International Voluntary Health Networks (IVHNs). A social-geographical framework.

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Abstract.

Trans-national medicine, historically associated with colonial politics, is now central to discourses of global health and development, thrust into mainstream media by catastrophic events (earthquakes, disease epidemics), and enshrined in the 2015 Sustainable Development Goals. Volunteer human-resource is an important contributor to international health-development work. International Voluntary Health Networks (IVHNs, that connect richer and poorer countries through healthcare) are situated at a meeting-point between geographies and sociologies of health. More fully developed social-geographic understandings will illuminate this area, currently dominated by instrumental health-professional perspectives. The challenge we address is to produce a geographically and sociologically-robust conceptual framework that appropriately recognises IVHNs' potentials for valuable impacts, while also unlocking spaces of constructive critique. We examine the importance of the social in health geography, and geographical potentials in health sociology (focusing on professional knowledge construction, inequality and capital, and power), to highlight the mutual interests of these two fields in relation to IVHNs. We propose some socio-geographical theories of IVHNs that do not naturalise inequality, that understand health as a form of capital, prioritise explorations of power and ethical practice, and acknowledge the more-than-human properties of place. This sets an agenda for theoretically-supported empirical work on IVHNs.

Keywords: volunteering, development, global health, socio-geographic theory, IVHNs

> 'Anything you can do over there is viewed amazingly positively by patients, by doctors, by the whole population. If you are helping the people then you get amazing feedback whereas here it's not quite so clear. It does make you realise what's important … as long as I just concentrate on doing what's right for the patient, focus on the patient not on the administration and not on the corporate side … that's all that matters.'

Volunteer surgeon, Tanzania

Introduction and method.

The above quote refers to medical work done episodically over some years by a member of an International Voluntary Health Network (IVHN). IVHNs, connecting communities in richer and poorer countries through voluntary healthcare activities, are positioned amongst the interests of global health and medicine, international development and various human sciences. By way of approaching IVHNs empirically, we prepare a framework of socio-geographical theory. We give some historical and political reasons for seeing IVHNs as important and problematic, and show how they occur at a blind-spot between the established interests of health geography and health sociology. To approach this problem we briefly show how health geography and health sociology are compatible through their political orientations *vis a vis* biomedicine and health inequality. We look in depth at theoretical engagements in health geography (interested particularly in the attribution of agency to place, and theorisation of people within place), before considering some social theories, also grounded in relation to place, that facilitate critical understandings of IVHNs. This latter section discusses ideas of professions and knowledge construction, inequality and capital, and power and conflict.

We close by summarising what our socio-geographical theory of IVHNs aims for in the context of current attention to global health. It emphasises social and material inequality as the basic enabling condition for, and ultimate concern of IVHNs; it urges us think of health as a form of capital continuous with other forms of capital (and International Voluntary Health (IVH) workers as engaged in capital exchange processes); it gives primacy to understandings of power and ethics; and it trains attention on the human capacities and potentials of IVHNs, while acknowledging the more-than-human agency of place.

Alongside literary sources, to display continuities between clinical-academic, public and experiential accounts and representations of IVH, we include selected empirical material (in the style of *vignettes*)

from our ongoing fieldwork activities. We draw upon participant observation at IVH-related professional networking events and conferences (notably the *Health Together* conference of 2015), interviews we have conducted with, and written accounts of members of IVHNs. *Health Together* brought together presenting speakers from 8 local (NHS, UK government and educational) organisations connected through an Academic Health Science Network, and others giving informal presentations on overseas health links. Intended to found a formal network of IVHNs within a UK region, it was the first event of its kind there. There were about 80 attendees in total. The volunteers' accounts comprise of semi-structured interviews (16) with volunteers and archived feedback questionnaires (37) from two IVHNs operating between the UK and two different low-income countries (Tanzania and Peru). This material illustrates a lived reality of IVHNs tallying with expressions found in scholarly and public media.

Excepting occasional examples from crisis events (the 2010 Haiti earthquake and 2014 Ebola epidemic), our attention is on scheduled, routine IVH. We explain this choice shortly, but first there are some exclusions to define. Much emergency international health work is done with a rhetoric of voluntarism but is well-remunerated and professionalised (for example UN Volunteers, Medecins Sans Frontieres). This kind of work is not our focus here, nor do we engage with health professionals who receive full salaries to work on long-term projects in developing countries (funded by philanthropic foundations), vacating their previous posts in richer countries. Building upon our wider interest in development volunteering ([anonymised] reference to 2 *transactions* pieces), we focus on unpaid, usually short-term IVH work, where volunteers often meet costs of organised working trips overseas. Also our interest here is in IVHNs linking richer to poorer countries, putting to one side (for now) the crucially important, under-recognised phenomena of 'South-South' IVH (reference [author details anonymised]).

Using a mixture of data from literary sources and first-hand empirical material enables us to see across this broad area of social life and identify theoretical traditions that provide compelling socio-geographic themes for understanding it critically. Our literary and empirical data could be systematically analysed

from different perspectives: a choice to be made advisedly, hence our concern to sketch out theoretical parameters for interpreting discourse around IVHNs. Our conceptual framework is not presented as conclusive, but a set of revisable heuristics for guiding thought about IVHNs away from clinical disciplines towards a more fully-realised socio-geographical awareness. We pursue theory broadly as an invitation to empirical socio-geographical study of IVHNs, which can be both critical and instrumentally useful as we anticipate the much-heralded era of globalism in health (Holden and Jensen 2017).

IVHNs: phenomena between disciplines.

Medicine and public health in rich countries have for centuries been entwined with international politics of security and commerce (King 2002, Weir & Mykhalovskiy 2010), while medicine transmitted from richer countries to poorer has historically been associated with socio-political projects of territorial colonialism and religious conversionism (Duffield 2005, Olakanmi and Perry 2006, Agensky 2013). King (2002:782) suggested conversionism is being superseded by a universalising project of integration, which enlists diverse cultures into the practices of biomedicine, and seems to dissociate Western medicine from its colonial and religious past. This dynamic simultaneously creates a 'brain drain' of health workers from poorer to richer countries (Mackey and Liang 2013), and brings opportunities for rich-country health professionals and institutions to extend their work systematically into resource-poor territories through partnerships allied with ideals of aid and development (Crisp 2007, Herrick 2017). Volunteering is an essential basic resource for these partnerships ([author details anonymised, reference]).

Biomedical healthcare consequently becomes truly a global enterprise in which volunteerism has a central role. This is reflected in health professionals' biographies of their experiences and successes in IVH, material that both reflects upon and constitutes global health work (and so offers a source of literary data, that we refer to in our discussion below). A recent special issue of *Globalization and Health* (2016) positions transnational health partnerships (incorporating volunteers) firmly within the agenda for development. With excitement surrounding possibilities for decades of incremental difference-

making IVH work to coalesce into a utopian global movement (Jamison 2013), multi-disciplinary (not just medical) understandings of IVHNs are needed for understanding the variable and socially-embedded nature of healthcare in diverse local contexts linked through ideals of global connectedness.

The sub-disciplinary traditions of health geography and health sociology in themselves, however, leave a discontinuity where IVHNs are found: both are concerned with understanding health distributions and experiences *within* geographic contexts. Health geographers investigate subtle and nuanced relationships between place and health (Poland et al 2005, Kearns and Collins 2010), or they map diseases and healthcare provisions, grappling with epidemiological trends such as increases in non-communicable disease (eg. Reubi et al 2016). Meanwhile health sociologists in the tradition since Parsons (1951) are well-accustomed to inquiring how the work of health professionals in richer countries is socio-contextually conditioned (see White 2016). IVHNs that temporarily move health workers from richer to poorer, unfamiliar contexts to work unpaid or pay to work philanthropically are marginal to both, and yet crucially significant for critically understanding constructions of global health.

Outside of clinical disciplines, investigation of IVHNs could fall into the realms of Volunteering or Tourism Studies, where it may become elided with other types of volunteering (eg. Roth 2015), or upstaged by 'medical tourism' in which health-service-users rather than providers are the people who move (Connell 2013). These fields are rich in critiques of global voluntourism (see Mostafanezhad 2016, Tiessen and Huish 2014) that could apply to IVHNs: however as we shall show, the directness of treatment provision through IVHNs sets up ethical and political intrigues that warrant specific attention in their own right. Other sub-disciplines can help with seeking critical space: medical anthropology has pedigree in calling out medical complicity with socio-economic inequality (eg. Scheper-Hughes 1984, 1995), and in problematizing an international morality which, although deploying rhetoric of advocacy and aid, colludes in silencing the voices of the global poor (eg. Butt (2002) on the 'suffering stranger'). Medical History has also been useful for making a context-crossing link between geo-political

colonialism and the sense in which Western medicine is always 'colonial in relation to the patient's body' (Anderson 1998:528).

Nevertheless IVHNs as phenomena that move people, knowledge and technology across socio-cultural and geographical boundaries have a contemporary salience that health geography and health sociology together should address directly. Deriving a conceptual framework from ideas established in these disciplines, our target is something more than simply a theory for projected application and empirical testing. Rather, we conceptualise the voluntary work of global health in continuity with sophisticated understandings that have been built in local contexts. Ultimately global health, if it is to be a coherent construction, must be provided with theory for crossing contexts, linking both richer and poorer into a consistent and unifiable intelligibility.

We face this conceptual challenge first by attending to social theory in health geography, then to health-sociological ideas connectable to place. These occupy different ontological territories (geography in understanding the properties of place, sociology in the properties of societies for determining meaning and experience). The compatibility between these territories (with places being cumulative multi-layered social constructions (Cummins et al 2007), and social conditions being materialised, embodied and spatial (Lefebvre 1991)) creates a common theoretical terrain for studying IVHNs. The empirical material we draw upon highlights practical problematics of IVHNs, as they encounter various issues which theory can help to clarify. Bringing disparate ideas into dialogue, we lay foundations for empirical work. Before proceeding towards theoretical objectives, a comment to demonstrate the political compatibility of health geography and health sociology.

The politics of social science critique.

A theoretically-critical attitude to spatialised inequality takes on heightened significance for the study of IVHNs, which connect places defined relationally by their richness and poverty. Although social sciences may ideally be defined by critical will (Pleasants 1999), the path to critique is not always straightforward. For instance, Kearns and Moon (2002:618) wrote that after a decade, the critical

impulse in Kearns' (1993) call to health geography had been attenuated by the market-oriented strictures of neoliberal academia. Although studies in health geography were politically-left and inclined towards equality, this inclination was not always carried through with full conviction. Kearns and Collins (2010:22) however, later expressed growing confidence in health geography's capacity to examine domination/resistance and oppose oppression.

Others have urged health geography to monitor itself for sustained critical intent through both theory and praxis (Parr 2004), to maintain activism for political change (Andrews et al 2012), and to do so in relation to global as well as local understandings of health (Craddock and Hinchliffe 2015). Other social sciences show similar sensitivities. In health sociology, for example, a distinction first made by Straus (1957) between sociology *in* medicine, and sociology *of* health and illness, is still invoked as a way of plotting critical disciplinary space (Emmerich 2011). Furthermore, health sociology also reflects the ambivalences of neo-liberal capitalism. Scambler (2012) for example, questions the strength of will in health sociology to confront global inequality. If sociologists are sincere about doing this, he says:

> "there will have to be a sociological reckoning with the contradictions of capitalism and the likes of transnational and national relations of class and command, a step well beyond a fascination with Socio-Economic Classifications and research designed to refine our understanding of the social gradient."
>
> Scambler 2012:144.

Likewise in political studies of global health, attention is strongly trained upon the problem of inequality but political differences are apparent. Kearns and Reid-Henry (2009:570), considering the 'geographical luck' of health inequality, comment that their multi-faceted approach to health-economic interventions 'might disappoint those who argue nothing short of abolition of the global capitalist system can address the fundamental causes of social problems'. Their analysis contrasts with Sparke's (2009) argument for a radical re-modelling of global health governance for economic justice, and his feeling that the idea of luck can de-politicise the geography of poverty (2009:146). In health geography,

Rosenberg (2013) positions this kind of tension in terms of ideal (utopian) theory oriented to end-state outcomes, and non-ideal theory which envisages more gradual transformations of messy realities.

IVHNs reflect an ethic of gradual transformation, and are implicated in a politicised discourse around spatialised differences in health just as they are embedded in the transnational and national relations of class and command to which Scambler (2012) refers. Studying IVHNs compels health geographers and sociologists alike to think outside of refined understandings of socio-geographical gradients, and in terms of grander spatial-temporal pictures of health and wealth distribution and movement. In this field nobody is unconcerned about inequality (Smyth 2008), but there is room for substantial disagreement upon what ought to be done about it. In such a context it is the conceptualisation of place in relation to people that is particular to health-geographical theory. Health geographers have explored this area in various ways.

Health geography, inequality politics and place.

Kearns' (1993, 1994) intentions for health geography were to occupy a critical position in relation to biomedicine, engage with social theory to deepen understandings of place, and deploy qualitative methods to connect with the human subjects of research: all concerns familiar to health sociologists whose chief theme of inquiry has been possibilities for understanding health, illness and medicine through social constructionist approaches (Conrad and Barker 2010, Collyer 2015). Kearns however, re-emphasised *place* at the centre of his expanded disciplinary remit, prompting a political question of assigning explicit or implicit responsibility for health and illness to places as well as to people. This recalls analytic distinctions between health inequality (factually-demonstrable variation in health), and health inequity (which has room for moral judgements of unfairness and responsibility – Kawachi et al 2002).

These are central concerns for understanding IVHNs as expressions of relational connections between places. Invoking place as a causal factor for better or worse health is not just descriptive of inequality but leads towards political responses for equity based on place distinct from those based on biological

processes and pathogens (as in medicine, public health) or purely socio-economic structures and conditions (as in sociology, social policy). The importance of theory for staking out critical ground in health geography, therefore, is that it can guard against lapsing into a de-politicised view of place. Preoccupations with causal patterns leading from place to health outcomes can obscure the ways in which health selectively determines the location and movement of people, therefore becoming inscribed into place (rather than consequent upon it – Smith and Easterlow 2005). Similarly 'neighbourhood effects' research has been criticised for a de-politicising concern to show that place works autonomously from poverty in determining life chances (eg. Slater 2013).

Places are material social accomplishments: without people to engage with place, whether through their active performances (Foley 2011) or pre-conscious affectivities (Andrews et al 2014), it does not make sense to think of places having agency. The adage that people create places, and places create people (Macintrye and Ellaway 2003) is a succinct emblem for this symbiotic process. Next we begin our theoretical explorations by seeing how health geographers have been concerned with this relationship.

(i) The agency of place.

To characterise place as a 'living construct which matters' (Kearns and Moon 2002:609), is to move it from passivity (being a receptacle) to activity (having powers of agency). This opens up possibilities for thinking about what places may do in relation to health generally, and specifically in the context of IVHNs where issues of human agency (for difference-making) across distance are the key focus. The simplest model for such thought rests upon a categorical distinction between context (the capacities of places and environments to influence health) and composition (the actions of individual people in those places). Curtis and Rees Jones (1998) criticised this distinction, a legacy of the medical-geographic tradition, as a foreclosure of various possibilities of continuity and connection between human and non-human agency.

Working away from the context-composition dyad health geographers have come to observe instead the continuities between people and place as context 'gets into the body' (Cummins et al 2007:1829), and

see places as interconnected, layered, dynamic and fluid socio-relational 'nodes in networks', imbued with contestable power relations, active through process and interaction (Cummins et al 2007:1827). This fluidity and connectivity of place and people is reflected in IVHNs whose implicit rationale is that places and populations connected by mutual difference are also potentially sites for coming-together and recognitions of sameness. They express a humanistic belief that acts of care can shrink vast geographical distances, and that cultural separations can be (at least temporarily) overcome.

Accordingly many of our respondents when asked about their impressions of the *places* they volunteer, make strongly people-centred responses, for example:

> "When you volunteer in these places, you get very humbled amongst the wonderful people you are helping."
>
> Nurse volunteer, Peru.

> "You can't really put a price on the rewards of seeing women who are ecstatically happy because their children aren't infected … people who have hope, when there was no hope."
>
> GP volunteer, Tanzania.

> "The people there are gracious, stoical and dignified, and although they have nothing in terms of material wealth, they have so much more that cannot be measured in monetary terms."
>
> Student volunteer, Tanzania.

These, and many other broad characterisations in accounts of IVH, make an unquestioned connection between place and people: in effect the people *are* the place, and it is through the people collectively that the agency and character of place can be apprehended (although particular members or sub-groups within these populations may simultaneously be characterised as problematic).

The relational model of place connects with broader philosophical debates of Actor-Network Theory, examining ascriptions of agency to human and non-human entities (Latour 2005) and troubling distinctions between natural and human/social (Braun 2005). In studying IVHNs, the idea of a network is useful to highlight the extended *social* connections that enable IVH work amid the structural politics of

global inequality, and the ways in which human-held agency (the will to make difference, for example) rubs up against the material but still human-made conditions of geographic isolation and resource scarcity. Poor health in low-income countries is not thought of as inherent to such places *per se*, but inherent to poverty, neglect and absence of infrastructure. IVHNs make space to imagine such places becoming healthy, while also already perhaps being healthy in human-centred ways that richer countries are not (see the quotation which opens this paper).

Recent health geography has seen a trend towards the human side of place-making, place-agency and the mobilisation of place in discourses of more-than-human selfhood (Larsen and Johnson 2016). Examples include the forging of 'healthy space' through practical routine (Dyck and Dossa 2007), the processes of resource acquisition that make places more or less health-giving for residents (Bernard et al 2007), the therapeutic properties of movement of people within and between places (Gatrell 2013) and the active mobilisation and use of place-based resources for health (Duff 2013). Such studies that show the healthy properties of place respondent to action, performance and interpretation are empirically-wrought, but uphold a theory of fundamental and repeated co-construction between people and place.

Such health-geographic studies are therefore intrinsically-social studies. Being generally focused on people and their bodies as carriers of good or ill health, their narratives tend to include health professionals peripherally, if at all, in the co-construction and regulation of health-related experience. In our opening quote, by contrast, it is the volunteer health worker who occupies the central role. Andrews and Evans (2008) and Connell and Walton-Roberts (2015) have called for health geography to further address the day-to-day realities and intricacies of health production by attending to health workers. Here is a natural crossing point into health sociology, where the tradition of interest in health workers is well-established. Next we consider a selection of sociological ideas around health work, still drawing attention to their compatibility with themes of inequality and place. Alongside our empirical material we focus on three areas of theory: professions and knowledge construction (after Freidson), inequality and capital (after Bourdieu) and power (after Foucault).

(ii) Professions and knowledge construction.

Sociologies of health professions build upon the work of Eliot Freidson, who began (Freidson 1970) by polemically exposing the self-promoting tendencies of a medical profession largely autonomous in pursuing new territories (conceptual and geographical) for medicalisation. Freidson's critics have emphasised the structural contexts in which medicine is judged more or less powerful in relation to the institutions of neoliberal capitalism (Coburn 2006), global markets (Evetts 2011), and attempts at bureaucratic regulation (Timmermans 2008). Given that these discussions are in large part concerned with the ethics of medical professionalism, it is notable that clinical literature around IVHNs has also been closely interwoven with surveillance of professional ethics.

A report from experience of training surgeons in Vietnam, for example, (Dupuis 2004) warns medical colleagues against the 'humanitarian colonialism' (2004:433) that allows visiting teams of surgeons to use the poor populations of Southeast Asia as a training resource. Surgical teams who visit for short periods, little concerned with development but rather with treating as many bodies as possible, without regard for follow-up care, and at a cost-per-operation which far exceeds that of good work done by local practitioners, give a poor impression of global health practice. Similarly doctors Wall and Arrowsmith (2006:559) scorned 'fistula tourists': doctors who go on short-term missions for personal and professional gratification, 'to try their hands at fistula repair, returning home well-stocked with stories to amaze their colleagues, but leaving a dubious legacy in places where their surgical sightseeing took place'.

A keynote speaker at *Health Together* (2015) gave some examples of unscrupulous practice, especially from the Haiti earthquake of 2010 where unnecessary surgeries (mainly amputations) were conducted by opportunists offering 'aid' to a vulnerable population (see Redmond et al 2011). Volunteer delegates at the conference dissociated themselves from such practices by emphasising signs of connectedness: examples of working with local people and knowledge, attention to sustainability and continuity, and the building of lasting and trusting relationships. This accent on responsible practice recurs elsewhere in

clinical literature (eg. Suchdev et al 2007, Wolfberg 2006) and policy recommendations (eg. THET's principles of partnership, 2017), alongside concerns to demonstrate the value of volunteering to volunteers and their home institutions (Jones et al 2013, RCPSG 2017).

Overlap between identifying opportunities for professional growth, and caution over deriving professional gains from inequality and poverty, produces some tension in this discourse. Biographical pieces in clinical journals attest to the increments that can be made in practical skill, especially by inexperienced/student clinicians:

> "experiences in many clinical procedures such as suturing, urethral catheterisation, central line insertion, nasogastric tube insertion and so on. I learned theoretically most of these procedures before but never had a chance to perform them."
>
> Chong (2015:164).

While some advocate volunteering as a route for health professionals and students to meet 'required competencies' (Riviello et al 2011), others worry about students expecting or being pushed to work beyond their training (Bhat 2008). The poverty of patients, Bhat argues, is tacitly used as justification for putting them at risk. Equally, several of our more experienced respondents (when asked about difficult decisions or regrets in IVH work) have also reported, with upset, particular patients who with hindsight they would like to have treated differently.

These contributions suggest a usually-hidden ambivalence over IVHN work. Through health partnerships members of IVHNs act collectively and with multiple institutions to stake claims in disparate territories, negotiating new forms of cross-cultural professionalism as they do so. Underlying this course are complex dynamics of self-interest and self-sacrifice, alliance with the interests of publics and stakeholders in different places (consonant with Freidsonian themes – Calnan 2015:302), a heartfelt will to care, and risks that are difficult to foresee. Relational differences of place create spaces for embodied health knowledge to be re-produced and re-formulated in ways otherwise not possible, driven by intentions to mitigate and lessen inequalities, confronting them directly if not politically. This

post-Freidsonian schema assuredly creates critical space, and keeps health professionalism and inequality in view. How convincingly does it allow for a consideration of place?

Bruno Latour (1983:155) wrote that 'scientific facts are like trains, they do not work off their rails. You can extend the rails and connect them but you cannot drive a locomotive through a field.' IVHNs show a contrast between advanced healthcare and this laboratory science evoked by Latour, as professional gains can be imagined in running health practices without bureaucratic infrastructure, downsizing the locomotive, and laying the rails as you go. Volunteers may negotiate *ad hoc* between knowledge from home and phenomena they encounter in an unfamiliar place (Schwartz et al 2012). This is significant given that biomedicine may on occasion be caricatured as automatically suppressing alternative knowledge forms (Baronov 2008). IVHNs suggest a more complex and open relationship between the places inside and outside the scientifically-disciplined clinical spaces of richer countries.

(iii) Inequality and capital.

To reiterate, the defining characteristic of IVHN work in resource-poor settings is crude inequality, in plain sight, as a basic condition for practice. While professionals donating time, skills and technologies to those 'less fortunate' (Toole 2016) do so because the relations of inequality cannot be denied, there are different ways of perceiving unequal relations between places. Money itself is one way: receiving-community perceptions of voluntary health workers have been shown to be influenced by economic concerns (Green et al 2009). Local practitioners are undermined (fiscally and symbolically) by visitors providing care for free, and visitors may not distinguish between levels of poverty to differentiate those who can and cannot afford local-based care (if they simply see *everyone* as poor). Richness, rather than poverty, seems to induce financial naivety.

In our own research, this has been apparent where a respondent involved with the funding of health services described (off-tape) how enthusiastic the people they worked with in a low-income country were to learn about the administrative coding of conditions treated in UK hospitals. These codes are the

means to securing payment from funding bodies. The absence of remuneration from voluntary work does not imply the absence of money from the dynamics of IVHNs, however in those areas where money and material resources are scarce, other streams of capital are observable. This points towards Bourdieusian ideas around forms of capital, fields of social action and the habitus.

Bourdieusian theory, already a staple of volunteering and migration studies, has begun to be applied more keenly in health sociology (eg. Dubbin et al (2013), Pinxten and Lievens (2014), Stephens (2008)) to explore the reproduction of social inequalities in clinical interactions and embodied health. Transferring attention from patients to practitioners, it is clear that IVHN-volunteers, working in socio-geographical fields placed in contrast to the familiar of their everyday, may look to develop skills and knowledge that become inscribed in their minds, bodies and social selves, their habitus. They invest energy, time and money in voluntary work so as to derive value for various interested individuals groups and institutions, so they are involved in the exchange and generation of capital.

Volunteering-clinical literature indicates that health volunteers attribute to their work cultural value which is not directly economic, but embodied in skill and self-worth. Campbell et al (2011) and Ravishankar (2014) both advocate volunteering to inculcate cross-cultural awareness. Titus (2011) recounts the personal rewards of disaster relief in Haiti, citing the 'never-ending gratitude' of 'virtually every individual' (2011:189). Vink and Lloyd-Hughes (2012), likewise, finish an article on short-term missions by exhorting volunteers never to despair in adversity, and so rediscover a sense of purpose in practice – their 'passion for medicine invigorated'. Limb (2013) uses the same terms, noting the immeasurable benefits and minimal costs involved, to produce doctors who 'return invigorated' to the NHS.

There is a dividend in professional-selfhood for health volunteers crossing the boundaries of national and cultural difference. By and large our respondents are effusive on the discovery of new capacities in themselves (individually and collectively) while volunteering, for example:

> "I was very surprised by the way that I managed to cope so quickly and adapt and find my feet, (…) just being with the team, you learn from each other's experiences, you embrace each other, you share your difficult moments (…). I don't think I was able to do it by myself. I think it's important that you are in the right setting with the right group of people."
>
> Volunteer surgeon, Tanzania.

IVHNs have the potential to enrich such volunteers symbolically as carriers of a trans-cultural global-health habitus.

This embodied capital suggests once again an ambivalent relation to inequality: IVHN work is direct action against health inequality, but still draws upon inequality for derivations of professional capital. This is a kind of capital profoundly connected not just to place but to mobility between places and the capacity to practice in a way apparently transcendent of place restrictions (hence *global* health). A contrast arises between this form of cross-cultural mobile health capital, associated with health workers, and embodied health as a form of capital, which patients stand to gain from successful clinical interactions. Alongside these streams of capital, other stakeholders in IVHNs (corporate sponsors, for example) are likely to have other capital interests at heart (Gautier and Pache 2015).

A helpful aspect of the Bourdieusian schema is that it offers a theory of capital exchange to include all participants in IVHNs, those involved more permanently (organisers, sponsors), temporarily (volunteers) and transiently (patients). While different forms of capital are associated with different actors, there is scope to make comparisons and find overlaps between these forms. Brought into contact by profound inequality, professional volunteers and their patients are situated in reference to a common frame of interest around health capital. Empirical research may shed further light on the ways in which IVHNs enable the production of different kinds of capital, their relative mobilities and attachments to particular places, and their potential to facilitate sustainable health equality, however incrementally.

(iv) Power and conflict.

Whereas Bourdieusian theory is a comparatively recent interest in health sociology, Foucauldian theory is better established there since *The Birth of the Clinic* (1963 – also a 'remarkable work of medical geography' – Philo, 2000). Foucault has been useful for helping health sociologists to think of medical knowledge as a form of disciplinary power (Lupton 1997) which regulates and governs human bodies (Turner 1995), but later Foucauldian ideas about productive power (the force that says 'yes' – Foucault 1977) can be particularly useful for juxtaposing the subjectively-productive aspects of personal experience in IVHNs (like those noted above) in interaction with more recognisably authoritative or structurally-supported impositions of power.

The power-conflicts of global health work are especially visible in high-profile crises, such as the Ebola epidemic of 2014. Public (and sometimes also academic) discourse routinely referred to volunteers *battling* Ebola (or fighting it – Mello et al 2015). Such conflictual language is classically biomedical, visualising disease as enemy and writing out the affected population, poverty and social relations. It sits uneasily with a humanitarian aesthetic of care for vulnerable groups and with the sensitivity of cultural interventions such as challenging local traditions of funeral practices (Richards and Mokuwa 2014), imposing curfews (Gonzalez 2015) and efforts to establish trust against suspicion of healthcare (Dhillon and Kelly 2015).

More subtle power-infused interactions are also detectable also around IVHN work, with ambivalence between assertive and cautious attitudes to cross-cultural healthcare practice. A recent policy-report ('Knowledge and Place', 2014) suggests a passive style of resistance by health workers in receipt of voluntary aid. In response to a problem encountered by an IVHN, where local workers were commonly absenting themselves (leaving UK volunteers to work alone in unfamiliar settings), the report explores the importance of 'co-presence' for sustainable IVH. It encourages 'stable and trusting partnership' as a condition for bilateral exchange, but there is also a consideration of 'enforcement' that could be applied where the local workers neglect their agreed responsibilities (2014:12). In the event of such

transgression, the gift-giving party (volunteer-sending organisation) is in the stronger position to dictate terms.

Incidents reported in our data indicate a complex world of unspoken power-boundaries that IVHN members must negotiate. One interviewee, for instance, discussed a case of a seriously ill patient who was beyond the capacities of local non-specialist doctors to treat in their customary practice, but whom the volunteer team saw as a manageable case. Persuading locals to work with volunteers to perform treatment was seen as a major success, both clinically and in terms of professional diplomacy. In contrast, archived written accounts bore witness to local practices which volunteers found medically and ethically unacceptable. Because these practices were felt to be culturally-embedded, however, there was no easy way to challenge them without bringing the IVHN into difficulty with local colleagues and publics. Intervention by the volunteers took the form of feedback sessions arranged *post-hoc* at which suggestions were respectfully made.

These vignettes suggest complexity in the micro-politics of interaction between international health volunteers and host workers, just as has been observed among other development volunteers (MacGinty 2015). Rhetorics of philanthropy and mutuality may slip towards rhetorics of control, securing the working environment for the volunteer, while host workers (to use a Foucauldian idiom) may seek spaces of resistance. In other cases, volunteers are themselves wary of challenging culturally-powerful practices, and look for ways to resist. These negotiations occur within a broader context of global wealth inequality, neoliberal political domination and structural power. Although they may be below the threshold of awareness when individuals or groups of volunteers focus attention on particular clinical or organisational problems and on the bodies of particular patients, broader political contexts are still present and active. They are intrinsic to the relationships of IVHNs, to their exercises of care and connection between places.

Embodied interactions of occupation and challenge to different channels of power are conditioned by, and contribute to, constructions of place. Health sociologists are well accustomed to thinking of the

clinic as a particular kind of social space, but studying IVHNs can draw geography into this tradition to differentiate between different manifestations of clinics. Procedures in these different clinics are always acts of power that intervene in the physicality of bodies, and are made substantially distinct by socio-geographical context. While a socio-geographical emphasis on power dislodges biomedical orthodoxies bringing social context to the fore, it can also be used to emphasise that health practice is never placeless: it is always embodied, interpretive and contributes to the continual construction of the world.

Conclusion

Although health geography and health sociology have been quite separate subdisciplines institutionally and conceptually, they have a natural overlap which situates them well to study IVHNs away from clinical perspectives on this topic, a topic crucial to understanding global health. From the point of view of health geography, this overlap activates ideas of place towards the realms of sociality, and brings health workers decisively into consideration alongside people who experience good or bad health. From the point of view of health sociology, it puts social actions – the regulation and reproduction of professionalism, the creation and exchange of health-related capital, the performances and resistances of power – firmly into the physical realm of place. In conclusion we encourage the following theoretical understandings for empirical study of IVHNs.

Firstly IVHNs are predicated upon inequality – not fine-detail inequality that has primarily interested health geography and health sociology as subdisciplines but coarse inequality, tangible enough not to need statistical demonstration. This is the inequality that moves health workers permanently away from poorer to richer countries as 'brain drain', and brings them from richer to poorer as temporary volunteers. IVHN members may experience a release from the bureaucratised routines of their usual work, understood perhaps as a return to a more elemental or primal form of practice. IVHNs embody a critique of these gross inequalities, being a form of direct action against their manifestations and symptoms: on the other hand the clinical literature on international health volunteering does not

generally suggest a close connection between IVHNs and the genesis of politicised consciousness to challenge inequality.

Social-geographic study of IVHNs can aim to bring the dynamics of inequality into clear view, both in a broad-contextual macro-social sense and in terms of on-the-ground interactions embedded in particular places and times. Secondly social-geographic study can attend to the construction of health-professional identity and health knowledge using a place-focused approach. This is a way to query presumptions of objective placelessness in biomedicine, and show how all health experience and healthcare practice is embedded in place. It can also protect against social-scientific caricature of biomedicine by investigating how health expertise adapts to place and attains credibility and pre-eminence in different contexts. This calls for a close scrutiny of the clinic as a place constructed variably in relation to institutions and stakeholders both close and distant.

Thirdly we see a possibility to discover the different kinds of capital, all place-related, associated with the health work of IVHNs. While clinical literature on IVHNs usually focuses on the benefits to volunteers, framing these benefits as social capital allows a fuller appreciation of their political implications, and allows for continuity of thought between monetary and material capital, capital as expertise for cross-cultural health practice, and capital as health itself. The benefits to recipients of care from IVHNs can be brought into view and appreciated in the context of experience in low-income countries. A move to think of health as capital builds upon research that aims to demonstrate causal connections between health and other capital forms. Rather than searching out these connections however, theorising health *as* capital allows one to take it as read that health has continuity with other kinds of social value.

Fourthly IVHNs encounter a world of profound complexity in social interaction that socio-geographical study can explore through attention to perceptions of power, resistance and ethical responsibility. To be fully critical, this approach should look for the effects of power not just amongst the sending, wealthier and biomedical side of IVHNs but on all sides (and there may be many sides to IVHNs) as they

operate in relation to each other. Fifthly a social-geographic model for IVHNs can acknowledge that these networks made fundamentally of humans are not freely active agents, but are embedded in more-than-human contexts that we can understand through close attention to the materially-experienced and representable properties of place.

While places are in turn made by people, they have a different kind of existence which endures and is slow to change, and can be the focus for a 'semiotics of materiality' (Powell 2007:318). The importance of place for studying IVHNs cross-cuts the socially-constructive dimensions we have discussed, to show that health practice is always political and never placeless. If inequality, capital, power and ethics are to be foregrounded it is helpful to keep an emphasis on human acts and potentials, but the materiality of place is a necessary anchor for understanding the work of IVHNs.

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