as partners. The recipient refers to professional contacts within the medical sector.

Even though the networks are diverse and offer various options to generate help for the project, they currently do not provide the necessary resources to implement the project. The contacts between the actors remain rather superficial. While the actors are encouraged to continue the engagement, no reliable support is offered.

Motives

A project idea that all the actors can relate to and motivates the donor and recipient is at the center of the engagement. While being vague in terms of implementation, the idea is accepted by the different actors and therefore it is very difficult to agree on changing or adapting the project.

Donors and recipients have strong ideas about the implementation of the project, which do not always match.

A strong sense of obligation and responsibility motivated by (perceived) expectations and strong conviction keeps the actors on track with the idea. Positive experiences (e.g. the achievement of milestones) and an optimistic attitude prevent actors from getting discouraged or frustrated and encourage them to keep up the engagement.

While there is a general sense of obligation, the involvement of many actors results in a situation in which nobody feels responsible. The complex constellation of interests prevent a binding commitment.

5.3 Outcomes and Influential Factors

The outcomes of projects depend on motives of actors, resources as well as the combination of resources and framework conditions. While motives and resources have been the basis for the constructed types (→ 5.2 Characterization of Types) now a look at the dynamics of dependence (5.3.1) will help to provide relevant factors to assess the sustainability of a TNHP.

The collection of examples for positive and negative influences, which relate to the different attributes, illustrates the multitude of factors that are relevant to the development of TNHPs (5.3.2).

In order to draw conclusions regarding the interplay of influential factors, the strategic adaptations are highlighted (5.3.3). Thereby, the supportive and hampering factors that have an impact on the implementation of TNHPs (objective 4) are presented.

5.3.1 Dependency

TNHPs depend on the engagement, motivation and resources that can be mobilized for a certain cause.

The donors state that they want to help people and institutions to ultimately be better off and self-reliant in terms of facilities, supplies and services[308], i.e. they emphasize the intended positive effects of TNHPs. The recipients' perception is more critical: the interview partners are aware that the help provided is often a "one-time assistance" which runs out or breaks down sooner or later. Problems may arise because donated goods and services have become part of the service spectrum and cannot be sustained by the means of the recipient. As a consequence, either scarce resources of a facility have to be rearranged at the expense of other basic services, or the expectations developed by patients are disappointed.[309] Donations from abroad were also described as a cause of unnecessary dependence that undervalues the capacity of the Ghanaian health system and manifests inequality between Africans and Europeans.[310]

In the context of the projects analyzed, the characteristics of "need" (importance of the service or equipment to the recipient) and "permanence" (level of difficulty to provide the resource with required continuity) were identified as factors that influence the degree of dependency.

In Table 22, the category "need for a TNHP" refers to the recipients' (e.g. an institution or a community) assessment and describes it in relation to already existing activities. In that context, a donation is "essential" if the activity cannot be performed without it. "Additional" means that the donation supports or improves an activity but is not crucial in the first place. The third category "not needed/ not adequate" refers to TNHPs that do not contribute to or hamper the recipients' work.

The permanence of donations is summed up in two categories that describe the accessibility of donations (services and equipment) given in the context of a TNHP: "Permanently available" refers to measures that are intended to support the recipients for the long term (e.g. hospital beds, skills). Other donations (e.g. the service of a medical doctor, supply of consumables and medication) depend on circumstances like

[308] P4 (01_01_01(122)); P3 (26_02_01(31))

[309] "So if it is a onetime assistance from the individual we would have to find ways and means of replacing it. And that's the challenge. They have to buy because they are already use to it and it's useful for the people, they have to.[...] The people benefited from it and it is no more working. The challenge is they have to get that one from their own-, from their own resources. This-, this is the challenge." (19_01_02(16))

[310] "I want to target Ghanaians because like I said, we don't have to always depend on people, benevolence of the-, I mean, Europeans, Americans and others, do you understand, Asians and so on and so forth. We are-, we have equal men who are equally good to-, to-, to do the task." (03_02_03(38))

the duration of a visit, a program or financial resources. They are meeting needs for a limited period of time.

Table 22: Degree of Recipients' Dependency on TNHP

(categories: need of TNHP and availability of resources)

	Permanence of the Donation	
Need for TNHP	Permanently Available/ Long Term	Determined by Circumstances/ Short Term
Essential (not existing yet, basic supply intended to be beneficial for recipients)	**Independence** *crucial* (e.g. hospital beds (P4))	**Dependence** *crucial* (e.g. med. doctors (P4), funding (P5))
Additional (supporting/ improving already existing activities)	*helpful* (e.g. hospital beds (P1), renovations (P2), training of med. personal/ skills (P3))	*helpful* (e.g. instruction and spare parts for hospital beds (P1), supply with consumables (P3), services (P3))
Not Needed/ Not Adequate	**Indifferent/ problematic consequences**	

Independence as well as dependence can also be described as attributes that increase or decrease gradually according to how important (essential/ helpful) the donation is for the TNHP and the institutions' work.

Dependence especially occurs if the donation of essential goods or services is not certain (e.g. because the provision of resources requires the persuasion of other actors) (upper right segment of the table). Examples from the data are recruitment and funding of medical staff, which are crucial to opening a clinic (P4)[311], or a project that was initiated and entirely built on engagement and support of Ghanaians abroad (P5). As long as the funding cannot be organized, or as soon as the source ceases, the projects do not progress and come to a halt. This situation is characteristic for Type III ("planning"), where the lack of necessary resources often prevents further activities.

When the donation of essential equipment or the provision of structures have a permanent character (e.g. building facility or hospital beds in P4), the project offers a

[311] "And also whatever decision we come to has to be dependent upon the medical doctors that will decide to partner with us." (01_03_01(74))

certain degree of independence to the recipients, since they have the items or structures at their disposal (upper left segment of the table).

TNHPs that offer equipment or services as an addition to already existing structures have less potential to create dependency on behalf of the recipient, since the activities can be continued even when the project ends (P1; P2[312]; P3). Generally, the support with additional activities and services is perceived as helpful. The permanence of donations determines the extent of engagement: while contributions that are designed to have permanent effects (e.g. training of staff, equipment) can cause long-term improvement (center left segment of the table), the provision of temporary engagement (e.g. in the form of services and consumables) can be supportive while it lasts (e.g. because patients benefit from operations performed by a specialist) but no solid basis for development (center right segment of the table).

TNHPs that are not helpful or not suited to the conditions in Ghana are not part of this study. Nevertheless recipients also referred to experiences they had with engagement that turned out to be not useful (e.g. wheelchairs with cushions[313], expired medication[314], technical equipment that needs electricity[315]). The outcome here is at best no effect but is likely to be negative (lower segment of the table).

One TNHP can consist of several elements with different degrees of permanence (e.g. P1, where the hospital beds are objects that can be permanently used as additional beds in the hospital, but since they have electronic features, the instructions for use and the supply of spare parts are helpful additions that depend on the donor's capacities).

The character of the support and its potential to make a TNHP (in)dependent also has an impact on the feasibility of an endeavor. Project 4, for example, builds on two major factors that are both essential to the project: while the hospital beds are already delivered, the doctors have not yet been found – the TNHP is not activated. Even when the project eventually starts, the crucial factor (employment of medical staff) will always be a factor of uncertainty as long as the funding for medical staff is not permanently secured.

According to interview partners, it is crucial that recipients develop a clear position of what they need, what is useful in the context of an institution or within a community,

[312] "Only ten percent, yeah. Because we don't actually depend on the donation before we work. When it comes we make use of it." (03_05_01(80)); "But it hasn't yet created a dependency syndrome because whether we get it or not we operate." (03_06_01(30))
[313] 18_02_01(13)
[314] 03_04_01(13); 28_01_01(10)
[315] 29_02_01(25)

and what can be sustained, even when the initial phase of the TNHP is over.[316] At the same time, donors need to recognize recipients' requirements in the beginning of a TNHP and include them in the planning.[317]

Especially for continuous engagement (Type I), but also for single action (Type II) it is important that the activities (no matter whether they are long- or short-termed) are considered as helpful and that the necessary resources are permanently available. In the case of Type II, a change in the perception of necessity can lead to a decline of engagement and instead of becoming active the planning phase is not exceeded (Type III), or to stopping the engagement entirely (e.g. when experiences of engagement for a ward trigger the development of a policy).

5.3.2 Positive and Negative Developments for a TNHP

The examples from the interviews show the variety of positive and negative effects that can develop over the course of a project.

However, not all competences are always necessary for the development of a project: even though medical knowledge in the case of P1 is crucial and characterizes the support, it is not an indispensable factor for success (e.g. in P3 the donor does not have a professional medical background, but the consultation of experts can be just as useful).

Depending on the context, most of the factors can have both hampering and supporting potential. The characteristics of actors and resources (→ 4.2 Characteristics of Actors; → 4.4 Resources), e.g. family ties, can be beneficial if they offer a reliable back-up (P4), but also limiting if high expectations and a lack of formal security (P2) become obstacles to implementing a project.

The successful completion of a project (e.g. when donated hospital beds are in use (P1) and services are delivered (P3)) can be considered a positive outcome. Moreover, the support offered by other actors is an indicator for the positive assessment and usefulness of the project. Appreciation of the project is also a sign that the contribution improves the recipients' situation. Based on a strong and reliable network, the engagement becomes (or at least appears to be) easier for the project partners. The actors are aware of their contribution but do not perceive it as a burden. Being in a position to contribute is considered as a privilege and is reported as a motivation.

Frustration for all project partners may result from delays and stagnation of the implementation (e.g. fulfillment of formal regulations and extra costs (P4)), which can be caused by a lack of resources from the beginning or by the occurrence of other

[316] 26_02_01(31) requirement for IOM project
[317] 29_03_01(28)

obstacles over the course of the project.

It is important to note that the assessment of a situation or of the current project state, are always influenced by the perspectives, interests and subjective goals of actors. The following example illustrates how the state of the same project (P2) can be characterized differently depending on the perspective:

- **recipient:** *"they* [donors] *haven't been around for a while and now we have an adoption policy. We are even going to remove the plaque* [sign displayed at the ward referring to the adoption]*."*[318];
- **relative of the initiator, contact person in Ghana:** *"they're* [donors] *doing very well. They're doing very well. They have-, they've adopted a children-, one children ward and then-, renovating-, they keep renovating the place from time to time, yeah."*[319],
- ***donor/ initiator**: "We are now facing some problems concerning money. So now-, I think the project has come to a standstill. We are-, we are trying to get help from maybe-, from other people. But it's not easy now to mobilize funds for such a project*."[320]

Certain influential factors are especially important during different phases of a project (→ 4.1.3 Trajectory of the Project, → 4.2 Characteristics of Actors).

While it has been described as especially beneficial for the set-up of a project to communicate about the recipients' interests and formal requirements early in the initiation phase of a project, networking and the involvement of reliable partners is helpful when it comes to the concrete planning and implementation of the project. Extensive communication in the planning phase can also have a negative effect if it is time consuming and does not recruit the necessary support (P4). Even though a formal evaluation of a project was only done in one case, (P3) the general assessment of experiences during and at the end of a project can support the planning of future engagement.

The implementation of every TNHP is characterized by supportive and hampering influences. Depending on the combination of factors, positive and negative effects for the outcome of a TNHP are created. The increased awareness of such influential factors (positive and negative)[321] that actors acquire over the course of a project helps the engagement to become more conscious and related to the actual needs and

[318] 03_06_01(92)
[319] 03_02_02(83)
[320] 03_01_02(38)
[321] 26_01_01(32)

resources of a recipient (→ critical engagement).

5.3.3 Strategic Adaptations

The assessment of the process and outcomes by different actors (donor, recipient, supporter) as well as observations made over the course of the study helped to characterize positive and negative developments that influence the overall outcome of transnational engagement.

The major topics of evaluation (→ 4.3.4 Documentation and Evaluation) mentioned in the interviews are resources, communication, set-up (requirements/ needs) and commitment (continuity/ sustainability). In Table 23 these topics are combined with the findings on effects that the attributes (→ 4.1 Setup of Transnational Health Projects; → 4.2 Characteristics of Actors; → 4.3 Activities and Interactions; → 4.4 Resources; → 4.5 Motives) have on the development of TNHPs. The strategic adaptations applied by actors to deal with the circumstances determine the progress of the project.

Table 23: Topics of Evaluation and Strategic Adaptations of Interview Partners

Resources	- diversification - intensification - consolidation - expansion - financial controlling - persistence
Communication/ Cooperation/ Partners	- regulation - continuity - discontinuation
Setup	- transfer - development - give back
Motivation/ Commitment	- conviction - conscious/ critical engagement - quality - flexibility - creativity - build competences - create ownership

Developments that are related to resources often affect the TNHP immediately. Funding is usually a crucial factor to implement a project, and its absence or disruption can significantly hamper the process. The actors have shown various initiatives to enhance the financial means: generating new sources of funding[322] and thereby increasing the variety of resources (→ diversification), making greater use of the existing resources[323] (→ intensification) or changing the concept of financing from dependence on membership-fees alone to long-term support by sponsors in order to establish activities[324] (→ consolidation). In the case that there is no shortage of funding, the excess money and experiences are used to start new projects or to extend the initial project[325] (→ expansion). A more restrained, yet efficient approach is usually taken if the development of projects and new ideas is subjected to the availability of funding[326] (→ financial controlling). Creativity and persistence in trying to generate funds for a project[327] (→ persistence) are characteristic to all projects, no matter how established the funding situation might be. The assessment of difficult developments over the course of the project can also lead to adjustments in the mode of cooperation and the project is (temporarily) discontinued. The (conscious or unconscious) conclusion of actors not to proceed with the engagement in the same way is another way to react in a situation where there is insufficient funding (Type II).

The availability of resources could be interpreted as a fortunate coincidence, but it is based on the competence of actors who make it available.

The combination of resources also influences the development of projects significantly (3.4 Resources). Social contacts alone, for example, will not support the implementation of a TNHP as long as the funds are not available (P5), and relevant project ideas will not be implemented if there is no reliable network (P4).

Project partners do not always share the same interests and expectations - a precondition that can lead to misunderstandings and disappointment and potentially hampers the project. It can be prevented by early communication and exchange of information between donors and recipients. Interaction whilst planning a project is a critical factor to avoid negative effects from divergent interests, such as disappointment or waste of resources by futile efforts. Other ways to communicate are the clear

[322] P1; P4; P3 access district assembly and national level and ask for contributions (26_01_01(29))
[323] P2 (members)
[324] donors perspective: P2 find permanent sponsors, do not depend on member fees (03_01_02(82)); recipients perspective: P2 develop an adoption policy to increase the reliability of resources for the health facility (03_06_01(92))
[325] P3: extend the service with support of an international organization (26_02_01(16)); P5: build more, use the sources (22_01_01(22))
[326] 03_01_02(132)
[327] 03_01_02(38)

formulation of conditions for cooperation[328], or the implementation of new requirements for collaboration[329] (→ regulation).

The way information and support are arranged and agreed on can range from formal letters, completed forms, applications and contracts to verbal agreements or implicit expectations. In order to support a project, the form of agreement depends on the context of interaction and the experiences of actors (e.g. trust in personal contacts, reliance on formal agreements).

In order to consolidate the engagement from the recipients' perspective, the strategy to stay in contact with the donor and to maintain continuous communication in order keep up the relations[330] (→ continuity) has proven to be beneficial.

Concerning the set-up of a project, it is crucial to consider the requirements and needs of the recipients. It can also be an advantage to rely on experiences that actors make over the course of the project. A promising and efficient way to stabilize and increase the engagement could be to reproduce a successful project idea at another location with a different institution[331] (→ transfer) or to develop new ideas for bigger and more complex (in terms of costs, partners, requirements) endeavors[332] (→ development). The idea of a mutually beneficial concept of engagement (→ give back)[333], combining the interests and support of many actors, may spark the development of completely new ideas that are meant to help Africa as well as Europe.

The motivation of actors forms the basis of a project. The belief that the engagement will contribute to the delivery of health services in Ghana, in the local community or a receiving facility[334] as well as religious belief (trust in God as reasoning for continuous involvement)[335] are strong motives that are not very susceptible to external challenges (e.g. difficult funding situation) (→ conviction). Depending on a project's development, motives can be subject to change over the course of the engagement. For example, positive experiences with the effects of high quality equipment influence the recipients'[336] idea of a useful donation (→ quality) and determine the communication with donors. One way to define a successful project is to focus on actual needs[337] (→ flexibility), and to prioritize the feasibility and implementation of a project over big ideas. Another approach is to plan comprehensive projects and creatively develop a vision to

[328] 23_01_01(38ff.) cooperation with international organization
[329] P2: 03_06_01(91-102) adoption agreement
[330] 18_01_02(28)
[331] P1: transfer of discarded beds from a German institution to Ghana (32_01_01(52))
[332] P1: buy land and build a research institution with focus on malaria (32_01_01(74))
[333] P1: give back, benefits for Africa, Europe, diaspora (32_01_01(103))
[334] 19_01_02(4); 26_01_01(18) hospital/ patients
[335] 01_01_01(33)
[336] 03_06_01(9, 87-90)
[337] 03_01_02(38) children's ward – orphanage (ideas to help with own resources)

strive for[338] (→ creativity). In the latter case, restrictions of funding and other resources are not considered hampering factors.

The idea of creating a benefit that goes beyond a single project is reflected in the approach of giving training and to ensuring that knowledge is transferred, thereby enabling the staff of a hospital to perform certain modes of treatment beyond the visit of the donor [339] (→ build competences), to use respective equipment and to be capable of repairing it if necessary[340] (→ create ownership). Success in this case is defined as empowerment that goes beyond the actual project.

[338] 03_01_02(38)
[339] 18_01_01(19)
[340] 03_07_01(58)

6 Discussion and Conclusion

In this chapter the major research findings of this study are critically discussed in context of the background information and aspects of the scientific discourse that have been presented in Chapter 1 and 2. Results from the analysis and synthesis (Chapter 4 and 5) are first summarised and reflected in (6.1) Critical Appraisal of Major Research Findings, followed by a discussion focused on (6.2) Limitations and Strengths of the Study. At the end, (6.3) Conclusion and Prospects are presented in the form of recommendations for different actors, including suggestions for future research.

6.1 Critical Appraisal of Major Research Findings

In the following section, for the purpose of critical appraisal the results from the analysis and synthesis (Chapter 4 and 5) are presented along the structure of the four objectives of the study[341]: (6.1.1) The Social Phenomenon of TNHPs with some of its major aspects (Objective 1 and 2), (6.1.2) Strategies of TNHPs in the Context of the Ghanaian Health System (Objective 3) and (6.1.3) Influential Factors and Dynamics of TNHPs (Objective 4).

6.1.1 Social Phenomenon of TNHPs

The first objective of this study has been to identify and explore the networks and interaction of Ghanaians living in Germany, who are engaged in different types of transnational health projects in Ghana. The social phenomenon of TNHPs has been investigated by identifying characteristic features of the engagement in respect of the project setup (→ 4.1 Setup of Transnational Health Projects), the actors involved (→ 4.2 Characteristics of Actors) and their activities and interactions (→ 4.3 Activities and Interactions).

Transnational health projects are a complex social phenomenon that includes different forms of activities and interactions, which are initiated or influenced by heterogeneous actors. They perform in the context of national and international, communal, organizational and corporate structures, depending on various kinds of resources and motivations. Even though the focus lies on activities in the health sector, the circumstances, constellations of actors, commitments and contributions are so diverse

[341] Social Phenomenon of TNHPs (objective 1), Actors' Interests, Motivation and Resources (objective 2), Logic of Action (objective 3), Development of TNHPs (objective 4)

that their exploration and interpretation of the phenomenon requires theoretical approaches from different areas of the social sciences.

The actor-oriented approach (Long 2001) provides a good framework that puts social practice of actors at the centre. At the same time it directs the interest towards key concepts like networks, social fields and agency.

Even though the TNHPs investigated are operated under similar (transnational) circumstances, the projects are strongly characterized by their individual actors and dynamic developments.

Social actors

The definition of social actors (→ 2.1.3 Actors Perspective and Interaction), which goes beyond the individual person and includes groups and organizations of all forms, reflects a spectrum of actors that has been found in this study.

The explorative study has made it possible to identify a range of projects that differ in terms of the location (urban/ rural), the objective of the project (services/ equipment), the target group (patients, neighbourhood, region). This heterogeneity can partly be attributed to the research method (→ 3.2 Methods and Tools of Data Collection), which was aimed at exploring the phenomenon of transnational engagement and detecting possible variations. However, the diversity of projects has also been a striking feature described by the recipients and the representatives of the Ghanaian health sector.

From the 1970s there as been a change from a state-centred notion of development, now putting emphasis on the market and on civil society. In this context, migrants can be seen as “the ideal agents for supporting economic and political development of their (former) home countries” (Faist et al. 2013:165).

The model of social order by Faist et al. (2013:160) highlights the interdependencies of civil society, putting it as a cross-cutting category in the context of family, state and market. According to these authors, civil society is an approach of “free collective action around shared interests, purposes and values” (Faist et al. 2013:161). Furthermore, transnational social spaces can be seen as “potential elements of civil society” (Faist et al. 2013:163). The activities of actors (e.g. not-for-profit NGOs, community groups, social movements) are often associated with the promotion of “democratization, human rights and gender equity” and the idea that they support social change (Faist et al. 2013:161). However, Faist et al. also point out that some aspects of civil society, e.g. strong political power, lack of formal legitimation, violent approaches, have been criticized (Faist et al. 2013:162). Actors of the diaspora, who

operate in a transnational space (e.g. hometown associations), can be seen as "ambiguous in that they may be the conduit of normatively desirable social remittances or the contributors to bloody and protracted violence" (Faist et al. 2013:162). At first sight, the engagement for health seems genuinely positive with donors aiming at supporting their family, health facilities and the Ghanaian health system (→ 4.5.2 Motivation). However, the actual effects on the recipients and on the entire health system in Ghana need to be carefully evaluated (→ 6.2.2 Conceptual Integration and own Contributions).

In order to better understand TNHPs as part of civil society, the findings from this study are put in context with the other elements of society (family, state, market).

Despite physical distance **family** ties have been found to be strong (Long 2008) across borders. Due to cheap travel and the availability of communication infrastructure (e.g. internet and cell phones) the contact in most cases is regular and intense. From the distance migrants have responsibilities and obligations for their families and they support their families in terms of "material and emotional needs" (Faist et al. 2013: 31). In Ghana, expectations to support not only the immediate but the wider family are strong (Mörath 2015) and at times overwhelming. The findings of the present study show that the reliance of personal relationships holds advantages and disadvantages at the same time. Interview partners report that for the implementation of TNHPs family can be a reliable partner, but the fact that there are no contracts makes it also difficult. Other relations that go beyond family, e.g. religious associations, not only "fulfil manifold spiritual but also social support functions" (Faist et al. 2013: 175). Religious communities play a major role for the life of Ghanaians in Germany and Ghana. They often support charitable projects (Mörath 2015:22f; Sieveking 2011). Similar to extended family, project ideas can be extended to more people through the community and also generate more support in Germany. The strong presence of religious organizations in the Ghanaian health sector (e.g. Christian Health Association of Ghana (CHAG)) also makes them a valuable cooperation partner for TNHPs.

According to Faist et al. the **state** has to provide a framework of human, civil, political and social rights, a certain degree of autonomy to civil society agents and "space for pluralistic political life" (Faist et al. 2013:168f). For the areas of migration and health, which are of particular interest in the context of this study, the position of the Ghanaian state has changed over the years (→ 1.3 Ghanaian Diaspora in Germany and Ghana). And while the state used to claim the power of "inducing and controlling societal development", now "the large majority of […] diasporic charity activities [are] focused on core activities of the state. Schools, hospitals and infrastructure are among the most important icons of statehood and public welfare in Ghana and represent uncontested

goals of community development. […] By supporting hospitals, schools and public infrastructure, migrants can represent themselves as collective actors who assume some of the responsibilities of the Ghanaian state." (Nieswand 2009:26).

Awumbial & Teye reported in 2014 that in respect of migration and diaspora Ghana had laws which aimed to "facilitate the participation of the diaspora in development" as well as laws which limited its "full involvement in some aspects of socio-economic development of the country" (Awumbila & Teye 2014). Their recommendation to pass a comprehensive migration policy (Awumbila & Teye 2014) was completed with the launch of the National Migration Policy (NMP) in 2016. The policy was developed in an inter-sectoral collaboration of state and non-state stakeholders (e.g. ministries, diaspora associations, migrant groups, development partners). Under the topic of labour migration, "transforming the brain drain into brain gain through the promotion of initiatives that would enhance engagement with highly skilled emigrants and the Ghanaian diaspora" (MOI 2016) is described as one of the key concerns.

Another topic of the migration policy relevant in the context of this study is transnationalism. It is presented from the perspectives of remittances, resources and dual citizenship (MOI 2016:69ff). The policy also holds an extensive collection of strategies for its implementation, which range from data availability to aspects of the institutional framework (e.g. review and harmonization of existing laws and policies) and institutional arrangements with different stakeholders. The explicit commitment of the Ministry of Health, for example, is to "create an enabling environment that will retain Ghanaian health professionals and attract those in the diaspora for re-engagement. It will be required to facilitate the process of re-engagement of health professionals in the diaspora when they return home to settle. The Ministry will also create a platform for the skills transfer of health professionals, both of those returning permanently and temporarily. MOH will further engage with Ghanaian health specialists in the diaspora to broaden the scope and capability of Ghana health care service." (MOI 2016:85).

The NMP outlines a comprehensive plan that also reflects some of the criticism expressed by interview partners of this study. One example is the establishment of a support structure (Diaspora Affair Bureau, Ghana National Commission of Migration (GNCM)) that coordinates the different interests and aims for better communication between the different stakeholders and for greater transparency. The implementation of monitoring and evaluation system as a measure to adjust the policy in its process seems to be in accordance with the dynamic character of transnational engagement in the area of health. However, the practical implementation of the policy poses challenges. One year after the launch, the GNCM, a crucial precondition for further activities, has not yet been established. According to an interview by Yeboah (Yeboah

2017), stakeholders attributed the stagnation to political developments (2016 was an election year in Ghana). Especially the commitments to implement the whole policy, and not just pieces of it, proved difficult. Furthermore, sharing collected data on migration between the different agencies has caused problems. To date, the role of NGOs and civil society organisations, which work in the areas of democratisation, governance, migration and development and which are described to "ensure government compliance in the implementation of NMP" (MOI 2016:88) have not been evaluated.

The Ministry of Health and its agencies regulate the Ghanaian health sector and provide most curative, preventive and promotive services (→ 1.2 The Ghanaian Health System). Important partners supporting governmental organizations are IOM and international development cooperation (e.g. the European Union, German agency for international cooperation (GIZ), the Dutch Embassy in Ghana). While the Ghanaian government acknowledges that the health sector can benefit from diaspora engagement, the requirements and regulations are not always clear. Standards for medical professionals (by the Medical and Dental Council) or the launch of Guidelines for Donations and Voluntary Medical Outreach Programmes are examples for the regulations by the state that affect TNHPs directly. However, the statements of interview partners illustrate that information about requirements are often difficult to obtain. At the same time, the extent of formal requirements poses challenges to the donors as well as to the recipients. Often they are described by migrants as a source of frustration (corruption). According to the interviews the role of embassies is not very prominent. In the context of TNHPs, the government has different, at times contradictory, strategies in place, aiming to attract engagement and at the same time control activities.

The third element of society is the **market**. Faist et al. describe a change from "state-led development through international organizations such as International Monetary Fund (IMF) and its structural adjustment programmes" since the late 1970s, resulting in a decrease of the public sector in developing countries and the strengthening of civil society "to replace the service provision and social care provided by the state" (Faist et al. 2013:172). The notion that allocating resources by competitive market mechanisms is "superior to the authoritative allocation of resources by the state" (Faist et al. 2013:172) has strengthened the position of civil society, and therefore migrants, as a force of development.

In Ghana the MOH has been working on a private sector policy since 2003. Private health providers only play a minor role in the context of this study, most of the TNHPs are cooperating with public health facilities. However over the years the utilization of

private health facilities by patients has increased. Reasons for that lie in the government's cooperation with the Christian Health Association of Ghana (CHAG) as well as the implementation of the National Health Insurance Scheme (NHIS), which covers services from public and accredited private facilities (Saleh 2013:9).

In addition, partnerships between public actors and NGOs in the health sector have been growing (Hushie 2016). While there is not much research on the topic, the qualitative study by Hushie (2016) revealed the heterogeneity of public – NGO partnerships in Ghana, their capacity to improve service delivery, reduce health inequities and disparities. According to this author the potential of NGOs "lies in their knowledge, expertise, community legitimacy, ability to attract donor funding and implementation capacity to address health needs in geographical areas or communities where the government does not reach and for services, which it does not provide" (ibid.:1).

Roles and (assumed) responsibilities of the different social actors in the field of health and migration are often not clear-cut. On the one hand, the entanglement of their activities can be fruitful and inspiring, e.g. if needs are clearly communicated and can be met with available resources or new projects are implemented and sustained). On the other hand, it can lead to adverse effects if a lack of communication or wrong assumptions lead to excessive demand and frustration. This study shows that sometimes diaspora organizations or individuals are overwhelmed with expectations. Compared to NGOs specialized in the health field, TNHPs usually cannot deliver the same professionalism in health care provision and systems development.

Reciprocity

Even though as an analytical heuristic to identify the direction of flows, it has been helpful to distinguish between donor and recipient in the context of this study, the interview partners do not necessarily describe the recipients as being passive and the donors as taking the active part of the exchange (→ 4.3 Activities and Interactions). Influenced by their experiences and expectations, the actors establish their strategies to promote their interest. However, it is important to realize that usually an actor is never exclusively giving (donating) or exclusively taking (receiving) (Mazzucato 2006).

Questions about resources (how is the TNHP organized?), interests (what is the topic of the TNHP?) and motives (why are actors getting involved?) have already been part of the interview guideline. Over the course of the data analysis, the different aspects of the respective categories have been differentiated.

The concept of resources in this study follows Bourdieu's theory of capital (Bourdieu 1983) (→ 2.1.4 Resources and Social Capital). It has proved applicable for organizing and grouping the different kinds of resources mentioned by interviewees, i.e. monetary, material (economic), structural, social (cultural) and human, immaterial (social) resources (Table 6: Resources of TNHPs). It is important to note that, depending on the topic of the TNHP, different resources are needed. Monetary resources and funding were often explicitly described as a prerequisite of a TNHP (→ 4.4.1 Monetary and Material Resources). Established projects that have proven successful and already receive funding and publicity (P1; P3) are likely to attract more funding, while projects that struggle have problems to convince investors (P4). Structural and social resources (→ 4.4.2 Structural and Social Resources) correspond to personal relationships, i.e. belonging to a group and other networks. These resources have been investigated for Ghana and Germany respectively. Within the frame of social, institutional, legal, national and community structures, the actors establish and strengthen transnational connections. At the same time, they influence their framework conditions. Existing relationships are described as valuable resources that help to build new interdependences. Human and immaterial resources (→ 4.4.3 Human and Immaterial Resources) relate to a wide range of qualifications, experiences, values and different forms of knowledge. The former are particularly relevant for the donation of services, while the donation of medical equipment does not necessarily require medical training or medical knowledge.

As it was defined earlier, one of the main characteristic features of transnational health projects is that they emerge and are shaped by actors and interactions that are not restricted to one country. The constellation of migrants living and working in Germany and at the same time entertaining ties to Ghana, their country of origin, is the key assumption.

The interaction between actors, social networks and a community, is said to be based on "values of trust, reciprocity and solidarity, bounded by rights and obligations of members towards each other" (Faist 2008:23). The values "constitute capital which yields interest; for example, access to financial and other social resources (Faist 2008:24). The interview partners in this study expect and practice reciprocity in the form of material as well as immaterial contributions, transparency and respect). Their approaches and attitudes are shaped by experiences and closely linked with expectations.

The assumed value of community ties for development has been recognized by the World Bank and by NGOs, which promote “participatory forms of development at the local level” (Faist 2008:24). According to the primary health care approach the participation of community helps to identify needs and problems (→ 2.2 Concepts of Health System Development), which is also shown in examples from this study. Migrants who were engaged in TNHPs either had a good idea bout what is needed (P3: engagement of a doctor who knows the Ghanaian health system by his own professional experience) or have connections via family and friends to acquire relevant knowledge about what is needed. Another advantage of the involvement of community is that a community has capacity and resources, which can contribute to the development and implementation of suitable solutions (→ 2.2.1 Primary Health Care and Community Participation). The exploration of resources, which TNHPs draw upon, has shown that the forms of contributions are diverse. They have the potential to advance health care in many ways: obviously, support of health care can occur through individual skills (e.g. if a qualified doctor gives training to students or provides services to patients in Ghana (P3)) or through material resources (e.g. donation of hospital beds (P1)), which are strongly connected to financial/ economic resources. In addition, the application of social resources (e.g. networks, knowledge about structures and different cultures) can foster development of the health sector indirectly as well. Leading by example, showing initiative and inspiring other people to become active and develop a motivation to become involved in community work - all this can be seen as beneficial for community development and may lead to the improvement of health issues as well. Even seemingly negative experiences with the engagement of the diaspora (e.g. donation of less useful equipment or expired drugs) can indirectly improve the health situation, when actors in Ghana become aware of their actual needs and actively develop their guidelines to generate donations of better quality in the future.

Agency

According to Long (2001) “agency (and power) depend crucially upon the emergence of a network of actors who become partially, though hardly ever completely, enrolled in the ‘project’ of some other person or persons.” (Long 2001:17) In order to better understand the dynamics and developments of TNHPs, it is important to consider the complex project structures in terms of actors and interactions. The maps of actors and their connections (Annex E0-E5) visualize the network structure for each project. By depicting the actors and interactions, the key positions held by some actors are highlighted. While the resources that individuals bring into a project can be very beneficial for the development of a project, the dependence on a singular person also

poses high risks: his or her withdrawal (planned or not) can have a hampering impact on the development of the project (→ 4.2.2 Individual/ Collective Endeavor).

One of the main aspects of TNHPs are interactions in terms of transferring money, equipment, ideas, skills, etc. from one party (donor) to the other (recipient). The donor/ recipient concept (2.3 Sampling) reflects an attitude that determines many interactions. Interview partners who support a project describe themselves, or their partners respectively, as being in need or as helping/ assisting. Several case studies found that the interests of migrants and of those who stay in the country of origin often differ. It is stated that the "relationship between migrants and non-migrants is characterized by a donor – beneficiary relationship rather than a collaboration of partners and equal members of the community" (Faist et al. 2013:79).

In the present study, similar to Faist (2010), donors who have knowledge about the health setting, professional expertise and current experiences in the medical field are described as supportive and helpful. However, the idea that migrants who get involved with their home country have an advantage (e.g. in comparison with international NGOs or development cooperation), only because of their knowledge of local circumstances and culture, is not always a given (Sieveking 2008:26). The discontent is mutual, with overly dominant migrants that do not sufficiently take local requirements into consideration[342], and with recipients that do not communicate their needs[343].

In the context of this study the concept of agency as "knowledgeability, capability and social embeddedness associated with acts of doing (and reflecting) that impact upon or shape one's won and others' actions and interpretations" (Long 2001:240) has been reflected in the findings on resources of different actors. Furthermore, motives and interests (of donors, recipients, supporters) are actor-related characteristics, the particular combination of which influences the development of a TNHP. Expectations inherent in social roles influence the attitude of actors. Depending on the different project settings, actors are confronted with expectations or develop their own expectations. Sometimes, merely thinking that something is expected of him or her already has an effect on an actor's motivation (→ 4.5 Motives) and triggers activities. Given that most of the explicit expectations imply high requirements from both sides,

[342] Statement of a representative of a health facility (P3 ("Engagement of a doctor") "They have the idea: we want to support our local hospital to improve health. Fine, but they sit there and decide what they think the hospital should-, will need. And they spend so much money and they ship it. Some of them they have to buy. And they ship it and come. And it's so expensive. But sometimes if they had even contributed the money and come and order it here it may be cheaper. And then they would bring the things and some of them-, that is not actually what the hospital needs at that time. So if they don't communicate with the people and they bring something that you may not need." (18_02_01 (9))

[343] Statement of a the donor (P3 "Engagement of a doctor") "Sometimes they [health facilities] need the help but they don't really know what they need. Sometimes they know what they need but they don't know how to get it." (26_02_01 (31))

there is also the likelihood of disappointment on both sides. It is not surprising that the experiences of donation often have a negative connotation. Interview partners have even described that high expectations towards Ghanaians living abroad, in terms of monetary support, in some cases prevent them from returning to their home country. Most of the interview partners have found a way to deal with frustrating experiences, e.g. by tolerating disappointments as part of the process (P3) or by ignoring problems and just planning other activities or talking to new potential project partners (P4). Sometimes resignation and setting one's own priorities are also options (P5).

Resources and motives can be seen as the major categories that determine whether TNHPs come into existence. With these preconditions given, the specifications of resources and motives influence the development of a project. Some of the above-mentioned resources are actor-related, i.e. their availability depends on the participation of certain actors. The withdrawal of key actors can have major consequences for the project. Other resources, especially structural conditions (e.g. regulations to import donations into the country, official guidelines to apply for funding, customs regulations), are defined by certain actors like MoH and GHS or by supporting organizations like GIZ or IOM. This means that they are also in a position to shape the conditions for TNHPs.

Focusing or specializing a TNHP is a way to generate interest, strengthen bonds, accumulate support and meet expectations. Some specializations need to be pursued more actively than others. While donating hospital beds that became available at one's workplace (P1) to a health facility in Ghana is a topic that comes as an opportunity, the idea to give training to students (P3) requires the active suggestion to do so by the donor. While the benefit of the latter is that an active decision for a topic can provide for the consideration of actual needs from the beginning, the seizing of an opportunity may help the project to start from a better basis. Some topics have the potential to direct and fuel a project over a period of time. Others might present obstacles (e.g. if the focus is too narrow and excludes ideas of the actors involved, or if it is not compatible with the existing resources).

All actors have "tools" to influence the development of a TNHP. This might be the development of guidelines to regulate donations to the country or to a health facility, agreements for collaborations (e.g. adoption of a ward), criteria about the preconditions that need to be fulfilled to apply for support (IOM), or to formally sign contracts and choose whom to work with. The availability and awareness of resources is crucial to the initiation, continuation and completion of a project. It has been found to affect the attitude of actors and to encourage or hamper their further engagement.

6.1.2 Strategies in the Context of the Ghanaian Health System

The third objective of this study has been to assess the logic of action that transnational engagement in the context of health is based on. By identifying actors' strategies (→ 5.1 Strategies and Logics of Action), the activities of actors have been contextualized and a typology of transnational engagement has been constructed (→ 5.2 Characterization of Types).

When we now try to better understand the social phenomenon of TNHPs, the goal is to learn about this specific area and how actors, their experiences, values, ideas and perceptions shape it.

The three types of TNHPs, which were developed from the data of this study, show three different forms of positioning in a transnational community on the basis of the general topic 'engagement for health'. Health is one of the main areas towards which engagement is directed (DeWind & Holdaway:21). Rooted in a traditional understanding of social security, where the community steps in if one of its members falls sick, health constitutes a high value for the community (Arhinful 2001:5f). Other areas of engagement that have also been found relevant in the literature are e.g. education, infrastructure and business. In Ghana, remittances for funerals also play an important role for the community.

Most of the available studies on the engagement of Ghanaian migrants for their home country (Mazzucato 2005, 2009; Nieswand 2011; Arhinful 2001) do not focus on one particular area but analyse all diaspora activities in the transnational context. However, health is one of the main areas of engagement. Especially the shortages of skilled health personnel (Asabir 2009) have directed attention and measures, of the Ghanaian state, international development cooperations (e.g. with Germany and the Netherlands), organization like IOM and UNDP as well as NGOs. This has taken the form of policy and programs, for example.

In her article about the Ghana TransNet research program, Mazzucato (2005) analyses the double engagement of migrants based on the argument that "migrants are oriented towards their home country and therefore invest little in their lives and their surroundings in The Netherlands" (Mazzucato 2005:6). She identifies three different strategies that are applied by migrants to support their home country. These strategies are related to their resources and their socioeconomic position in The Netherlands. The connection between personal resources and the ability of migrants to strategically plan activities for Ghana, or the host country for that matter, is an interesting perspective that is also reflected in the typology developed in this study. A situation of economic hardship can prevent migrants to become active, which might be the case in TNHPs of

Type III. On the other hand, an approach of reacting to evolving needs sometimes has the consequence of overwhelming the actors, which is why projects might end as described in Type II. A situation where migrants set up a profitable business and generate funds can be related to Type III TNHPs, where independence and continuity also determine the development of the project.

Actors communicate throughout the whole course of a TNHP. In a transnational environment that is characterized by a large number of actors with their different interests and expectations, the likelihood for misunderstandings is high. Especially at the beginning of a project, getting in contact with the respective other actors (donors, recipients, supporters) has been mentioned as a crucial factor by most interview partners (→ 5.1.1 Strategies Regarding: Interaction and Communication). During the course of the interviews, a number of innovative ideas have been described about how to diversify the sources of funding in order to minimize the risk of running out of funds. In a rather resource-poor setting, it is highly competitive to organize funding for a project. The availability of the resources required has an impact on the development of TNHPs, as has been described within the scope of developing the different types (→ 5.1.2 Strategies Regarding Resources).

When contextualizing categories and indentifying strategies within the scope of the data analysis, it has turned out that while these topics are at the centre of each TNHP, no strategies were put forward that focused on the interests of actors. Since some of the answers, which interview partners gave about “interest” were connected to “motivation”, for the further course of the analysis those two aspects have been summarized under strategies regarding motives (→ 5.1.3 Strategies Regarding Motives).

Types (5.1.4 Type Construction; 5.2 Characterization of Types)

The development of Types has served as an instrument to contextualize the strategies identified and to specify transnational engagement in the area of health (4.1.4 Type Construction). By combining the striking patterns concerning resources (**availability** of resources, as a combination of network strength and degree of need) and motivation (**attitude of actors**, as a combination of positive/negative experiences and degree of motivation), new categories have been created. Their relevance has been tested by allocating the cases (actors) to these categories and thus the typology has evolved.

The types of transnational engagement that have been constructed are “continuous engagement” (Type I), “single action” (Type II) and “planning” (Type III). The presence (or absence) of continuity and the provision (or lack) of resources are the main

characteristics. A TNHP can have facets of different types. As the way in which motivation and availability of resources develop over time is a crucial factor, it is also possible that the type changes over the course of the project. Some developments seem to be more likely than others, e.g. the change from a single activity to planning is more likely than from continuous engagement to planning. At the same time, there is no guarantee that a project will work out or be continued.

Looking at other actors involved in transnational activities (e.g. institutions of the state, health facilities, NGOs), their approach towards TNHPs reflects some of the characteristics that were identified in the three types.

With the implementation of the National Migration Policy, the government sets clear objectives and strategies to create conditions under which migrants can continuously contribute to the country's development. The launch of Guidelines for Donations and Voluntary Medical Outreach Programmes by the MOH, for example, was an attempt to provide information to ensure best preparation for TNHPs. The complex explanations illustrate that engagement in the health sector requires thorough knowledge of the structures. They also suggest that experience, in the health sector and/ or in the transfer of donations and services, is desirable. Under these circumstances, the routine and resources of "continuous engagement" (Type III) clearly has an advantage. The provision of information, as done in the guidelines, as well as the plan to establish the Ghana National Commission on Migration, as it was proposed in the NMP, might become an important resource for actors in the diaspora as well as their counterparts in Ghana. They have the potential to support continuous engagement.

By implementing guidelines, health facilities also aim at setting a clear framework in order to use existing resources in the diaspora most efficiently. The interest in collaborating with reliable actors on continuous projects is high.

Type I projects are success- and growth-oriented, and often receive the confirmation by their partners that their contribution is valuable and appreciated. However, the engagement that refers to Type II is also valuable and success-oriented, but has no perspective or orientation towards additional or more promising ideas and projects.

For Type III projects, being involved, keeping in touch and showing engagement often already constitutes an achievement under difficult conditions. Continuity also plays a major role, but the engagement does not so much depend on success.

If the primary goal is not (cannot, should not be) to actually improve the Ghanaian health system, from the actors' perspective Type III can be just as valuable as Type I in terms of involvement and motivation.

6.1.3 Influential Factors and Dynamics of TNHPs

The fourth objective of this study has been to identify factors that support or hamper the implementation of transnational health projects (→ 5.3 Outcomes and Influential Factors). This has been done by looking at the dynamics of dependence/ influential factors, but also adaptations on the basis of actors' own evaluation. The involvement of actors in TNHPs and the way in which this is connected to available resources (→ 4.2 Characteristics of Actors) have been identified as influential factors for dependency. Different degrees of dependency have also been identified: These are determined by the importance of the service or equipment to the recipient (need) and the level of difficulty to provide the resource with the continuity required (permanence) (→ 5.3.1 Dependency).

Dependency

Dependency may serve as an indicator for how well the permanence of donations and needs are aligned. The projects under study have shown different examples of dependency. The range starts from a project that is not completed because it depends completely on the provision of health care personnel for operating a clinic (P4), over the donation of hospital beds that are in use and serve as a comfortable addition to the health facility (P1), to an engagement that involves services and training of health workers to support the capacity of health care delivery in the long run (P3). It is striking that if the donation is made by the actors' own means (e.g. professional medical skills, financial resources), the organizational effort is less and the engagement can be more reliable. By contrast, if the means have to be generated on a voluntary basis or in the way of formal contracting, progress is often more difficult.

Continuity

The feature of continuity and its influence on the development of TNHPs can also be found in the Typology. It is important to note that continuity is not only a characteristic of continuous engagement (Type I). TNHPs that refer to a single action (Type II) can be of continuous benefit for the recipient, when they have long-term effects that reach beyond the project as such (e.g. equipment that can be used when the project is already completed or competences that are transferred to Ghanaian health workers).

With their commitment the TNHPs contribute, to different degrees, to the crucial characteristics of effective health care (availability, accessibility, acceptability, utilization and quality). The provision of hospitals beds and renovations can improve the quality of health facilities. Working as a medical doctor in health facilities increases the provided services and because of special qualifications certain treatments become available. With the attempt to open a CHC in the North a project even aims for accessibility.

Attempts of TNHPs to provide healthcare in the form of professional medical services, may it be through their own medical qualification or by employing other people, has been shown to be difficult. While the offer of temporary services (e.g. performance of a limited number of surgeries during a visit (P3)) are possible to organize with the given time resources, to provide continuous funding to employ medical staff is not doable for the TNHPs, which were subject of this study. Since especially the development of HRH depends on continuity (Campbell et al. 2013) the role and relevance of TNHPs in this area of the health sector needs to be assessed.

Cooperation

The health sector is a good example for the different forms of engagement (e.g. establishing healthcare centres, sending medical equipment) and the at times conflicting expectations and interests. While the donors side is often driven by altruism and self-interest (Lucas & Stark 1985) as well as obligations, reciprocity and solidarity (Faist 2000), the confrontation with difficult formalities, high costs, bureaucracy, the suspicion of corruption can also prevent engagement. The Ghanaian government and receiving actors (e.g. health facilities) often in need for support and show appreciation. But they also have quality standards, minimal requirements and sometimes struggle to harmonize the charitable engagement with running an institution or facility.

On the one hand, communication in an environment of physical distance and in the face of cultural and professional differences has been described as challenging (→ 4.3.3 Communication and Cooperation). This is despite the development of technical communication making it much easier to stay in contact (→ 1.1 Ghana – country profile). On the other hand, communication about needs has been named as a crucial factor by donors, recipients and supporters alike. Some have highlighted that the recipients gained more influence over the course of the projects (→ 4.3.2 Categories of Activities).

In the perception of donors and recipients, the exchange of information and the agreement on common goals for a TNHP are essential. They facilitate the design of projects that are valuable for all actors and promote independence rather than

dependence. Thus they are examples of supporting and hampering factors as they show in the different Types can have an influence on the development of a project. Clear objectives, which are characteristic for Type I and II, often lead to concrete advice and activities that can promote the smooth progress of a project. Unclear and open approaches, as they are characteristic for Type III projects, are unlikely to lead to activities, but rather stay vague and fade eventually. A complex topic that requires extensive funding over a long time, e.g. the need for medical personnel, can be too difficult to be organized by one actor (Type III). By contrast, contributing with one's own medical skills (Type I) seems more feasible, e.g. when delivering services or trainings.

The lack of supporting factors does not necessarily imply that the process of a TNHP is hampered. Neither does the existence of supporting factors "automatically" have a positive impact. The influential factors illustrate that factors are usually not exclusively negative or positive, but an accumulation of certain factors often leads to either progress or stagnation. The assessment of interview partners themselves also serves as an indicator for positive and negative developments of TNHPs.

The benefits of cooperation are not only limited to interaction between donors and recipients. According to Mörath "the diaspora lacks a strong and unifying leadership that would succeed in mobilising as many clubs/associations as possible to advance development in Ghana. Ethnic, political and individual interests predominate. There is too much rivalry and competition among the clubs/associations, which prevents collective efforts to drive development in Ghana." (Mörath 2015:39).

6.2 Limitations and Strengths of the Study

The discussion in this section focuses on (6.2.1) Practical and Methodological Challenges, including the limitations, which result from applying qualitative research methods in a transnational setting. The strengths of the study are delineated under (6.2.2) Conceptual Integration and own Contributions. Major findings with regard to the aim of the study, e.g. the overarching research question concerning the impact of TNHPs on the Ghanaian health system and on transnational networks, will also be assessed.

6.2.1 Practical and Methodological Challenges Met

Field access and sampling

By applying the methods of theoretical and snowball sampling among the Ghanaian diaspora in Germany and their counterparts in Ghana (Chapter 3), I have been able to explore the different perspectives (donor, recipient, supporter) of TNHPs. The sampling strategy was also applied in order to identify interview partners among representatives of the governmental institutions and health facilities in Ghana. Thereby, a large number of interviews was generated, not all of which contributed directly to answering the research question. However, they have been necessary to get access to the networks and structures in Ghana and Germany that affect transnational engagement. This approach has also helped to develop my understanding of the subject, the actors in the field and procedures. The flexibility of the approach suited the difficult planning conditions, but it also turned out to be a time-consuming technique. Furthermore, it is geared to accessing a certain type of migrants (Mazzucato 2009), namely those who are highly motivated and engaged in projects that mostly relate to established health facilities of GHS, and those who are integrated into diaspora networks.

The strategy to meet interview partners at their workplaces and at the project sites required extensive planning, arrangement for meetings and then travelling to the sites. While the effort was high, the opportunity to experience the working and travelling conditions also contributed to a better understanding of the circumstances under which TNHPs are carried out.

The order by which the interviews were conducted was determined mostly by the restricted time of the research phases in Ghana and the availability of interview partners. Analytical considerations, as suggested by Przyborski and Wohlrab-Sahr (2009), had to be subordinated. The main focus of research interest was on actors in Ghana or those related to the Ghanaian health system. Most of the interviews, even the ones with Ghanaians who lived in Germany at the time of the research, were done in Ghana. A simultaneously matched sampling methodology (Mazzucato 2010) was rejected due to limited resources for the research. This would have been necessary to access more interviewees within the Ghanaian diaspora in Germany and to gain a better insight into their community and their social structures.

Shaped by the given circumstances (e.g. research program, funding, time) the study was set up between Ghana and Germany and focused on diaspora activities in the context of these two countries. However, networks and social practice of Ghanaian migrants spread worldwide and are not restricted to nation states. In order to avoid

"methodological nationalism" (→ 2.1.1 Transnationalism) it would also have been appropriate to follow network structures regardless of national borders (Faist et al 2013:137ff). On the other hand, the national context does shape the community structure of the Ghanaian diaspora and is also particularly relevant for the field of health systems development. Therefore, the chosen approach was justifiable.

At the point of research, the projects under study had reached different project stages (Table 1). Therefore the assessment of the individual projects took place under different conditions. Some projects had already been completed at the time of the interviews and the interview partners reflected on a completed process (P1). Other projects were right in the middle of the engagement and current developments were assessed (P3). In other cases, the reported engagement related to past events that had to be recollected.

Problem centred interviews

In most of the cases, the interview partners expected to be asked specific questions about their projects. The broadly formulated introductory questions of problem-centered interviews (Witzel 2000) often did not work out as a trigger for free account about the project and personal assessments of the interview partners, even though I had described the method in the briefing (Annex D3). Over the course of the research, and in accordance with Witzel's method of applying different conversation strategies flexibly, I shifted to asking specific questions based on my knowledge of the project or the professional context of the interview partner at the start of a conversation. Follow-up questions ensured the deeper understanding of complex descriptions regarding structures and procedures. The questions "Where do you see the project in ten years from now" or "Do you have anything more you would like to bring up, or ask about, before we finish the interview?" were asked at the end of an interview. In many cases, these questions triggered the free narrative and motivated the interview partners to talk about additional topics and aspects that they considered most important.

Development of a typology

According to Kelle and Kluge, the development of a typology is determined by the research question and has an impact on the sampling (Kelle & Kluge 2010:47). Grouping the cases and analyzing empirical regularities, which has been described as the second stage of constructing a typology, depends on the size of the sample. However, the decision to build a typology of transnational engagement has been an outcome of the first data analysis within the scope of theoretical sampling. Since the projects were not directly comparable due to their different states of implementation,

building a typology offered a feasible possibility to integrate the findings into a frame that does not focus on a direct comparison of cases. The method was selected after the data collection had been started. Therefore, the development of the typology needed to be adapted to the existing data basis. Initially, I had chosen TNHPs as cases of analysis, since my intention was to look at transnational engagement not solely from the individual's perspective. Instead, I had chosen an actor-oriented approach that also considers other entities as social actors (Long 2001:16). Since the study is limited to five projects, it has been difficult to develop the types from this sample size by contrasting cases. In order to differentiate between the different types by developing internal homogeneity and external heterogeneity (Kluge 2000), a larger number of cases would have been necessary. Therefore, I chose to consider individuals as cases (Table 20), so as to develop an idea about the different types of engagement. The process of developing the typology has been a useful instrument to gain a better understanding how Ghanaians living in Germany engage with Ghana and sharpen the findings in respect of characteristic features of transnational engagement. The complexity of the phenomenon is revealed. At the same time, approaches to explain different dynamics are offered.

The methodological approach has helped to contextualize the different strategies pursued by the different actors and thus to identify differences in their engagement. However, the size of the study does not allow generalizing the results in a statistical manner. The typology that I have eventually developed would need to be reviewed and verified with a larger number of cases to reach a stronger result in terms of generalizability. Nevertheless, the detailed analysis offers many starting points for further investigations, in a qualitative or quantitative sense.

6.2.2 Conceptual Integration and own Contributions

The aim of the study was to evaluate the possible effects of TNHPs on availability, access and perception of health services in Ghana as well as the potential influence on transnational networks. Based on the findings from Chapters 4 and 5, the possible effects of TNHPs are discussed in the following.

Impact of TNHP on Ghanaian Health System

Given the scope of the study, the findings do not allow for identifying a causal connection between the diaspora engagement and development in the Ghanaian Health Sector. However, depicting possible connections and providing a broad overview of different aspects of TNHPs (including experiences, background information

etc.) allows for the identification of factors that influence developments of health service provision.

The original concept of PHC included the introduction of low-skilled health workers in order to increase the coverage as broadly as possible and to focus on prevention. This idea is not reflected in the interview material gathered, neither in this nor in other studies concerning lay people's perception of health services (e.g. Haddad et al. 1998). The interview partners' actual approach and the content of their projects rather puts a emphasis on hospital-based (or at least facility-based) curative care.

Over the past years, with measures like Community-Based Health Planning (CHPS) and the National Health Insurance Scheme (NHIS) the Ghanaian government has aimed to strengthen primary health care and UHC in Ghana (PAI 2017). A study by Fenny et al. indicates that in Ghana the majority of MDG indicators, and therefore living conditions, have significantly improved (Fenny et al. 2017). However, the study also shows that especially with regard to maternal and child health (MDG 4 and 5) progress has been slow. According to the authors of this study "key investments need to be made in the health sector, especially in the areas of access to good quality care, to narrow gaps in access and financing" (Fenny et al. 2018:233). Based on the experiences from the MDG-process Fenny et al. point out lessons that can be learned for the development of policies to achieve the SDGs. They identify Public-private partnerships (PPPs) as a promising solution to improve the healthcare system. Another important factor is the strengthening of governance "through rigorous monitoring mechanisms for results and budget tracking" (Fenny et al. 2018:233). In the context of implementing SDG in Ghana and especially in respect of primary health services (SDG3 on good health and well-being) Fenny et al. highlight the role of civil society and community. The UN Communications Group (UNCG) in Ghana and the Civil Society Platform on SDG (CSO) encourage civil society organisations and NGOs to raise awareness "about the importance of good health, healthy lifestyles as well as people's right to quality health care services" as well as to "hold government, local leaders and other decision-makers accountable to their commitments to improve people's access to health and health care" (UNCG 2017).

As part of the transnational community TNHPs under study all relate to the structures of the Ghanaian health system. Some of them do so more directly, as they offer services and equipment to governmental health facilities (P1; P2; P3), others follow the aim of building services that are supposed to compensate for a perceived lack of governmental structures. This may be undertaken in collaboration with GHS (P5) or as a private endeavour (P4). Representatives of governmental institutions, either at the national level or at the level of health facilities, emphasize the benefits of transnational

engagement as a useful addition to the services offered. However, it also became clear that the adherence to standards (e.g. with respect to equipment) and procedures (e.g. donation guideline, see Annex A) is important to not only be beneficial but to also prevent negative effects. While transnational engagement on the one hand can be seen as a form of contribution that is comparable to private sector involvement in the health system, on the other hand it also shares characteristics with development aid (Phillips 2013).

The approach of SDG has been criticized for its „vague obligations for non-governmental actors“ and how “key SDG documents remain[…] state-centric with great room for state sovereignty, self-regulation and respect for national circumstances“ (Bexell & Jönsson 2016).

Putting the engagement of TNHP in context of the needs and developments in the Ghanaian health sector it is important to note critically that while “in most cases migrant associations donate goods that are of practical use for the receiving institutions […], compared to the limited volume of most donations the discourse on diaspora and development often appears ‘oversized’.” (Nieswand 2009:28). To create realistic expectations on the donors’ as well as on the recipients’ side seems to be just as important the state to takes responsibility for the sustainable development of the health system.

In terms of development potential the health sector has gained attention over the last years (Asabir 2011). The discourse of migration and diaspora communities (Faist 2008) has changed from “brain drain” to “brain circulation” and “brain gain”, from financial resources (remittances) to other forms of (social) contributions. The development of policies shows a comprehensive approach that aims to integrate the potential of migrants and create mutually beneficial cooperation. While it is widely agreed that the engagement of the diaspora does have an impact, the actual contribution is difficult to describe. Some of the reasons might be: that the forms of engagement (the efforts) are difficult to measure when the donation of medical equipment is seen as a “development ritual”, the (symbolic) relevance and impact of the donation (e.g. a couple of hospital beds or an ambulance) is difficult to evaluate (Nieswand 2009), the definition of development is not clear and the responsibilities of actors is debated.

Dependency and evaluation

The findings about dependency, i.e. the typical pattern that has been identified, points out how the development of TNHPs can be interpreted in terms of sustainability. They

indicate how an impact of TNHPs on the Ghanaian health system can be generated. As interview partners, representatives of health facilities displayed an awareness of the problems inherent to dependency on donations. Different measures directly related to the practice of health facilities were brought to my attention (donation guidelines). The extent of development aid programs of international organizations and their impact on the Ghanaian health sector are significant. This has brought the topic of aid dependency to the national agenda and has facilitated a sector-wide approach to establish norms of donor and government behavior (Wood Pallas et al. 2015). The Ghanaian government has taken measures to improve the situation by implementing aid effectiveness principles (OECD 2012). The major principles (ownership, alignment, harmonization, management for results, mutual accountability) that refer to the national level and international donor programs can also serve as an orientation for small-scale projects.

Interview partners in the present study expressed that their goal was not only to help and support but to **improve the health care** for the Ghanaian people. The results from this study do not allow for general conclusions on effects of TNHPs. However, while in some cases TNHPs presumably increased the quality (e.g. by renovations, hospital beds, training of students) and availability of health care (e.g. by performing surgery), their engagement mostly reaches places where structures and health services already are available. Engagement in the North of the country and in rural areas, where access to healthcare is least developed (→ 1.1 Ghana – Country Profile), is a logistical challenge for donors. Additionally, most Ghanaians in the diaspora are from the South and urban places and their engagement is primarily directed towards their families and home communities. This constellation bears the risk that inequalities are not reduced but maintained and even increased (→ 2.1.4 Resources).

Impact of TNHPs on transnational networks

Despite the discrepancies with official health policy described above, transnational engagement in the health field carries another important feature of the PHC concept, which is the idea of community participation. Ghanaians abroad can be seen as (transnational) members of the community. Their desire to improve health care and access to health care etc. in their home country might not always be compatible with the needs the recipients, but on the other hand, the expectations towards the heterogeneous diaspora community can also be overwhelming.

According to Nieswand “it is difficult to evaluate the impact of the donation of a limited number of mattresses, beds or an ambulance to a hospital respectively some computers and books to a school on the development of a town, an ethnic group or

even the country as a whole. This disparity between the rhetoric employed in the diaspora and development discourse and its practical impact highlights the relevance of the symbolic dimension of these activities.“ (Nieswand 2009:28). The TNHPs have in the context of this study, with their strategies and resources, have creates different outcomes with respect to the health system but also with respect to their community in Germany. The effects of engagement (e.g. being part of a community, serving as an example for people in Ghana and abroad) need to be taken into account in order to assess the full potential and “success” of TNHPs. As a consequence, the actors involved in the development of policy and projects need to adjust their expectations accordingly.

With transnational engagement in the area of health, lasting effects can also be achieved for the individual actors. For example, the feeling of success after having completed a project might provide for the motivation to get engaged again at a later point in time. Another positive effect might be that active actors serve as a positive example to other actors from the community. Even when a project is not completed, the engagement and continuous effort shows a strong sense of belonging and has the potential to strengthen the ties between the diaspora and residents in Ghana. Since all Ghanaian interview partners living in Germany mentioned that they are planning to return to Ghana at some point, continuous engagement for structures of the Ghanaian Health system can create good access to possible permanent working arrangements. As such, engagement in transnational health projects yields incentives for return migration.

6.3 Conclusion and Prospects

Based on the research findings, the following conclusions about the potential influences of transnational health projects on the Ghanaian health system can be drawn. The five TNHPs that serve as examples for this explorative study, interviews beyond these projects with actors from the field in Ghana and in Germany, findings from literature, studies, articles and reports from the internet allow for an outlook and for recommendations concerning different areas and actors that were found to be relevant to the implementation of TNHPs.

TNHPs provide an opportunity to Ghanaians in Germany to take an active role and contribute to health care in their home country by sharing knowledge, skills and resources. The social phenomenon of transnational engagement is characterized by

motives and interests (of donors, recipients, supporters) as well as their actor-related resources, the particular combination of which influences the development of a TNHP.

Outlook for donors and recipients:

Since in the process of implementing a TNHP donors and recipients often represent "two sides of the same coin" and are closely interlinked in their activities, the outlook refers to both actors.

- Communication about needs, resources and expectations was identified as one of the main supporting factors that helps to implement a TNHP. In order to be able to identify and then communicate needs, recipients have to be aware of potential problems in the collaboration and have to be in a position to strategically develop the organizational structures of the health facility.
- An awareness of the partner's capacities, realistic goals and the adjustment of own expectations are critical considerations for donors and recipients alike.
- The assessment and evaluation of projects offers important insights for donors and recipients. Especially when the projects continue (Type I), a systematic review (as it is was done on the context of the MIDA program by IOM) offers important insights that can improve the performance of TNHPs.
- Rivalry between different diaspora groups in Germany and competition for resources to support projects prevents synergy effects. Even though collective efforts might require more communication, it is likely that the coordination of activities and joining forces could also strengthen the actors' position for development in Ghana.

Outlook for policy development:

- Over the past years the Ghanaian diaspora policies have already changed towards a more activating approach. Taking the findings of this research into account, the development and implementation of policies seems to be most promising when the needs and interests of donors, recipients and supporters are included. Even though it often is a lengthy process, relevant actors with experience in the field should be included in the development of policies in order to improve acceptance and adherence. This was done by the Ministry of Interior with the development of the National Migration Policy and also by the Ministry of Health with the development of guidelines for donations and voluntary medical outreach programmes in the health sector of Ghana for

example, but it applies to any administrative level (e.g. organizational, district, national)). However, the participation of actors needs to be secured beyond the development phase of a policy. Information and communication about the policy are crucial for its successful implementation. At the same time the experience with the NMP and also with the guidelines for donations shows that inter-sectoral approaches are prone to stagnation when administrative entities do not exist, are not functional or lack the necessary power/ agency.

- As much as the promotion and integration of diaspora engagement has the potential to create benefits for the Ghanaian health system, the responsibility remains with the Ghanaian government to provide adequate health care to all Ghanaian people. Therefore, the development of policies should strengthen the position of government agencies and health facilities and should be aligned with laws and adequate funding which are essential to improve the Ghanaian health system sustainably (even though non-governmental actors should also be included into the strategy).

Outlook for further research

Having pointed out patterns of interaction and compiled experiences of Ghanaians living in Germany as well as from the side of the connected communities in Ghana, it is possible to identify different perspectives for further research:

- For the purpose of feasibility, this study has focused on the engagement of Ghanaians who live in Germany and get involved with health projects in Ghana. It would be also interesting to look at other constellations of transnational engagement, such as activities of the Ghanaian diaspora in other countries concerning the health field (e.g. United Kingdom, the United States of America or other African countries), engagement in other sectors (e.g. education) or engagement of Germans or other foreigners in Ghana. This would allow for analyzing different circumstances (e.g. cultural, structural, political) and comparing the outcomes.
- The focus in this study has been primarily on TNHPs and their effects in Ghana as the receiving country. Being aware that TNHPs can have an effect on the sending as much as on the receiving community, it is necessary to also look at the mutual influences and interdependencies. Therefore, the effects on donors and their communities in e.g. Germany would be interesting to investigate, in order to better understand the full potential of transnational engagement. The

Project “Meeting Bismarck”[344] is a good example for continuous engagement (Type I) that was initiated by a German midwife in 2012 and since then triggered health and education-related developments in a Ghanaian community (e.g. donation of an ambulance, renovating the local health facility and a school as well as building a quarter for nurses and establishing an exchange program with German nurses). The engagement for Ghana was also the starting point for the campaign #aufdentischhauenfürhebammen[345], which subjects the current situation of obstetrics in Germany to public debate.

- A broader data basis (qualitative and quantitative) regarding transnational activities would allow for a more thorough impact assessment of transnational projects on the development of the Ghanaian health system. The transnational character of the activities often requires a combination of data collected locally or nationally in order to produce meaningful research findings. To be able to reflect the complex actor constellations and requirements of different (national) systems, this data needs to be collected from different actors like individuals, communities, health facilities and state agencies in Ghana and Germany. International organizations like WHO and IOM can play an important role to collect and provide such data.
- The exploration of transnational health projects in this study illustrates the complexity of this social phenomenon, which is tangent to different levels (e.g. personal motivation and expectations, interpersonal relationships, agency, policy development, approaches to primary health care). With the intention of better understanding TNHPs and their contribution to the development of public health, an interdisciplinary research approach is required to include different perspectives.
- While on the one hand a stronger quantitative data base would be helpful to further explore the phenomenon of TNHPs, on the other hand a participatory research approach would be an appropriate method to not only include the actors perspective but also to empower especially the Ghanaian diaspora (Ross 2017). The topic of TNHPs already has attracted a certain degree of awareness among leading actors (e.g. Ghanaian government, health facilities, development organizations) and is firmly based in the community setting (e.g. diaspora community in Germany, context of primary health care). Therefore, the participatory approach seems to offer various starting points to generate new

[344] https://www.meeting-bismarck.de [Accessed 10.06.2018].

[345] http://www.gerechte-geburt.de/home/veranstaltungen/aufdentischhauenfürhebammen/ [Accessed 10.06.2018].

knowledge and at the same time provide benefits to the participants (ICPHR 2013).

The assessment of supportive and hampering factors is influenced by expectations on all sides. For the Ghanaian health system, TNHPs represent valuable contributions that have the potential to complement the access to and provision of health care for the country. However, it is also challenging to coordinate and integrate the donations and services offered. While the projects under study show a positive impact on the development of Ghanaian health facilities, it also becomes clear that TNHPs are not in the position to remove the structural constraints (Faist 2011:11) that the Ghanaian health system faces.

The study contributes to a better understanding of the transnational links between Ghana and Germany. Such documentation of transnational engagement by the Ghanaian diaspora can be used as a tool to efficiently coordinate activities and to benefit from the resources. Those suggestions have the potential to promote the perception and effects of the engagement of Ghanaians living in Germany and may serve as a resource for Ghana – especially in the health sector.

The expected findings about transnational health projects will be accessible for both regional and national institutions and organizations in Ghana and Germany who work with the Ghanaian diaspora, such as the Ministry of the Interior (Migration Unit), Ghana Immigration Service and actors in the field of public health (Ministry of Health, the Ghana Health Service). Ghanaian associations in Germany as well as organizations engaging in development cooperation between Ghana and Germany (such as the CIM) can also benefit from the study.

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Annex

Annex A: Donation Guidelines

Source: Guidelines for Donations and Voluntary Medical Outreach Programmes in the Health Sector of Ghana. Ministry of Health. Pages 1 - 6

1

Introduction

The Guidelines for Donations and Voluntary Medical Outreach Programmes in the Health Sector of Ghana (MOH) has been issued by the Ministry of Health (MOH) of Ghana. The guidelines are based on the guidelines for Drug Donations (second edition, 1999) developed by the World Health Organization (WHO) in collaboration with major International Agencies active in humanitarian relief.

The WHO department of Essential Drugs and Other Medicines released the file with the guidelines in which necessary changes have been made to address the country and sector- specific issues.

Further to this, the Minister of Health inaugurated the special task team to co-ordinate donations and Voluntary Medical Outreach Programmes within the Health Sector . The team which is multi-sectoral in nature has representatives from key stakeholders such as the Ministry of Health (MOH), the General Health Service (GHS), the Food and Drugs Board (FDB), the Komfo Anokye Teaching Hospital (KATH), the Korle-Bu Teaching Hospital (KBTH), the Ghana Atomic Energy Commission (GAEC), the Customs Excise and Preventive Service (CEPS), Medical and Dental Council (MDC),the Biomedical Engineering Unit (BEU) of the Ministry of Health & the Ministry of Manpower, Youth and Employment (MMYE).

Anecdotal evidence shows that there are different scenarios for donations and voluntary medical outreach programmes in the Health sector of Ghana. They may take place in acute emergencies or as part of development aid in non-emergency situations. They may be corporate donations and voluntary medical outreach programs, (direct or through voluntary organisations), aid by governments, or donations aimed directly at single health facilities.

Although there are legitimate differences between these scenarios, there are many basic rules for appropriate donations and voluntary medical outreach programmes that apply to all. The Guidelines aim to describe this common core of "varied donations and voluntary medical outreach services or programmes" and how these activities are conducted.

It also aims to improve the quality of donations and voluntary medical outreach programmes in the health sector and also to encourage more of these well- intentioned donations and medical services.

The Guidelines are a binding regulation for all parties involved in donations and voluntary medical outreach programmes, that is donors, recipients and institutions facilitating the donations and voluntary medical outreach programmes. They are to be implemented in the public and private health sector.

This document starts with a discussion on the need for guidelines, followed by a presentation of the four core principles for donations and voluntary medical outreach programmes.

2 The Need for Guidelines

In the face of disaster and suffering there is a natural human impulse to reach out and help those in need. Medicines and other medical supplies are essential elements in alleviating suffering. Donations and voluntary medical outreach programmes can enhance relief effort. However, the inappropriate way and manner some of these exercises have been conducted, defeats the purpose and intent for which it was instituted .These guidelines are therefore developed to guide the exercise of donations and voluntary medical outreach programs to obtain the desired purpose.

2.1 Current Concerns & Problems

There are many examples of donations and voluntary medical outreach programmes which cause problems instead of being helpful (see annex 1). It has been noted that very often donations and medical outreach programmes are not always preceded by needs assessment based on epidemiological data and past experience. Emotional appeal for massive medical assistance is issued without guidance on what is priority or felt needs.

Donated medical equipment are usually used devices decommissioned from health facilities abroad. Most of these devices are near the end of their useful life span and are therefore associated with frequent breakdown when re-used. In an environment where technical support is inadequate, they soon become non-functional and unusable.

Furthermore, those who are actually involved in the donation process may not be very technical and may not have adequate knowledge on the devices they are donating. There are several instances where useful accessories and manuals are omitted from the donations leading to non utilization of the donated item.

A frequent unacceptable occurrence is when hospitals in the developed world decommission equipment, dismantle them with the

intention to scrap them and pay scrap removers to convey them to scrap warehouses for disposal, only for these scraps to be repacked and shipped in addition to personal belongings of the donors. The package is subsequently presented to the Ministry of Health as donation of medical equipment in order to enable the donor enjoy free taxes, duties and shipping cost on personal items imported into the country.

The main problems identified with the donations can be summarised as follows:

(a) Donation of drug, non-drug consumables and medical equipment

. Inadequate needs assessment on beneficiary institutions that receive such donated items
. Lack of clarity on policy guidelines on donations to the Ministry and its Agencies
. Non-adherence of donors to existing guidelines on donations as a result of institutional weakness in the enforcement of such guidelines
. The tendency of some donors to use donations to the Ministry as a decoy to engage in fraudulent activities, including dumping of unserviceable goods.
. Undue political pressures often put on health facilities to receive items they may not need
. Relative poor quality of some donated items
. Lack of information on clearing requirements, which result in undue delay in the clearing of such donations from the ports
. Lack of coordination between relevant stakeholders involved in the entire exercise
. Lack of impact assessment on donations to the health sector and beneficiaries
. Lack of information bureau on donations to potential donors
. Many donated items arrive unsorted, unlabeled or labeled in a language that is not easily understood
. Some donated drugs come under trade names which are not registered for use in the recipient country, and without an International Non-proprietary Name (INN, or generic name) or other required labeling details.

. The quality does not always comply with standards in the donor country. For example, donated drugs may have expired before they reach the patient, or they may be drugs or free samples returned to pharmacies by patients or health professionals.
. The donor agency sometimes ignores local administrative procedures for receiving and distributing medical supplies. The distribution plan of the donor agencies may conflict with the needs in the recipient country or the wishes of national authorities.
. Donated items may have a high declared value, e.g. The market value in the donor country rather than the world market price. In such cases import taxes and overheads for storage and distribution may be unnecessarily high, and the (inflated) value of the donation may be deducted from the government drugs and medical supplies budget.
. Drugs may be donated in the wrong quantities, and some stocks may have to be destroyed. This is wasteful and creates problems of disposal at the receiving end.

(b) Coordination of voluntary medical outreach program.

. Absence of needs assessment
. Inadequate information on the profile of the health professionals who undertake the medical outreach programmes in the country
. Inadequate involvement of regulatory bodies and other agencies in the coordination of such programs
. Lack of monitoring and evaluation of the quality of services rendered by the outreach teams
. Inadequate follow-up actions/ review on patients treated by the outreach team owing to the non- involvement of local counterparts
. Possible permanent incapacitation of patients who may receive medical treatment from quack or unqualified persons
. The likelihood of medico-legal issues that may crop up from professional negligence of the voluntary medical outreach team

- Absence of inadequate documentation of actions /procedures taken during such outreach programmes by the medical mission.

There are several underlined reasons for these problems. Probably the most important factor is the common but mistaken belief that in an acute emergency any type pf drug is better that none at all.

The guidelines for Donations and Voluntary Medical Outreach Programmes contain instructions that are specific to the Ghanaian situation. They should be used in conjunction with the existing regulatory framework in Ghana.

In summary guidelines are needed because:

- Donors intend well, but often do not realize the possible inconveniences and unwanted consequences at the receiving end.
- Donors and recipients do not communicate on equal terms.
- Recipients may need to be supported in identifying their needs.
- Donations must be based on a sound analysis of the needs, which may vary between countries and from situation to situation.
- Donations must be based on a sound analysis of the needs and their selection and distribution must fit within existing policies and administrative systems. Unsolicited and unnecessary donations are wasteful and should not occur.
- The quality requirements of medical supplies are different from those for other donated items, such as food and clothing. Drugs can be harmful if misused; they need to identified easily through labels and written information; they may expire; and they may have to be destroyed in a professional way.

3

The Overall Vision, Strategies, Core Principles & Key Stakeholders

3.1 OVERALL VISION:

The overall vision of the MOH in developing this guideline is ***"to ensure that the health sector and nation as a whole derive maximum benefits from future donations and voluntary medical outreach programmes."***

3.2 KEY STRATEGIES :

3.2.1 Development of comprehensive Guidelines on Donations and Voluntary Medical Outreach Programmes
3.2.2 Build requisite advocacy on the guidelines
3.2.3 Enforcement of the provisions in the guidelines.

3.3 FOUR CORE PRINCIPLES:

3.3.1 All donations and voluntary medical outreach programmes should benefit the recipient.This implies that all donations and voluntary medical outreach programmes should be based on an expressed need and that unsolicited donations are to be discouraged.

3.3.2 All donations and voluntary medical outreach programmes should be conducted in conformity with existing government health policies and administration guidelines

3.3.3 All donations should meet international standards and quality. There should be no double standards in quality; if the quality of an item is unacceptable in the donor country it is also unacceptable as a donation.

3.3.4 There should be effective communication in procedures regarding donations and voluntary medical outreach programmes between the donors and the recipient.

3.4 KEY STAKEHOLDERS

- MOH and its Agencies
- Ministry of Finance & Economic Planning
- Ministry of Manpower, Youth and Employment
- Ministry of Local Government and Rural Development
- Customs Excise & Preventive Service
- The VAT office
- The Foreign Missions
- Non- Governmental Organizations
- Faith-Based Medical Institutions
- Private Health Institutions
- Religious Bodies
- Quasi-Government Institutions.

4

The Guidelines

The Guidelines are in two parts:

1. Guidelines on Donations of Drugs, Medical Supplies and Healthcare Equipment.
2. Guidelines on Medical Outreach Services

4.1 GUIDELINES FOR DONATIONS OF DRUGS, MEDICAL SUPPLIES AND HEALTH CARE EQUIPMENT IN GHANA

4.1.1 SELECTION

1. All donations should be based on an expressed need and be relevant to the disease pattern in Ghana. These should be based on existing and approved selective list on drugs, medical supplies and equipment.

2. All donations items should appear on the national standards lists.
   - Drugs or their generic equivalents should appear on the list of Essential Drugs
   - Medical supplies on the standard list available
   - Medical equipment list.

An exception can be made for items needed in sudden outbreaks of uncommon or newly emerging diseases

3. The specifications of donated items should be similar to those of items commonly used in Ghana

4.1.2 QUALITY ASSURANCE

Practical Implementation

Donor should forward application for registration to the FDB. *(It takes approximately 3 months to register a product with the FDB)*

1. Drugs and non-drug consumables (household chemicals, cosmetics and medical devices) must be approved by the Food & Drugs Board (FDB) in Ghana.
2. For equipment, approval by the Biomedical Engineering Unit (BEU) of the Ministry of Health in consultation with the Ghana Standards Board is needed.
3. No items issued to patients and returned to the pharmacy or elsewhere, or were given to health professionals as free samples should be donated.
4. All items intended for donation should have a minimum shelf life of one year on arrival unless otherwise mutually agreed with the recipients
5. All items should be labeled in English with the following information :

- Full designation of product, i.e. Generic name, dosage form, composition, doses and routes of administration/ directions for use and product license or registration number
- Compendia standards (e.g. British, U. S. & European Pharmacopoeia)
- Content
- Manufacturing and expiry date;
- Name and address of the manufacturer;
- Name and address of supplier;
- Storage condition;
- Warning instructions.

6. Products requiring refrigeration or freezing for stability must specifically indicate storage requirements, both on labels and containers as well as on the documents and be shipped in special containers to ensure that the cold chain is maintained.

4.2 THE FOLLOWING GUIDELINES APPLY TO HEALTH CARE EQUIPMENT:

4.2.1 Used Equipment

Donor shall submit the following detailed information to the Biomedical Engineering unit of the Ministry of Health **before** the items are shipped. Donor should wait for a feedback and the authorisation before the items are shipped.

1. The names of the items
2. The model, the manufacturer, the serial numbers and the year of manufacture.
3. Availability of user and technical manuals
4. The year of commission and decommission
5. The name and address of previous user
6. The state and current location of the items

Failure to comply with this requirement shall lead to outright rejection of the donated items.

4.2.2 New Equipment

Donation of new equipment must fit into the Ministry of Health Equipment Development Planning Program (EDP). Donors intending to support healthcare activities in the public sector through donation of new equipment must therefore consult the Biomedical Engineer Unit of the Ministry of Health for a list, specifications and application guidelines.

4.3 THE FOLLOWING GUIDELINES APPLY TO ALL ITEMS:

1. International and local transport, warehousing, port clearance and appropriate storage and handling costs shall be borne by the donor, unless specifically agreed otherwise with the recipient in advance.

2. Each outer carton (with reasonable storage size) should be clearly marked with the following:

   . Code number of product
   . Pack sizes
   . Total quantity in carton;
   . Serial number of carton;
   . Name and address of suppliers;
   . Name and address of the beneficiary facility (consignee)
   . Storage conditions

3. Each shipping carton should meet the following minimum specification (possible exceptions for equipment):
   . Kg double wall (B&C Flute);
   . Bursting test 25 kg per square cm;
   . Total weight of lining material 5 kg per 1,000 square cm;
   . Size limit 120cm x 100cm x 100cm;
   . Gross weight limit 50 kg.

4. Packing of different items in any carton is not allowed. Each outer carton shall contain the same items from the same batch only.

5. As much as possible, donated items should be presented in larger quantity units and hospital packs.

4.4 JUSTIFICATION AND EXPLANATION

Large quantity / packs are cheaper, less bulky to transport and conform better with public sector supply systems in most developing countries. This provision also prevents the donation of drugs in sample packages. In precarious situations, donation of pediatric syrups and mixtures may be inappropriate because of logistical problems and their potential misuse.

1. All drug donations should be packed in accordance with international shipping regulations, and be accompanied by a detailed packing list which specifies the contents of each numbered carton by international non proprietary name, dosage form, quantity, batch number, expiry date, volume, weight and any special storage conditions. The weight per carton should not exceed 50 kilograms. Drugs should not be mixed with other supplies in the same carton.

4.5 JUSTIFICATION AND EXPLANATION

This provision is intended to facilitate the administration, storage and distribution of donations in emergency situations. It is also to make the identification and management of unmarked boxes containing different drugs and non drug consumables less time consuming and labour intensive. This provision specifically discourages donation of small quantities of mixed drugs. The maximum weight of 50 kilograms ensures that each carton can be handled without special equipment.

5 Voluntary Medical Outreach Programmes

5.1 Registration Of Practitioners For Short Programmes

The Ministry of Health views with grave concern the practice where voluntary health service are provided without recourse to registration and regulation of practitioners.

In some cases the practitioners practice and leave the country without being registered. This is illegal. In other cases, patients are managed without provision for adequate follow-up arrangements. These constitute professional misconduct under the existing Regulatory Bodies Act.

In accordance with existing legislation therefore, health and allied health professionals who intend to practice in Ghana require appropriate registration with relevant regulatory bodies.

The MOH requires that all institutions and individuals responsible for the organisation of voluntary medical outreach programmes especially foreign based practitioners must adhere to the following:

- Application forms for temporary registration of the practitioners should be obtained from the Registrars of the relevant regulatory bodies.
- All completed application forms should be lodged with the respective Registrars at least three months before the arrival of practitioners.
- The Ghana Health Service, the Teaching Hospitals and other Health providers where practitioners intend to work must be informed of the pending visit **THREE MONTHS** before arrival of the team.
- In cases where medical treatment is provided by the medical teams, a written report should be submitted to the Ministry of Health and the relevant agencies for purposes of monitoring.

6 Clearing Requirements on Donations

The Ministry of Health facilitates port clearance of donations to the health sector. Some of these may be exempted from import duty, import VAT and National Health Insurance Levy (NHIL).
Other levies such as the ECOWAS levy, the export development investment fund (EDIF), Ghana Community Network (GCNet) fee and processing fee must be paid. In addition , port handling charges and demurrage charges shall be borne by the donor/ recipient.

With the exception of ambulances and hearse, all other vehicles attract import duty and VAT unless by parliamentary approval. The following conditions must also be met:

1. An expressed need by the beneficiary
2. A comprehensive packing list from the donors with estimated value for customs purposes.

The declared value of a donation should be based upon the wholesale price of its generic equivalent in Ghana, or if such information is not available, on the wholesale world-market price for its generic equivalent. This provision is needed solely to prevent over invoicing which may lead to elevated overhead costs for import tax, port clearance and handling in the recipient country. It may also result in a corresponding decrease in the public sector drug budget in the recipient country.

3. Donors Certificate or Deed of Donation
4. Bill of Lading or Airway Bill
5. In case of drugs and other medical devices, an approval letter from Food and Drugs Board is needed at the port

6. In case of hazardous chemicals, approval from the Environmental Protection Agency is needed
7. In case of radioactive materials and equipment, approval from the Ghana atomic energy commission.
8. NGOs require recommendation letters from the Ministry of Manpower, Youth and Employment (MMYE). (Application from the NGO on their letter head with photocopies of all import documents must be submitted to the MOH and routed through the MMYE to the Ministry of Finance and Economic Planning).
9. Ministry of Finance if satisfied with the application will then issue letters to VAT and CEPS. The response from VAT will be attached to the CEPS' copy from the Ministry of Finance. These shall be presented to CEPS headquarters.
10. CEPs shall issue a duty and VAT exemption letter under the existing laws to the Port of Entry.
11. Any other item apart from those consigned to Health and Education shall attract the appropriate taxes and levies as spelt out in ACT 594 of 2001 for example, food and clothing.
12. The processing of documents must start early (at least 3 months) before the arrival of the goods to avoid any inconvenience.
13. When the above conditions have been fulfilled, the following are applicable:

IMPORT DUTY	-	EXEMPT
IMPORT VAT	-	EXEMPT
NHIL	-	EXEMPT
ECOWAS	-	0.5%
EDIF LEVY	-	0.5%
GCNET FEE	-	0.5%
PROCESSION FEE	-	1%

Other appropriate taxes are to be paid. Specific grants and credit agreements which have exemption clauses shall be treated as such.

7

Information Management on Donations and Voluntary Medical Outreach Programmes

1. Donors should provide timely and adequate information on all donations and voluntary medical outreach programmes to relevant stakeholders and all stakeholders shall act in a reciprocal manner.

7.1 JUSTIFICATION AND EXPLANATION

Many donations arrive unannounced. This practice is unacceptable. Detailed advance information on all donations and voluntary medical outreach programmes is essential to enable the recipient plan for the receipt of the donation or medical outreach service and to co-ordinate the donation or medical outreach service with other sources of donations. The information should at least include:

- The type and quantities of donation drugs including their International Non-Proprietary Name (INN or generic name)
- The strength and dosage form
- The manufacturer and expiry date
- Reference to earlier correspondence (for example, the letter of consent by the recipient)
- The expected date of arrival and port of entry.
- The identity and contact address of the donor.

Annex B: Adoption Agreement

ADOPTATION AGREEMENT

BETWEEN

.....

ADOPTEE

AND

[redacted]

.....

CLIENT

IN RESPECT OF ADOPTING

.....

ADOPTATION AGREEMENT

This agreement is made this.....between the Client [redacted] on one part and ..... (Herein after referred to as the Adoptee on the other part)

Whereby it is agreed as follows: The client lets and the adoptee takes care and maintain

.....

For the term of **ONE YEAR (12 Calendar months commencing from** .....)

REQUIREMENT FOR ADOPTATION OF WARDS/BLOCKS

The following and other responsibilities that may become necessary from time to time shall be the requirement that qualifies one to adopt ward(s) / block(s)

1. To keep the adopted premises in good and habitable condition.
2. To do internal painting annually.
3. To repair/replace electrical, carpentry and plumbing fittings at least quarterly.
4. To maintain and keep the floor finished in good condition.

GENERAL CONDITIONS

The Adoptee can terminate this agreement by;

1. Giving one month notice in writing to the client, vice versa.
2. The agreement is subject to review and renewal annually.
3. Inspection of the adopted premises would be carried out by the two parties every three months.

Provided that after the said term of **one year**, it shall be open to the adoptee and the client to review the agreement upon such terms as to adopt, as shall be agreed upon.

ADOPTATION AGREEMENT

In witness whereof the parties have hereunder set their hands this

Day.....

ADOPTEE/REP. (SIGNATURE).....

Name of individual/organization .....

.....

Position .....

Address / Tel. No. .....

WITNESS: (SIGNATURE) .....

Name: .....

Address / Tel. No. .....

CLIENT: (SIGNATURE) .....

Name: .....

(CHIEF EXECUTIVE [redacted]

WITNESS: (SIGNATURE) .....

(HEAD OF DIRECTORATE/REP. [redacted]

NAME: .....

Position .....

ADOPTATION AGREEMENT

3

Annex C: Research Phases

Interview	Date	Phases	Project	Ghana; PH2; PH4
01_01_01	28.08.2010	PH1	P4	Germany; PH1; PH3; PH5
02_01_01	20.09.2010	PH1		Netherlands; PH3
09_01_01	30.11.2010	PH2		
03_01_02	07.02.2011	PH3	P2	
01_01_02	08.02.2011	PH3	P4	
04_01_01	17.02.2011	PH3		
08_02_01	03.05.2011	PH4		
08_04_01	04.05.2011	PH4		
18_01_01	05.05.2011	PH4		
19_01_02	05.05.2011	PH4	P5	
08_05_01	06.05.2011	PH4		
03_02_02	12.05.2011	PH4	P2	
05_02_02	16.05.2011	PH4		
05_03_02	19.05.2011	PH4		
21_01_01	26.05.2011	PH4		
07_01_03	27.06.2011	PH4		
03_02_03	28.07.2011	PH4	P2	
18_01_02	02.08.2011	PH4	P3	
18_02_01	02.08.2011	PH4	P3	
20_02_02	04.08.2011	PH4	P5	
22_01_01	04.08.2011	PH4	P5	
20_01_03	05.08.2011	PH4	P5	
24_01_01	29.08.2011	PH4		
23_01_02	01.09.2011	PH4	P3	
25_01_02	21.10.2011	PH4		
25_02_01	26.10.2011	PH4		
03_03_01	01.11.2011	PH4	P1	
03_04_01	01.11.2011	PH4	P1	
03_05_01	01.11.2011	PH4	P1	
03_06_01	01.11.2011	PH4	P1;P2	
03_07_01	02.11.2011	PH4	P1	
03_08_01	02.11.2011	PH4	P1	
26_01_01	03.11.2011	PH4	P3	
26_02_01	03.11.2011	PH4	P3	
25_03_01	09.11.2011	PH4		
25_04_01	10.11.2011	PH4		
27_01_01	11.11.2011	PH4		
01_03_01	16.11.2011	PH4	P4	
27_03_01	16.11.2011	PH4		
28_01_01	21.11.2011	PH4	P1	
28_02_01	21.11.2011	PH4		
29_01_02	05.12.2011	PH4		
30_01_01	05.12.2011	PH4		
28_03_01	09.12.2011	PH4		
29_02_01	12.12.2011	PH4		
29_03_01	13.12.2011	PH4		
31_01_01	13.12.2011	PH4		
29_04_01	15.12.2011	PH4		
32_01_01	17.03.2012	PH5	P1	
33_01_01	05.07.2012	PH5		

Annex D1: Interviews Guidelines Experts

Interview guide – for Ghanaian people who know about the Ghanaian diaspora

Introduction – personal background		
For a start I would like to ask you a little bit about your personal background. Can you please tell me about what you do?		
Content	Questions	Follow-ups
- (Migration biography) - education and vocational training - work/ occupation - daily routines - activities - priorities	- (How did you come to Germany?) - What education and vocational training or studies did you complete? (in Ghana and/ or Germany) - What is your occupation? - Can you please describe a typical working week to me? - (How is your life here in Germany related to Ghana?) - (Are you a member of an association/ organization that is related to Ghana?) - In what organizations/ institutions are you involved? - (Has your engagement for Ghana developed/ changed over time?)	

Ghanaian community		
1 Please tell me about your experience how Ghanaians living in Germany are engaged with Ghana. 2 How is the Ghanaian community organized in Germany (Germany)		
Content	Questions	Follow-ups

Who?	- Who are the Ghanaians that are engaged with their home country?
	- Who is involved?
	  o Men/ Women
	  o how long in Germany?
	  o what are their plans?
	  o what do they do?
	-	

What?	- What are the topics of interest? - Could you identify areas of engagement? - Where or for what or for whom are Ghanaians in Germany engaged? - What is essential for health projects? Any difference to other projects (e.g. for education, infrastructure, investment in economical development, …)	

How?	- How do Ghanaians in Germany organize their engagement?
	
	- What formal structures need to be considered when people cooperate with Ghana?
	
	- With whom do people work together?
	  o Are there counterparts in Ghana?
	  o Do people cooperate with people from other African countries?
	
	- From your experience: what makes projects work?
	- What is necessary to organize a successful project in Ghana?
	- When would you call a project “successful”?
	
	- What is the main source of funding for projects/ engagement?
	
	- Is there anything special about setting up projects from Germany (in terms of formalities, support, topics) compared to other countries (US, GB, …)	

Why?	- Why do people from Ghana get involved with their home country? - What is the purpose of their engagement? - What do they want to achieve? - What promotes engagement? - What hampers engagement? - Do they get back anything for their engagement?	
Perspective…	- How is the engagement perceived in Ghana? - Have the activities of the Ghanaian diaspora changed over time? - How is engagement going to develop in the future? - Do you know people who have set up projects with a focus on health?	

Annex D2: Interviews Guidelines Actors

Interview guide – for Ghanaians who organize Transnational Health projects in Ghana

Introduction/ Personal Background		
1 Please tell me about how your life here in Germany is connected to Ghana. 2 For a start I would like to ask you about your life here in Germany and how it is connected to Ghana. 3 Can you please tell me about how you live here in Germany and if that has anything to do with Ghana?		
Content	Questions	Follow-ups
- work - family and friends - free time - daily routines - activities - priorities	- how did you come to Germany? - Can you please describe your routines at work/ at home? - How would you describe a typical week? - Who are the most important people in your everyday life? - anything else? - and then?	
- transnational relations - network structures - means of communication - types of contact - frequency/ intensity	- How would you describe your personal relations to Ghana? - How would you describe your communication routines to Ghana? - How do you communicate and with whom? How often? - Are you connected to people in other countries as well?	

Project(s)		
You have mentioned that you have organized a project for Ghana. Can you please describe the project?		
Content	Questions	Follow-ups
What… - setup - structures - budget - course over time - topic - location - target group	- do people work for you/ your organization? - What are they doing - When you think of the formal framework of your project. What is important that is works? - Do you need equipment? - What is done in Germany and what in Ghana? - How do you raise money for the project? - When you think back to the beginning of the project and how it developed, has anything changed? - Did something become easier or more difficult? - How do you choose the topics that you work for? - Why “Health”? - How do you know what the people in Ghana need? - How do you/ did you choose the sites/ places where you wanted to implement your project? - for whom are you organizing your project? - Who benefits from your engagement? - anything else? - and then?	
How… - personal commitment - competence	- How much time do you spend working on the project? - What have you done before? - What are is your formal qualification? - How much does the project depend on you as a person? - How would you describe your contact/ relation to Ghana?	

Context - social/ professional network	- Who supports you? - Who is the most important person? - Do you take advice from anyone? - Do you have role models? - Are you a role model for other people? - - Is there anything special about organizing this project from Germany? - How important is it that you organize your project from Germany? Could you do the same thing from Ghana? - Do you know people who do the same work? - Do you connect with them? - Do you cooperate/ communicate with other organizations? - What is important when you work with other people? - How do you choose your partners?	
Why… - aims - motivation	- why did you start the project in the first place? - what do you want to achieve? - Why are you doing this? - Which problem do you want to solve with your engagement? - What inspires you? - Where do you take your strength from? - Do you get anything back from your work?	
Evaluation - problems/ obstacles - solution strategies - appreciation -	- what is the biggest challenge? - what obstacles do you face in your work? - What is the biggest success so far? - What frustrates you? - Have you ever been frustrated with you work? - What motivates you? - What is difficult? - What is easy? - What hampers you? - What supports you?	

	- What are the difficulties on the Ghanaian / German side of the project? - What was the biggest mistake in the context of this project? What have you learned form it? - How do you deal with setbacks in your project? - Where would you turn for help? - Are you happy/ satisfied with what you do? - do the people in Ghana appreciate what you do for them?	
Perspective	- Where do you see yourself/ the project in 10 Years from now? - do you have any plans how long you want to continue with this work? - Do you have any ideas for new projects?	

Annex D3: Briefing

Briefing

- define the situation
- tell about the purpose of the interview, the use of the recorder
- ask if the interviewee has any questions

At first I would like to **thank you** for taking the time for this interview.

Before we start with the interview I would like to explain briefly **about the study** which is part of my PhD-Project.

- This interview to me is a great opportunity! I want to take this chance to learn about your personal experiences.
- I am conducting the study to find out about the engagement of people from Ghana who don't live in Ghana but sustain connections with people and are involved in activities in Ghana.
- I am interested in all different kinds of connections and cooperation. How they are build and what keeps them up. I am looking at transfer and exchange between Germany and Ghana. And I am also looking at activities in Ghana.
- To get information I am talking to people from Ghana who live in Germany to learn about their experience with exchange or transfer activities. I want to get a picture of those connections and activities.
- I would like to know more about how ideas for projects emerge and what is necessary to put them into action.

Interviewee: Why do you want to know that?

I hope that you understand that I don't want to talk too much about the purpose of the study before the interview. That is just because I want to be open for all the new things you are going to tell me. But after the interview I'll be happy to answer all your questions.

In the course of this interview/ conversation I will pose different **open questions** and I would like to ask you to tell me everything that you consider relevant and important. For the answers there is no "right" or "wrong". I am interested to learn more about your personal point of view.

And even though today we only have approximately 1 hour for our conversation: We are not in a hurry. Please **take your time** to answer the questions. I won't interrupt you when you are answering.

As I have already mentioned before I would like to **record** and later **transcribe**/ write down the interview. Doing that is necessary for the following analysis. Another positive effect of the recorder is that it will be easier for me to follow our conversation since I don't have to write down your answers immediately. However I will probably take some notes during the interview as well, just so that I don't forget the questions that are crossing my mind.

Of course the material from this interview will be treated strictly **confidential and anonym**. That means that all personal data will be erased or anonymised to ensure that no one will be able to determine your identity based on your answers.

(In any case you can still decide after the interview how the material can be used for further analysis.) Therefore and to avoid any confusion concerning the data privacy I have prepared a text which summarizes the basic information about the study and all the formalities, that I will hand out to you after the interview.

Is that ok for you?

Do you have **any questions** at this point?

Then I would like to start with my first question…

Debriefing

- round off the interaction
- give the interview partner the chance to add (unexpected) aspects to the topic after you think everything has been said

"Now I have no further questions. Do you have anything more you would like to bring up, or ask about, before we finish the interview?"

THANK YOU VERY MUCH!

Interview

"How was the interview for you?"

"How did you perceive the interview?"

Motivation

"Why did you initially agree to participate in the interview?"

Annex E0: Project Description and Visualization

With the aim of giving an overview of the complex constellations of actors and interactions that characterize each project and in order to contextualize the analyzed data, the projects descriptions are structured according to the following topics:

- Data base (e.g. number of interviews, observations, additional material) and process of data collection (e.g. interaction with actors in Germany and Ghana, information that is needed to understand and contextualize the collected data)
- Project setup (e.g. timeframe, size, scope, topic, characteristics, involved actors, relationships and exchange process)

Furthermore each project is visualized in the form of a map after each project description. The following information serves as a reading aid:

- The map depicts actors and institutions (boxes) as well as interactions (arrows) in relation to the main subject of a TNHP.
- The size of the boxes and the length of the arrows do not indicate the importance of the actor or the intensity of the contact.
- Color coding of the boxes:
    - Red: main subject of a TNHP
    - Blue (and purple in Project 4): persons / real people
    - Green: organizations / institutions
    - Turquoise: groups of people that are defined by profession but do not belong to an institution (e.g. doctors, journalists)
    - Yellow: (inter)national (non)governmental organizations
- The dotted line around a box indicates that the person was interviewed.
- Red arrows stand for interaction between actors (e.g. communication, transfer of resources, support of any form)
- Black arrows indicate that the person / department is part of a bigger organizational entity.
- Grey arrows indicate the project idea and point from the person who initially had the idea to the project or to other people who developed the project further.
- Arrows interrupted with “xxx” mean that the connection broke off.
- In order to depict the complex projects as clearly as possible the number of actors and interactions has been limited to a minimum. By doing this sometimes not all actors and interactions are in the map.

Annex E1: Project 1 - “Donating beds to a hospital”

Data base

Number of interviews	8 (7 Ghana/ 1 Germany)
Number of interview partners	10
Data collection period	from 11/ 2011 till 03/ 2012

- The engagement of a Germany-based Ashanti Union came to my attention when I was collecting data in one of Ghana’s big teaching hospitals. Initially inquiring about project (P2).
- The interviews in Ghana were conducted within two days (November/2011) with representatives of different units (Person 3, Public Relations (03_06_01); Person 4 (03_03_01), Person 5 (03_05_01) and Person 6 (03_04_01) Supply Chain Unit); Person 7 (03_07_01) and Person 8 (03_08_01) Obstetrics and Gynecology).
- The interview partners were all involved at different stages of the donation process (from the first contact with the Public Relations Unit to the ward, where the beds are in use).
- Some of the interview partners belonged to the Donation Contact Group (DCG)[346]
- The representative of the GHS - Unit for Supplies, Stores and Drug Management Unit, Person 2 (28_01_01), mentioned the case of hospital bed donation from Germany as an example for good practice.
- Back in Germany I had the opportunity to interview two Ashanti Union members. Person 1 was the main interview partner (32_01_01; March/2012). He is the initiator of the project and secretary general of Ashanti Union. I also participated in an Ashanti Union meeting and got to talk to other union members as well.
- The interviews were done seven month after the donation process was completed in Ghana (and four month later in Germany).
- The statements of interview partners are complemented by personal observations made during the phase of data collection as well as information taken form

[346] The **Donation Contact Group** (DCG), also referred to as Hospital Donation Committee, is composed of the Director of Nursing Services, the Director of Pharmacy, the Deputy Director of the Supply Chain Management Unit, biomedical engineers and the Public Relations Officer. This Committee was established in 2011, and according to the hospital’s donation policy it is responsible for the following tasks: to educate staff on donation issues on a regular basis, review of requests from prospective donors, inspect donated items and to advise management on all donation issues. During the interviews people, who belong to the committee, mentioned the DCG as a crucial authority in the donation process. The group was specified as a team and is characterized as an internal controlling body that combines expert knowledge and administrative powers in order to improve the donation process and its outcomes for the hospital. While reacting to and coordinating emerging tasks according to the group member’s expertise the committee does not actively promote donations.

documents (e.g. the hospital’s donation guideline, adoption agreement, online articles, etc.).
- The activities were completed by the time the interviews took place.

Project setup

- The project idea was to donate discarded hospital beds, other medical equipment and material (e.g. 70 electronically controlled beds, spare parts, wheelchairs, paper towels) from a service company in the field of elderly care in Germany to a hospital in Ghana.
- From the initial project idea to the actual delivery of hospital beds and medical equipment it took one and a half years. The time in between was characterized by communication on personal and professional levels, formal and logistical challenges as well as achievements.
- In Germany an Ashanti Union, which aims for the welfare of its members in Germany and supports development in Ghana, coordinated the project
- In Ghana the major actor is a hospital, the receiving institution.
- The secretary general of Ashanti Union (Person 1) knew about available beds through his work at the said service company in Germany. He made inquiries and was told by the management that he should get in touch with them if he was interested in the beds. He discussed the idea to donate hospital beds with members from Ashanti Union, who then agreed on the project. Before an official enquiry was made Person 1 contacted a friend at GHS (Person 2), sent pictures of the beds and tried to find out at which facility in Ghana they would be most useful.
- In order to obtain the donation officially, Person 1 together with some of his colleagues founded an initiative within the service company.
- After the board of management of the service company in the field of elderly care had agreed they told the secretary general that the Ashanti Union could get the beds if no additional costs were entailed for them[347]. In return the service company received publicity in the local press and the magazine of a local umbrella organization of migrant associations.
- To cover the transportation costs they applied for support from the German development organization GIZ, who runs a program to support donations. GIZ agreed to pay 75 percent of the total expenses. By cleaning and packing the items the Ashanti Union had already covered its 25 percent share of the costs. The Ashanti Union also tried to find out more about the formal procedures and

[347] 32_01_01(30)

customs regulations from the Ghanaian embassy but did not receive information in time.

- Due to the fact that the electronically controlled beds needed to be placed in an environment with constant electricity supply and enough space, the experts at GHS recommended sending the shipment to one of the bigger hospitals. Once the hospital was selected the communication between donor and recipient started.
- The main contact person at Ashanti Union was the Secretary General (Person 1).
- The Public Relations Officer was the first contact point for the donor. Over a period of almost one year[348] he oversaw and facilitated the planning process within the hospital until the donation was delivered.
- The donors were also in contact and wrote letters to the Ministry of Finance. In order to get the donation into the country without paying taxes or duties the complete documentation (e.g. application letter by MoH, bill of lading, packing list) needs to be submitted. Once the “paper work” was done the hospital and its clearing agents performed standardized requirements to clear the goods form the harbor and transported it to the hospital.
- Once the donation arrived at the facility it enter the hospital’s system like purchased goods. While equipment is usually first inspected by biomedical engineers, consumables and instruments are checked by the Director of Nursing. Then the staff from the Stores Section administers the donations depending on their intended use.
- In the initial phase of the project nurses from the ward were consulted on the question where in the hospital the beds would be useful.
- When the hospital beds were delivered the Secretary General of the Ashanti Union (Person 1) visited Ghana to hand over the items personally to the hospital. The events were covered in the German as well as in the Ghanaian press and online.
- Within the hospital in Ghana different actors (e. g. departments, groups and individuals) were directly and indirectly involved in different phases of the project.

Assessment of interaction

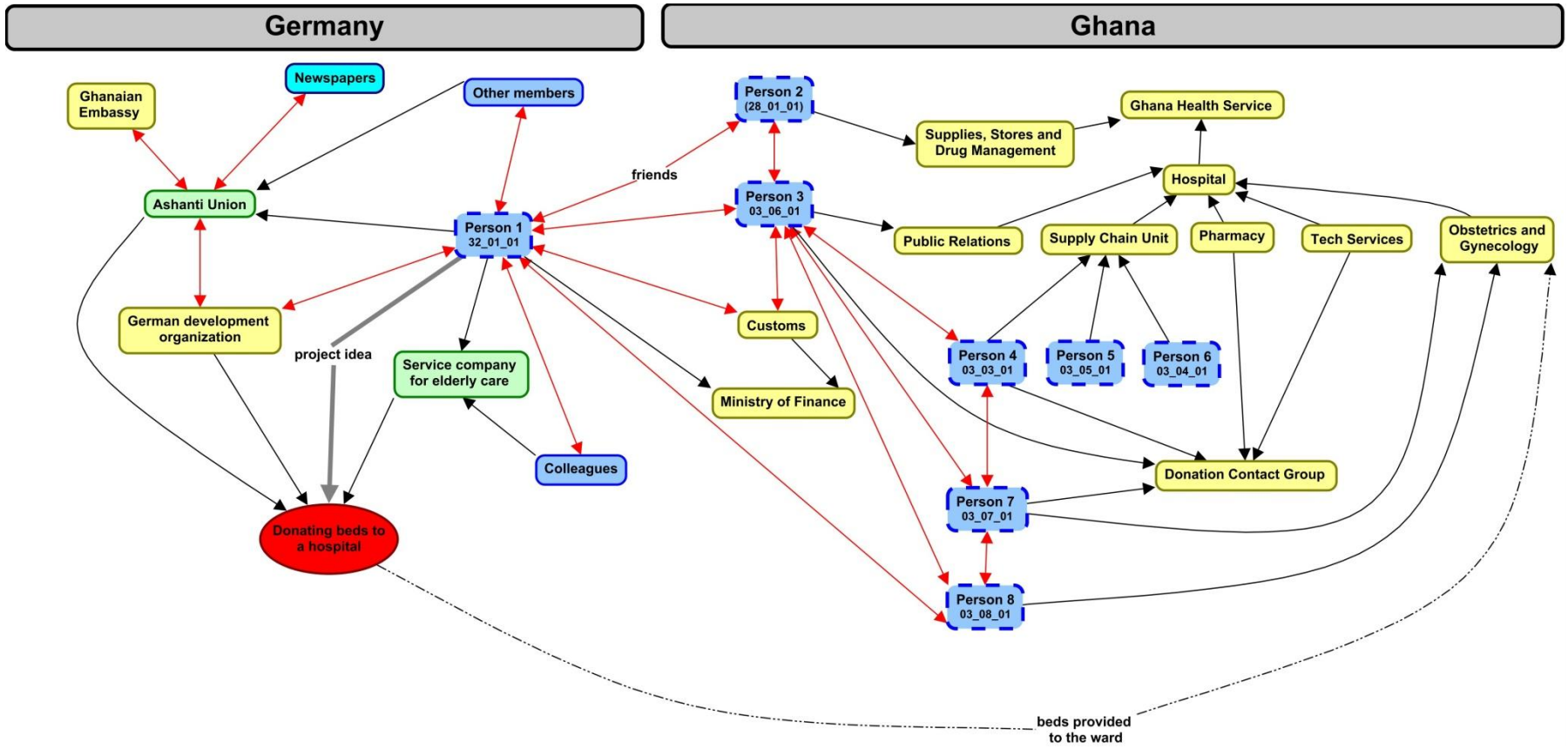
- From the first idea to the handing over of the donation, the communication was about obtaining and disseminating information (about the availability of hospital beds, needs in Ghana, official procedures, contact partners, funding options, etc.) and to become active (e.g. in form of making telephone calls, founding an initiative, writing emails and letters, personal visits etc.), it was always guided by

[348] 03_06_01(84)

the goal to donate hospital beds. While many actors were involved throughout the process there have been “key communicators” on both sides. The constant exchange between Person 1 from the Ashanti Union and the Public Relations Unit of the hospital in Ghana (Person 3) established a reliable working relationship.

- Among the interviewed actors and from the account they gave of the project some individuals stood out as more involved and active than others. Person 1 seems to be a key actor. He has been in contact with most of the other involved actors and always actively pursued his goals (he had the idea, took the initiative, explored the necessary formalities, sought consultation and support, communicated with his fellow members of Ashanti Union, coordinated the activities in Germany and was the main contact person for the partners in Ghana). From his key function within the Ashanti Union he was leading the way. The project was developed on the basis of his personal and professional contacts.
- The Ashanti Union can be described as the “vehicle of the project”. While Person 1 initiated the project and kept it going with his contacts, ideas and persistence the realization would not have been possible without the Ashanti Union as a trustworthy organization that, among other things, was in the position to apply for funding of transportation costs.
- The friend at GHS (Person 2) holds a position within the institution that enables him to ask people and make references even though it is not his immediate area of responsibility. In the very beginning of the project he activated his network and used his position to obtain information from engineers. His support is greatly appreciated by his old friend and regarded as a success factor for the project.
- The formal procedures that regulate donations, designated people who are responsible for everything to do with donation. Within the hospital the Donation Contact Group officially regulates the processes for donations. The key contact person during the project was the Public Relations Officer (Person 3). He was in touch with the donors and coordinated the communication. He made sure that all affected of actors in the hospital were involved.
- The personal contact between hospital staff and donor was especially encouraging for Person 1. He saw that the donation was excitedly received by the nurses and got a very positive feedback on the quality of the donation.

Visualization of Project 1



Annex E2: Project 2 - “Renovation of hospital ward”

Date Base

Number of interviews	4
Number of interview partners	3
Data collection period	from 02/ 2011 till 11/2011

Project setup

- Though the Home Town Association in Germany officially carries out the project, Person 1 initiated and plans the activities can be identified as a key person.
- The trigger to start the project was when during a visit to the hospital in Ghana the initiator (Person 1) perceived the situation of patients in the wards as inadequate. He had the idea to help sick people by improving the facilities and environment.
- As a next step Person 1 convinced the executive board and members of the Hometown Association to support the project.
- When the members of the union were convinced of the project (consensus) they contributed each 150 Euro. At that point the union had about 130 members and a total amount of around 19,000 Euro was raised. For most of the members the contribution of 150 Euro was a significant amount of money in relation to their income and other expanses[349]
- Attempts to identify alternative ways of funding were made (e.g. participation in a workshop organized by bengo[350]) but did not diversify the financial sources for the organization. The necessary documentation and procedures to apply are described as time-consuming and not feasible under the given time resources[351]
- To rely on members as a source of funding is difficult since the number of members has been declining (at the time of the interview the union had about 60 members) and because members are very critical and unwilling/ unable to give more money for the project.[352]
- Financial constraints influenced the development of the project (e.g. when it came to finding a contractor to do the renovation work[353] and prevent the completion of the work[354]. At the time of the interviews major work is completed (e.g. painting, tiling, renovation of six toilets). Form the perspective of the donor some other activities are still to be done (e.g. curtains, two more toilets).

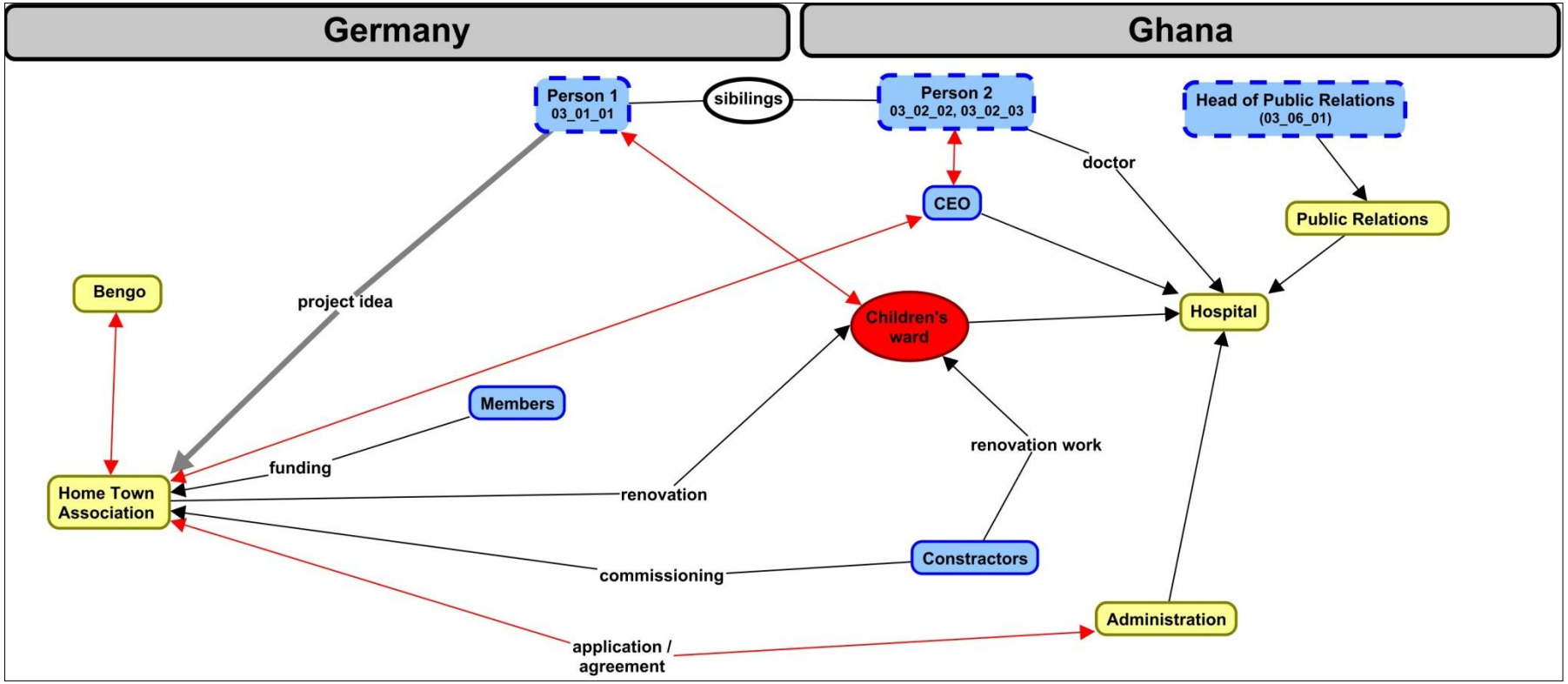
[349] “contributing 150 Euros wasn't something easy for them.” 03_01_02
[350] http://www.engagement-global.de/bengo.html [Accessed 27.09.2017]
[351] 03_01_02
[352] 03_01_02
[353] 03_01_02
[354] 03_01_02

- The communication with the hospital about the project started when Person 1 asked his brother in Ghana (Person 2) for a contact to the Chief Executive Officer (CEO) of the hospital. The brother set up the contact and Person 1 and the CEO agreed on the project. The Home Town Association then applied trough the hospital’s administration and the conditions for the engagement were set.
- The Public Relations Officer was not working for the hospital when the project was started. He only had little information on the progress of the project since there had not been any recent activities. The plaque in the ward that refers to the engagement of the Home Town Association will probably be removed soon. He explained, that the engagement now is more regulated (Adoption Agreement).

Assessment of interaction

- Within the Home Town Association the process to agree on a project is complicated and requires time and persuasion.
- The Home Town Association developed the project without considering the needs of the hospital.
- The commissioning of the contractors is difficult to initiate and oversee from abroad. But described by Person 1 as the most reliable way to invest money.
- Person 2 establishes the contact but does not function as a contact person for the project in Ghana

Visualization of Project 2



Annex E3: Project 3 - “Engagement of a doctor”

Data base

Number of interviews	6
Number of interview partners	5
Data collection period	from 05/ 2011 till 11/2011

- The total number of 6 interviews was conducted in Ghana from May to November 2011.
- At the center of the project is the Ghanaian doctor (26_02_01; November 2011), who at the time was living and working in Germany (Hospital 1) and doing projects in different Ghanaian health Facilities (Hospital A-D, Training School).
- The first information about the engagement of the doctor I received from the administrator (18_01_01; May 2011 and 18_01_02; August 2011) and nurse manager (18_02_01, August 2011) of Hospital B in the Upper East region.
- The IOM representative in charge of the MIDA program in Ghana, which sponsored the majority of the doctors’ activities, talked about the program and experiences with the engagement in the medical sector (23_01_01; August 2011). He helped to establish the contact with the doctor to set up the interview.
- When the doctor visited Ghana I met him at Hospital A. In one day he showed me around the facility of Hospital A and introduced me to the administrator (26_01_01; November 2011). I also had the chance to accompany his visit to the training school were he gave a lecture to future health workers.
- The interview with the doctor took place in the evening at a restaurant (26_02_01; November 2011).

Project setup

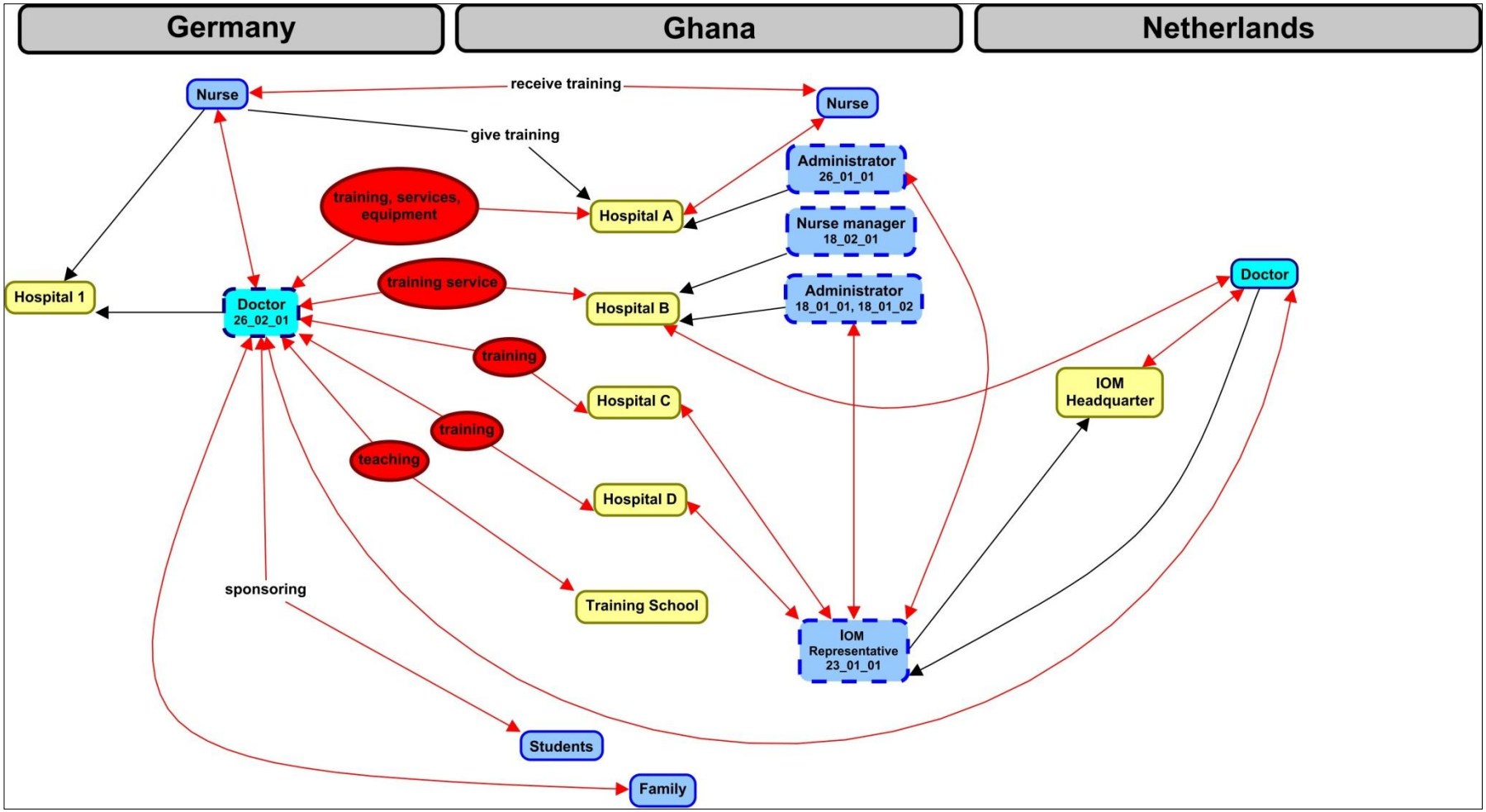
- The project comprises the different activities of a Ghanaian doctor who lives in Germany and contributes to Ghanaian health facilities by delivering services, trainings and equipment.
- The basis of the engagement of the Ghanaian doctor is his professional competence and his knowledge about the Ghanaian health sector. He completed his medical training in Ghana and worked in different facilities before he went to do his specialist training in Germany.
- During his stay in Germany his personal networks with former colleagues in Ghanaian hospitals help him to stay in contact with the facilities where he used to work.

- His employer, the German hospital, also supports the doctor e.g. when granting unpaid leave.
- In the beginning his engagement did not receive any additional funding. He organized everything by himself and with his own money. The cooperation with the recipients in Ghana was based on individual agreements.
- Only when his activities were brought to the attention of a Dutch doctor, who was doing a project at the same Ghanaian hospital (Hospital B), he came in contact with the IOM.
- The MIDA program of IOM offers funding for activities of Migrants from Africa, which aim to support the development of their home country. For all actors (doctor and cooperating hospitals) the participation in the program brings with formal conditions (application and reports) that require planning and active participation.
- The recipients (Hospital A and Hospital B) appreciate the engagement of the doctor and try to continue or extend the cooperation.
- Besides the offer of his own expertise and labor (e.g. when conducting surgeries and working as a doctor in the hospitals) the doctor’s engagement aims to build competences by training and teaching Ghanaian health workers.
- By mobilizing German colleagues (e.g. a nurse) to support a training in Ghana as well as working closely with a nurse from Hospital A and organizing a training for her in Germany, by distributing competences the doctors aims to put more people into a position to help and take over responsibility. He tries to create attitudinal change within the Ghanaian health sector and strives for sustainable development.
- The doctor’s contact to Ghana is not limited to his professional engagement. He also has close family bonds and sponsors students (school fees) with his personal resources.

Assessment of interaction

- The setup of this project shows that engagement that is based on personal competences (e.g. medical knowledge or personal networks) is strongly relying on a key person.
- The building of competences is a characteristic feature of this project.
- While the engagement of the doctor is the precondition for the project, the funding of IOM adds the financial opportunity to continue and expend the activities.
- The IOM program also offers a network that has the potential to connect donors (e.g. Dutch doctor) to exchange experiences.

Visualization of Project 3



Annex E4: Project 4 - “Building a clinic in Accra”

Data base

Number of interviews	4
Number of interview partners	5
Data collection period	from 08/ 2010 till 11/2011

- The initial contact was made in Germany with “Family B Person 1”. This Person helped to build contacts with her family in Ghana (“Family B Person 3”) and with her friends from Family A (“Family A Person 4”).
- The interviews with “Family B Person 1” (01_01_01; August 2010 and 01_01_02; February 2011) were done in Germany at her workplace and in her private home.
- When the interview with “Family A Person 4” (01_03_01; November 2011) took place in her private house in Ghana two members of her family joined in (“Family A Person 2” who was visiting from the US at that time and “Family A Person 5”).
- Two site visits at the clinic took place: the first with “Family B Person 3” (November 2011) and the second with “Family A Person 4” and “Family B Person 1” (September 2011), who was visiting from Germany.

Project setup

- The subject of the project is to build a medical clinic on the outskirts of Accra to deliver health care free of charge for everyone in the neighborhood.
- It was the idea of “Family A Person 1”. She worked 30 years in the US as a medical doctor and planned to organize the clinic when retiring to Ghana. She organized the property from the extended family (Family A Extended) in Ghana, built the clinic with her own money and was in contact with medical doctors in the US and South Africa who were supposed to work at the facility.
- When “Family A Person 1” died before the project could be established in 2004, her financial resources as well as her contacts with medical doctors broke off. Still her siblings took over the project. Some of them also have a medical background (“Family A Person 3” is a Pharmacist in the US and “Family A Person 5” works as a nurse in a Ghanaian hospital) and give advice to the development of the project.
- “Family B Person 1” is a friend of Family A. She and her husband (“Family B Person 2”) founded a small charity organization to support projects in Ghana. When she heard about the clinic project she organized hospital beds in Germany with the religious organization. The religious organization also shipped the hospital beds to Ghana. Then “Family B Person 1” had to clear the goods from customs.

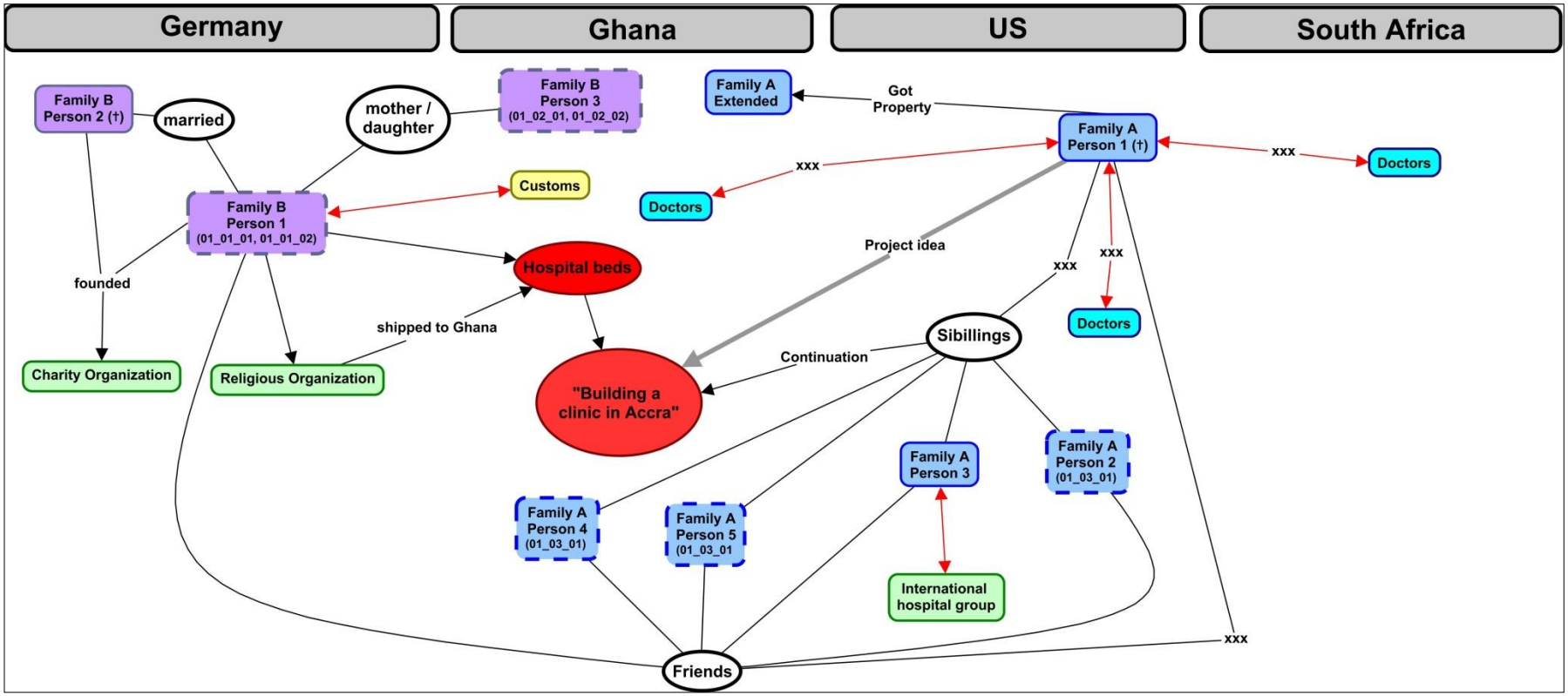
This was a long and costly procedure that “Family B Person 1” funded with her own money. Then the beds were brought to the clinic building in Ghana.

- “Family B Person 1” is very active in promoting her course among family, friends and her religious community and also knows about the structures in Ghana. When her husband died in 2010 an important source of support and funding broke off. Her efforts to organize doctors to work at the hospital were have not been successful.
- Besides the idea to run the clinic on a non-profit basis with volunteering doctors, Family A also talked to Ghanaian doctors, but the funding could not be organized so far. Via the contacts of “Family A Person 3” negotiations with an international hospital group were in planning at the time of the interview.
- The clinic was build over 4 years by the personal money of “Family A Person 1”. It was finished in 1999. By the time of the interview the building was 10 years old and needed renovations. The hospital beds form “Family B Person 1” were delivered in 2009. At the time of the interviews there was no concrete time schedule for the project in place.

Assessment of interaction

- When actors who are central to the project because they developed the idea but also contribute with personal resources (e.g. relationships and medical knowledge) break off the continuation of a project becomes difficult.
- The lack of a clear idea for the project and a multitude of actors with different interests make it difficult to direct the project.
- Extensive family networks as a resource that at the same time pose the challenge to integrate many different interests.
- The establishment of clinic requires extensive medical knowledge and an understanding of the Ghanaian health system. In order to recruit medical personnel the funding needs to be secured.

Visualization of Project 4



Annex E5: Project 5 - “CHC in the north of Ghana”

Data base

Number of interviews	2
Number of interview partners	3
Data collection period	from 05/ 2011 till 08/2011

- The project was brought to my attention during an interview with two representatives of the Northern Presbyterian Health Service (Person 3 and 4). The Interview was conducted at the office of the Northern Presbyterian Health Service (19_01_02) in Mai 2011.
- Person 3 helped to initiate the contact with the chief of the village.
- The interview with the chief (22_01_01) took place in the village in August 2011. It was joined by a group of men from the village who participated silently. In addition to the interview the site of the CHC was visited.
- It is important to notice, that the information about the project were almost exclusively collected from one person (chief) and therefore cannot be compared to perspectives of other actors.

Project setup

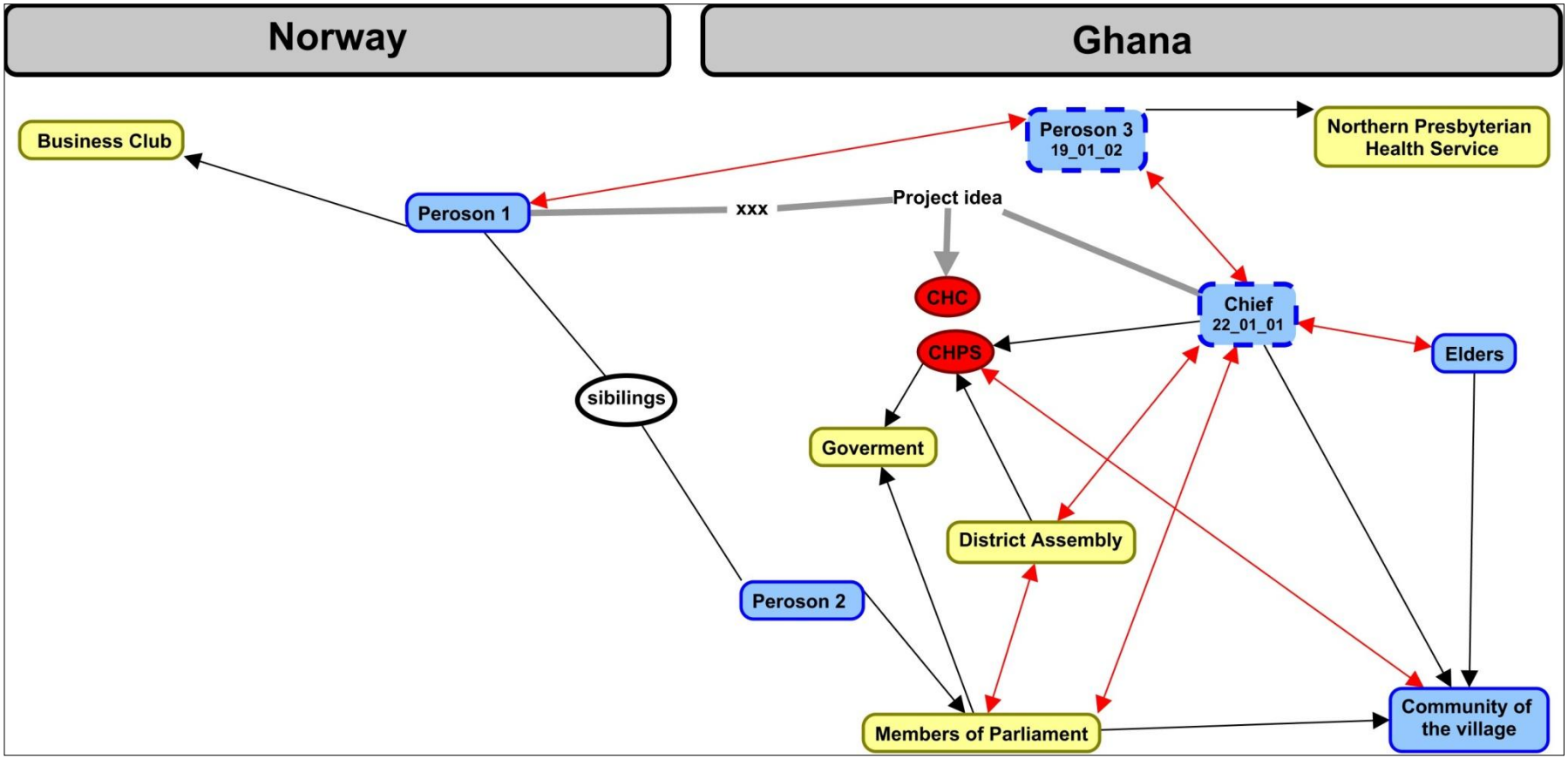
- The subject of the project is to build a CHC in a village that is located in the Upper East Region.
- The chief of the community was planning to establish a health facility in the village, when Person 1, who comes from the village, is a nurse and lives in Norway, offered her support.
- Person 1 had contacted Person 3 in advance of her engagement with the village to find out about how to support a clinic project.
- Besides her own money, which bought the first building materials, she tried to generate more funds from a business club in her country of residence.
- Before the project developed further, the contact with Person 1 and the business club stopped. The reason for the stop of the project is not known to the chief.
- Throughout the development of the project the subject of establishing a health facility was discussed within the village community and brought to the attention of the District Assembly. The chief is at the center of the official communication. He receives advice from a group of elders who serve as advisors from the community.
- The community was involved into the actual building process of the health facility.

- The village applied through the District Assembly for the governmental program CHPS and was supported by members of parliament for the district, one of which was the brother of Person 1 (Person 2). The facility was build.
- For further needs that relate to the establishment of the CHC, e.g. quarters for the health workers, a borehole for water supply, extension of the facility) the chief tries to reactivate the contact with Person 1 and the business club.

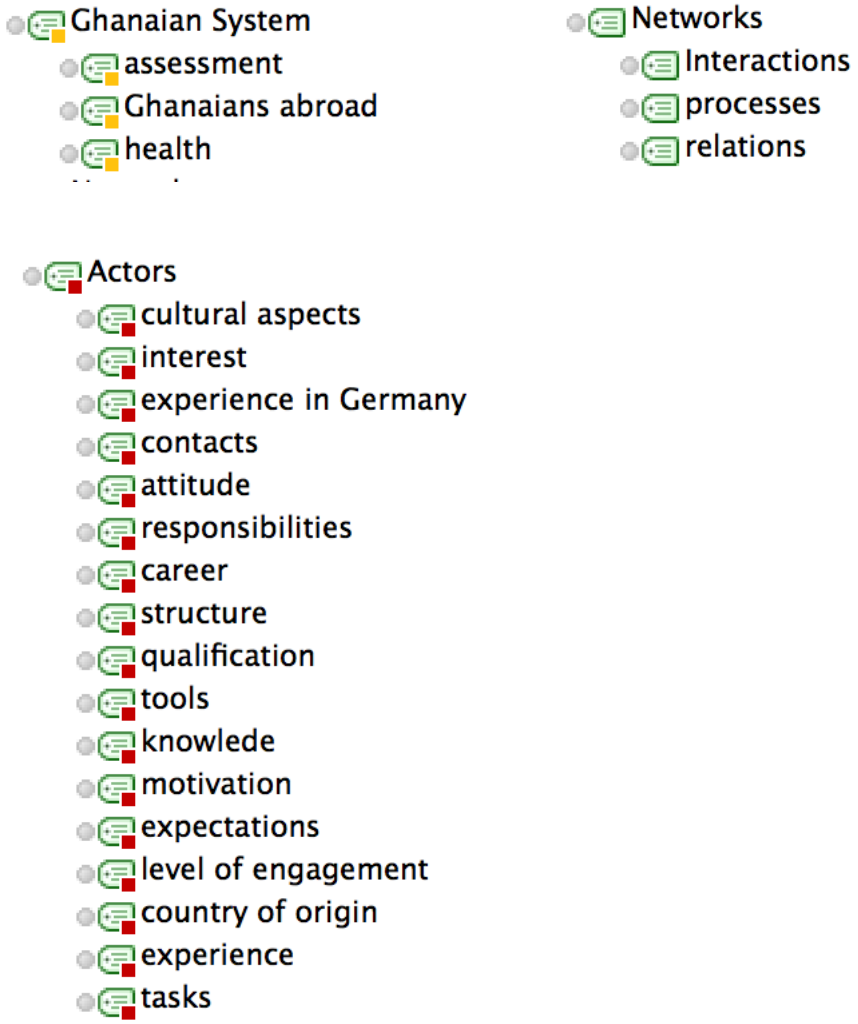
Assessment of interaction

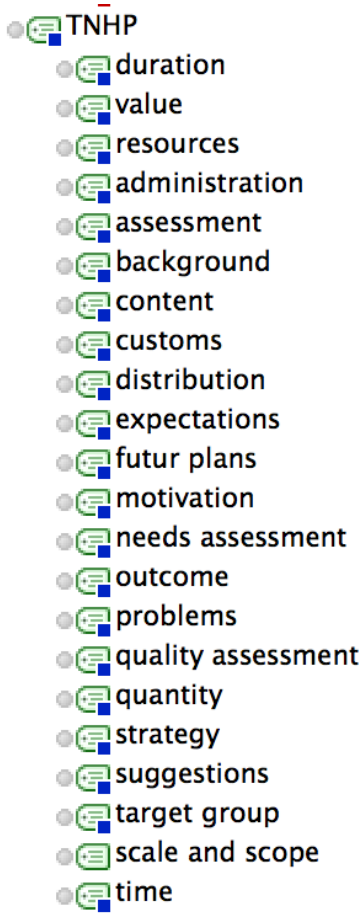
- Since a health facility needs to be built from scratch the required resources are high and a long-term engagement is needed.
- While the rural environment poses challenges to the implementation of a project (e.g. great effort to transport material, recruit medical personnel), community structures offer resources, which can be integrated, and support the development of a project to a certain degree.
- A personal connection with the place and medical knowledge does not guarantee the persistence of the engagement.
- When a project idea depends on only one source of funding it comes to a halt when this source dries up.

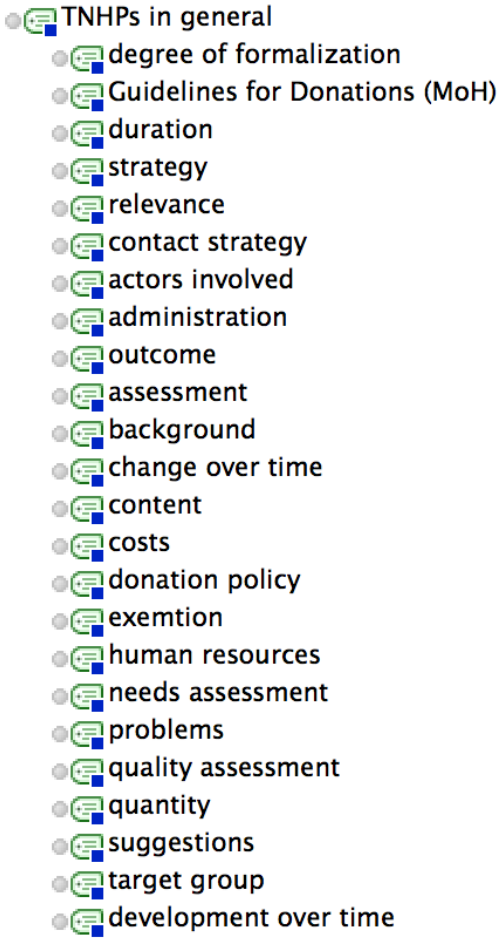
Visualization of Project 5



Annex F: Coding Categories and Sub-Categories







Since not all the interview partners were directly involved with TNHPs the category “TNHPs in general” includes statements that refer to personal experience with TNHPs other than the five projects under study, or to general opinions on the subject.

Annex G: Project Summary

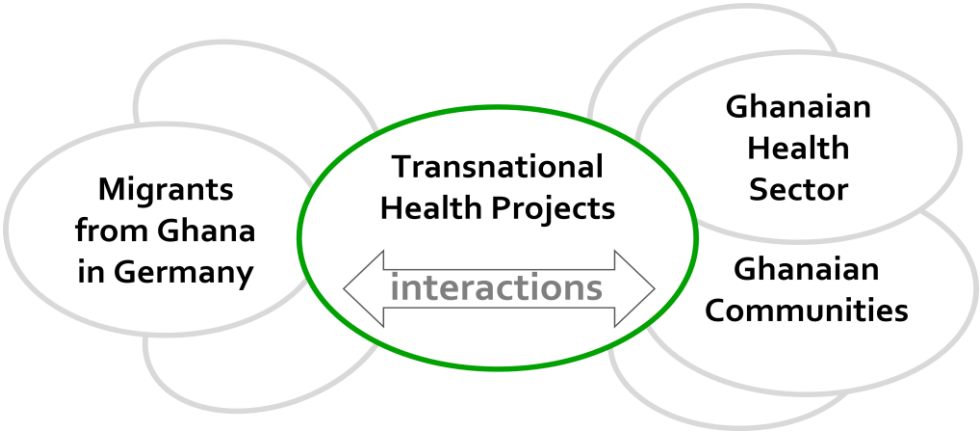
Transnational engagement in the area of health

a Ghanaian-German case study

by Carolin Sobiech (PhD-Student)

Context and Rationale

The Ghanaian diaspora in Germany is a socially and economically active community that has developed extensive transnational networks over the years. They are engaged in various activities that aim to support development in different areas (economy, infrastructure, education, health) in Ghana. While projects that intend to contribute to the Ghanaian people's health have been numerous so far there has been no adequate documentation of interaction patterns that would allow for an estimation of the influence that transnational health projects might have on the development of the Ghanaian health sector.



Transnational health projects are the unit of analysis and will serve a a starting point to explore interactions and networks between the different actors who are involved.

Aim and objectives

The aim of the study is to analyse interactions of Ghanaians living in Germany who are engaged in transnational health projects with relevant actors on the community level in order to evaluate the projects' possible effects on availability, access and perception of health services in Ghana as well as the potential influence on transnational networks.

Therefore the following objectives will be pursuit:

- To identify and explore the networks and interaction of Ghanaians living in Germany who are engaged in different types of transnational health projects in Ghana (e.g. in respect to characteristics like setup, topics, size, trajectory)
- To define interests, motivation and resources of the different actors who are involved in transnational health projects (e.g. migrants, communities in Ghana, (inter-)national organisations, actors from the health sector in Ghana, etc.)
- To assess the logic of action that transnational engagement in the context of health is based on
- To identify factors that support or hamper the implementation of transnational health projects

Methods

The methodology of the study is based on the grounded theory approach. The characteristic process of interwoven sampling, data collection and analysis will allow to explore the phenomenon of transnational health projects and underlying concepts and ideas of this

engagement. Different forms of data collection (open and semi-structured interviews, group discussions, non participant observation, analysis of available policy documents, reports, statistics) will be combined. In order to compile a comprehensive analysis it will be crucial to identify individuals who have personal experience with organizing transnational health projects or have knowledge about interaction patterns, networks and structures that build the context for transnational engagement.

Expected Outcomes

Within the scope of the study it might be possible to draw first conclusions about the potential influence that transnational health projects may have on the Ghanaian health system. The documentation of transnational engagement by the Ghanaian diaspora can be used as a tool to efficiently coordinate activities and to benefit from the resources.

The analysis of different case studies will allow for policy recommendations. Those suggestions might have the potential to promote the perception and effects of the engagement by Ghanaians living in Germany and may serve as a resource for Ghana –especially the health sector. The expected findings about transnational health projects will be accessible for both regional and national institutions and organisations in Ghana and Germany who work with the Ghanaian diaspora as well as actors in the field of public health.

By pointing out patterns of interaction and compiling experiences from Ghanaians living in Germany as well as from the side of the connected communities in Ghana it might be possible to promote further research and interdisciplinary and transnational cooperation.

Annex H: Consent Form

Carolin Sobiech, MA Social Science

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General information and consent for participation in research project

Dear _____ ,

Thank you very much for your interest in my research project! I would like to invite you to participate in my study and to share your personal experience and knowledge about Ghana and the engagement of migrants for their home country. With this letter I want to give you more information about my research project.

Information about the context of the research project

As a doctoral student I am enrolled at the Department of Epidemiology & International Public Health, Bielefeld School of Public Health (BiSPH), Bielefeld University, Germany.

My work is part of a joint research project at the Ghanaian-German Centre for Development Studies and Health Research at the School of Public Health, University of Ghana, Legon, Accra, which is funded under the *African Excellence Program* of the German Foreign Office and the German Academic Exchange Service (DAAD).

Topic and purpose of the research

The research focuses on the engagement of Ghanaian migrants for their home country particularly in the area of health. Relationships and cooperation between Ghana and Germany will be explored, as well as activities and projects that are initiated by migrants. For this purpose I will conduct qualitative interviews in Ghana and in Germany. My aim is to analyse interactions between migrants and their home country on the basis of their personal experiences. With the study I wish to contribute to a better understanding of how the engagement of migrants can influence the development of communities and health structures in Ghana.

Participating in the study

Before the interview I would like to kindly ask for your personal consent to participate in this research project. Please find below the related information on confidentiality and data handling.
I would greatly appreciate if you agree to participate by signing the form below.
Thank you very much in advance.

Yours sincerely,

Carolin Sobiech

Statement of consent

(Please cross out non-applicable statements, if any)

Hereby I agree to participate in the research project, which will include giving an open qualitative interview to Carolin Sobiech.

My participation is voluntary and I am aware that I have the right to refuse to answer to any of the interview questions, to withdraw at any point of the research or to ask for the non-utilisation of certain data sequences after the data collection is completed.

I have been informed that any material gathered from me, either in the form of interviews, observation or unpublished documents, will be treated with strict confidentiality and will only be processed anonymously (names of persons and places as well as distinct dates will be masked).

I agree that the interview will be recorded on a digital recorder, to facilitate the research documentation and correct transcription.

Date:

Signature:

Erklärung

Ich versichere, dass ich die Arbeit selbständig verfasst und keine anderen Quellen und Hilfsmittel als die angegebenen benutzt, sowie die Stellen der Arbeit, die anderen Werken entnommen sind, unter Angabe der Quelle als Entlehnung kenntlich gemacht habe. Das gilt auch für die verwendeten Tabellen und Abbildungen.

Ich versichere, dass die vorliegende Arbeit nicht anderweitig in dieser Form als Dissertation eingereicht wurde und ich bisher keine weiteren Versuche zur Promotion unternommen habe.

Köln, 28. Juli 2018

Carolin Sobiech