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Global health volunteering and instrumental humanitarianisms: Sierra Leone and the Ebola outbreak.

Abstract

Geographers have long been concerned with the spaces, scales and conceptual significance of volunteering. They have, however, been slower to engage with the global surge in medical volunteering, whether in times of everyday or acute emergency. Volunteering is a crucial component of the architectures of global health and humanitarianism, but it remains marginal to the concerns of both health and development geographers. This paper seeks to address this lacuna through drawing on the case study of the 2013-16 Ebola outbreak in Sierra Leone. When the outbreak was belatedly declared a Public Health Emergency of International Concern in 2014, volunteers flowed into Sierra Leone to aid in the response. In drawing on qualitative research with volunteers from a small, Freetown-based NGO, we aim to close two explicit theoretical gaps. First, we draw out the geographical significance of volunteering during an outbreak of such exceptionality that the modalities, methods and architectures of global health and humanitarianism closed in on one another. Second, we explore how the act and experience of volunteering during the Ebola outbreak helped those involved apprehend what global health might *mean* and *be*. In so doing, we also reflect on the *instrumental* use of humanitarianism within a global health field whose professional contours are often remarkably difficult to navigate. In empirical terms, this intervention is rendered even more significant given the discipline's wider neglect of the Ebola outbreak as a crucial moment where the failures of global health were exposed and the toolkits of humanitarian intervention were pushed to their limits.

Keywords: Sierra Leone, humanitarianism, instrumentalism, volunteering, global health, Ebola

Introduction

The medical historian Randall Packard has argued that global health is ‘about the lives of people in countries across the globe and how they have been touched in one way or another by the efforts of strangers to improve their health’ (2016, 10). One of the primary means by which an ever-growing multitude of ‘strangers’ aim to improve health ‘across the globe’ is through volunteering in times of everyday medical need, the exceptional moments of humanitarian emergency or the multiple times and spaces in between. And, as global health teaching and partnerships mushroom, so too does the demand (and need) for volunteers (Crane 2011). However, and Baillie Smith and Laurie note (2011, 546), despite the fact that ‘geographers are particularly well positioned to examine international volunteering’ because of the discipline’s ‘emphasis on a connected world and the circulation of people and ideas mediated by the historical and structural forces of North–South inequality’, critical engagement with the topic across geography’s subdisciplines continues to be ‘patchy’ (Ibid). Significantly, contributions in development geography remain sparse (although see Schech, 2017 and McLennan, 2014) and even though health geography has enjoyed a supposed ‘voluntary turn’ (Skinner & Power, 2011), its interest in the ever-expanding dominion of global health (Herrick & Reubi, 2017) has tended to be overshadowed by efforts to document how domestic volunteers fill the gaps left by the neoliberalisation of healthcare in the global North (Milligan, 2007; Skinner & Fleuret, 2011). This means that critical reflection on the ever-growing phenomenon of transnational medical volunteering across global health and humanitarian emergencies has largely remained the domain of medical anthropology and biomedicine. Geography, we argue, must be central to critical conversations on the contours and conceptual significance of these endeavours.

As a long-overdue corrective, here we critically reflect on the motivations and experiences of a group of international medical volunteers who worked in a small university-led global health

partnership based in Freetown, Sierra Leone during the 2013-2016 West African Ebola. We draw on this example to close two explicit theoretical gaps. First, we aim to draw out the geographical significance of volunteering during an outbreak of such exceptionality that the modalities, methods and architectures of global health and humanitarianism closed in on one another. More precisely, in asking people to narrate the pathways through which they came to volunteer in a particular place within a pre-existing global health partnership at a time of humanitarian emergency we shed light on the points of synergy, contradiction and tension between the fields. Second, we explore how the act and experience of volunteering during the Ebola outbreak helped those involved apprehend what global health might *mean* and *be* and, therefore, how to forge a professional career in a field often characterised as impenetrably ‘obscure’ (Fassin, 2013) and more ‘aspiration than actuality’ (MacPhail 2015). In so doing, we also reflect on the *instrumental* use of humanitarianism within a global health field whose professional contours are often remarkably difficult to navigate given its complexity, scope and somewhat problematic relationship with domestic health priorities in the global north (Crane, 2011; Hanrieder, 2019). Using the empirical example of volunteering during the West African Ebola outbreak to map the permeable and frequently-contested border between global health and humanitarianism thus represents an important and novel contribution to geographical scholarship. In empirical terms, this is rendered even more significant given the discipline’s wider neglect of the Ebola outbreak (although see Pallister-Wilkins, 2016; King, 2004; King, 2015b; King, 2015a; Herrick, 2019) as an epochal moment where the international politics of global health unravelled and the toolkit of humanitarian intervention was pushed to its limits.

To move from disciplinary omission to theoretical contribution we first explore Sierra Leone’s ongoing state of “chronic emergency” and offer an overview of the 2013-2016 Ebola outbreak. We then critically consider the humanitarian and global health literatures to interrogate how volunteering during Ebola beclouded the two fields as the outbreak morphed into a ‘health-

humanitarian crisis' (Harman & Wenham, 2018, 366). Our discussion draws on detailed qualitative research on the King's College London Sierra Leone Partnership (KSLP), a small, UK-led, Freetown-based NGO located in Connaught Hospital, the country's main tertiary, teaching and referral site. KSLP started in 2011 as a global health programme, aiming to strengthen clinical skills and medical training, transitioned to accommodate the emergency humanitarian response to Ebola and, since 2016 has re-engaged with its main Health System Strengthening (HSS) mandate. This organisational trajectory is significant because even though anthropologists have explored the interpersonal dynamics and motivations of emergency humanitarian staff (Fox, 1995; Redfield, 2013; Fassin, 2011a) and those undertaking short-term medical electives (Wendland et al., 2016; 2017a; Sullivan, 2016a); scholars have largely neglected those spaces and contexts which defy neat categorisation. In this case, the volunteers we interviewed were unique in that they worked for a global health partnership trying to cling onto its founding organisational principles even while responding to an unanticipated biomedical and humanitarian crisis (Walsh and Johnson, 2018). They were also particular because, for most, this was their first experience of working during a major humanitarian crisis. This places them in stark contrast to the professional humanitarian responders that tend to hold coveted roles in NGOs such as Médecins Sans Frontières (MSF) and whose experiences have tended to dominate the literature (see for example Redfield, 2013). Drawing on these interviews, we explore two themes: (1) *Calling*: the contexts, motivations, justifications and expectations that guided volunteers' decisions to go to Sierra Leone during the outbreak. (2) *Careers*: how this humanitarian experience fed into and was strategically put to work in charting future global health career trajectories and aspirations. This analysis allows us to tread new conceptual and empirical ground between health geography, critical humanitarian studies and medical anthropology. Most importantly, in so doing, we bring geography into the purview of these otherwise self-referential disciplinary perspectives.

Sierra Leone's chronic healthcare emergency

The Human Development Index (HDI) ranking places Sierra Leone at 181 out of 187 countries, with an estimated GDP per capita of \$1,329 in 2016 (World Health Organisation, 2018). The Global Burden of Disease Survey (GBD) estimates female life expectancy at 60 years and male at 58 years (GBD, 2016). While life expectancies have risen by almost a decade since 1990, they remain below that which the GBD would predict given Sierra Leone's level of development. The country's most significant health challenges are exceptionally high rates of maternal and infant mortality and a scarcity of healthcare workers and material resources. Maternal mortality is almost three times that of the low-income country (LIC) average (1320 v 436 per 100,000) and under-five mortality is 120 per 1,000 (LIC average is 73) (Sierra Leone Ministry of Health and Sanitation, 2016). The current ratio of doctors to patients is 0.18 per 10,000 against an African average of 2.6 and the UN's Sustainable Development Goal threshold of 44.5 per 10,000. This healthcare worker shortage is compounded by serious clinical flight with estimates suggesting that up to half of graduates from the College of Medical and Allied Health Sciences (COMAHS), one of KSLP's key partners, have recently emigrated (Brooks and Herrick, 2019). This is prescient to the arguments presented here for, as Reid *et al* note, healthcare inequalities ironically move 'health workers permanently away from poorer to richer countries as "brain drain", and [in turn] brings them from richer to poorer countries as temporary volunteers' (2018, 78).

Sierra Leonean hospitals lack access to the x-rays, anaesthesia, running water and fuel needed to perform the most basic of surgeries. These deficiencies are further entrenched by financial constraints: low government health spending; high out of pocket health costs; and an overwhelming reliance on external aid and the whims of donor priorities (Anderson and Beresford 2016). This 'long-wave', chronic emergency (Barnett and Blaikie 1992; see also Kenji and Harpham, 1992) necessitates global health intervention and represents a persistent

fragility that enabled the Ebola outbreak to rapidly escalate from containable to uncontained humanitarian disaster (Rothstein, 2015). Sierra Leone's fragile and under-resourced health system thus was a cause and continues to be a consequence of the 'human disaster' of Ebola (Boozary et al., 2014; Farmer, 2014; O'Hare, 2015; Walsh and Johnson, 2018). In such a state, the humanitarian and global health ethic and mode of working are often entwined and the programmatic boundaries between them incredibly porous. And, as we examine in this paper, both fields of activity indelibly shape the reasons why volunteers seek to help others, their longer-term career trajectories and wider social aspirations.

Ebola has long been a disease that inspires fear and awe, with Richard Preston's infamous book *The Hot Zone* (1994) igniting media and public fascination (Herrick 2019). However, in contrast to the hyperbole of Preston's work, until the West African epidemic (and the current, rapidly-escalating outbreak in the DRC), Ebola outbreaks had a history of being relatively small in scale and quickly contained. There was a misplaced degree of complacency following the early reports from Guinea in late 2013. Concern should have been higher because the index case was the first to have ever occurred in West Africa. The three Mano River Union (MRU) countries of Guinea, Liberia and Sierra Leone have deep historical ethnic, economic and cultural trans-border connections (Richards, 2016). Chains of transmission thus mapped out the spatial networks of the hyper-mobile MRU region (Abdullah and Rashid 2017). By Spring 2014, cases of Ebola were appearing in Sierra Leone and by June a state of emergency was called as case numbers continued to rise and the healthcare system was quickly overwhelmed. However, it was not until August 2014 that the World Health Organisation declared Ebola to be a Public Health Emergency of International Concern (PHEIC) based on its spread to three countries, almost 1000 deaths and, crucially, the possibility and fear of *global* transmission.

The PHEIC declaration was inexcusably belated, but it immediately hailed the international community to provide significant emergency assistance. While many in-country NGOs – and

in particular MSF – had been demanding the international community acknowledge and act upon the ‘unprecedented’ Ebola outbreak for months (MSF, 2015), many others decided the risk to their staff was too high and (temporarily) pulled out of West Africa even though the human and developmental needs that justified their presence had been magnified by the outbreak (Walsh & Johnson, 2018). Just as international airlines halted their scheduled flights to Freetown, an influx of humanitarian volunteers and staff arrived in Sierra Leone. The international response also, notably, mapped out post-colonial geopolitics, with the French deployed to Guinea, the British armed forces to Sierra Leone and the US response centred on Liberia.

It is essential to recognise that the overwhelming majority of Ebola volunteers were Sierra Leonean. International volunteers were only a small, yet well-publicised, proportion of the overall workforce (Street 2019, Richards 2016). This complicates the humanitarian and global health worldviews of helping distant, suffering strangers (Pallister-Wilkins, 2018) given that most ‘help’ came from those who were *not* distant. The politics of recruiting Sierra Leonean volunteers, the inadequacies of their risk protection and the ephemerality of their promised hazard pay have been ably and damningly explored by Walsh and Johnson (2018). This paper may not be focussed on the bravery and disproportionate risk faced by local volunteers, who also extended their care to strangers, but this was always a point of admiration, motivation, and painful reflection among the international volunteers.

Volunteering, global health and the humanitarian impulse

Even before the Ebola outbreak, Sierra Leone was a global health ‘hotspot’ (Brown & Kelly, 2014; Pallister-Wilkins, 2018) deemed to be ‘in need’ by virtue of having poor health outcomes and resources. This kind of chronic, ‘crude inequality, in plain sight’ has become ‘a basic

condition for [the] practice' (Reid et al., 2018, 77) of global health volunteering. The result is now a crowded geography of intervention (Herrick, 2017a) characterised by a plethora of unsustainable and 'disarticulated health programs' (Packard, 2016, 331) that can never adequately address the overwhelming African healthcare crisis. This ongoing failure, in turn, perpetuates more global health, more international volunteering and, at moments of acute and exceptional crisis, a complex oscillation between the ideologies and modalities of global health and humanitarianism (Beshar & Stellmach, 2017; Harman & Wenham, 2018). Volunteering fills the gaps that emerge as state provision shifts and drifts (Redfield, 2016). Medical volunteers move from North to South, between countries of the South (Laurie & Baillie Smith, 2017) and they also increasingly 'reimport' their skills back into the spaces of need generated by profound health inequalities in the global north (Hanrieder, 2019). But, it must also be remembered that the enterprise and architecture of global health is composed of a significant *domestic* voluntary labour force. For example, many of Connaught Hospital's nurses are not on the Ministry's payroll and instead work on a "voluntary" basis securing money through patients' out of pocket payments, selling medications and, sometimes, through involvement in global health projects (Brown and Prince 2016). The landscape of global health volunteering may have temporal, spatial and motivational similarities to other spheres such as voluntourism or development volunteering (Guttentag 2009; Mostafanezhad 2014), but it remains distinctive because of the ways in which it geographically validates expertise. Put another way, global health volunteering is distinctive because it is only through putting expertise accrued *somewhere else* to work in another geographic context that this expertise gets validated as "global health". For example, a surgeon from the UK transmogrifies into an expert in 'global surgery' by practising their trade in the under-resourced settings of the global south. Thus, when medical practice combines with resource deficiencies in a particular place, global health emerges.

Given the conceptual and practical significance of global health volunteering, critical engagements in medical anthropology and the health sciences have understandably been thematically far-reaching. These include the perceptions of local hosts (Roche & Hall-Clifford, 2015; Lukolyo et al., 2016; Kung et al., 2016a; Sullivan, 2016b; 2016b; Bozinoff et al., 2014; Wendland, 2012), the possible negative impacts of volunteers on healthcare settings and patients (Guttentag, 2009; Sullivan, 2017a; 2017b; Dowell & Merrylees, 2009; Berry, 2014) and the ethics of volunteering (Wallace, 2012; Crump & Sugarman, 2008; Brown & Prince, 2016). Research has also explored the differing motivations for taking part in volunteering schemes between volunteer and host (Sullivan, 2016a); the changing nature of African domestic volunteering (Brown & Green, 2015) and volunteering under specific emergency contexts (Redfield, 2016). Within geography, critical reflections on the assumed binary geographies – north/south, host/volunteer – of volunteering (Baillie Smith et al., 2017; Laurie & Baillie Smith, 2017), how volunteering forms part of the compassion of the humanitarian worldview (Mostafanezhad, 2013; 2014) and the ‘embodiment’ of volunteer experiences (Griffiths & Brown, 2017) have come to shape a small, but theoretically significant, body of research. Moreover, geographers’ concern with the spatial and temporal dimensions of the practice have been expanded into the examples of international health volunteer networks by Laurie and Baillie Smith (2017) and the globalisation of volunteer work (Jones, 2011). Yet, when compared to work in development geography, health geographers have under-explored medical volunteering despite occupying an ideal conceptual vantage point from which to draw out the salience of the field’s topography, its relational geographies and its co-production of particular subjectivities across linked temporalities and spatialities (2017, 102).

By contrast, medical anthropologists have been prolific in their critical consideration of global health and humanitarian volunteering. Among this broad canon, a number of studies have explored volunteer motivations (Lasker, 2016; Malkki, 2015; Bjerneld et al., 2006; Withers

et al., 2013; Caldron et al., 2017; Berry, 2014). These are instructive for, as anthropologist Noelle Sullivan has argued, ‘attention to the desires of volunteers sheds light on the ways that aspiring health professionals are internalising the popular discourses and narratives of global health, international medicine and humanitarianism’ (2016a, 163). Notably, medical anthropologists have actively critiqued global health volunteering as a supposedly benevolent endeavour. This stands in contrast to the domains of public health and biomedicine which have been far more accepting. This signals the degree to which volunteering, like humanitarianism and global health, has become something of an undisputable good within certain professional health communities (Crisp, 2007; Wendland et al., 2016). As a result, anthropologists have argued, volunteering has become a ‘monolithic’ and ‘depoliticised’ phenomenon (Sullivan 2016a, 179). Yet, in reality, the mounting presence of volunteers in the global south has the capacity to undermine national health sovereignty and even cause patient harm (McLennan, 2014). For those reasons alone, medical volunteering is a deeply situated and political endeavour, despite the tropes of global freedom, mobility and opportunity that often accompany it (Jones, 2011). With this in mind, Wendland *et al* have suggested that we need to ask, “what works?” in global health volunteering to get beyond its ‘rhetorical simplicity’ of assumed good, morality and compassion (2016, 182). This resonates with the critique of humanitarianism’s ‘morally prized social activity’ (Fassin, 2011b, 37) and how this ‘tends to elude critical analysis’ (ibid, 35). As we explore here, when global health and humanitarianism start to fold into one another, then critical exploration becomes even more essential.

Most qualitative accounts of health volunteering explore the actions of volunteers *in situ* with less attention paid to the circumstances at home or the personal and professional trajectories that led them there. Yet these pathways are important because they imbricate the altruism, pragmatism, instrumentalism and self-interest of humanitarianism in ways that serve to *animate global health* as a field of practice that affords significant professional promise.

Volunteers ‘do not necessarily work for the greater good or as free agents’ (Brown & Prince, 2016, 6). Instead, through its ‘practice[s] of self-fashioning’ (ibid, 9), volunteering can enable those involved to ‘shape a new identity, to become more employable, more experienced or a “better” person’ (ibid, 24). Some volunteers use the experience as an instrumental means to ‘a coveted educational programme or job, to become more culturally competent, to have an adventure and “know a place” other than home’ (Sullivan 2016a, 162). Altruism is thus rarely absolute, but rather constituted as such by context, time and place (Berry, 2014). Volunteering, even (and perhaps especially) during times of emergency, can go beyond ‘saintly self-sacrifice’ and can instead become a conscious and vitalising act of ‘distinction-making’ aimed at setting oneself apart while formulating personal and professional strengths (Malkki, 2015). Amid the mass of writing on the West African Ebola outbreak, this paper stands apart for being the first to explore the line between self-sacrifice and professional advancement.

Ebola, as an ‘acute on chronic’ episode (Levy, 2017), made Sierra Leone’s longstanding chronic healthcare emergency internationally visible. In such contexts of need, the line between humanitarian and global health interventions quickly became blurred, especially in the everyday practices and experiences of those ‘helping’ on the ground. Mapping the contours of each is further complicated, because, as Ticktin has argued ‘humanitarianism is not easily defined. It is, among other things, an ethos, a cluster of sentiments, a set of laws, a moral imperative to intervene, and a form of government... [it] is one way to “do good” or to improve aspects of the human condition by focusing on *suffering* and *saving lives* in *times of crisis or emergency*’ (2014, 274, emphasis added). The ‘morally motivated interventionism’ (Beshar & Stellmach, 2017, 7) of humanitarianism is, in theory, a temporally and spatially-bounded endeavour, limited to exceptional times and places. Yet, under conditions of chronic emergency, the suffering inherent in everyday lives drives more implicit forms of medical humanitarian intervention under the banner of global health. Underpinning this is an elision

between, on the one hand, ‘a global spectacle of suffering’ and, on the other, a ‘global display of succour’ (Fassin, 2011a, ix). The humanitarian impulse emerges from affective, visceral and material deprivations. And yet humanitarian practices themselves are composed of profoundly unequal relationships between ‘benefactors’ and those expected to react with the ‘humility of the beholden’ (2011, 4) in ways that chime with geographical critiques of the unequal forms of capital possessed by volunteers and host communities (Baillie Smith & Laurie, 2011) and of the architecture of global health (Crane, 2013). Even as global health and humanitarianism self-identify as qualitatively different endeavours – and research tends to be siloed between the two fields – the line between them is especially faint when an ongoing state of chronic emergency becomes acute.

As Brada argues (2016), humanitarianism, in common with global health, has always been determined both by the willingness to set boundaries around those forms of suffering that are considered “appropriate”. Ebola was a clear instance of this exceptional-everyday suffering. The outbreak led to the closure of vital medical facilities and – as a particularly cruel ‘caregiver’s disease’ (Farmer, 2015) – the tragic deaths of hospital cleaners, nurses, doctors and community workers, compromising the quotidian treatment of diseases other than Ebola. While Harman and Wenham assert that Ebola ‘widened the gap’ (2018, 369) between global health and humanitarian responses, we place a question mark over this assertion. Indeed, outside the realm of key global health actors such as WHO or the US Centers for Disease Control and humanitarian organisations such as MSF, many volunteers at small organisations on the ground saw their response as a confusing amalgam of the two. For those volunteers, there was no ‘fundamental divide’ (*ibid*, 370) between global health and humanitarian activity but rather a fraught and often improvised effort to blend aspects of the two modes of delivery to save lives. As the ideologies and practices of humanitarianism and global health juttied up against one another during the outbreak, examining what motivated volunteers enables us to

understand the array of “needs” that justify intervention. Moreover, in following Laurie and Baillie Smith’s advice to bring ‘stories and experiences into view’ (2017, 99), better understanding how these then configure volunteers’ career trajectories and aspirations helps bring the ephemeral field of global health – often critiqued as being far more a ‘bunch of problems’ than a coherent field (Kleinman, 2010) – into far clearer sight. As we shall demonstrate, it was only through *being humanitarian* that volunteers were able to reify global health, imagine and realise its professional promise.

Methods and case study

The King’s Sierra Leone Partnership brings together King’s Health Partners (King’s College London, Guy’s and St Thomas’, King’s College Hospital and the South London and Maudsley NHS Foundation Trusts) and three Sierra Leonean partner institutions: Connaught Hospital, COMAHS and the Ministry of Health and Sanitation. KSLP has a long-term national and international staff based in Freetown and shorter-term skilled volunteers and staff that rotate through the partnership (KSLP, 2016). Since 2011, over 100 volunteers and staff have worked for KSLP and the partnership is undergirded by a strong commitment to HSS, co-development, collaboration, capacity building and research. KSLP was not founded with an express humanitarian purpose, but the Ebola outbreak necessitated an urgent and improvised response (Walsh & Johnson, 2018). Whereas many global health NGOs left Sierra Leone during the outbreak, KSLP expanded, built an Ebola Holding Unit (EHU) at Connaught and developed its own screening, diagnosis, isolation and treatment protocols and procedures (Johnson et al., 2016). Ebola wrought human tragedy, but it also brought significant funds, volunteers, prestige and international visibility to the partnership. However, the loss of Sierra Leonean healthcare

workers (both paid and volunteer) and the temporary closure of COMAHS further accentuated the ongoing challenges of HSS (Evans, et al. 2015).

Despite its short history, KSLP offers up a fascinating case study to explore the complex and often conflicting motivations of volunteers because as the partnership has transitioned between distinct phases – from healthcare partnership and clinical training origins, to emergency humanitarian and medical response, to a post-Ebola recalibration orientated around research capacity – so the rationales for volunteering at Connaught have also fluctuated. In this paper, we focus on those who volunteered during the Ebola outbreak, offering a counterpoint to the more frequent explorations of large humanitarian NGOs such as MSF (Arie, 2014). Instead, by drawing on a global health partnership that temporarily transitioned in its role, we capture a qualitatively different set of volunteers. They were a small group often recruited through interpersonal connections, drawn to a different, arguably more improvised set of experiences than that provided by the universal and high-tech “kit” deployed across humanitarian emergencies by major agencies, such as MSF (Arie, 2014; Redfield, 2013). They were also often those who were desperate to volunteer during the outbreak but who did not meet the stringent pre-conditions demanded by MSF (i.e. that you had worked for them previously). We thus capture those volunteers for whom their first global health and humanitarian experience was amid the largest outbreak of perhaps the world’s most feared disease, in other words, defined by its exceptionality.

This paper forms part of a broader project for which we conducted 40 semi-structured interviews with KSLP’s past volunteers and staff in late 2016, both in London and remotely through Skype. The need to do so reflects the highly international composition and career destinations of many volunteers. In early 2017 and 2018, we undertook a further 37 interviews with KSLP’s current staff, partners and volunteers at Connaught. While in Sierra Leone, we

also undertook ward observations, attended meetings and workshops, had informal chats, discussions and made observations in the hospital and KSLP's offices. The larger project involved interviewing the full spectrum of KSLP's volunteers and staff from clinicians, physiotherapists, educators, psychiatrists, researchers, operations and logistics specialists, engineers and lawyers. Interviews were semi-structured and wide ranging, but particularly focussed on eliciting narratives of how volunteers came to work for KSLP – the life choices, strategies, opportunities, barriers and, frequently, moments of serendipity that led them to Freetown – and how their experiences in Sierra Leone had shaped, enabled and, in some cases, hindered their ongoing career trajectories. In order to avoid response error, we purposefully avoided asking direct questions about the altruism of their motivation, preferring instead to let their opinions and feelings emerge from the discussion of particular events or experiences. The interviews were recorded, transcribed and anonymised. We explore two themes – calling and career – using interview material from international volunteers coded as either being *carried out* in Sierra Leone (code: SL) or in London (code: L) and assigned a random number. The first section, 'calling', examines the motivations drawing volunteers to the humanitarian context of Ebola – despite the obvious and significant personal risk – and their perceptions of need (both their own and that of Sierra Leoneans). The second, 'career', examines how these humanitarian experiences have been put to use in mapping out and staking a claim to the professional field of global health. Taken in tandem, these two sections help draw attention to the tension between global health and humanitarian action under conditions of chronic emergency and, in turn, how this interweaving animates the professional potentiality of global health.

Calling: the porosity of global health and humanitarianism

For many of those we interviewed, volunteering satisfied a long-standing curiosity about what they ‘might be able to contribute’ and a desire to use their skills ‘somewhere in need of help’ (SL14). For clinicians who had done medical electives in resource poor settings in other countries this ‘experience’, combined with being the ‘right person, at the right time’ meant that they felt ‘compelled to help out’ (L5) during the outbreak. As another volunteer elaborates:

...it was almost like *I can therefore I am going*. And reading in the news about the shortage of healthcare workers and how more manpower was needed on the ground in terms of providing healthcare and I figured, well you know if I can be of any service, I would be more than willing to go (L12, emphasis added)

A marked sense of having a professional obligation to assist because they possessed the right skills and because fellow healthcare worker colleagues were dying was shared by many. Ebola particularly hailed Infectious Disease (ID) doctors in a way that other humanitarian emergencies ‘like the tsunami’ had not because they ‘had the right skill mix’ (L5). For these clinicians, KSLP offered a unique opportunity to see a disease they had only read about in textbooks. For ID doctors the opportunity to gain *experience* in treating Ebola was an essential prerequisite for professional *legitimacy*: ‘more than one said to me that, if they hadn’t have gone, then no one would have ever taken them seriously, ever again’ (L37). Helping thus became synonymous with developing professional experience expertise to maintain credibility amongst peers. Credibility, however, could also be deployed in a different sense. For instance, one volunteer who had previously trained Sierra Leonean surgeons explained: ‘I had trainees in Sierra Leone who were suffering and I was safe in England and I didn’t feel that was acceptable... I only did it so that I was a credible person then after Ebola’ (L16). Here then, credibility was exercised and realised in the sense of staying true to long-standing interpersonal obligations. The experience of having ‘been there’ gave health professionals invaluable

credibility and also demonstrated their commitment to a country, its people and a particularly “charismatic” infectious disease (Herrick, 2019).

For Sierra Leone, a country long in need of help, incessant and graphic international press reporting about Ebola rendered the need acutely visceral (Towers et al., 2015; Pallister-Wilkins, 2016). As a result, the suffering became “an event” of international importance that many volunteers were keen to experience:

I really was very determined to go to West Africa, *just to kind of experience history* ... I just really wanted to gain some first-hand experience in how that all goes down so I think it was *less just seeing patients with Ebola*, (L9, emphasis added)

The idea of volunteers being driven to help during the “spectacle” of Ebola because of what one described as ‘the global importance aspect to it’ (L11) and another as ‘a really big, important, international thing’ (L9) starts to challenge the altruistic suppositions of humanitarianism. To date, there have only been two small-scale qualitative study of the factors that led healthcare workers to volunteer in Sierra Leone during Ebola (Greenberg et al., 2018 ; Gee & Skovdal, 2017). And, even Rexroth et al.’s large scale survey concluded only with the sweeping statement that ‘general interest in participating in such missions, thinking to be of help and physical fitness’ were determining factors (2015, 5). Our research instead shows that the scale, horror and spectacle of human suffering actually – and somewhat perversely – rendered Ebola an event of such global magnitude that sucked volunteers in: ‘this is a moment in history that I want to have been part of’ (L41). Such narratives challenge the assumed moral orientations of humanitarianism and show how it might be better thought of as a mode of ‘instrumental action’ (Redfield, 2013, 3) angled to the self as much as others. The spectacle of Ebola showed volunteers that it was something *more than* the often pedestrian and frustrating global health experiences, often experienced during electives, but rather offered up the potential to be a moment of international humanitarian significance. The presence of

humanitarian emergency in a well-trodden global health hotspot also made Ebola seem more accessible for volunteers and a chance to combine experiences across the domains.

When explicitly asked whether the need to help was a form of humanitarian altruism, respondents were often candid and reflective. Not one respondent was happy with the suggestion that volunteering was a pure expression of altruism, although their views may be self-presentational and a collective narrative could be at work here. Elsewhere this cohort of volunteers have capitalised on the status conferred by their actions and reinforce the altruistic narrative, for instance through social media posts or online dating profiles. Nevertheless there was a clear sense that the ‘individual benefits much more than any other individual that they might have impacted during their time’ (L9). Despite the significant health risks posed by Ebola, one respondent recounted their surprise at ‘how alive I felt... I was in the right place at the right time and I felt very energised’ (L12). What volunteers took from the experience varied widely, but as one tried to explain, ‘nothing is purely altruistic, I guess within my personality there is maybe a need to be appreciated, there is that wanting within me for people to think, “oh, he’s done a good thing...”’ (L5). This need to feel appreciated and respected was particularly acute before departure when, ‘lots of people were coming up and saying, “Oh, you’re so brave, you’re so brave”’ (L5). The heroism complex associated with many emergency medical organisations was vehemently opposed by most interviewees. This opposition may well be traced to tensions and conflicts that played out between different Ebola response teams as to how best to handle the outbreak in the absence of clear global leadership (Walsh and Johnson, 2018). Even so, this did not seem to stop some enjoying the fleeting feeling of being a short-term hero at a moment of crisis. This not only contrasts with some of the more circumspect notions of heroism found among global health volunteers, but also importantly with the findings of Greenberg *et al* (2018) and Gerson *et al* (2016) who have suggested that the stigma US-based Ebola volunteers felt from colleagues and friends was often a barrier to

travel. Not one of our respondents mentioned stigma as a barrier to volunteering, but instead cited institutional barriers (i.e. difficulty in getting time off from the NHS, being turned down by other NGOs due to a lack of precise qualifications or experience). The difference between their findings and our research may also be traced to the specific culture of KSLP (UK, small, university-based) and its volunteers (mostly young, single and often recruited through close-knit contact networks), as well as the differences in the media coverage of Ebola between the US and UK

‘Making a difference’ is a far from selfless endeavour and instead, largely about a highly-calculated form of self-fashioning (Brown & Prince, 2015; Baillie Smith & Laurie, 2011). This was especially true for some Ebola volunteers ‘it was like being promoted to the premier league for a couple of weeks when you are used to playing in the second division... there was a lot of media attention and attention from your family and stuff and I kind of like that’... (L34). While the ego-boosting thrill of the Ebola response was a very particular moment, even the idea of going to Sierra Leone – which for some was the first time they had been to Africa – offered a form of distinction-making. One interviewee told us how volunteering had conferred a ‘genuine level of respect’ as they ‘worked with Ebola and in Africa in general’ (L18). Combining the geography of global health with the temporality of the humanitarian moment further magnified this process of distinction-making. Yet this also points to an important disjuncture that is key to preserving the distinction-making potential of global health volunteering. While Ebola was associated with risk, personal sacrifice and inhuman conditions; volunteers recalled that outside the immediate ‘moshpit of tragedy’ (L12), living in Freetown was fun. As one respondent explained, ‘in Sierra Leone you’re respected and it’s a fun place to live, it’s an adventure’(L41). In a country so dependent on international aid and with a vibrant expat community, volunteering provided status and unique work and life experiences. Beyond this, and as Malkki’s (2015) research also found, it furnished volunteers with intimate

friendships, valuable contact networks, time away from home and a springboard to explore a new, exciting country. It therefore comes as little surprise that, despite the risks of working in Freetown during Ebola, the personal rewards were significant: ‘I think personally it was very impactful, I met some amazing people, made good friends, certainly learned a lot from the experience in terms of my career’ (L9). It is to these careers in the ephemeral field of global health that we now turn.

Careers: reifying global health through humanitarianism

Within the expansive, interdisciplinary global health literature, little attention has been paid to how individuals build a career and, in the case of clinicians, combine global health work with their existing medical careers. Indeed, while global health has been critiqued for being ‘chimeric’ (Nading, 2015); efforts to define and systematise what the field is and should be (Koplan et al., 2009) have yet to ask how individuals put the field ‘to work’ both literally and figuratively. Even within the medical anthropological literature, it is often taken for granted that volunteers know what the professional field of global health is and means *in situ*. This omission is precipitated because such research has tended to be situated in these global hotspots, rather than following the dynamic geographies of global health employment in the vein of Craggs and Neate’s recent work on ‘careering’ (2017; although see Crane, 2013). These lacunas in global health also stand in contrast to geographers’ explorations of how volunteering prefigures and configures professional worlds (see for example, Jones, 2011). These gaps are significant because the question of how to make global health work as a career was a real, pressing and often troubling preoccupation (Lasker, 2016).

Frustrated by bureaucratic working environments at home; global health instead seemed to offer unique potential to be creative and impactful. As neatly summed up, ‘it’s fun to influence

change and see your ideas implemented... *It just felt like global health...* you felt like you were making a difference' (L14, emphasis added). This sense of something "feeling like" global health not only underscores the field's ephemerality, but also highlights how pursuing a career in it could be exceptionally challenging. Global health runs the length of humanitarian medicine and development and occupies a context-contingent and dynamic place along this continuum. *What* global health *is* thus often depends on *when* and *where* it touches the ground. The global health of Ebola is thus woven into the global health of Sierra Leone's chronic emergency, but also stands alone as a career event with complex causes and consequences that span spatial scales. At a practical level then, knowing how to get ahead in a field that seems to demand particular knowledge and skills, but is not really dependent on a particularly deep attachment to place – despite these geographical particularities being so central to the genesis of health needs – presented a conundrum to many volunteers. Knowing this, volunteers could be incredibly strategic in carving out career opportunities in a range of global health hotspots. As one interviewee explained,

I have travelled in Kenya and Uganda and ... if I could use nursing as a way to travel then that was my aim. My dream was to work for MSF, so I did the tropical medicine diploma and I was working in intensive care, trying to check all the boxes (L4)

Many had realised that having a Diploma in Tropical Medicine or Nursing was an essential pre-requisite for being able to 'do' global health. For those with medical degrees, the Diploma offered their first academic glimpse of development, social justice, inequality and history as core issues for global health. Graduates also benefitted from an immediate social network; many KSLP volunteers were recruited through personal contacts from their Diploma studies. Others had completed Masters in Global Health which fuelled their desire for hands-on work. However, it also brought home the realisation that such work could not readily be combined with the strictures of NHS training and work schedules except in the short-term medical missions that their courses had most likely spent time critiquing. As a result, the idea of

‘helicoptering in’ to deliver short-term interventions was anathema to most working at KSLP who were, by now, far more sold on the long-term global health partnership model (reference hidden). In this sense, volunteering in Sierra Leone - and especially under the emergency conditions of Ebola - was seen by many as a strategic stepping stone within a longer global health career that would necessarily exhibit geographical fluidity.

Given the acute-on-chronic nature of Ebola, it is notable that few volunteers were familiar with Sierra Leonean history, politics or culture in any great depth prior to their arrival. This lack of awareness has been recognised as common issue among global health volunteers, despite such contextual factors being core to the curriculum of global health academic training and key to understanding the local needs that volunteers were ostensibly there to address (Wallace & Webb, 2014; Lasker, 2016). The unfolding of the Ebola outbreak cannot be considered apart from the history of colonialism, civil war and post-war recovery, the geography of the MRU or the multi-scalar political economic forces that impart the kinds of ‘structural violence’ (Farmer, 1996) that shape vulnerabilities to infectious diseases in Sierra Leone (Richards 2016). Volunteers may have been less attuned to the genesis of the emergency, but they were acutely aware of the complex politics of humanitarian-health response and the multiple barriers they faced in providing care on the ground. Indeed, within the immediacy and urgency of an Ebola Holding Unit, the contexts driving everyday, chronic emergency often faded in their significance. This, combined with episodic, short-term placements, starts to explain the ‘lightness’ typical of much global health volunteering (Redfield, 2012) and the ‘addictive’ (L21) characteristics of the work. Many volunteers were consumed with trying to find the next placement and recognised that this might require following the trail of money and opportunities (predicted on human suffering) rather than emotionally or professionally investing in facilitating a more sustainable global health approach. In this sense, the notion of volunteering producing ‘fixed’ geographies was challenged by the Ebola outbreak (see Laurie & Baillie

Smith, 2017). Instead, volunteers got a taste for emergency and were acutely aware that they needed to be mobile and pro-active in seeking out new geographies of professional opportunity:

It goes along with what's hot in the world right now like obviously, refugees and the migrant crisis, would I love to be a part of that? Yes, it would be great, but do I want to be part of it because it's hot right now, or do I really want to be part of it because that's how I really want to spend my time and my efforts? And I think it's a little bit of both. (L15)

In practice the experience of 'doing global health' morphed from being the abstract ideas depicted in journal articles and training modules to being a real-world experience that harboured exciting professional possibilities. As a result, volunteering exposed how 'interacting with this field as a career in the future would be' (L33). The idea of global health as a career reconfigures the assumed altruism of humanitarian work as something that might be packaged for a CV and instrumentally deployed within a broader professional trajectory. This is not to be cynical, nor to deny the altruistic compulsions, but rather to reveal how such experiences facilitated career advancement particularly in contexts where the global health and humanitarian fields melt into one another. As one respondent described, their experience at KSLP was as 'a feather in my cap on my CV' (L9) without which they would not now be in their highly coveted global health role with an international agency. Thus, as Ticktin argues, humanitarian workers 'often choose their careers to help themselves' (as forms of self-care or as fulfilling their own needs) as much as for those whom they purport to help' (2014, 279). Such pragmatism and instrumentalism, deployed with varying degrees of consciousness, were present among many we interviewed. Indeed, as one longer term KSLP staff member suggested,

Everyone spins it as altruism and I think that's a farce, and laughable. The majority of people are not out here primarily for altruistic reasons, they're out here for self-interest. That's really changed my perspective. Also, you realise what a small world development, global health and humanitarian response is. Everyone knows each other and... you have

to make sure you navigate that appropriately because it could affect what job you get ten years from now (SL37)

The small and self-referential professional world of global health is one that volunteers had to become instrumental enough to traverse. This may mean using contact networks to hunt for future opportunities in other resource-poor settings or using their experiences or research undertaken while in Freetown as a platform for self-promotion and self-fashioning in the field. Volunteering then, even for short time periods, could be an immensely valuable form of career development as it led to invitations to present work, attend conferences and author papers. As the same staff member mused,

At home [in the global north] there's populations with health outcomes that are also terrible. So, why wouldn't I choose to stay there? I think it's because career development is easier in low income settings, because you're given opportunities you might not be given in high income settings (SL37)

Many others expressed how volunteering had furnished them with a range of soft, managerial skills that had helped propel them into more senior roles as, for example, leading a small team during the outbreak was something ‘novel and interesting and provoking in a consultant interview or a job at a university in the future’ (L36). In settings where overseas agencies and organisations are charged with the funding and management of vast swathes of the healthcare system – even when ostensibly working “in partnership” – global health volunteers often find themselves thrust into positions of seniority and power that far outstrips that of their regular job. Whether they are able to deliver on this elevated position is often a contentious and frustrating issue out of their immediate control (Herrick and Brooks, 2018). Global health can offer a platform and opportunity for fast-track career development (Sullivan, (2016b). Yet, volunteers leave behind those whose absolute need sanctioned their presence. Global health is thus made necessary and possible by these vast differentials in mobility (Redfield, 2012).

Conclusion

In this paper we have explored the beliefs, values and ambitions that motivated volunteers to travel to Sierra Leone to work with KSLP during the Ebola outbreak, how these experiences demonstrate the flexible borders between global health and humanitarian contexts and, finally, how this made global health *real*. This is a new realm of exploration for geographers concerned with volunteering, medical humanitarianism and global health and our research offers up original empirical insights significant to all three fields. The volunteers we interviewed spoke were a far from homogenous group in terms of ambition, character or skills set. This means that motivations remain distinctly personal reflections of self-need interwoven with concerns and interpretations of the needs of others. While the allure of the ‘virtuous glow’ (Redfield, 2013, 30) of the humanitarian endeavour was apparent among the volunteers, the unique context and geographical mystique of Ebola was also put to work in quite instrumental ways in individual global health careers. Little has been written about such ‘careering’ (Craggs & Neate, 2017) in the context of global health, yet for a field so self-consciously desperate for coherence and meaning (Kleinman 2010), careers are an empirical and geographical site where global health becomes real (Hanrieder, 2019). Respondents were deeply reflective about their motivations for being in Sierra Leone, never apologetic and never trying to sanction their presence, such was the mutual understanding of the crisis facing the country. However, the experience of trying to improvise a response to Ebola in a context of resource scarcity, biomedical risk and political instability (Walsh & Johnson, 2018), had also proven to be epochal moments for many in their professional lives. Indeed, for some respondents, volunteering during the outbreak marked the end of their NHS careers and a new life of international global health mobility.

This starts to get to some of the problems and tensions inherent within forging a career in a field as diffuse and ephemeral as global health. Even for those volunteers trained in global

health, it was only through *doing* it that they came to really know and understand what it meant. As one respondent recounted, ‘I think it was only when I got to Sierra Leone where it just clicked, and I was like, this has to be it!’ (L28). In essence, it was only once volunteers travelled south to a global health hotspot – constituted as such through funding flows, personnel, research and projects and visceral conditions of obvious need – that what it might mean to self-identify as “a person working in global health” became real. Unlike humanitarianism, global health lacks a noun to describe someone who works in the field. There is no “global healthian”, but rather a diffuse array of people with allied skills who come together in particular places, times and contexts of need to *make* and *do* or ‘co-produce’ (Laurie and Baillie Smith, 2017, 102) something that they then call “global health”. These constellations are often temporary and opportunistic spatial expressions made up of projects funded by soft money or instigated through development assistance flows. Volunteering made a career in global health seem an exciting counterpoint to professional life at home, but the experience often left them struggling with how best to make it possible and workable in the longer-term. Given the nature of global health’s episodic, ‘projectified’ landscape (Meinert & Whyte, 2014), humanitarian medicine was the most logical and accessible entry point for many clinicians despite their misgivings about the short-term and unsustainable nature of the field. Very few of our respondents may have actively considered themselves to be humanitarians, but Ebola demonstrated that, in contexts of acute-on-chronic emergencies, the modalities and ideologies of two fields are incredibly and at times imperceptibly inter-porous. Indeed, being instrumental about humanitarianism allowed volunteers to penetrate the veneer of global health, peek inside and get to work in making the field work for them.

For geography, which has arguably ceded the critical global health field to medical anthropology (Herrick, 2017b), these insights mark an important point of interjection. The

West African Ebola outbreak was an unmitigated and avoidable human tragedy. It was also a tragedy whose genesis can be traced (Richards, 2016) and which has left a legacy of global health research investments, interventions and professional networks in the region that have further solidified Sierra Leone's status as a global health hotspot. The immediate humanitarian imperative may have lifted; but significant human needs remain and volunteers thus continue to come to Freetown to *do* global health. The instrumental deployment of humanitarian opportunities in the forging of future careers may represent a corrective to the assumed altruistic values of humanitarian intervention, but it should come as little surprise to those familiar with other critical accounts of the multiple motivations of medical volunteers (Lasker, 2016). Indeed, as emergency funding streams dry up in West Africa and demand for volunteer posts wither as attention turns to the 'next big thing'; new questions of how to continue to motivate volunteers to travel south to 'help' are emerging. Indeed, as Ebola now rages in the DRC - and largely off-screen for the those in the anglophone global north - important questions should be asked of the relative *absence* of any visible international volunteer push. The immediacy of acute emergency motivates action and resources far better than the *long durée* of chronic emergency (Herrick, 2019). In the same way, 'exceptional suffering' often calls to volunteers more than that of the 'everyday suffering'. Ironically then, cultivating a sense of humanitarian necessity amid a landscape of global health professionalism is now a core concern of those organisations reliant on a steady stream of volunteer labour. How then to think instrumentally about humanitarianism and global health is an issue that remains long after the acute emergency has waned. Geographers must occupy their rightful place in these crucial conversations.

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