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International clinical volunteering in Tanzania: A postcolonial analysis of a Global Health business

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ABSTRACT

This article traces how scarcities characteristic of health systems in low-income countries (LICs), and increasing popular interest in Global Health, have inadvertently contributed to the popularisation of a specific Global Health business: international clinical volunteering through private volunteer placement organisations (VPOs). VPOs market neglected health facilities as sites where foreigners can 'make a difference', regardless of their skill set. Drawing on online investigation and ethnographic research in Tanzania over four field seasons from 2011 to 2015, including qualitative interviews with 41 foreign volunteers and 90 Tanzanian health workers, this article offers a postcolonial analysis of VPO marketing and volunteer action in health facilities of LICs. Two prevalent postcolonial racialised tropes inform both VPO marketing and foreign volunteers' discourses and practices in Tanzania. The first trope discounts Tanzanian expertise in order to envision volunteers in expert roles despite lacking training, expertise, or contextual knowledge. The second trope envisions Tanzanian patients as so impoverished that insufficiently trained volunteer help is 'better than nothing at all'. These two postcolonial racialised tropes inform the conceptual work undertaken by VPO marketing schemes and foreign volunteers in order to remake Tanzanian health professionals and patients into appropriate and justifiable sites for foreign volunteer intervention.

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Introduction

Global Health[1] is increasingly imagined as a site for business and financial investment, both within and beyond official channels (see Erikson, 2016). One enterprise converging around popular Global Health imaginaries is international clinical volunteering, whereby individuals go to healthcare settings in low-income countries (LICs) to volunteer through private volunteer placement organisations (VPOs).[2] Private VPOs remake the needs of postcolonial health facilities into a market, attracting mobile foreigners with aspirations to 'do' Global Health. The popularisation of international clinical volunteering relies on long histories of under- and unevenly resourced health systems in LICs, which make the journeys of foreigners abroad to assist in health facilities appear justifiable, even laudable. This article reveals the problematic postcolonial racialised tropes underlying the marketing, discourses, and practices that make up international clinical volunteering.

Health systems in LICs have never been well resourced. During the colonial period, insufficient resources stymied aspirations to create robust health systems in colonies (Tilley, 2016), an issue echoed in the post-independence period when insufficient state revenues thwarted health system strengthening efforts (Prince, 2014). After the economic crisis of the late 1970s and early 1980s,

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most LICs underwent structural adjustment programmes in exchange for World Bank and IMF loans, through which state budgets were slashed, public services semi-privatised, and governance systems decentralised in hopes of stimulating foreign investment. Health systems were particularly hard hit (Beste & Pfeiffer, 2016). It is onto these weakened systems that a variety of contemporary Global Health engagements have been mapped (Pfeiffer & Chapman, 2010). Indeed, these health system weaknesses have become important resources for Global Health enterprises (see Crane, 2013; Street, 2014).

The impact of Global Health on flows of personnel, resources, and technologies has been remarkable. Some flows are connected to official channels, such as programmes funded by national governments, bi- or transnational donors, NGOs, or public private partnerships. I call these types of engagements 'official Global Health interventions'. Since the mid-2000s, unprecedented Global Health funding has funnelled into LICs, prioritising narrow vertical targets aimed at selective populations or ailments, primarily reproductive and child health, HIV/AIDS, tuberculosis, and malaria (Prince & Otieno, 2014; Whyte, Whyte, Meinert, & Twebaze, 2013).

However, official Global Health interventions often undermine national health systems (Livingston, 2012; Prince & Otieno, 2014; Street, 2014). Health facilities targeted by official interventions are not necessarily under-resourced insomuch as they are unevenly resourced (Prince & Otieno, 2014), with abundant resources available for targeted forms of care, but chronic shortages more broadly (Sullivan, 2011, 2012). Predominantly, Global Health funding prioritises agendas of foreign actors; recipient governments and local workers implement programmes not of their own devising (Brown, 2015). This top-down approach has historical roots in colonialism, and continues to 'influence both who is invited to the policymaking table and how global health agendas are then prioritized' (Greene, Basilico, Kim, & Farmer, 2013, p. 71).

Similar trends characterise Global Health endeavours beyond official interventions. There is significant public discourse about what Teju Cole terms the 'white savior industrial complex' (2012), referring to how predominantly white and privileged groups assume they can 'make a difference' without understanding the complexities of context of those being 'helped'. Thus, Global Health is 'haunted by a postcolonial power differential that it continually struggles against' (Crane, 2013, p. 161), in which imaginaries of 'resource poor' people and places are coded as inherently 'Other' (Brada, 2011), and well-intentioned (largely upper class or middle class) foreigners can 'make a difference'.

Of course, health professionals and students' movements from 'North' to 'South' are not new; however, these journeys multiplied alongside 'Global Health' (Brada, 2011; Drain et al., 2007). As official interventions' narrow priorities neglected significant aspects of health systems in LICs, health facilities in these countries became appealing as sites for prospective Global Health travel. Due to the increasing popularity of Global Health among (prospective) students, many universities within the United States and elsewhere develop and advertise Global Health programmes and excursions. Universities unable to meet surging student demand for Global Health opportunities (e.g. Drain et al., 2007; Hanson, Harms, & Plamondon, 2011; Shah & Wu, 2008) often outsource international placements to VPOs (Lasker, 2016). However, universities' and students' expanding Global Health interests also create a variety of dilemmas, particularly for hosting institutions (e.g. Crane, 2013; Kumwenda, Dowell, Daniels, & Merrylees, 2015; Street, 2014; Wendland, 2012).

Several scholars have noted uncomfortable neocolonial echoes inherent in international volunteering (Calkin, 2014; Green, Green, Scandlyn, & Kestler, 2009; Pinto & Upshur, 2009; Simpson, 2004),[3] and clinical volunteering in particular (Wendland, Erikson, & Sullivan, 2016). Because of biomedicine's historical relationship to imperialism (Anderson, 2003; Tilley, 2016; Vaughan, 1991), neocolonial echoes are made more salient in healthcare settings of former colonies. While often envisioned as a universal healing practice, 'biomedicine so frequently, and yet so covertly, collapsed normality into an unmarked whiteness' (Anderson, 2003, p. 464), informing identities of colonised and coloniser alike. That is, biomedicine's close ties to imperialism enable it to remain conceptually, if unconsciously, tethered to notions of whiteness, where volunteers from the global

North conceptualise whiteness as an 'unspoken norm' (Frankenberg, 1993), and Africanness as a deviation from this norm.

Drawing on Tanzania as a case study, this article unearths two prevalent postcolonial racialised tropes informing both VPO marketing and volunteers' discourses and practices in LICs. First, volunteers understood Tanzanian health professionals through prominent 'global racialized hierarchies' (Pierre, 2013, p. 548) wherein Black professionals had to prove their expertise, but a volunteer's expertise was assumed just by virtue of being white (c.f. Benton, 2016). To wit, regardless of level of training or expertise, volunteers conceptualised themselves as affiliated with a 'global medical imaginary' – or with what they saw as 'real medicine' (see Wendland, 2012) – yet understood Tanzanian practitioners as lacking sufficient professional status to merit full recognition as professionals.

Second, VPO marketing and volunteers envisioned patients as 'suffering strangers' (Butt, 2002; see also Livingston, 2012),[4] thus justifying their providing sub-standard medicine 'good enough for the poor' (Feierman, 2011, p. 172). Crane argues, 'global health relies upon a very strong notion of *bodies in place* in which certain kinds of patient bodies are linked to certain kinds of places, and, by extension, certain kinds of biomedical learning opportunities' (2013, p. 157, emphasis in original). Imaginaries of bodies in place reflect wider postcolonial narratives conceptualising 'places-in-the-world' not just as geographical locations, but also as ranked 'in a system of social categories (as in the expression "knowing your place")' (Ferguson, 2006, p. 6, parenthesis in original).[5] LICs are thus locales where populations are imagined as impoverished suffering strangers. Conceptualising patients and places as 'resource-poor' or 'local' enables Northerners to imagine themselves as experts able to 'do' Global Health (Brada, 2011) regardless of their level of training, thereby justifying interventions that would be wholly unacceptable at home[6] (see Wendland et al., 2016). Meanwhile, VPOs employ these tropes to sell placements.

Below, I reveal how VPOs and international clinical volunteers in Tanzania draw upon these two types of postcolonial racialised tropes as part of their conceptual work to remake health professionals and patients into appropriate and justifiable sites of foreign volunteer intervention. Drawing upon online and longitudinal ethnographic research, I demonstrate how foreign volunteer mobilities are inscribed with postcolonial power inequalities in which volunteers marginalise the very people they are meant to serve.

The scope and definition of 'international clinical volunteerism'

Since the mid-2000s, interest among individuals in the global North to participate in Global Health experiences has grown significantly (Drain et al., 2007; Lasker, 2016). There are a variety of types: medical missions or brigades, international clinical volunteering, and health electives/internships (in medicine, nursing, dentistry, midwifery, etc.). While some participants are qualified health professionals, countless others are unlicensed health practitioners, whether career-leavers, undergraduate or health professions students, or medical residents. Many volunteers go abroad for 'experience' to bolster their resumes in a competitive education and job market (Colvin, 2016; Hanson et al., 2011; Lasker, 2016; Shah & Wu, 2008). Global Health experiences presumably benefit health professions students by engendering cultural competency, improving work efficiency, increasing awareness of health disparities, and stimulating interest in care for underserved populations (Drain et al., 2007; Godkin & Savageau, 2003).

The effects of short-term volunteer trips on host communities are ambiguous, with both benefits and challenges reported (Friedman, Loh, & Evert, 2014; Kumwenda et al., 2015; Lasker, 2016; Loiseau et al., 2016). Ethical dilemmas highlighted include students practicing beyond their training (Bauer, 2017; Elit et al., 2011; Green et al., 2009; Shah & Wu, 2008); trips benefiting volunteers more than host communities (Bajkiewicz, 2009; Green et al., 2009; McLennan, 2014); volunteers' misunderstandings of what is helpful or harmful in context (Berry, 2014; Elit et al., 2011); perpetuation of the notion 'some care is better than none' (Berry, 2014; Lasker, 2016; Shah & Wu, 2008; Wendland et al., 2016); lack of external evaluation mechanisms measuring community impact

(Bauer, 2017; Berry, 2014; Crump & Sugarman, 2008); and potential long-term deleterious effects on hosting countries' health systems (Bauer, 2017; Berry, 2014; DeCamp, 2007; Green et al., 2009).

While missions and brigades commonly comprise teams working on pre-planned activities, VPO journeys prioritise individuals' schedules, rather than specific hosting institutions' stated needs or targeted agendas and timelines. Volunteers commonly arrive lacking contextual and cultural knowledge, let alone specific notions of what precisely they will do. Volunteers thus arrive and interact in an ad hoc fashion.

Wendland refers to these journeys as 'clinical tourism', defined as 'the activities of health-professions students and clinicians who learn or volunteer (a distinction that is often unclear) for periods of less than a year outside their home countries' (2012, p. 110, parenthesis in original). However, pre-health[7] students volunteer in clinics also (Evert, Todd, & Zitek, 2015; Hanson et al., 2011; McCall & Iltis, 2014; Wallace, 2012), but there is a dearth of empirical research investigating pre-health activities abroad (Stewart, 2013; but see Loiseau et al., 2016; Sullivan, 2016). Given the number of pre-health students engaging in the practice, and research participants' rejection of the description of their actions as 'tourism', in this article, I employ 'international clinical volunteerism' to denote activities of individuals engaging in short-term placements in foreign healthcare settings, whether pre-health students, health professions students, or licensed health professionals. Below, I focus specifically on international clinical volunteering arranged through a VPO.

Methods and setting

Over four field seasons since 2011,[8] I have done ethnographic research on international clinical volunteering through VPOs in Arusha region, northern Tanzania, within six health facilities, including public and private health centres, and public and missionary hospitals. Since 2013, I have been conducting comparative online research of 10 major VPO websites offering placements in Tanzania, with research on additional VPOs ongoing.

Arusha is an attractive volunteer placement site. A tourism hub, the city is the launching ground for safaris in Tanzania's most popular game parks, two hours' drive from Mount Kilimanjaro, and near an airport with flights to Zanzibar – a popular vacation destination. According to Tanzanian health professionals, foreign clinical volunteers started arriving in Arusha in 2007.[9] I observed early days of clinical volunteering in 2008, during 11 months of fieldwork on a different project within one health facility in the region. In 2008, that hospital hosted less than 30 foreign volunteers. Between September 2012 and September 2013, it hosted around 100 foreign volunteers. By 2015, some facilities in Arusha hosted over 200 volunteers in high season alone.[10] Most facilities receive volunteers from numerous VPOs simultaneously. To date, I have counted nearly 20 VPOs, large and small, operating clinical placements in Arusha. More companies scout prospective placements every year.

In Tanzania, a six-week placement costs US$1000–5900, depending on the VPO. In addition, volunteers pay for flights, tourist activities, immunisations, health insurance, and the mandatory US $200 volunteer work permit. Facilities received between US$100 and 150 per volunteer, regardless of placement length. Hosting health professionals were uncompensated for working with volunteers, despite expectations staff would supervise, teach, explain things to, and translate for volunteers. Given staffing and resource shortages, and significant patient and administrative duties, hosting foreigners was a heavy burden.

Research in 2011 and 2013 was observational, exploring dynamics of international clinical volunteer practices within health facilities. Between June 2014 and August 2015, qualitative semi-structured interviews were conducted with 90 Tanzanian healthcare workers.[11] As described elsewhere (Sullivan, 2016), Tanzanian health facilities host foreign volunteers to generate additional income beyond donor and state funding. Staff also engage with foreign volunteers in hopes of generating long-term relationships leading to future institutional, professional, or personal benefits.[12]

In addition, 41 foreign volunteers were interviewed: 29 females, and 12 males, ranging from 18 to 27 years old. This gender and age distribution reflects wider trends in international volunteering: volunteers are predominantly female and relatively young (Mostafanezhad, 2013). Interviews were semi-structured, lasting from 30 minutes to two and a half hours, conducted in a private room within the placement facility, or at a nearby eating establishment. All interviews were audio-recorded, with full consent of each participant. Interviews covered motivations for coming, selection of VPO and placement site, expectations before arriving, best and worst moments on placement, and relationships with hosts and other volunteers. Most volunteers are from the U.K. and U.S.A., so below I focus on their perspectives and practices. However, volunteers from Scandinavia, Canada, Australia, Asia, the Middle East, and Africa increasingly participate.[13]

International clinical volunteerism business

International clinical volunteerism is part of a rapidly expanding volunteer tourism industry. Empirical data about this burgeoning industry are sparse. One sustainable tourism expert estimates that worldwide, up to 10 million volunteers travel abroad per year, spending up to US$2 billion (Popham, 2015). The proportion of volunteers working in health is unknown.

There is little consistency between VPOs in terms of number of volunteers placed, trips sponsored, or placement sites. Some are small, operating exclusively within the host country. Others cater to specific nationalities of volunteers (e.g. a British company sending British volunteers). Others are transnational, with offices across the globe, providing volunteering opportunities in dozens of LICs to individuals from anywhere. Transnational VPOs sometimes contract services through local VPOs. Some organise specific timeframes for trips; more commonly, VPOs accept volunteers on a rolling basis, enabling maximum flexibility catering to volunteers' schedules. Volunteers' fees generally cover pre-departure information, airport pick up, accommodation (hostel, volunteer house, or host family), some food, and placement site arrangements.

Popular destinations are mainly LICs, many former colonies, most of which are also tourist destinations: Tanzania, Ghana, South Africa, Cambodia, India, Nepal, Thailand, Vietnam, Argentina, Costa Rica, Ecuador, Guatemala, and many others. Many VPOs offer multiple types of placements: clinics, orphanages, schools, building projects, agriculture, and conservation, for instance. While some VPOs only place qualified volunteers or health professions students, others have no skills requirements whatsoever. Some have a vetting process for volunteers, others have none.

Depending on hosting country, placements range from one week to four months; most students go for two to six weeks. Prices differ based on location and type of placement. VPO websites rarely state what proportion of fees compensate hosting institutions, although many highlight donations provided, philanthropic initiatives sponsored, or local economies affected.[14] Many partner with tourist companies to expand offerings to their clients.

Most volunteers are students, undertaking private VPO volunteering instead of, or in addition to, their university-approved activities abroad. While pre-departure orientations or guidelines exist (e.g. Crump & Sugarman, 2010; Melby et al., 2016; Todd & Prasad, 2015), many universities are hands-off about what students do abroad (Evert et al., 2015). Some universities formally vet VPOs,[15] many do not. Several VPOs certify volunteers' experiences for university credit, although VPOs rarely assess student volunteers.[16]

As shown below, VPOs frequently employ postcolonial 'suffering stranger' tropes in marketing. Websites commonly emphasise the volunteer experience, rather than local partner organisations on which volunteer experiences rely.[17] On most websites, communities or institutions where volunteers work are 'othered', often depicted as 'vulnerable', or so short on resources that volunteers become the key to making a real difference. Many VPOs emphasise how volunteers – despite lack of relevant skills, language competency, or familiarity with context – can teach locals, whether communities or licensed professionals, thereby saving lives. Volunteers are rendered 'global' and mobile in ways those they purport to serve are not (Wendland, 2012); this globality and mobility enables

volunteers, regardless of their actual race, to be coded with the unmarked whiteness prevalent within colonial biomedicine as it echoes into the present (Anderson, 2014).[18]

For example, Projects Abroad, a large VPO, has main offices in North America and hundreds of projects throughout the world. Per the website, since its inception in 1992, it has placed nearly 100,000 volunteers, with the founder asserting, 'Last year, we channelled into less developed countries the energy, skills and commitment of some 10,000 volunteers, not to mention over $18,000,000' (Projects Abroad 'About us'). The website markets a variety of placements types.

A glance at Projects Abroad's 'Medical Management Plan: Tanzania' document is illustrative of the postcolonial tropes in VPO marketing. Their stated 'priority goals' are to 'Encourage an understanding of medical practices and promote an exchange of medical knowledge' and to 'Improve access to basic healthcare for disadvantaged groups'. Here, pre-medical volunteers are said to learn from local staff, but also from one another by 'sharing their experiences'; meanwhile, 'Professional medical volunteers are able to share their knowledge and experiences both with other volunteers as well as the local teams, initiating a discussion and exchange around best practices' (Projects Abroad Tanzania Medicine & Healthcare Management Plan). Several studies have challenged the presumed globality of biomedicine, highlighting that biomedicine in under-resourced contexts is necessarily 'improvised' (Livingston, 2012) and 'unstable' (Street, 2014). In such places, 'best practices' are far from universal. However, in this VPO's rendering, the presumed universality of 'best practices' presents a naturalised postcolonial trope in which professionals from the global North are presumed to possess mobile and universally applicable skills, regardless of the specificities of place.

As the Projects Abroad Plan's subsequent goals outline, volunteers do medical outreach, to bring 'basic healthcare' to underserved areas and educate 'vulnerable groups' about pressing health issues in the country. Similarly, volunteers 'participate in raising awareness and protecting [Tanzanians] from the spread of diseases through training, workshops, seminars and practice into our local hospitals' (Projects Abroad Medical Management Plan: Tanzania, p. 3). That is, volunteers, regardless of skill level, train Tanzanian communities and health professionals about Tanzania's problems, despite lacking language and contextual skills. The VPO outlines what Tanzania's problems are, and how foreigners will address them. Near the end of the document, volunteers are lauded as 'our most crucial asset in achieving our goals'. In VPO website marketing, the 'care' volunteers provide appears global, as 'the norm', effacing contingencies of place, let alone existing expertise and resources on which volunteers depend. In this way, VPO marketing embodies postcolonial racialised tropes.

Volunteer testimonials on Project Abroad's website reinforce these tropes. An American pre-medical student testimonial linked at the bottom of the Tanzania medical internship page asserts, 'Some of the simple medical procedures and tests I was allowed to perform were experiences I thought I wouldn't have until after three or four years in medical school' (Projects Abroad Mario Martinez Volunteer Story). A 45-year-old retired police officer's testimonial describes in significant detail delivering babies, assisting in caesarean sections, and: 'I was asked if I wanted to scrub in and assist – did I ever! I got to assist with two circumcisions (my hand was shaking so much it wasn't funny). Believe it or not I got much better by my 4th operation!' (Projects Abroad Margaret Suanez Volunteer Story, parenthesis in original).[19]

Both testimonials confirm Tanzania as a place-in-the-world where learning on 'the poor' seems justifiable. Similar testimonials litter other VPO websites and travel blogs. Indeed, these tropes are a key means by which VPOs advertise placements to prospective volunteers. As discussed below, upon arrival, volunteers are expected to inhabit this unmarked white postcolonial subjectivity. When they draw on these tropes, volunteers pose significant risks to the very health facilities and patients they aim to assist. It is to health facilities in Tanzania that I now turn.

'Maybe I can do a better job'

Inspired by their presumed affiliation to a global biomedicine (Wendland, 2012), volunteers commonly over-estimated their abilities and actively worked to conceptually delegitimise the expertise

of their Tanzanian hosts. Twenty-one-year-old British pre-medical student Mark[20] described how his hosts asked him to do things he was unqualified to do: 'they start doing something and they ask me to take over kind of thing, and I feel often, you know, that maybe I can do a better job [laughs]' (26 June 2015). Mark's sentiments were echoed across numerous interviews and in casual commentary between volunteers on placement. Similarly, Micah, a 20-year-old British pre-medical volunteer, embodied the way Global Health figured place and local expertise: 'Global Health is such an upward-hill battle. And you're just carrying all these other waste men [Tanzanian staff] who are dragging their heels with you because you […] can't just push them out of the way and do your own thing' (18 June 2014). Here, Tanzanians are figured as 'waste men', an encumbrance to individuals from the global North, who actually fight the battle. Later in the interview, Micah complained that Tanzanian health professionals 'do not want to gain knowledge', presuming that knowledge transfer rightly moved from untrained (white) aspiring health professional from the global North, to local licensed and experienced Tanzanian health professionals, and not the other way around. In interviews, volunteers commonly complained that Tanzanian health professionals did not want to learn from them.

Others, like American pre-medical student Lucy, recognised in retrospect her former unconscious bias, stating prior to arrival, she expected 'a shortage of knowledgeable professionals and that, almost, I guess it's very arrogant, but I guess that I could catch up quickly and be able to help a lot' (23 July 2014). While race was not explicitly mentioned, her 'arrogance' reflected prevalent racialised postcolonial discourses (Pierre, 2013): she, as an unskilled American, could 'catch up quickly' presumably in a way unskilled Tanzanians could not by virtue solely of her self-conceived affiliation with a global biomedicine. Meanwhile, prior to arriving it was difficult for Lucy to conceptualise Tanzanians as 'knowledgeable professionals' at all (Brada, 2016). That is, by virtue of being *local* professionals, Tanzanians were excluded from a supposedly universal biomedical expertise to which volunteers, solely by virtue of where they were from and not necessarily due to demonstrated expertise, could lay claim (see Benton, 2016; Street, 2014).

Second-year British midwifery student, Michaela, disapproved of her peers' attitudes, saying,

Figure 1. Volunteers observe a surgical procedure, hospital in Arusha (Photo NS).

> I think there's a slight sense of entitlement, in that people are quite keen to get hands-on with doing the interesting bits or the deliveries or the catheters and things like that. But then will refuse to do the cleaning of the instruments or the beds because they're not here to clean. (11 August 2015) (Figure 1)

Volunteers often saw themselves as entitled to particular experiences by virtue of their self-perceptions as future professionals and as citizens of a higher-ranking (predominantly white) country; cleaning was a menial task professionals did not do. Some VPOs were similarly dismissive of Tanzanian expertise. Said 27-year-old Scottish nursing student, Rachel, '[Local VPO staff] told us that the nurses here are not as qualified and that I, even as a student, would be more qualified than the nurses' (4 August 2015).

Tanzanians found volunteers' over-estimation of their skills perplexing. One doctor said:

> You find [volunteers] who have studied biology come to practice in the hospital, and they don't know anything! I don't know what criteria they [foreign institutions] are using for practicing in a hospital just by knowing biology alone, which we here – we study biology in secondary school, and you still can't come and do anything in a hospital with just that! (21 July 2015).

This Tanzanian doctor assumes that foreign pre-health students are permitted to practice medicine in their home countries, and notes that Tanzanians would be prohibited from practicing medicine having only studied biology. Another physician specifically asked me whether unqualified volunteers would be permitted similar access to restricted sites in American hospitals, to which I replied 'no'. While volunteers ubiquitously used the statement 'I'm pre-med' to justify their entry and interests in being hands-on to their hosts, many Tanzanian professionals viewed volunteers' enthusiasm with suspicion, concerned about violations to patients' rights and safety, although these concerns were rarely voiced publicly (see Sullivan, 2016).

Hosting staff were right to be concerned. Volunteers actively encouraged and coached one another to deliver babies, set bones, dress wounds, and read X-rays, often entirely beyond the purview of hosting health professionals. For instance, Alina, a 21-year-old third-year British midwifery student, was on a two-week placement. As a student, she was told she must be observational only as she was not covered by the U.K.'s liability insurance. Brushing aside Tanzanian midwives in the maternity ward, Alina delivered several babies without supervision. She said, 'I'm kind of like the person who, if there's something going on and there's nobody free to deal with it, I mean I'm done with my education. I'm practically qualified. I couldn't stand there and not do something' (11 August 2015). Alina cognitively dismissed the presence of the many Tanzanian professionals surrounding her. According to Michaela, 'Sometimes [Tanzanians] will come over and try [to talk volunteers through procedures], say a few words and what they think should be happening [with patient care], but in general the volunteers don't really pay much attention to it' (11 August 2015). However, it was not that there were no Tanzanians 'free to deal with it'; more often, experiences with volunteers' disrespect discouraged local professionals from intervening. Like Alina, numerous volunteers disobeyed restrictions from their home universities upon arrival in-country; with minimal oversight, there were few repercussions, but significant opportunities to put patients at risk. Foreign volunteers regularly dismissed the advice of Tanzanian professionals (cf. Benton, 2016; Brada, 2016), embodying instead the (white) professional identity they aspired to (but that was unavailable to them) at home.

Work-arounds

Several volunteers found ways to circumvent Tanzanian rules and authority. While there were few restrictions across the six sites, two facilities prohibited pre-health students from accessing labour wards. However, volunteers found work-arounds so they could observe or intervene upon patients. Some volunteers found they could do more if they attended night or weekend shifts, when facilities were minimally staffed. In July 2013, I observed an 18-year-old American pre-medical volunteer advise peers to do night shifts, because with fewer staff on duty, volunteers could deliver babies

unassisted. Similarly, when asked what he has been able to do as part of his volunteering placement, 20-year-old British pre-medical student George said he 'was able to assist a few births, when it's quieter – really on the weekend' (21 July 2015).

When Tanzanian doctors were hostile to unskilled volunteers entering their department, volunteers often collaborated by texting one another when the doctor left. A 20-year-old American pre-medical student, Allison, described a Tanzanian physician, Dr. Meena, becoming agitated when finding six volunteers in the labour ward:

> she came in and there were definitely too many people standing at that curtain, and there was a woman in active labour, and we were just observing but I think [Meena] kind of freaked out that there were so many people there. (20 July 2015)

Allison continued, 'every time I want to go to maternity now I kind of have to make sure Dr. [Meena]'s not there'. Complaints about Dr. Meena's imposed limitations on volunteer access in the labour ward emerged independently across several interviews. Although not uncommon among health professions students, disrespect for local authority was particularly pervasive among pre-health students. Volunteers' self-perceptions as representatives of a 'modern' medicine back home, coupled with constructed postcolonial racialised imaginaries of Tanzanians as 'waste men', or 'suffering strangers', and therefore 'other', justified skirting local authority which volunteers felt should not apply to them.

Other volunteers lied directly or disobeyed rules – a concern brought up by several Tanzanian professionals in interviews: 'I would simply like that a volunteer follows the rules the hospital put in place', said one nurse (29 July, 2015).[21] Yet Tanzanians rarely voiced their concerns openly. Hospitals needed the income, and VPOs were one of few available sources beyond the state and donors (Sullivan, 2016). The case of Simone, a 22-year-old American volunteer, illustrates the risks of Global Health businesses operating within neglected health facilities, where meaningful supervision and regulation is sporadic or unattainable.

In an interview, Simone described her placement in a maternity ward in central Tanzania two years prior, where she assisted in multiple deliveries. Returning to Tanzania in May 2015, she disclosed to her roommate she was a pre-medical student, but told volunteer peers and Tanzanian staff she was a second-year medical student. Simone explained, 'medical students, I mean, [Tanzanian staff] treat us like we're doctors!' (26 June 2015). Her familiarity with deliveries and C-sections, and (unverified) claims of being a medical student, garnered her nearly unlimited access. She described taking the lead on the C-section of a critically ill patient, who subsequently died. She also described her first breech delivery. When asked how breech deliveries differed from other deliveries, she responded thus:

> It's pretty much the same. Honestly, I was gonna do the episiotomy but then I was asking for the supplies to do the episiotomy.[22] […] They're hesitant to do episiotomies here, which I don't really appreciate very much [laughs]. But […] they wouldn't give me the supplies, they were like 'no it's fine', so I just like stuck my hand in to try and make the hole bigger. And then the baby comes out. When it's breech, you take a little more care to make sure that it's breathing okay and that the cord's not wrapped around its neck and that kind of thing. Kind of have to pull a little harder to get it out.

The procedures Simone suggested in this case (episiotomy, pulling breech babies) violate best practices in midwifery and obstetrics.[23] Her actions put the health of mothers and newborns at risk. My research assistant and I became aware of her deception about being a medical student when we encountered her roommate after Simone's departure. We verified Simone was an undergraduate student through public social media. Her actions present a telling example of concerning ways postcolonial racialised hierarchies mark Global Health business; Simone rendered peripheral the very experts and patients she was meant to serve. Within the selective mobilities enabled by VPO Global Health business, such egregious ethics violations can and do emerge.

Conclusion

In the neglected 'shadowlands of global health', staff struggle to meet the overwhelming needs of patients amid inadequate resources (Prince & Otieno, 2014). To the significant burdens they already shoulder, VPOs add foreign, well-meaning but inadequately skilled volunteers. The racialised postcolonial tropes on which VPOs and volunteers rely ensure volunteer action is couched in morality.

A postcolonial analysis of VPO and volunteer representations and practices belies volunteering's presumed virtues. Imagining themselves able to 'do it better', and patients as justifiable sites for volunteer learning, requires cognitive work, enabling foreign volunteers to conceptually unsee existing professional expertise in order to envision a role for themselves that would be impossible, and even criminal, at home (Figure 2).

VPOs rely specifically on neglected aspects of health systems in LICs to create profit, drawing on prevalent postcolonial tropes of 'suffering strangers' (Butt, 2002) and notions of health care 'good enough for the poor' (Feierman, 2011, p. 172) to justify sending foreign volunteers with inadequate and inappropriate skills to 'make a difference'. Projects Abroad's stated goal to 'Improve access to basic healthcare for disadvantaged groups' (Projects Abroad 'Medical Management Plan: Tanzania') cannot be attained through foreign volunteer attention. If anything, foreign volunteers sap scarce resources away from those who need them most, and intervene inappropriately, endangering patients. To wit, VPOs rely on and perpetuate the very inequalities they purport to address through volunteers. Doing so is good business. International clinical volunteering is thus the embodiment of a most commoditised form of altruism.

These findings highlight the importance of going beyond the taken-for-grantedness of Global Health interventions as inherently 'beneficial' – whether VPOs or large-scale donor-sponsored projects. Ethnographic research enables us to attend 'to the structural, political-economic, and discursive global workings of the systems being put in place by particular insistences on "doing something"' (Pigg, 2013, p. 133). In international clinical volunteering marketing, testimonials, and practices, VPOs and volunteers' representations and predominant assumptions determine the scope of what gets to matter, despite little accountability to those they purportedly help (Berry, 2014). Global Health discourses continue to promote mobilities from North to South (rarely the other direction),

Figure 2. Volunteer takes photograph during a surgical procedure. Hospital in Arusha (Photo: NS).

targeting narrow diseases and populations with ambiguous effects despite enormous resources; meanwhile, 'the shadowlands' are places where universal primary care is desired but denied, as states' inadequate budgets – tied to pervasive global inequalities – are ill equipped to sufficiently expand meaningful services. Foreign volunteers' prospects for improving such shadowlands are low. If VPOs and foreign volunteers truly wish to 'improve access to basic healthcare' (Projects Abroad), they will have to do the necessary work, over the long term, to address global inequalities head-on, taking seriously the systematic, racialised postcolonial systems on which those inequalities rely.

Notes

1. For critical anthropologists, Global Health remains an 'obscure object' (Fassin, 2013). Characterised as 'more a bunch of problems than a discipline' (Kleinman, 2010, p. 1518), some scholars have used ethnography to explore how this unwieldy term is constituted in practice (e.g. Brada, 2011), rather than defining in advance what it is (e.g. Koplan et al., 2009). By capitalising Global Health here, I emphasise the conceptual work the term does, and the socially constructed imaginary travelling with and often justifying actions – an imaginary tied to racialised histories of colonialism and biomedicine.
2. By 'private' VPOs, I mean those not directly affiliated with a religious organisation, university, or corporation (cf. Lasker, 2016).
3. Claire Wendland argues a neocolonial analysis risks making all such travel appear invariably extractive, when some journeys foster long-term and mutually beneficial connections (2012, p. 116). I take this critique seriously. My intention is to demonstrate how postcolonial imaginaries tied to Global Health inform such journeys, but they do not necessarily homogenise experiences of either volunteer or host. I am thus interested in how VPOs market placements to appeal to would-be travellers, and how imaginings about the world and one's place within it inform what is seen as ethical or acceptable in practice.
4. Butt explores academics' employment of the suffering stranger trope within activist scholarship. She warns that decontextualised images and strategically placed brief accounts of suffering 'mask a set of assumptions about global moralities' rather than prioritising the perspectives of locals (2002, p. 3). Suffering strangers also mark how volunteers conceptualise host countries as places-in-the-world, couching volunteers' actions in a laudable morality.
5. These narratives have a long history. Exploring colonial missionary medicine, colonial doctors were complicit in 'constructing an image of … "Africa" through a narrative of biomedical endeavor' (Vaughan, 1991, p. 155).
6. In February 2016, Florida teenager Malachi Love-Robinson was arrested for practicing medicine without a license in a clinic he had opened, garnering significant media attention for 'duping' his victims. See Jacobson (2016).
7. 'Pre-health' refers to individuals intending on pursuing a career in the health professions (medicine, nursing, occupational therapy, midwifery, physical therapy, dentistry, etc.).
8. Field seasons occurred in volunteering 'high seasons': June through August, in 2011, 2013, 2014, and 2015.
9. Why volunteers began coming in 2007 is unknown, although it coincides with increased Global Health programming and funding.
10. My estimates. Given significant resource and capacity shortages in hosting facilities, compiling data on volunteering for local use is not a priority.
11. Interviewees included nurses, doctors, physical therapists, pharmacists, lab technicians, and one radiologist. Fifteen interviewees were in leadership or supervisory positions at their respective health facilities.
12. This is not new. In the early postcolonial period, Tanzanians conceptualised foreign volunteers as political tools in order to negotiate resources or influence the course of a development project (Jennings, 2016).
13. Regardless of origin country, the practices and perspectives of volunteers were remarkably similar.
14. Some VPOs support their own microloan initiatives, for instance.
15. Different universities have different personnel doing this work. Health professions schools often develop partnerships with specific institutions in LICs. At undergraduate levels vetting can be done within the study abroad office, pre-health advising office, or any number of other offices dedicated to student safety or programming abroad.
16. In Tanzania I have never encountered VPO staff supervising students; this was confirmed by numerous volunteers. One British fifth- year medical student characterised VPOs as enabling them to go on 'a massive holiday' in which the company will 'just sign you off at the end' (15 August 2015).
17. While there are a few exceptional VPOs doing ethical work, they are the exception. Discourses noted here are ubiquitous within clinical volunteerism marketing.
18. Importantly, Benton (2016) highlights the conundrum of intersectionality for African expatriates working for humanitarian organisations. As experts and expatriates, they are expected to conform to Euro-American professional ethics regardless of race – that is, they become affiliated with what Anderson (2014) terms an

'unmarked whiteness'. However, they are also seen as 'native', and thus must navigate foreignness and Africanness simultaneously.

19. Subsequent to a publication in Scientific American in which this testimonial was described (see Sullivan, 2017), Suanez's testimonial was altered, expunging this quote from the original. A May 2017 statement was added to the testimonial in which Suanez suggests she did not perform procedures, and that the depiction was 'quite offensive'. However, in her public blog, Suanez describes in detail performing and assisting in procedures for which she was not qualified. The blog entry is available here: http://www.margaretsuanez.com/tanzania.html
20. All names are pseudonyms.
21. Interview in Swahili, author's translation.
22. A surgical procedure to widen the birth canal through an incision to the perineum, or skin between the vaginal opening and anus.
23. Due to possible long-term adverse effects for the mother, including postpartum fecal incontinence, current guidelines restrict episiotomy to exceptional cases (see American College of Obstetricians and Gynecologists, 2016; Liljestrand, 2003). While breech foetuses are most often delivered by C-section in high-income countries, in cases of vaginal breech delivery, best practice is *not* to use traction (i.e. not pull) or intervene until the foetus' elbows and chin are in the birth canal and the umbilicus has been delivered (Kotaska et al., 2009, p. 170 n. 18, p. 174). Use of traction has been associated with increased rates of foetal injury or death by asphyxia, an issue well covered in academic obstetric literature since the 1960s (see Tunde-Byass & Hannah, 2003, p. 39).

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