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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.

> '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

1. 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

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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 (Baillie Smith and Laurie, 2011, Laurie and Baillie Smith, 2017), 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 (Baillie Smith et al., 2017).

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).

2.1. 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 and 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 (Baillie Smith and Laurie, 2011).

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 et al., 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 that, 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