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Client or Volunteer? Understanding Neoliberalism and Neocolonialism Within International Volunteer Health Work

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Abstract

As international volunteer health work increases globally, research pertaining to the social organizations that coordinate the volunteer experience in the Global South has severely lagged. The purpose of this ethnographic study was to critically examine the social organizations within Canadian NGOs in the provision of health work in Tanzania. Multiple, concurrent data collection methods, including text analysis, participant observation and in-depth interviews were utilized. Data collection occurred in Tanzania and Canada. Neoliberalism and neocolonialism were pervasive in international volunteer health work. In this study, the social relations—“volunteer as client,” “experience as commodity,” and “free market evaluation”—coordinated the volunteer experience, whereby the volunteers became “the client” over the local community and resulting in an asymmetrical relationship. These findings illuminate the need to generate additional awareness and response related to social inequities embedded in international volunteer health work.

Keywords

community and public health, capacity and development, international

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Background

International volunteer service is growing in prevalence worldwide, both in the number of volunteers seeking international experiences and the organizations providing them (Clark, 2003; McBride, Benítez, & Sherraden, 2003; McBride & Sherraden, 2007). In response to the recent demand for experience abroad, there has been an outpouring of organizations and companies advertising opportunities to facilitate volunteer placements (Tiessen & Heron, 2012). Appealing to highly skilled professionals and students alike, placements promise an opportunity for volunteers to gain experience and expertise in a country “in need,” as considered by the volunteers. Sherraden, Stringham, Sow, and McBride (2006) refer to the surge of international volunteer work in recent years as a “quiet expansion” because research and reporting on its impact in the communities served, as well as information about the volunteers themselves, are limited (Hills & Mahmud, 2007; Machin & Paine, 2008a; McBride, Lough, & Sherraden, 2012). International volunteer experiences vary tremendously as volunteers serve in a variety of capacities for varying periods of time (Sherraden et al., 2006), depending primarily on the desire and means of the volunteers. Volunteer placements can range from participating in a medical caravan in Tanzania

for 3 weeks to teaching health promotion in schools in Malawi for 2 months. Short-term missions (2 weeks–6 months), volunteered time in a resource poor country, have gained popularity over long-term missions (>6 months) in Canada and abroad (Harteveldt, 2014; Heron, 2005, 2007). Although it is unknown exactly how many volunteers participate in short-term international placements abroad, also referred to as “voluntourism,” a 2007 report entitled “Go Away and Do Good: Voluntourism the Noble Niche” claimed that approximately 3.5 million Americans have participated in voluntourism excursions (Harteveldt, 2007). This figure reportedly tripled in 2014 (Harteveldt, 2014). Americans, followed by Europeans, constitute the clear majority of international voluntourists in the global landscape (Harteveldt, 2007, 2014). A CBC documentary entitled “Volunteers Unleashed,” claimed that more than

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100,000 Canadians will have participated in voluntourism trips abroad (CBC, 2015). In addition to the endless opportunities for volunteer work abroad, these short-term volunteer placements are often endorsed by hospitals, clinics, government agencies, universities, and private companies validating these experiences by way of academic credit, paid leaves, organizational recognition, or fundraising.

Despite the growing expansion of opportunity and affirmation for short-term international work, scholars of international development, sociology, and social work have raised critical questions about the benefits such supposed “intercultural” experiences have on communities and volunteers alike (Tiessen, 2011; Tiessen & Heron, 2012; Tiessen & Huish, 2014). A common critique has been that short-term international work may be fraught with power imbalances that reinforce colonial legacies (Tiessen & Huish, 2014). And yet, there is a tendency for these experiences to be indiscriminately valorized as procommunity achievements to be celebrated (McBride et al., 2012). Research related to the impacts of these placements is still burgeoning (R. Campbell & Warner, 2016; Tiessen & Heron, 2012), particularly in health fields. Tiessen (2011) in her conceptualization of “global citizenship” deconstructs its impacts, noting paternalism, othering, neocolonialism, and objectification as ongoing problems. She further states that “those who are committed to global citizenship embody a great deal of promise for effecting the changes necessary to create a more equitable world, yet their actions may unwittingly reinforce the very issues they aspire to overcome” (Tiessen, 2011, p. 573).

The bulk of the theoretical and empirical literature related to international volunteer work stems from the social sciences, including international development. Health fields, including nursing, have severally lagged. And yet, health fields are not remiss to the recent surge in popular desire for international voluntourism. According to Chatwin and Ackers (2016), 42% ($n = 911$) of the medical staff they surveyed at a clinic in the United Kingdom have described some form of overseas volunteer placement experience, 21% of whom were nurses or midwives. Considerable literature related to international volunteer health work is dominated by personal narratives with additional attention paid to the practical aspects of the volunteer mission and logistics (McLennan, 2014). A few authors have examined motivations related to volunteer health experiences (C. Campbell et al., 2009; Withers, Browner, & Aghaloo, 2013) and found that the volunteers’ needs were often prioritized over the local community needs. Furthermore, most medical missions were indeed short term in nature with limited time afforded to addressing the broader socioeconomic and political issues contributing to poor health outcomes (McLennan, 2014). And yet, the primary issues faced by host countries are often interlaced with environmental and social determinants of health such as public health infrastructure, primary health care accessibility, and poverty (Green, Green, Scandlyn, & Kestler, 2009), along with issues of sanitation and nutrition

(McLennan, 2014; Niska & Sloand, 2010). Despite this information, most short-term international volunteer health work is focused on the provision of immediate curative and surgical services. It is not surprising that this type of work could be criticized for its inability to provide upstream solutions that address the root causes of ill health. This article reports findings from an ethnographic research study that addresses the social relations embedded in international short-term volunteer health work. There are several learnings that can be drawn from this pedagogical body of work, including how such placements have a potential to reinforce racism, colonialism, and ambivalence. Specifically, this article addresses the research questions:

Research Question 1: How is international volunteer health work in Tanzania socially coordinated?

Research Question 2: What social relations shape this work?

In this article, neoliberalism represents the geopolitical practice of using capitalism, trade globalization, and cultural imperialism to control or influence (Sartre, 1964/2001). Furthermore, it refers to the political–economic governance premised on market relationships, often at the expense of social goods (Larner, 2000). We use the term “Global South” throughout this article instead of “Third World” or “Developing Countries” to draw the reader’s attention to hegemonic forces rather than hierarchical or evolutionary terms. Neocolonialism refers to the forms of control embedded in policy and practice that allow for colonialism in present-day conditions (Reimer-Kirkham & Browne, 2006).

Existing Literature

Pedagogical Understandings of International Volunteerism in Health Care

Although fields such as international development and sociology have extensively examined the role international volunteers in the global context, health fields have been relatively remiss. Predominating the literature on international *health* placements has been the student-learner perspective. Indeed, the few occasions where “culture” was even considered as a variable important to this work was when it was contextualized as a learning outcome. It is also important to consider literature related to international volunteer placements as the practice has long been an attribute of many health care training programs (Reardon, George, & Enigbokan, 2015), including nursing. Service learning experiences are offered as opportunities to enhance “cultural competence” and expose practitioners (as well as future practitioners) to the “cultural Other” (Brown & Varcoe, 2006; McGrath & Phillips, 2008), while claiming to result in immediate skills acquisition (St. Clair & McKenry, 1999; Walsh & DeJoseph, 2003). In fact, the bulk of the nursing

literature to date praises such cross-cultural experiences, including study abroad experiential learning. In existing literature, they are identified as opportunities for students to demonstrate significant cognitive growth (Zorn, Ponick, & Peck, 1995), increase awareness of self and others (St. Clair & McKenry, 1999), and even improve health outcomes for communities (Fortier & Bishop, 2004; Gebru & Willman, 2010). When examined critically, Harrowing, Gregory, O'Sullivan, Lee, and Doolittle (2012) found that claims of gaining cultural expertise through cultural immersion experiences were exaggerated. Instead the authors found that nursing students' understanding of culture did not change with their experience. A literature review by Allen (2010) concluded that although the literature may support the effectiveness of so-called cross-cultural teaching through international placements, racism persisted among some nursing students. Furthermore, current nursing practice may further reproduce stereotypical notions of culture as a static binary variable ("us" or "other/non-us").

Numerous scholars external to nursing have critically challenged pedagogical assumptions related to experiential learning in the field of international development, social work, and other fields (e.g., Das & Anand, 2014; Haug, 2005; Heron, 2005, 2007; Mapp, 2012; Razack, 2002; Tiessen, 2014, Tiessen & Smillie, 2017) and have referred to the significant amount of "unlearning" that needs to occur before students are prepared to engage with local communities (Tiessen, 2014). These authors have looked extensively at the role of student experiential learning opportunities abroad and their relationship to global citizenship and have noted their skepticism for positive change for local communities. In fact, several authors have noted the potential for reproducing colonial legacies related to these placements (Baaz, 2005; Heron, 2007; Simpson, 2004, 2005; Tiessen, 2012, 2014; White, 2002). In Huish's (2014) reflection on the role of Canadian medical students' participation in student placements in the Global South, he noted that student placements abroad tend to be low-cost learning opportunities that revolve around the student. He exposed the power of the hidden curriculum, among other influences, in shaping student's conceptualization of culture. These issues require serious attention as they have the potential to reinforce cultural norms such as ambivalence, potentially emphasizing hierarchy, and undermining collaborations (Huish, 2014). Although there has been extensive critique of the role of students learning abroad, particularly outside of the field of nursing, very few studies have examined its application with skilled workers, nor has there been consideration for the social context in which practitioners provide care abroad. Although this article does not focus on student practitioners, there are several learnings that can be drawn from this pedagogical body of work, including how such placements have a potential to reinforce racism, colonialism, and ambivalence. The purpose of this article is to attend to the participants' everyday work as well as how their experiences are ruled discursively and

therefore constructed ideologically among knowers. We focused primarily on a portion of the data, the volunteer experiences, to expose the "organizational social relations" in the context of international nongovernment organization (NGO) "health work" in Tanzania. It is critical to note that the participants in this study were not the topic of interest but rather entry points in understanding the organizational social relations.

Short-Term International Volunteer Health Work

Empirical literature related to short-term volunteer health work, although scarce, at its best has mixed findings and at its worst neglects the cultural context in which this care is provided. Examples include, a comparative study of short-term medical missions in the South Pacific and Central America, whereby the authors quantified the number of training opportunities for local providers as a measure of success and found that such missions in the South Pacific accomplished more in terms of providing health care knowledge, skills, training equipment, and drug administration when compared with missions in Central America (Chiu et al., 2012). The authors were inattentive to the implications of valuing Western expert knowledge over local knowledge as a measure of good practice and also reduced the positive outcomes to unidirectional application of service. Although they did report that proficiency in native language is essential to the success of short-term medical missions, providing culturally responsive care extends beyond simply speaking the native language. Other authors have honed in on topics such as anatomic pathology services available in international medical missions (Naujokas, 2013), ambulatory population health needs such as intestinal parasitosis and hypertension in Haiti (Niska & Sloand, 2010), and the opportunities for nutritional surveillance through medical missions to improve growth among children living in Honduras (Oken, Stoffel, & Stern, 2004).

A theme across these studies has been the attention on curative measures as good practice, with little or no attention to local practices. Furthermore, some authors have gone as far as to state that short-term medical missions are important in overcoming the vast medical needs of a population in Jamaica, stating that practitioners simply need to have relevant literature outlining the needs of the population and provided such statistics (Popovic et al., 2013). Another study by Withers et al. (2013) examined volunteers' experiences of international short-term medical missions in Mexico, using interview and participant observation data. The authors concluded the study by offering motivating factors such as psychological buy-in and career-promoting strategies to better attract health care volunteers and presented recommendations to facilitate first-time volunteer experiences (Withers et al., 2013). This work had little consideration for the implications of volunteerism beyond the benefits to the volunteers themselves. Furthermore, these findings are in stark contrast

to several editorials related to international volunteer health work that have raised concerns regarding the potential ethical implications and unintended consequences of “medical tourism” in vulnerable communities (Bezruchka, 2000; Bishop & Litch, 2000; Lluberias, 2001; Scarisbrick, 2002; Wall, Arrowsmith, Lassey, & Danso, 2006). A nurse describes his impressions of medical tourism as a “wolf in sheep’s clothing,” citing the possibility of doing harm to communities in the Global South as cause for concern and a need for responsible engagement (Grennan, 2003).

Social dimensions of short-term international health work. A recent study by Rozier, Lasker, and Compton (2017) found that upon review of online survey data responses of short-term medical mission volunteers ($n = 334$), there was conspicuous disconnect between organizer practices and host community staff preferences. Similarly, when the social dimensions of short-term international medical missions were examined, the findings were limited to a qualitative study. This study examined the perceptions of short-term medical volunteer work in Guatemala among Guatemalan informants ($n = 72$) and found that the perceived impact of short-term medical projects was highly variable and ranged from helpful to lacking coordination (Green et al., 2009). The authors noted that short-term medical services provided by foreign volunteers failed to address local public health infrastructure needs. Instead, they aided in the form of physician and surgeons service, where there were no health human resource deficits. Furthermore, the burden for meeting the needs of volunteers and coordinating the services they provided often fell to the local host organizations. The authors noted that short-term medical volunteer work could have been enhanced by coordinating with local practitioners, demonstrating respect for local health practices, and understanding of the country’s existing health care resources (Green et al., 2009). Their call for greater evaluation measures of short-term work and the potential dependence on foreign providers caused by short-term medical missions are also important to highlight. However, the study lacks emphasis on the broader relations that shape health work, including the social dimensions of culturally responsive care such as historical attentiveness to colonial relations that may be reproduced by way of short-term medical missions.

Methodology and Methods

This work was guided by critical social theory to best understand social order, the intersections of race, gender, and other social locations germane to structural economic inequities (Darder & Torres, 2004). Because social relations occur systematically, racism and racialized class become embedded in broader social structures such as neoliberalism (Darder & Torres, 2004). Therefore, we use a critical perspective on race and class to inform this work (Racine & Petrucka, 2011). Furthermore, this study uses a Marxian lens to acknowledge

the influence of market forces of supply and demand. It incorporates other relevant factors at play in the globalization of a world economy and the influence of corporate giants on the free market today. This theory was relevant as a theoretical framework because it expands our knowledge beyond “economic growth.” In doing so, it reveals how the economic process is enacted through power and political inequities, particularly between a bilateral funding agency, NGOs, and volunteers.

In keeping with these theoretical foundations and grounded in the experience of the study participants as entry point, we conducted an institutional ethnography (IE) to examine power and knowledge in contemporary society as ruling relations (D. E. Smith, 2005, 2006). According to D. E. Smith (2005), we should pay attention to the local and everyday experiences of people, particularly, those in positions of subordination and examine how power is imbued in several ways, such as through texts and organizations (Smith, 2006). The relations of ruling refer to those dominant forms of power in structure and agency. Agency refers to the human deliberate action and navigation in an environment of constraints. Structure refers to the complexities of social institutions that people live and act in (Giddens, 1984; Jenkins, 2002). In this study, we sought to illuminate the social relations, which refers to people’s doings in a particular local setting. Social organizations refer to the purposeful coordination of how social relations interrelate (Deveau, 2009; D. E. Smith, 2005). Social relations, in this context, does not refer to a social relationship, such as the “nurse–patient” relationship. Instead, it refers to taken-for-granted action and thinking coordinated around ideology. For example, how nursing care can be taken-for-granted as gendered work. As such, we were less concerned with a descriptive reporting on a population and more focused on selecting participants living in different circumstances that share a common set of social organizations and work processes, as informed by institutional ethnography (DeVault & McCoy, 2002).

Recruitment and Sampling

Recruitment for participant interviews continued until we reached a saturated understanding of the institutional social relations at play (Morse, 1995; Sandelowski, 1995b). A diverse study sample of 37 individuals was recruited, representing a range across the categories of sex, professional status, years of experience, degree of involvement, length of time in Tanzania, and age. This type of purposive sampling made obvious identifiable patterns of commonalities and differences existing between and among participants, such as professional influence on work (Sandelowski, 1995a). An adequate sample size was achieved to gain an in-depth understanding of the relationship between and among participants in ethnographic research (Morse, 1991a).

A “health work volunteer” refers to someone with or without a professional designation, who provides direct or

indirect health-related service through an NGO. Although many of the participants in this study possessed a professional designation. Health work was broadly defined as work that seeks to improve individual and community health. This form of work ranged from direct patient care, taking place in an HIV/AIDS clinic or acute care facility, performed by a volunteer health care professional, to health promotion development work within an orphanage, provided by a non-specialized volunteer health worker. It is important to note that health work in this study did not include emergency-relief work. The nature of relief work is conceptually different to community (nonemergency) health work. In addition, the temporality of the social process is dissimilar to the planned and intentional development-type of health work studied here. Participants self-identified as being involved in health work. We used a purposive sampling strategy which permitted us to connect with participants based on their experiences in their roles as international volunteer health workers (Morse, 1991; D. E. Smith, 2005). For reasons related to confidentiality and preserving the privacy of the participants in this study, all volunteers, regardless of professional status, are referred to as “health work volunteers.” Given that the purpose of the study was to illuminate coordinated work activities, we chose to focus on participant definitions of the individuals’ relationships with their work rather than emphasizing their professional designation as the sole measure of their participation in “health” work. The aim of recruitment in this study, therefore, was not to categorically describe a sample, rather identify diverse experiences to portray a broad picture and to offer multiple perspectives on how organizational social relations are coordinated among volunteers within Canadian NGOs providing health work in Tanzania. An “NGO administrator or staff” refers to someone who works for an NGO administratively and who is familiar with the interworking of the NGO. A bilateral organization employee refers to someone who is employed by a bilateral institution. The criteria for participation broadly included (a) proficiency in spoken English and (b) volunteering with a Canadian NGO, or employed by a Canadian NGO, or employed by a bilateral agency that funds Canadian NGO work.

Data collection continued until saturation of the theoretical categories produced a rich data set. This ultimately resulted in a sample size of 37 individuals. This was adequate to obtain comprehensive descriptions sufficient for ethnographic research (Morse, 1994) and to elicit an in-depth understanding of the relationships between and among the participants (Morse, 1991a, 1991b, 1991c). Recruitment for participant interviews continued until we reached a saturated understanding of the organizational social relations at play (Morse & Field, 1995; Sandelowski, 1995a). This type of purposive sampling made obvious identified patterns of commonalities and differences existing between and among participants, such as professional influence on work (Sandelowski, 1995b). And yet, when recruiting NGO staff,

perspective saturation occurred more rapidly—this might be attributable to the similarities in their work. Furthermore, the number of bilateral agency employees interviewed was entirely dependent on available personnel. A total of four such employees working in Tanzania participated in interviews.

Of the 37 study participants, 23 were women and 14 were men. There was a cross-section of participants from various regions of origin in Canada, including British Columbia, Ontario, Quebec, and Nova Scotia. A total of 30 health worker volunteers, 4 bilateral employees, and 3 NGO staff/administrators were recruited. Ages ranged from 24 to 72 years, although most participants were under 35 years of age. The professional status of the sample varied and included five medical doctors (MDs), five registered nurses (RNs), one occupational therapist (OT), one professor with a PhD, five engineers, four official delegates, and 16 “other” baccalaureate-prepared participants. The length of stay ranged from 2 weeks to 1 year, although the majority of the participants engaged in short-term mission-work less than 3 months.

Data Collection

Data collection occurred for a period of 19 months in Tanzania and Canada, beginning in August 2011. To gain an understanding of how care is enacted, data were collected in regions in Tanzania with several NGOs and Canadian volunteers. These regions included Zanzibar, Arusha, Moshi, and Dar es Salaam. Multiple, concurrent methods were utilized, including interviews, participant observation, and text analysis. Because multiple methods were employed, data collection in Canada varied; it included semistructure, in-depth telephone interviews, participant observations within NGOs in Canada, and review of online texts.

A semistructured interview guide was used for both face-to-face and telephone interviews. We collected and analyzed data according to D. E. Smith’s (2005, 2006) description of IE. All interviews were audio-recorded and transcribed verbatim. To promote discussion that reflected the participants’ positioning within their social surrounding, we offered the option of individual or group interviews. One-to-one interviews offered a more conducive space to share an honest account of the lived experience, whereas group interviews comprising two participants allowed the participants to reflect simultaneously on events. In total, 29 individual and four group interviews were conducted. Interviews ranged from 0.5 to 2.5 hours in length. The length of time in the interview process varied because it reflected a balance of leading with open-ended questions, while also following the lead of the participant.

Participant observation, which explored the “social in motion” was used to record insights from (a) “in the field” as an observational description of the participants’ actions and our reflections on the power relations at play and (b) “during the

interview” to capture the nonverbal forms of communication and the implications for the social organizations. Participant observation “in the field” occurred in a formal setting such as in the waiting room at the Canadian Consulate in Tanzania or a Canadian owned and run clinic in Moshi. The “in field” observations also occurred informally, for example, at the “Coffee House” in Arusha, an exclusive setting where mostly volunteers can afford to congregate to eat/drink. All participants were aware when they were being observed and provided consent. Recording methods consisted of field notes documented by the first author. These data were used to pose questions, reflect on the context, and inform the semistructured interview guide.

Finally, text-based forms of knowledge are essential in understanding ideologies, working activities, and organizational social relations of an institution. Text analysis included multiple sources of information. To systematize how texts were utilized in this study, I collected text from three perspectives: (a) health care professional organizations, (b) Canadian NGO’s, and (c) CIDA policies. My approach to obtaining such texts was primarily web-based, including seeking information off public websites; however, I also invited participants to share any documents that they deemed relevant to their work. Interestingly, as work became more broadly coordinated, text became more apparent in talk. For example, at the interpersonal social relational level, volunteers primarily talked about job descriptions from websites and preparation guidelines, which were unique to each NGO. At the institutional social relational level, work seemed highly coordinated and mediated by specific policies.

Data Analysis and Rigor

Preliminary analysis consisted of an examination of transcribed interviews, paying specific attention to the social organizations, represented by the culmination and enactment of power relations (M. Campbell & Gregor, 2008). NGOs were perceived and described as real entities—something that was branded and packaged and required preservation and work to sustain. Members acted collectively to deliver work on behalf of the organization. Furthermore, by way of analysis, comparisons were made between what was stated in text and what is enacted in everyday life, as stated by the participant in the transcribed interviews. The evaluation of “health work” was described as being shaped by the enactment of power.

Once the preliminary analysis was complete, we attended to the structural order of data including the interactional dimensions of discourse. The six main stages of discourse analysis according to Chouliaraki and Fairclough (1999) are (a) identify a problem, (b) determine the practices that enable the problem, (c) identify the discourses that inform those practices, (d) illuminate the implications of the problem within practice, (e) shed light on the opportunities that exist for the problem to be overcome, and (f) reflect on the analysis process. These six stages assisted in making comparison

between and among the insights outlined for each participant in the chart. Furthermore, it facilitated bringing our attention to the broader social organizations as each individual experienced them.

Recognizing that research is inherently subjective, it was essential for us to be self-reflective on our influence in relation to the socio-political context. We relied on Lather (1986) to provide guidelines for establishing rigor in this critical research study, including four strategies: triangulation, construct validity, face validity, and catalytic validity. We used a chart to “triangulate” transcript, field note, and text data. This chart allowed us to understand crosscutting themes from multiple standpoints. We established construct validity through our examination of how the participants’ account extended beyond the everyday experience and translated into the broader institutional structures. Face validity was accomplished by posing questions of the participants related to how their actions came to be. We addressed catalytic validity through knowledge sharing to those participants who wanted to be contacted and further involved in the study. We have since expanded this work through a knowledge mobilization initiative that uses performance arts to relay findings to audiences.

Approval for this study was obtained from the Ethics Reviews Board at the Western University in Ontario, Canada. We obtained written consent for participation from all study participants. Consent included the participants’ participation in a semistructured interview as well as participants observations. All participants were aware of when they were being observed.

Findings

Directed by the speech and actions of the participants, this study focused on investigating what social relations, embedded in international short-term volunteer health work, coordinated the participants’ recorded experiences. For instance, how does paying for a clinical experience abroad become a part of providing good care? When distinct forms of coordinated work were reproduced again and again they became social organizations. In the following section, we discuss how three organizational social relations of health work—“volunteer as client,” “clinical experience as commodity,” and “free market evaluation”—were reproduced as social organizations (neoliberalism and neocolonialism) in health work in Tanzania. These organizational social relations, although described separately in this article, occur simultaneously and are dialectically interconnected.

Volunteer as Client

In contrast to its common use in health provider–client relations, “client” in this context referred to the one providing work rather than the one receiving care. Three Canadian health work volunteers traveling together in Tanzania

described how their experiences of working in a local hospital were unfulfilling and did not meet their expectations as clients. Interestingly, the participant in the following quotation states, “as a volunteer, we’re giving our time and our money” followed by a statement that implies a desire for recognition. The language in this statement is more congruent with the expectations of a “client” or “customer” than a volunteer. This quote exemplifies how one nurse sought return in the form of recognition for her invested dollars as a “client”:

I feel, as a volunteer we’re giving our time and our money. They [volunteers] should be more valued than it is at home but again, like since I’m a nurse and I just think it’s the way I am, and my mom’s a nurse so it’s the way I was brought up, that I should always be giving as much as I can because, like I have so much more than everyone else around me. I feel like I should be more valued by the doctors and by the other nurses and, okay, you come from Canada and you do this, this and this and this and this and this and this for patients. Can you help us? Can you teach us? Can you show us? And there’s just no value whatsoever. They don’t even notice if we’re here or not. And it’s so disheartening. It’s just not what you expect and want to try and accomplish. (Health Worker Volunteer 1)

The economic arrangement, according to the volunteer, was her payment and time given in return for an opportunity to be valued as a clinical expert. Because this volunteer’s time (service) would typically be remunerated (as a paid employee), time in this context also takes on a monetary measurement. This participant equated feeling valued as an expert as fair compensation for her contributions. She also suggested that because of the degree of expense incurred, her contribution should have been “more” valued than local health care workers. The “client” role then affords status and power. Compounding the issue is her desire to impart knowledge, without regard for local practices. Knowledge was discursive in this context when it was interlaced in power and reward and valued over local knowledge.

Those supplying the good or service are often vulnerable to the needs of the consumers and must make concessions to accommodate their requests. In this example, the under-resourced hospital was expected to adapt to the demands of the consumer (the volunteer), as coordinated by the NGO. The failure of the hospital to provide a clinical experience to the volunteer left her questioning the worth of the experience.

In this context, the market is the ruling relation whereby the participants in this study engaged in exchange. Market, in its simplest form, refers to the structure that allows buyers and sellers to exchange goods and services for money. The following quote further demonstrates the influence of market on the volunteer experience and specifically addresses how consumerism can lead one to identify with service, the ability to practice, products, and supplies, according to their marketplace values. In this case, a participant describes how she was dissatisfied with the terms of the economic arrangement made between her (the client) and the NGO:

Over and above every other cost for the volunteering, but for a specific medical placement, was \$80, and when we spoke to Matron about it, there was no difference whether you stayed for a year or two weeks. I mean . . . it was \$80 . . . and then we asked her, we said well, because of the experience we’ve had [a perceived negative experience] and how we’re not going to be here, I think this is my fourth day here and we have two more days and then we’re going home. So, I said well, where’s the money going? Or we said, is it refundable if we’re only here for four days? No [the Matron replied], non-refundable, so well where does the money go? She said she allocates the money herself and the money goes towards supplies like gloves and syringes and things like that, and then we sort of piped in and said well, we haven’t really seen many supplies here. We brought our own gloves, we brought our own supplies, so we’re just curious where that money goes, and she said it’s her discretion, that’s where the money goes. (Health Worker Volunteer 2)

The health work volunteer focused on disbursement of funds because her relationship with the facility had been premised on an economic transaction created by the NGO. By insisting to know how her funds were being spent, her actions and thinking followed that of Western ideology to demand transparency in the name of accountability. In this ideology, accountability tends to be unidirectional, with the receiver of funds being held accountable to the supplier. Furthermore, the concept of “refunding” a dissatisfied consumer aligns with the capitalist principle that the “client is always right” and therefore privileges the volunteer over the community hospital. This understanding ultimately acted to reinforce an inequitable relationship as significance is placed to her financial status. As a result, the community hospital is unable to compete financially:

If I was just doing blood pressures or temperatures all day, I would feel at least like I was contributing to the team. We were told nothing. We were very naive, we didn’t ask a lot of questions, we didn’t ask any questions, we were just like “they do it all the time.” Now we have a totally different view but we didn’t even know where we were going to be, we had just kind of said we would prefer this area. We didn’t know if we were going to be in the hospital or clinic or what we were going to be doing. Basically all that was said as far as limitations was, you won’t be performing surgery. Well I kind of knew I wouldn’t be performing surgery, that was a given, I am not a surgeon. It would have been nice to say stuff is very limited so you may not be able to do . . . because then I would have gone somewhere else, but they [NGO] want money and they want you to sign up. It was supposed to be challenging, life changing experience, and it was challenging because I couldn’t believe I was here, I came all this way to do nothing. (Health Worker Volunteer 3)

The above quotation illustrates how the participant equated value with clinical tasks. In fact, this ideology became so ubiquitous that concrete tasks such as “taking blood pressure” were associated with a meaningful contribution. The participant described how, in the absence of fulfilling such tasks, she was led to believe that she did “nothing.”

Using market as an organizational social relation, her experience was interpreted by its quantifiable worth as a commodity. Her focus was on accumulating skills and experience as payment for work. In this context, “volunteer as client” became a morally questionable construction because of the power imbalance that it created. It also demonstrated the potential to be clinically hazardous and ethically dubious, especially, when practitioners worked beyond of their scope of practice. Furthermore, it leaves the community vulnerable to volunteers feeling entitled to opportunities to skills bank. This asymmetrical relationship further reinforces colonial legacies by emphasizing that Western lives are more important than the “other.” It also makes it difficult for the local hospital to hold the practitioner accountable for their clinical actions, which can be especially precarious in the event of malpractice.

Payment in return for a volunteer experience took many forms. It included paying an NGO for accommodations, placements, and possibly travels and might have also entailed a “donation” to the NGO. The concept of volunteers making financial contributions for their experiences is not necessarily a new phenomenon. However, what is an emerging phenomenon and requires review are volunteers becoming “clients.” In this model the experiences of the volunteers are compared with the magnitude of their investment. As a result, the discourse surrounding volunteers as clients contributed to beliefs of entitlement. This became problematic when dominant market forces turn international service efforts to accommodate the needs of volunteers over communities. These extra-local market-driven practices are the organizational social relations that coordinate action and thinking.

Clinical Experience as Commodity

The discourse of “volunteer as client” was actualized when experience was examined economically and reified by the participants as a commodity. Fields such as tourism, leisure, and hospitality have examined the role of experiences in the economy, and more specifically, how businesses have transformed memorable events into profitable products. The commercialization of a “medical experience abroad”—a promise to work with marginalized and disadvantaged groups in a clinical capacity—has contributed to the commodification of the “volunteer experience” (a tradable good). Compounding the issue in health care is the desire for a positive experience that translates into “doing for” rather than situating oneself within the broader context of culturally responsive care.

In the next quotation, the volunteer health care worker critiques the worth of her volunteer experience using language such as “feeling cheated.” The quality of the product (clinical experience) was premised on being able to participate in a high intensity activity, such as labor and delivery. In other words, she equated the worth of her experience with the opportunity to enhance her skills. And what is worse is she

felt cheated when such an experience was not afforded to her:

I mean, originally we thought we were going to a maternity clinic, where we’d be assisting with delivering babies. Which is out of my comfort zone, but still, it would have been an experience I would have enjoyed. If we had a specific role like, you’re in theatre, you are going to be doing this, this, this and this while you’re here, then I think at least we’d know what we could be expecting, and if it’s laid out for us and even if our personal expectations don’t get met, at least if what is said we were going to be doing was done, then I think we wouldn’t feel as cheated I guess, or like not valued. Yeah, so I don’t know if it’s within the volunteer agency or within a hospital that someone should develop some sort of protocol or some sort of outline as to what nurses abroad can be doing while they’re here. (Health Work Volunteer 2)

This example demonstrates how “the experience” is part of a desire to accumulate skills and exposure to high intensity or extreme situations. The experience becomes a commodity when it is used to acquire social leverage, authority in the clinical setting, or skills banking. Furthermore, the participant does not discuss the genuine value of the experience. She does not acknowledge the contributions that she has made, rather focuses on situations and spaces where she was unable to provide external expert assistance and, ultimately, reinforce her role as the “knower.” It is important to consider the expectations and financial pressure unfairly placed on community hospitals to supply such experiences to international volunteers. Visiting nurses expected to be privileged over local nurses in Tanzania and even other health work volunteers, despite the fact that their contributions were disconnected, short term, and morally questionable:

One of the other nurses is in one of the clinics doing immunization so we said to the placement organizer, if you are going to have practicing nurses. Especially practicing nurses, because students can come here and they may be comfortable to just sit back and watch and learn but if I know different I can’t sit back and watch them not treat. I can’t just sit back and watch them [local practitioners] do nothing. We just said if you know that the nurses are coming that are practicing nurses, because there were eight of us here one day, certified practicing nurses standing around. (Health Work Volunteer 2)

In this example, the participant draws our attention to the potential waste of valuable resources by having practicing nurses “standing around.” This is suggestive of entitlement and privilege as the participant fails to recognize the importance of local practices and resources. It is important to consider the exploitation of local community members that can occur by way of health practices. And yet, what attracted most practitioners was the desire to work with vulnerable populations, as though their services are more valuable, skilled, and important than local practices.

Sadly, there were occasions where the volunteers became so consumed with their own experience that they failed to identify their objectification of local people and, in many cases, reduced them to the experiences that have contributed to their marginalization in the first place. In the following quote, the volunteer refers to acquiring experiences and states through two distinct and intricate activities, which seemed to be simplified to items on a checklist: “I really wanted to become educated on and experience female genital mutilation and delivering babies.” In this case, the commodification of the experience refers to packaging it into something tangible and how it contributed to objectification, that is, its reduction and dehumanization from the social world:

So I wish I had of known or they would have at least not have advertised that they could, you know, “if you’re a nurse, you can go here and you can do that . . . deliver babies.” You know, one of the things that I really wanted to become educated on and experience was the female genital mutilation, and also delivering babies. And being able to have interaction . . . hopefully with opportunity for education with those things and I’ve yet to see or do any of those things. The other thing too is to work with the pediatric AIDS population. And again, I have yet to see or do any of those things. So I’m trying to outreach and make connections, like with [local hospital] and different physicians there. I’m trying to arrange a meeting with the [another NGO] to hopefully at least, maybe not, if I could volunteer that would be awesome but if that’s not available than I could at least become educated on like the struggles that they have here, and be familiar with the population. (Health Work Volunteer 5)

The volunteer further explained that she was seeking to gain such experiences to qualify for a more advanced volunteer position with a renowned emergency-relief NGO. Although the volunteers themselves have agency in reproducing the organizational relations, ultimately many are uncritical of the broader ideologies at play, largely because they are so pervasive and socially accepted. Furthermore, NGOs as organizations contributed to the commodification of the experience:

Yeah, well I mean it . . . I don’t think there’s an easy answer for the single health professional that wants to go overseas for experience. And, and I realize that now because I was one of them, you know 13 years ago. I wanted work in development, I wanted experience, so how do I get experience. And, a lot of the NGOs that are organized they ask for experience. (Bilateral Agency Employee 2)

NGO advertisements provided objectified accounts of everyday life by highlighting pieces of information that formed the conceptual “facts” about a volunteer experience. For example, when NGOs marketed an experience in an objectified way as “cultural” and centered it around the volunteer to make the experiences seem desirable. These advertisements set the expectation that the “experience” was a commercial event that was easily reproduced despite

the setting rather than an experience that was indeed relational. Such advertisements homogenized those who were living in the Global South as bystanders in the volunteer experience rather than real people with their own experiences. This reduction reinforces colonial legacies. Furthermore, the advertisements (text) were used as textual facts to coordinate and control the broader organizational social relations by influencing the volunteers’ expectations for an experience (what the volunteers know about their experience).

Expectations played a significant role in determining the caliber of the experience. As noted in the previous quote, expectations were often preset within the marketing strategies of NGOs. The following is an excerpt from an NGO advertisement addressed to nurses:

By interning on this program, you will have a great opportunity to understand how health care systems work in a developing country. Hospitals and clinics are often understaffed, so depending on your education, experience level, and work capabilities you may be able to assist with duties such as bandaging, taking blood pressure and generally caring for the patients. If you work as a midwife at home, then you are likely to be located in a busy maternity clinic, helping both pre and post-natal patients, and assisting staff with deliveries on an internship overseas. (Text sample from NGO advertisement)

Furthermore, the criterion to measure the “experience” was predetermined as an opportunity to achieve self-importance by demonstrating one’s expertise as a Westerner. The NGO sets expectations for volunteers to find self-fulfillment through the application of their expertise and skills banking rather than assisting the community and/or care recipient. The following two examples demonstrate how the NGO promises volunteers a sense of “importance”:

No matter your choice of region or project to volunteer in Africa, you will have an important role to play and your efforts will be greatly appreciated. School children will benefit from the knowledge you impart, wild life will gain from your conservation efforts, and locals will benefit from your journalistic perspective. (Text sample from NGO advertisement)

Although health care volunteer positions are often filled by doctors, nurses, paramedics, or medical students, many volunteers are surprised to learn that they can contribute in these types of placements even if they have little, if any, formal training. While those with formal training can participate in treating patients with complex or difficult procedures, those without can offer their help by assisting nurses, helping with routine patient check ups, doing administrative work, and other tasks. (Text sample from NGO advertisement)

Despite the pervasiveness of commodification as an organizational relation, some volunteers questioned the value of the “experience.” As one health work volunteer cautioned, future volunteers should not be disillusioned by the “experience.” The

volunteer considered the resources spent on her experience excessive in relation to her impact:

As much as I loved being here, I think some of my comments are kind of jaded now, only because sometimes I think that what I've wanted to accomplish here, I could have actually done it at home. The money I spent, which is good, and I've learned a lot and was wonderful for me, and in retrospect, I could have used that money for something else. And I think that's the thing I would tell people, that it's great to volunteer, but the work I do, I work with kids and stuff, but there's also kids that I could have worked with in my own community who also could have benefited. I don't have to go across the world to help, and the other thing, yeah, I guess maybe just by telling people, I don't know, maybe just like a sense of better knowledge of what the problem here is. Cause I think what I thought about Tanzania and how it is so off from the reality. (Health Work Volunteer 6)

In this example, the volunteer describes how her pre-existing expectations did not match her experience. It is important to note that both volunteers and NGOs feed the social construction of these expectations.

In addition to some volunteers questioning the value of the experience, some bilateral agency employees also described ways in which expectations can be curtailed to meet the needs of both the consumer (volunteer) and the community:

Well volunteers, they may end up frustrated because they aren't being used the way they think they should be. And, you know, some of that is about expectations and some of that is just about placement and maybe they shouldn't be in a nursing role in a clinical care facility. Maybe they need to be working with nurses to train them. Like they need to find a different way to use [the] volunteers who bring a whole realm of skills that [local] people don't have. (Bilateral Agency Employee 1)

Although this statement begins to acknowledge that nurses should perhaps not hold clinical roles in care facilities, there is still an attempt to find a niche that suits the volunteer experience. Furthermore, although it is unclear who represents "they" in this particular statement, it is assumed that the participant is referring to the NGO. This suggests a less than participatory approach to "finding work" for practitioners to have an engaging experience.

The following participant laments on his experience as both a physician and a bilateral agency employee and articulates the reward in the experience as "immediate gratification." This notion sheds light on the appeal and reward that is unique to health work in the context of volunteer:

And, and it's true, and I must admit that you, you mourn the loss of that immediate gratification and, that style of helping that is, perhaps quite singular to health professionals you know, but you know I also did public health before coming here so, I, and I was convinced that non-medical interventions have at least as much, if not more impact on health outcomes, as curative, or preventative

one on one treatment. So I was, I was already sold to the idea that I could put away my stethoscope and still deliver change, and health, you know, so public health is good in that sense, it reminds you that you can work to get, you know decent hygiene in place, and or scale-up HR, and you will have an impact, even though you're not wearing your stethoscope or prescription pad or anything like that. (Bilateral Agency Employee 2)

Unfortunately, it is problematic when some NGOs capitalize on those elements such as immediate gratification that attract consumers to the "experience." NGOs today are silently rooted in capitalist economy. Furthermore, the disengagement from the state and market is illusory. Instead, some NGOs are mechanisms of globalization, as is demonstrated by the enactment of volunteers of *experience as commodity* in this section. When a "worker" or "human resource" offers service in a voluntary capacity, it is important to acknowledge the context in which labor (paid or unpaid) has been conceptualized. If service has traditionally been valued as a commodity, then it might be difficult for individuals to separate themselves from their service contribution, which can lead to feelings of entitlement. It is important to consider the implications of this sense of entitlement, for both those providing and receiving the service, when examining a form of volunteer service that is traditionally paid. The findings from this study revealed that volunteers struggle not to feel "resentful" or "cheated" when their work went unrewarded.

Free Market Evaluation

Presently, health outcomes of Canadian NGO work internationally is rarely evaluated, apart from the self-reporting mandated by funding agencies. The regulation of these organizations is dependent on their charitable status, which in Canada is overseen by Canada Revenue Agency. The issue of cost-containment becomes a moral dilemma when some NGOs risk providing suboptimal service. For example, by using in-kind donations of medical supplies, such as expired medication to provide health care service delivery. Furthermore, cost-containment risks render NGOs vulnerable to the potential privatization and corporatization of the sector (Evans, Richmond, & Shields, 2005). In addition, shifting responsibilities from government to organizations, such as NGOs and individuals, places additional responsibility on individuals for their own service provision.

Because the NGO industry has few mechanisms in place to evaluate volunteer health work abroad, by and large, it is left to forces of the free economy to weed out low quality organizations. In other words, if enough volunteers are dissatisfied with their experience, for extended periods of time, the message will be relayed to the market and theoretically the NGO will cease to recruit volunteers to provide health work abroad. The concern is, however, that damage can still occur—and, in communities that are already marginalized by poverty—while these NGOs "die a natural death," as one

participant in this study states. Ultimately, in consumerist terms, it is the responsibility of customers to test, judge, consider, and perform due diligence on their “purchases.” The following quote exemplifies this notion:

I mean, in that sense it is buyer beware. I mean you get involved in any kind of organization, and, they’ll say “oh yeah we can post you in any country,” like sounds fishy, to start off with. It just sounds like commercial opportunity, you know, it’s just it’s someone said well let’s call ourselves project.com and link people up. (Bilateral Agency Employee 1)

While volunteers should aim to ensure that their work is meaningful for both themselves and the communities they serve, an emphasis on individual agency displaces accountability from NGOs, as well as the broader organizational social relations that reproduce the issues. In the following quotation, an employee from a bilateral agency describes how market laws will ultimately filter out low quality NGOs. And yet, is it fair that we leave it to the free market economy to evaluate this type of work? Should there be other mechanisms in place to evaluate health work in the Global South?

The market laws being what they are or rules being what they are, if a dozen nurses have experiences like that [negative experiences], then they’ll tell 2 friends and they’ll tell 2 friends and then this organization should die it’s natural death. Unfortunately it’s going [to] create a lot of bitterness in the process. (Bilateral Agency Employee 2)

The influence of neoliberalism on the volunteer sector has become increasingly pervasive and accepted. With NGOs being held to the same processes of evaluation as private industry, the principles of neoliberalism that contribute to the privatization of the volunteer experience are also responsible for policing it. This is not to suggest that there is a need for NGO regulation necessarily, however, demands innovation in how we conceptualize volunteer work in global contexts, particularly, when the unintended consequences can undermine development in the Global South.

The following quotation offers insights into some of the unintended consequences of volunteer health experiences in Tanzania. In particular, it exemplifies how volunteer health work, when conducted irresponsibly, can undercut local health care systems:

We were completely disconnected with anything that the government had to offer, so even the one or two cases in 4 days in the 800 people that I saw, would have needed referral to a specialist . . . And there were no formal linkages whatsoever. And, we were not treating; we were not stamping out disease. I was distributing toothpaste, toothbrushes, Tylenol, and dandruff shampoo. That’s basically what we’re doing. And unfortunately when, I don’t like giving antibiotics without a diagnosis, but if I would turn around and prescribe a third generation cephalosporin, it would be overkill medication that they [health work volunteers]

just got for free and they brought down. So that’s not even intelligent prescribing. So, I think we did a lot of damage. I mean, people [volunteers] were high fiving at the end of the day [saying] “yeah! 220 today we kicked medical ass!” And I kind of felt sad because, well, I mean these people definitely had a lot of good will, and a lot of energy, there was no teaching going on, no significant teaching going on whatsoever, and they were really undermining the public clinic that was 15 km away. (Health Work Volunteer 7)

This participant highlights two very important unintended consequences of practicing clinically as a health work volunteer. First, he showcases the disconnect that occurs with this type of piece work, where international volunteer clinicians provide temporary, primary health care without adequate knowledge of the local health care system and are therefore unable to appropriately refer community patients to sustainable local services. Second, he states, “I think we did a lot of damage,” referring to the type of medication that was distributed to local people. At the time of interview, it was common practice for the health work volunteers who participated in this study to bring donated medications for which the expiry date had passed. This practice is no longer permissible through Tanzania Customs. However, the practice illuminates how forms of care have the potential to cause more harm in communities than prevolunteer intervention. It also reinforces privilege to Western “knowers.” Furthermore, it begs the question whether free market evaluation is a sufficient response for work that can have so many detrimental health outcomes.

Similarly, the following participant describes how, in her practice as an international health work volunteer, she provided HIV testing in contradiction to local government policy. More specifically, she describes how a medical caravan traveled through local communities and implemented HIV testing without permission from the Tanzanian government:

HIV testing is through the government . . . because here you have to go through district medical officers office, because all the stats go back [to the office] so that’s why we’re not supposed to be doing it here, HIV testing. But we have HIV testing, and then everyone can see the doctor. The doctor does her exam or whatever, prescribes, then they go, get their HIV test or whatever. If they’re positive, they [the patients] are brought back to [a health work volunteer] talk about it. We had, probably about 10 new HIV cases during our last Caravan, which is pretty high. Oh, we also had someone from [organization removed] who was doing, giving out information about research and how research, a lot of people think research is bad and that we’re using them as guinea pigs. So they had a Tanzanian come and explain to everyone in line, “oh I’m just going to talk to you about research, like not all research is bad.” She was also advocating HIV testing, so she actually got people. We couldn’t see everyone, sometimes there’s 600 people, but she got a whole whack load of people who couldn’t be seen but got them, you should get an HIV test, so we had a way higher yield of HIV testing this time, which is amazing. (Health Work Volunteer 8)

Indeed, in this example, the participant is describing a form of cultural hegemony, whereby the health work volunteers are vehicles of the dominant class and Western culture and are manipulating local systems in an attempt to impose their worldview and ideology. Collaboratively, as an organization, the volunteers felt it was more appropriate for them to conduct HIV testing (as opposed to local practitioners) and enforce their research values. The participant discounts any critique of research, with a pejorative assumption that it relates to them having a sense of being “used” as “guinea pigs,” and little regard for their own position of power or the legacy of colonialism in Tanzania that might have shaped this skepticism. They did so by disguising their actions in the name of “advocating for HIV testing.” Instead, their actions are indeed reinforcing cultural imperialism by promoting and imposing their cultural beliefs of “appropriate care” on a marginalized population.

It is important to note not only the role of the NGO, but the broader organizational social relations (structures) that shape this form of work. Although the individual volunteers have agency in their actions as health workers, ultimately the context allows this form of work to be reproduced. This is evident because many of the volunteers in this study work for an array of NGOs, in several locations across Tanzania, with unique professional backgrounds and experiences. In fact, very few volunteers knew each other, or of other Canadian health work that occurred concurrently. And yet, several participants shared a similar clinical experience of providing temporary and disconnected work. In the following quote, another health work volunteer describes other unintended consequence of this form of work. In particular, he illuminates the health human resource repercussions that can ensue locally when NGOs utilize local doctors:

Like a lot of people think it's a good thing but sometimes NGOs, they take away doctors that we could be working in the [local] industry but because NGOs space is better . . . you're taking away, your pulling, you're taking the doctors. A lot of NGOs—there's certainly a lot of NGOs that have questionable objectives who have—who also have—who have benevolent intentions with bad effects and who regulated them? I think there needs better supervision, or, accountability. Not at the expense of discouraging people to do an initiative that they will like. (Health Work Volunteer 8)

Currently, neoliberalism is enacted in delivering volunteer health work in Tanzania, which includes a reliance on principles of free economy to evaluate health work. This has implications not only for the Tanzanian community but health service in general. In the following quote, an employee from a bilateral agency states the need to communicate “bad experiences” to other health workers. Given his bilateral agency's commitment to “lead Canada's international effort to help people living in poverty,” is it important to consider whether additional measures should be taken?

And I think that's what ultimately is dangerous because it's, I mean the impact that it can have on the ground—on the people, is kind of piecemeal, ad hoc work that doesn't do, doesn't contribute a lot in the long term. But it also, I think it's unfortunate that for someone who did decide to take time off from whatever practice they have, leave with a bad experience, perhaps just because they weren't given a heads up. Had they been given a heads up they might not have gone, and that's maybe better. Cause if you go, have a bad experience, come back and tell all your friends that it sucked, whereas if you get a heads up and you think oh that's awful, and you won't even go. And if you say, well that's not what I expected but I'll give it a try, at least if you know you'll be less likely to be disappointed. (Bilateral Agency Employee 1)

These unintended consequences have tremendous implications for the development of a health care system in Tanzania. Although this study only showcases the work being conducted by Canadian NGOs in Tanzania, these findings have applicability in many countries in the Global South. In the previous quotation, the agent expresses empathy for the volunteer. The consequences of this are that it further prioritizes the experience of the volunteer rather than the social context in which this exchange transpires.

Discussion

This ethnographic analysis has demonstrated the dynamically evolving social processes that humans unconsciously and routinely engage in through their participation in everyday volunteer health work in Tanzania. Although data were collected in 2011 to 2012, the findings still have relevance and meaning today as the demand for global volunteer health experience continues to grow. Volunteer work was organized through broad organizational social relations that determine ideas, actions, and expectations for the volunteer “experience.” This article expands our understanding of how the organizational social relations (NGOs) coordinated a multitude of volunteer work experiences in various regions in Tanzania. Texts, such as NGO advertisements, were examples of discourses that mediated the extra-local tensions that were generated beyond the individual. This article adopts Tiessen's (2011) approach in her exploration of sports for development work, in which she analyzed text from an organization's website. She determines that volunteers engaging in global citizenship are often Western, upper-middle class, White, and predominately young (Tiessen, 2011). Importantly, Tiessen identifies the “central” role that NGOs play in further “reinforcing partial and incomplete conceptions of global citizenship by reifying the role of Western volunteers in solving the problems of the South” (Tiessen, 2011, p. 575). Her findings resonate with this work, where most the participants were Western, White, upper-middle class with the means and access to travel.

This study also builds on existing works that have explored volunteer work as a form of cultural and economic capital (Jones, 2005a, 2005c; Sherraden et al., 2006; Simpson, 2005). It exposes how power and status were afforded to those in the position of “client,” which included the volunteers who participated in health work via an NGO and not the supposed members of the local community they intended to serve in Tanzania. Compounding this issue was the imbalance of power that occurred when health work volunteers expected clinical placements over local practitioners. The struggle for power between volunteers (clients) and local practitioners resulted in their inability to authentically advocate for the community and ultimately resulted in the undermining of local systems. This was exemplified by a health work volunteer who carried out HIV/AIDS testing contradictory to local Tanzanian policy. The power imbalance became especially problematic when the volunteers’ positions of power exempted them from accountability within the local community and provision of health care services. The lack of accountability, in culmination with the volunteer’s designation as a client and their desire to be valued as a clinical expert, proved to be particularly hazardous for the supposed “recipient” of care. Furthermore, it put into question whether this modality of health work was indeed more damaging than beneficial. Western practitioners need to rethink whether there is a clinical role to play in international health work. With this mind, NGOs need to shift from service-orientation to a mode of development that empowers the local community and, at the very least, acknowledges their expertise. This is not to suggest that this is type of work is not already being performed by some NGOs, the problem occurs when NGOs are indiscriminately valued as “good.” Health promotion in local communities could include a volunteer exchange program with learning objectives that meet bidirectional needs.

The classification of “who is expert” was informed by the organizational social relations identified in this study. Distinctions of authority, knowledge, and expertise were mobilized to support the neoliberal agenda (Kothari, 2005, 2006). In this study, “volunteer as client” and “clinical experience as commodity” were predicated on the opportunity for volunteers to impart their expert knowledge in a “developing” country. The NGOs valorized Western expertise and skills through advertisements that recruited volunteers to provide “a helping hand to someone in need.” The findings from this study resonate with Simpson’s (2005) assessment of gap year students who seek out professionalization by way of volunteering and travel. More specifically, Simpson notes the shift from collective idealism to individual career enhancement that occurs when students seek out an “expert” experience (Simpson, 2005). This study adds to Simpson’s findings suggesting that the need to seek out “professionalization” or “expert” experiences are not limited to gap year students. The participants in this current study were health work volunteers, many of whom had extensive educational

and professional backgrounds. Despite their achievement of professional status, many still sought out “expert” experiences, suggesting that individual motivations went beyond career development. The organizational social relations shape the volunteer experience and perpetuate the expectation and reward of gaining “expert” experience.

Knowledge and expertise described by the participants in this study were founded in modern science. The interpersonal social relations informed and were informed by Western notions of progress and technical knowledge associated with “modern,” which afforded the volunteer’s cultural capital. The volunteers not only acquired cultural capital but also continuously adapted to maintain their status and legitimize their actions. For example, one nurse described how she was better suited to insert an IV over a local physician. Modernity and the acquisition of cultural capital are inherent in neoliberal ideology. The participants in this study actively reproduced neoliberalism and neocolonialism by suppressing and ranking forms of knowledge. Although several authors have examined forms of cultural and economic capital gained through volunteer work (Jones, 2005b; Simpson, 2005), the literature has primarily focused on the individuals who participate in this form of work and the personal motivations for seeking out this form of capital. A review by B. M. Smith and Laurie (2011) examined the discourses and practices of citizenship, professionalization, and partnership reproduced through international volunteer work. In their review, the authors paid specific attention to some of the processes that inform international volunteer work and described the genealogies of development and volunteerism (B. M. Smith & Laurie, 2011). The authors noted that if the Global South was broadly constructed in terms of its “continued need” (B. M. Smith & Laurie, 2011, p. 549) and volunteerism was centered on the volunteers’ experience, these processes of professionalization would continue to be reproduced. This study adds to the limited empirical knowledge in international volunteer health work that focuses on these broader processes. Like Smith and Laurie’s review, this study yields specific findings that exemplify the neoliberal processes inherent in international volunteer work.

The organizational social relations reproduced neoliberalism by favoring a consumerist approach. The needs of the client, that is the volunteer, were prioritized above all else, including the needs of the community. The product was the “experience,” and the client ultimately decided whether the cost of the experience was worth the benefits. The client assessed the benefits of the experience based on their ability to impart their expertise. The NGOs in this study, as a collective entity, participated in the organizational social relations that reinforced neoliberal professionalization by marketing and selling an “expert” experience. Bondi and Laurie (2005) commented on the promotion of professional development and the surge of corporate citizenship producing a new relationship between NGOs, the private sector, and the state. More specifically the authors noted that this new relationship

reinforces neoliberal ideology that transcends the volunteer experience (Bondi & Laurie, 2005). B. M. Smith and Laurie (2011) further suggested that “new opportunities mean that neoliberal professionalization of NGOs and volunteering is being framed and performed in increasingly global ways and spaces” (Smith & Laurie, 2011, p. 550). Although these authors have examined the role of ideology within NGOs and among volunteers in the literature, this study offers data to support insights about the social relations that coordinate those experiences, linking the NGOs and international volunteer work through an examination of the social relations.

Future research should assess the experience from the standpoint of the local community in Tanzania. Some authors have stipulated that temporary international volunteer experiences might burden the host community rather than provide sustainable benefits (Green, 2009). Green, Green, Scandlyn and Krestly (2009), in particular, found that volunteer tourism resulted in negative outcomes such as disregard for local residents’ wishes, incomplete work performed by the volunteers, fewer employment opportunities for local community members, greater dependency between the receiving country and the donor country, as well as “othering” of locals by volunteers. Furthermore, Raymond and Hall (2008) suggest that development of cross-cultural understanding is not a natural result of volunteer tourism, but rather it should be prioritized as a goal. Canadians interested in participating in temporary international health work should consider traveling and supporting the local economy rather than seeking out experiences that service their needs as “experts.”

Conclusion

The findings from this study were theoretically derived and grounded in ethnography. Neoliberalism and neocolonialism ruled the coordination of international volunteer health work. “Volunteer as client,” “clinical experience as commodity,” and “free market evaluation” were the organizational social relations pervasive in talk and text. Despite their achievement of professional status, many still sought out “expert” experiences. The needs of the client, that is the volunteer, were prioritized above all else, including the needs of the community. The product was the “experience,” and the client ultimately deemed whether the cost of the experience was worth the benefits. The client assessed the benefits of the experience based on their ability to impart their expertise. The NGOs in this study, as a collective entity, participated in the organizational social relations that reinforced neoliberal professionalization by marketing and selling an “expert” experience.

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