Looking beyond face value: Neoliberal practices in a cleft lip and palate NGO

by

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Abstract

There has been a rise non-governmental organizations (NGOs) as part of a global health system that seeks to treat children with cleft lip and palate (CLP) in resource-poor countries. As a craniofacial abnormality, CLP affects a child's ability to communicate and consume food, and the stigma associated with the condition leads to both social and physiological suffering. International NGOs use an apolitical humanitarian rhetoric to justify the need to provide this life-saving surgery. This thesis assesses CLP interventions by applying a critique of neoliberalism to explore the ways economic rationalities are extended to the domain of humanitarianism. By employing an ethnographic approach of "studying up," this thesis critiques a North American NGO, referred to as Mission Smile. To reveal how neoliberal rationalities are embedded within the organization, this research draws on data from media analysis, participant observation, and interviews with medical volunteers and employees at Mission Smile. This thesis argues that neoliberal rationalities permeate throughout the organization. Economic calculus are not only embedded in the organization's goal to provide surgery to "as many children as possible," but also undergirds the distribution of humanitarian aid. Moreover, the surgery Mission Smile provides is described as an "investment in a child's future" that enable children with CLP to become a contributing member of society. While this study reveals how neoliberal rationalities can converge with values of humanitarianism, it also shows that the extension of neoliberal rationalities into new domains is not a cohesive process. Volunteers describe an emergence of *communitas*, a feeling of bubbling joy and a shared humanity, and a development of a moral relationship with their recipients that lies partially outside the domain of market rationalities.

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Dedication

I dedicate this to all the women educators in my life, your bodies and mind are made of steel, and your hearts are made of gold. Thank you for going above and beyond your call of duty to guide me academically and personally. Your belief in me and the high standards to which you hold me accountable have allowed me to surpass my own expectations on what I can accomplish. Without you, none of this would have been possible.

Chapter 1: Problematizing the moral need to help

> I believe it's a very worthwhile cause to help children. I mean really, how can you not? But to be involved and even make a donation, my personal view is I want to know where my money is going… Because I trust my friend, I know she physically goes there. I know that the volunteers with Mission Smile, when they go on [medical trips], everybody has a role to play. They touch a child and they make a difference in the lives of these kids. So, it's very grassroots. It's not a big bureaucracy where you give money, [they] have photo ops. It's very hands on and you're close to your audience, close to the people you're trying to help. (Nancy, Administrator)

Before becoming an employee, Nancy was a regular donor to Mission Smile, a pseudonym for a non-governmental organization (NGO) that provides cleft lip and palate surgery to children in international settings. Volunteers within the organization travel to countries in the global south where there are barriers to accessing healthcare. On their medical trips, volunteers provide surgery to correct cleft and lip palate in young children. As a donor to the organization, Nancy was emotionally moved to help children in need of surgery; as she expressed, "it is a very worthwhile cause to help children. I mean really, how can you not?" However, for Nancy, the need to provide cleft lip and palate surgery to children is intertwined with concerns about how organizations, like Mission Smile, manage their funds. Like Nancy, many donors and volunteers are concerned with knowing, "where [their] money is going." Donors prefer to support organizations like Mission Smile who demonstrates moral and financial accountability by directing their donations towards CLP treatment. This provides a morally fulfilling experience to donors who feel "close to the people you help." This thesis investigates how an NGO reconciles values of charity with business practices.

When donors talk about giving money to an NGO, they often rely on secondary information sources of the organizations' work. This serves as a proxy to witnessing first-hand the positive impact that emerges from funding cleft lip and palate surgery to those in need. NGOs, like Mission Smile, use performance indicators to demonstrate their responsible use of funds along with the appropriate production of social good. NGOs adopt the use of metrics, a quantitative statistical measurement frequently used by businesses, to prove that healthcare services have been delivered to recipients. Metrics use the language of economics to evaluate the performance of an NGO, which can determine a donor's action. Donors' emphasis on funds and on metrics can influence how organizations, like Mission Smile, conceptualize cleft lip and palate as a disease, how they intervene, how many patients they operate on, and how much surgeries should cost (Adams 2016). This thesis explores how the use of metrics that seek to communicate financial and moral accountability influence the values and practices of Mission Smile. The organization has to prove to donors and volunteers, like Nancy, that the surgery they fund, "touch[es] a child and they make a difference in the lives of these kids" with cleft lip and palate. These moral and economic logics are rooted in a perception that cleft lip and palate is a physiological impairment that can be fixed surgically.

As a biological impairment, cleft lip and palate (CLP) refers to a congenital split in one side (unilateral) or both sides (bilateral) of the upper lip or palate (Zeytinoglu and Davey 2012). CLP occurs in 1 in 800 live births globally (Poenaru, Lin and Scott, 2016). The causes of CLP are unknown. However, studies indicate that genetic and environmental factors such as pollution (Dixon et al. 2011), consanguine marriages (Elahi et al. 2004), and malnutrition during pregnancy (Shaw et al. 1995) can lead to

higher risk of babies born with CLP. Higher rates of CLP are present in the global south, where structural inequalities are more likely to expose individuals to those risk factors.

As a craniofacial deformity, CLP can impede nursing and the ingestion of food. According to Talley (2014), the risk of starvation is perceived to be a looming threat for children born with CLP in resource-poor countries. In addition to a threat to life, the condition is perceived to cause social suffering (Kohn 2000; Macgregor 1990). Children with CLP are often described by cleft organizations as vulnerable to stigmatization (Operation Smile website; Smile Train website). According to those organizations, children with CLP experience social isolation and bullying that can lead to a child's psychological suffering (Edmonds 2007; Talley 2014). As the face is a symbol for conveying and maintaining an individual sense of self, CLP is also viewed as a discrediting attribute that reduces the individual to something less than human (Ainlay et al. 1986; Beuf 1990, MacGregor 1990; Talley 2014). Rooted in claims that a free and simple surgery can fix a child's mouth and reduce stigma directed towards the child, CLP has become a target for interventions globally.

CLP requires a straightforward surgical intervention that is highly amenable to humanitarian aid. According to Barnett and Weiss, the provision of humanitarian aid is "motivated by an altruistic desire to provide life-saving relief" (Barnett and Weiss 2008, 11). Humanitarian NGOs, like the Red Cross and Médecins Sans Frontières, provide humanitarian aid in times of emergency when states have failed to provide relief and suffering is rampant (Malkki 2015; Redfield 2005). The emergence of numerous NGOs in the 1990s sought to save the lives of the world's vulnerable and neglected populations (Barnett 2011; 2013). Increasingly, humanitarian organizations provide healthcare on

both chronic and acute diseases in the Global South (Kevshavjee 2015; Redfield 2013). Following this rise of humanitarian organizations who contribute to global healthcare are NGOs, such as Mission Smile, who provide cleft lip and palate treatment in the Global South.

This seemingly apolitical humanist imperative to provide surgery to children with CLP is not as straightforward as it might initially seem. Neoliberal policies were made dominant in the 1980's led by Margaret Thatcher and Ronald Reagan who deregulated, liberalized, and privatized public health services (Basilico et al. 2013; Harvey 2005; Steger and Roy 2010, 14). As a political-economic ideology, neoliberalism perceives the market to be fair and efficient in allocating resources. In the 1980s, the International Monetary Fund provided loans to countries in the Global South on the condition that they adhere to neoliberal policies, including cutting funding to public health sectors (Basilico et al. 2013). The privatizing of healthcare precipitated the presence of humanitarian NGOs as private actors to meet healthcare needs. Scholars have argued that humanitarian NGOs who use business or financial approaches to solving healthcare problems are concerned with their bottom lines (Adams 2013; Erickson 2012; Hopsgood and Vinjamuri 2012; Kevshavjee 2014). International health organizations, they argue, should be viewed as private firms and market actors rather than non-profit charity organizations. They have identified and highlighted how humanitarian global health organizations who employ neoliberal rationalities transform the provision of medical aid, such as drugs and medical devices, into commodities that can generate profit (Basilico et al. 2013; Erikson 2016; Walkover 2016).

The way neoliberalism intrudes into the realm of humanitarianism deserves anthropological attention. In particular, this thesis builds on anthropological insights on how the seemingly incompatible use of neoliberal rationalities, or economic calculus, to distribute humanitarian aid can attend to the moral desire to save lives (Adams 2016; Barnett 2013; Muehlebach 2012; Timmer 2010). At the core of humanitarian intervention is a putatively apolitical stance where "the language of interest has no place in a humanitarian discourse that concerns itself with defending the world's most vulnerable populations" (Barnett 2013, 384). Humanitarianism attempts to construct an ethical world by preserving life and alleviating suffering in the name of a higher moral principle (Barnett 2013; Fassin 2007). This ethical humanitarian world is outside the purview of economization. In other words, it assumes that value of life cannot be equated with a monetary value. This thesis unpacks this assumption and questions the ways in which humanitarian organizations reconcile the polarizing aspects of humanitarianism and neoliberalism.

1.1 Research Question

This thesis addresses the ways in which neoliberal rationalities extend into Mission Smile, a humanitarian NGO who claims that they are motivated by an apolitical and moral desire to help children with CLP. This study questions the apolitical quality of humanitarian NGOs (as morally good) which puts humanitarian institutions "above suspicion" (Fassin 2011a, 37).

As these organizations are powerful institutions who shape the lives of volunteers in the global north and their recipients in the south (Nader 1972; Wright 2004), a critical

examination of humanitarian organizations is important (Allen 2009; Barnett 2013; Buchbinder and Timmermans 2013). Central to studying institutions is analysing "the culture of power" (Nader 1972, 289) that looks beyond the relationship between the powerful and powerless to reveal the hierarchies that remain hidden. By applying the methodology of "studying up," this research studies Mission Smile from a vertical cross-section to understand if, and in what ways, neoliberalism is present throughout the organization.

Comprehensive research questions were formulated to uncover Mission Smile's values and their operation in distributing care, their goal of providing CLP to children, and how the organization influences the experience and actions of their volunteers. This thesis uncovers the ways the moral desire to help are entangled with neoliberal rationalities. It assesses if the use of metrics to demonstrate financial and moral accountability causes economic rationalities to undergird the values and various practices at Mission Smile. To explore how economic rationalities are embedded within the organization, this research asks:

1. *What are Mission Smile's practices in providing CLP treatment and in what ways, if any, do neoliberal rationalities inflect the organization's values and practices?*
2. *Are neoliberal rationalities present in promotional materials used by Mission Smile, and if so, in what ways?*
3. *What role do affective feelings play in shaping the experience of Mission Smile volunteers and how does affect link to neoliberal rationalities?*

In the following sections, I draw from a diverse area of scholarly work that puts into perspective the various issues and challenges that humanitarian organizations have to contend with. The literature provides a holistic context on some of the practices humanitarian organizations employ to demonstrate accountability, how the goals of providing aid are constructed, and the ways humanitarian organizations appeal to volunteers and donors. I argue that neoliberal rationalities percolate throughout Mission Smile as the organization adopts an economic framework to evaluate the organization's success and enact their goals. In order to investigate the ways neoliberal rationalities are entangled with humanitarian organizations like Mission Smile, I provide a more detailed definition of neoliberalism in the next section. I then review academic literature that reveals the social, economic, and health impacts on recipients as neoliberal rationalities pervade among humanitarian organizations.

1.2 Neoliberalism in global health

As a political-economic ideology, neoliberalism is often referred to as a set of economic policies that is characterized by the deregulation of the economy, liberalization of trade and industry, and the privatization of state-own enterprises (Steger and Roy 2010, 14). Scholarship on humanitarianism are concerned with how the restructuring of health policies around the ideas of a free market economy can impact health outcomes (Ganti 2014, 94). This shift in policy has transformed healthcare as a public service into a commodity that can generate profit (Basilico et al. 2013). Anthropological studies have highlighted that the consequences of this shift is accompanied with the rise of informal charity and humanitarian markets that adjudicate who are worthy of treatment and

resources (Barnett 2013; Fassin 2011b; Staples 2018). Moreover, scholars have pointed out that the conditional distribution of aid that propagate neoliberal policies elsewhere can exacerbate conditions. For example, in his ethnography, Kevshavjee explains that Aga Khan Foundation provides financial aid to support local health services on the condition that clinics privatize, which further restrict access to healthcare (Kevshavjee 2014, 116).

Scholars in global health often view neoliberalism as a macro-structure. They investigate how neoliberal policies can be transformed, reconfigured, and implemented in different locations (Barnett 2011, 10; Kingfisher and Maskovsky 2008). Studies have revealed the negative effects of neoliberalism that have led to the increase in poverty, deterioration of life conditions, and exacerbating social inequalities (Ortner 2016, 55). Rather than viewing neoliberalism as inherently negative, I build on the work of scholars who view neoliberalism as a cultural system (Caporaso and Levine 1992; Finn 2006; Kingfisher 2002). For them, neoliberalism is a cultural framework used to understand and interpret the world, and that informs one's practice (Kingfisher 2002, 13).

It is important to recognize that economic institutions are social constructions rooted in cultural values (Finn 2006; Kingfisher 2002). This means that neoliberal practices emerging from economic institutions have their own morality (Finn 2006, 39). Finn (2006) explains that this morality is separate from an individual's morality. He further points out that economic institutions allow for certain behaviours in which an individual's personal morality can either endorse or condemn this economic system (Finn 2006, 40). Muehlebach's (2012) ethnography on Moral Neoliberalism in Lombardy, Italy illustrates effectively the inter-play between personal morality and the morality of

neoliberal economic institutions. Her ethnography highlights how neoliberalism allows other seemingly oppositional forms and practices to become co-constitutive of each other. She shows how Italian citizens engage in volunteerism as a form of social solidarity in order to challenge the immoral values of neoliberalism that results in alienation. Muehlebach argues that the unwaged, pathos-driven labour that volunteers provide is an integral component of neoliberal reform in Italy as volunteers fill the gap in social services caused by the rolling back of public services. Her work also exemplifies the importance of recognizing neoliberalism as a "culture [that] always contains within it polyvalent, potentially contestable messages, images, and actions" (Comaroff and Comaroff 1992, 27).

In order to recognize the various forms of neoliberalism that enable actors to navigate their social world in places such as in NGOs, it must first be located (Kingfisher 2002, 13). I use Michel Foucault's definition of neoliberalism that focuses on the extension of market practices and economic calculation into everyday life. As a cultural system, neoliberalism uses economic calculus as a framework to organize and govern society (Kingfisher 2002, 13). According to Foucault, neoliberalism refers to "the overall exercise of political power [that is] modeled on the principles of a market economy…. [it is] taking the formal principles of a market economy and referring and relating them to, of projecting them on to a general art of government" (Foucault 2008, 131). Foucault's conceptualization of neoliberalism highlights the extension of market practices and economic calculations into everyday life. In other words, domains that were previously excluded from the market are understood in market terms. Moreover, Foucault notes that this application of economic calculus into everyday practice, referred to here as

neoliberal rationality, becomes a means to manage human life and conduct. Foucault further explains that this entails "extending the economic model of supply and demand and of investment-costs-profit so as to make it a model of social relations and of existence itself, a form of relationship of the individual to himself, time, those around him, the group, and the family" (Foucault 2008, 242). Enacted through a set of everyday mundane practices, neoliberal rationality functions as a mode of evaluation in other social domains, such as conceiving social relationships as business alliances or individuals manging themselves as a business (Brown 2016; Gershon 2011; Rudnyckyj 2011).

As a cultural system, neoliberalism is always contingent and in need of accomplishment. Building on Foucault's work, I approach neoliberalism as a relatively mundane set of practices. In other words, I look at how neoliberal rationality is accomplished through a mundane set of practices. One way mundane practices reinforce neoliberal rationality is through the use of metrics. Humanitarian organizations use metrics as a tool to manage and allocate resources. However, Merry highlights that "the growing reliance on indicators is an instance of the dissemination of the corporate form of thinking and governance into broader social spheres" (Merry 2011, 83). In the next section, I look at metrics, the use of quantitative statistics, such as performance indicators and audits, as a technology to interpret complex social reality and employ economic strategies to address social problems that are widely used among humanitarian NGOs, including NGOs that provides free CLP surgery.

1.2.1 Metrics

Hopgood and Vinjamuri argue that as a firm, humanitarian organizations, like Mission Smile, strive to maximize outputs and lower cost when providing CLP surgery

(Hopgood and Vinjamuri 2012, 19). To ensure a continuous stream of funding, the authors argue that these organizations need to demonstrate the success of their programs. This includes communicating moral accountability, such as the alleviation of suffering (Bornstein 2003; Fassin 2011b, 2013; Malkki 2015; Redfield 2005), as well as financial accountability that proves the services provided were financially sound (Adams 2013b, 2016; Kevshavjee 2014; Taylor-Alexander 2017).

Metrics, or performance indicators, are often used to demonstrate the need to provide services to the poor and the organization's delivery of social goods (Walkover 2016). The common use of metrics reflects the growing influence of corporate thinking into social spheres (Merry 2011). In particular, indicators have the capacity to convert complicated and messy social conditions of life, such as the reduction of suffering with CLP surgery, into accessible yet impersonal and standardized numeric knowledge (Erikson 2016; Merry 2011; Walkover 2016).

In his article on auditing surgical outcomes on CLP organizations in Mexico, Taylor-Alexander observes that a good and ethical doctor is represented through performance indicators (Taylor-Alexander 2016). He observes that auditing functions as "paper panopticons" (Dunn 2005, 185), that directs surgeons' attention towards their technique in order to produce positive surgical outcomes. The use of performance indicators ignores the complexities of clinical life in the global south where unstable infrastructure or power relations can affect surgical outcomes (Taylor-Alexander 2016; see also Porter 2012; Scott 1998). As performance indicators "thin" out complex social life, becoming a good doctor is construed through performance indicators and not through one's moral disposition or investigating how one's political, economic, and

social environment can influence clinical outcomes (Taylor-Alexander 2016, 399). Building on Taylor-Alexander's work, this thesis will look at how a volunteer-based non-profit organization such as Mission Smile uses performance indicators to demonstrate the delivery of social good. In addition, I will describe and discuss the ways in which the pursuit of positive performance indicators influence the organization's practices in multiple ways, including patient selection.

In the next section, I look at the place of children as the focus of NGO work on cleft palates. I explore how meaning is attached to children and their bodies, and why children are ideal candidates for receiving humanitarian aid.

1.3 The appeal of children in humanitarian aid

To compete for financial and physical resources in a highly saturated humanitarian market, humanitarian NGOs have to brand themselves to enable donors to identify with their humanitarian causes (Vestergaard 2009). Branding enables organizations to communicate what the organization does (its cause) and what values (including religious values) the organization holds (Hopgood and Vinjamuri 2012). In this section, I briefly outline discourse surrounding children's bodies in order to situate the place of children within a larger neoliberal framework, where children function as branding strategies to promote specific NGOs.

Children, who are conceptualized as morally pure and economically priceless beings (Zelizer 1985), are powerful figures that can produce morality sentiments that compel the need to help (Malkki 2015). Children are viewed to be vulnerable as they are reliant on adults and are often viewed to be deserving of aid. Moreover, within the

context of medical humanitarianism, children are seen to have the potential to be cured and deserving of free aid (Barnett 2013; Bornstein 2003; Fassin 2011b, 2013; Staples 2018; Talley 2014; Timmer 2010). Children's dependence on adults and the malleability of their bodies and their futures make children ideal recipients of aid (Bornstein 2003). In his ethnography, Fassin (2013) notes that central to increasing children's access to HIV medication was the representation of children's bodies as victims of their disease and corrupt political leaders. At the same time, Fassin notes that this conception of children as innocent victims is unstable as the same children can grow up to become dangerous criminals without help (Fassin 2011b, 177-8). The undertones of this emotional anxiety also drives humanitarian aid targeted at children. In other words, NGOs programs intervene into the lives of children. NGOs attempts to transform the lives of "future criminals" or dependent subjects into productive citizens (Fassin 2011b). The depiction and meanings attached to children's bodies and their future are central to constructing the narrative of children as deserving of help.

This pattern of constructing a narrative of children in need of help is especially evident in understandings and practices surrounding CLP. Children with CLP are perceived to be physiologically and socially abnormal. The pursuit of a normal appearance is culturally constructed and intimately associated with the social, political, and moral order (Lock 2015). The identification of CLP as abnormal bodies is followed by medical attempts to discipline, modify, and restore bodies into a state of normality (Davis 2002). The medical community understands CLP as a physiological abnormality that is characterized by exclusion, physiological impairment, and being markedly different from others (see Gimlin 2007). If being normal is to be valued and desired, then

the abnormal body of a child with CLP is undesirable and in need of normalization (Kittay 2008).

Although CLP surgery falls under reconstructive surgery that aims to restore function, it is also intended to improve a child's appearance. Both components are considered essential to improve a child's wellbeing (Kohn 2000; Talley 2014; Edmonds 2013). However, the real therapeutic object in CLP surgery is not the aesthetic or physiological defect. Instead, surgery is a fix to a child's physical and emotion pain (Edmonds 2007) and the potential loss of opportunities as a result of social exclusion (Talley 2014; Wickstrom 2010). Therefore, the therapeutic object of CLP surgery is to mitigate future suffering and improve a child's future.

Surgery functions as an investment in a child's future in a society where a normal body is required to gain access to social, economic, and political participation (Edmonds 2007; Talley 2014; Taylor-Alexander 2017). Taylor-Alexander explains that a normal appearance with CLP surgery in Mexico is equated with a child's participation in modernity (Taylor-Alexander 2017). The normalization of a body with CLP through surgery is perceived to be essential to social, economic and political participation. In a similar vein, Wickström (2019, 294) explains that children who receive orthodontic treatment not only feel better about their appearance but also improve their social and economic possibilities. The body is understood to be part of an individual's flexible assets, or human capital, that must be continuously invested, nurtured, and managed (Feher 2009; Martin 2000).

This thesis explores whether or not putatively neutral humanitarian aid provided to children with CLP could be best understood as a project to bring "normalcy" to a

disfigured child. It argues that neoliberal rationalities dominate the need for surgery as it gives that child a future in social, and market, participation (Aspinall 2008; Kittay 2008; Talley 2014). I assess how volunteers and NGOs depict and give meaning to children's bodies within the realm of humanitarianism focused on CLP.

In the last section, I review the important field of volunteers' affect. I assess how volunteers' affective attachments to their volunteer activities are pivotal to the operations of NGOs.

1.4 Orchestrating an affective call to action

The discourse of vulnerability and innocence surrounding the image of a suffering child makes for an ideal promotional material for humanitarian NGOs. These images and stories of suffering caused by CLP aim to inspire pathos and mobilize donors into action by donating or volunteering (Adams 2013; Malkki 2015; Redfield 2005). Charity organizations often use narratives to elicit feelings of compassion and pathos to garner support for humanitarian projects (Barnett 2011; 2013; Fassin 2011b, 2013; Kleinman and Kleinman 1997; Talley 2014). Nonetheless, scholars have noted that adults who bear witness to a suffering child can elicit an emotional response that does not necessarily lead to action (see Hardt 2007; Rudnyckyj 2011). This thesis focuses on volunteer affect because, unlike emotions, affect compels individuals into action.

There is ample evidence that the depictions of needy persons are structured in ways to heighten a narrative of suffering in order to justify and garner financial support for global aid programs (Butt 2001; Kleinman & Kleinman 1997; Nguyen 2010; Timmer 2010). The pathos that emerge in these stories or testimonials is commodified to enable

the exchanges of resources between recipients, humanitarian NGOs, and donors (Fassin 2011b; Talley 2014). For example, Adams' ethnography on rebuilding post-Katrina New Orleans illustrates how tragic situations and feelings of hopelessness become a marketing tool that calls individuals into action as volunteers (Adams 2012, 2013b; Muehlebach 2012). Not only does the desire to alleviate suffering of others enable these for-profit humanitarian agencies to be seen as morally good, these lucrative businesses are perceived by the state to be more efficient than public programs. Adams' ethnography, like much other research in the same field, illustrates and exposes the various ways neoliberal rationalities undergird the practices of humanitarian NGOs (Fassin 2011b, 2013; Kevshavjee 2014; Nguyen 2010; Pandolfi 2008).

Muehlebach further problematizes the affective pull that mobilizes volunteers. She argues that the moralization leads to the hyper-exploitation of volunteers who are not only pressured to volunteer through moral discourses, but they are also encouraged to perform acts of sacrifice (Muehlebach 2012, 8). Scholars have point out that humanitarian organization's focus on individual suffering, which elicits an emotional response towards its victims, do not actually seek to implement systematic changes (Barnett 2013; Guilhot 2012; Muehlebach 2012). Pandolfi argues that volunteers operate in what she calls a "gray zone" where volunteers do not consider the impact of their work within the larger humanitarian apparatus, but only understand their work in the number of lives saved (Pandolfi 2008, 160). Consequently, scholars argue that volunteers pursue feelings of self-fulfillment and satisfaction in helping others and do not actually seek to alleviate suffering or produce equality (Pandolfi 2008; Malkki 2015; Muehlebach 2012).

These anthropological studies have shown how neoliberal rationalities can be extended onto organization's relationship with their volunteers (See also Nguyen 2010). By manipulating volunteers' or donors' affective sentiments, these charity organizations seek to develop an advantageous business alliance with their volunteers. At the same time, Ilana Gershon warns against viewing neoliberalism from a homogenous perspective that turns individuals into corporate actors who seek to balance alliance, risk, and responsibilities (Gershon 2011, 546). Heeding Gershon's advice to recognize new forms of social relationships that are conceived outside of neoliberal rationality, I turn to the emergence of a shared sentiment that Edith Turner refers to as "communitas" (Turner 2012). Communitas describes the affective experience of volunteers that is outside the purview of neoliberalism.

Communitas has been defined as feelings of bubbling of joy, a group's pleasure in sharing common experiences, and a sense of togetherness that "warms people toward their fellow human beings" (Turner 2012, 3). Turner explains that communitas appears unexpectedly by a group of people when their lives take on full meaning. It is the unstructured form of communitas that overrides sociological constructs (Turner 2012, 3), which allow volunteers engage with a shared humanity with their recipients that is partially unburdened by neoliberalism. I apply the concept of communitas to explore how volunteers are able to prevent neoliberal rationalities from encroaching. I analyze the relationship volunteers foster with their recipients and their affective sentiments of providing surgery to children, which challenges the business-like relationship that neoliberal practices attempt to foster. At the same time, I investigate how volunteers' reflexivity of their actions within the wider humanitarian apparatus preserve an apolitical

and humanitarian desire to help children in need that in their experience is separate from a neoliberal world view, and that this role of affect is also at the heart of Mission Smile.

By looking at neoliberalism as a set of practices that permeates throughout various facets of one volunteer-based CLP organization, my research significantly departs from previous studies of international CLP initiatives. In the final section of this chapter, I outline the ways neoliberalism intrudes within the humanitarian organization "Mission Smile[1]" in each chapter of this thesis.

1.5 Outline of thesis

In the next four chapters of this thesis, I investigate the ways and the extent to which neoliberal logics percolate at Mission Smile. Chapter Two looks at the methods I used to conduct ethnographic research with volunteers at a North American NGO who provide CLP surgery to children in the global south. I argue that studying up is an appropriate methodology to conduct research focused on professional established physicians and specialist nurses within NGOs. I describe how I used web and film analysis, participant observation, and interviews to study up Mission Smile and their employees and volunteers. I evaluate the strength and limitation of using studying up as a methodology to understand how neoliberal logics undergird the practices at Mission Smile.

Chapter Three begins by describing the culture and structure of Mission Smile as a CLP organization. I show how Mission Smile's moral call to action attempts to emulate

[1] A pseudonym of the organization is used to protect the anonymity of the organization and participants.

values of humanitarianism by providing a personalized and high standard of care to those in need. I show that despite Mission Smile's claims to resist economic rationalities, neoliberal practices and language percolate throughout the organization. I show how the use of performance indicators to demonstrate financial and moral accountability to donors consequently influence the organization's goals, values, and practices.

Chapter Four looks at ideas of the body articulated by Mission Smile volunteers. I describe culturally imbued ideas about the body of the children with CLP. I focus in particular on how volunteers assess CLP bodies as abnormal, and how they view this abnormality as preventing a child from practicing self-management. Using discourse analysis on a documentary film, *Smile Pinki*, I show how a volunteer-formulated discourse of abnormality stems from both physiological impairment and social stigma. I illustrate how these discourses of abnormality are pervasive among CLP organizations, including Mission Smile. I show how volunteers view the inability to regulate a CLP body is often accompanied with perceived loss of autonomy. Volunteers problematize the loss of control and the need to re-establish autonomy as crucial in order for children to practice self-management. I demonstrate how volunteers understand the body in economic terms, especially how a normal body is an antidote to social and economic exclusion.

Chapter Five looks at the affective experiences of volunteers. I investigate how Mission Smile manipulates the volunteers' affective experiences to encourage volunteers to become fiscally and morally responsible for their patients. Therefore, volunteers not only pay to participate, but they are also motivated to perform a high volume of surgeries. I show how neoliberal rationalities are present in Mission Smile's relationship with their

volunteers. However, I also show that volunteers articulate their affective experiences in the form of communitas that, for the volunteers, is external to neoliberal rationalities. I show how the emergence of communitas encompasses the moral, apolitical relationship volunteers develop with each other and with their patients. I conclude that while volunteers' affective desires to help can be manipulated toward a neoliberal end, it is also important to recognize that volunteers' experience of communitas is also fundamental to their experience.

Finally, in Chapter Six, I summarize the main argument and themes of this thesis. I address the implications of this research. I reflect on the limitations of this research and offer suggestions on future areas of research.

Chapter 2: Research Methodology in Studying Up Mission Smile

> A senior member, Mr. A, has become so warm and hospitable towards me since we met during the volunteer meeting in September, when I felt that he was somewhat dismissive towards me – like a fly that he wanted to wave away. But at the meeting yesterday and with the interview today, he was very warm and friendly towards me. It was as if he was talking to an old friend – he even whipped out his phone to show me photos of some of the patients and people he worked with on past medical trips.
>
> Fieldnotes, 12th November 2019

Like many other anthropological researches, gaining access is crucial to one's study. However, gaining access into a humanitarian organization that is made up of members with high socio-economic status posed an additional set of challenges. In an organization comprised of medical professionals with skills and financial resources to offer, my lack of connections, qualifications, and resources as reflected in my fieldnotes above, rendered me insignificant. I needed to encourage potential participants to share their personal thoughts and experiences as volunteers and employees at Mission Smile despite the fact that I had little to contribute. This chapter describes the methods I used to conduct an ethnographic study between June and November 2019 at a North American non-profit CLP organization I call "Mission Smile." Studying powerful institutions requires a different set of techniques and strategies. This thesis uses the methodology and strategy of "studying up" outlined by Laura Nader (1972) and Karen Ho (2012) that is suited for an ethnographic study on an organization. I sought to build trust and rapport with the organization and facilitate access during my fieldwork. In this chapter, I show how developing the persona of a "competent idiot" improved my credibility as a researcher and defined me as a non-threatening intruder, which enabled me to build trust and rapport with members of the organization. I was able to transform my presence as an

"unwanted fly" to a welcomed stranger within the organization. By employing studying up as a methodology, I used a vertical cross-section perspective in order to reveal how neoliberal practices and neoliberal rationalities are present in across different levels of the organization.

I begin the chapter by outlining my research protocol and participant eligibility. Next, I explain how utilizing the persona of a "competent idiot" was useful in gaining access into the organization. I provide an overview of the methods used and demonstrate why those methods were effective and appropriate in studying up Mission Smile, a gated organization who is highly selective and not every medical professional can participate. I then outline data management and my analytic approach. Finally, I elaborate on the importance of practicing reflexivity to recognize how my socio-historical locations, values, and interests orientate my research (Hammersley and Atkinson 2007, 15). As someone who has traveled fairly widely, I combined my awareness of global mobility and helping others with the persona of the "competent idiot" as a strategy that enabled me to gain insights into the worldview of volunteers and employees. I also recognized the limitations of this persona, as I was challenged throughout fieldwork not to adopt the worldview that my charismatic participants believed in and that motivated their volunteer activities.

The next section outlines my research protocol. Careful attention was paid as I designed the research protocol to ensure that the organization and participants would not have any negative repercussions as a result of their participation in this study.

2.1 Research Protocol

"Mission Smile" is a pseudonym for a small NGO located in a different North American city from where I was living in. The fieldwork that took place between June to November 2019 consisted of five trips to that city, with each trip ranging between two to four days to meet volunteers and employees at Mission Smile. The first and second trip to Mission Smile were used to build rapport. On my second trip, I received consent from Mission Smile to conduct my fieldwork. Prior to contacting the organization, I received ethics approval from the University of Victoria Human Research Ethics Board (HREB). Upon receiving ethics approval, I approached Mission Smile for permission to conduct a study of their organization. I explained that their organization's participation in this research would consist of interviews with some of its employees, volunteers, and participant observation at their volunteer meetings. I informed the organization that I would also be conducting media analysis of their website and social media. I stressed to the organization and participants in the study that I was accountable to them and maintaining confidentiality was ethically important to me. To protect the anonymity of the organization and confidentiality of information, pseudonyms were used and all identifying features of the organization and participants have been modified or omitted, including the location of the organization, the numbers and makeup of the staff and volunteers, and the names and identifying details of all respondents.

Before an interview or observation session, I gave participants a copy of the consent form, which was reviewed in detail (see Appendix A). Participants were given time to ask questions or express concerns before starting the interviews or observations. Consent was obtained from all participants to record audio during interviews and observations.

2.2 Participants and Recruitment

This research worked with three groups of respondents: program managers, media administrators, and medical mission volunteers. These groups are essential to reveal how Mission Smile operates as an organization and the affective experiences of both employees and volunteers. I chose to work with program managers and social media officers to understand how the organization's values are translated into practice and how the organization seeks to remain accountable to their donors. To understand how affective values and emotions are challenged or reproduced, I conducted in-depth interviews in person or via video calls with six medical mission volunteers. A total of 12 participants, 3 program managers, 2 media administrators, and 7 volunteers agreed to be interviewed.

Program managers and social media administrators were recruited through purposive sampling. Participants with specific characteristics who met my research goals were recruited (Palinkas et al. 2015). I sought to recruit members who held decision making roles in medical missions and media. The four program managers involved in Mission Smile were volunteer coordinator, operations manager, mission planning, and volunteer recruitment. Some program managers were certified surgeons and nurses. All of the program managers also took part in the medical missions according to their expertise. The two media administrators I interviewed were in charge of gathering media materials including conducting interviews with parents and volunteers, editing the media content, and publishing. The job descriptions of Mission Smile employees are generalized to the position of “administrator” to prevent participants from becoming identified.

Mission Smile disseminated a recruitment poster of this study via email (see Appendix B). Of the seven medical volunteers, three female nurses and four male plastic surgeons participated in this study. Most participants (n=4) were recruited through snowball sampling, which occurs when existing participants tap into their social networks to facilitate the recruitment of future participants (Bernard 2006). I followed up with participants' interest by setting up interviews with the date, time, and location of their choosing. Interviews took place at participants' workplaces, cafes, and over Skype or Facetime when we were unable to meet in person.

Table 1: Participant's role within the organization

	Pseudonym	Professional status	Mission Smile Status	Volunteers' Employment status
1	Nancy	Administrator	Employed	-
2	Michael	Administrator	Employed	-
3	William	Administrator	Employed	-
4	Daniel	Administrator	Employed	-
5	Eddie	Administrator	Employed	-
6	Emma	Volunteer, Registered Nurse (RN)	Volunteer	Retired
7	Liz	Volunteer, RN	Volunteer	Retired
8	Manasa	Volunteer, RN	Volunteer	Retired
9	Sherman	Volunteer, Medical Doctor (MD)	Volunteer	Active
10	Ron	Volunteer, MD	Volunteer	Retired
11	Harry	Volunteer, MD	Volunteer	Active
12	Theodor	Volunteer, MD	Volunteer	Active

Table 1 illustrates the social positions of participants in this study. The majority of the participants were senior administrators and doctors who occupy a higher social status. The all of nurses who participated in the medical mission had retired. Due to the highly hierarchical nature of the medical institution, one's seniority is often associated with status. As such, even nurses, who are often viewed to occupy a less prestigious role within the medical system, often held leadership roles or accumulated a higher status than their younger counterparts. The number of medical missions participants volunteered at ranged from two to nine. Specific numbers are withheld in order to protect the anonymity of the participants. All participants expressed that they identified with the organization's values and they have largely enjoyed their experience volunteering with Mission Smile.

2.3 Getting Access

Without pre-existing social networks to gain access into Mission Smile, I organized the research in a way that allowed me to establish rapport, create networks, and build a relationship with the organization and its members. In the early stages of the research, I reviewed Mission Smile's web and media materials to build familiarity with various activities the organization conducts. I actively sought opportunities to attend events organized by Mission Smile. In June 2019, I attended the organization's volunteer appreciation dinner. This event was important in facilitating access into the organization as I was able to identify key administrative staff and potential gatekeepers of the organization. Through this event, I connected with volunteers that gave me a sense of the organization's culture and through presentations at the event, I was introduced to the values and goals of their organization. My observations at this event guided my interview

questions to learn more about the experiences and perspective of volunteers. Thus, I was able to discern the ways and the extent to which neoliberal practices are entangled and naturalized in Mission Smile. Gaining access to the organization was crucial to uncovering how medical missions operate. To ensure access, in the next section I describe how I created a non-threatening persona in efforts to build trust and rapport with the organization and its members.

2.3.1. Becoming a "competent idiot"

To encourage participants to share their affective experiences and thoughts in volunteering at Mission Smile, I used my positionality, my location in social life as a young graduate student to play a role which can be understood as a "competent idiot." This persona is based on Loftland's "acceptable incompetent" where the ethnographer understands the participant's culture by making blunders through trial and error and asking questions (Loftland 1971 in Hammersley and Atkinson 2007, 79). However, Loftland's persona is inappropriate for studying within a mostly medical community where "blunders" are frowned upon. My persona of a "competent idiot" was based on a young professional who is able to keep up with complex and technical conversations. Yet, my persona was also as an "idiot" who is unfamiliar and removed from the corporate and medical community and unable to cause any harm to the organization or participants. Therefore, my role as a competent idiot emphasized both my credibility as a young researcher and a benign presence.

Scholars have suggested that interviews can be understood as a social performance (Denzin 2001; Manderson et. al 2006). Hence, I needed to be mindful of

how structural factors such as age, class, and power structure could shape my relationship with participants and the process of the interview. A central component to playing a competent idiot is self-disclosure, which I enacted both online and in-person as a strategy to create rapport. I revealed professional and personal information about myself in an attempt to build on familiar experiences that I might potentially share with participants. I shared professional information about myself through my student profile posted on the anthropology department website at the University of Victoria. These practices are tactics suited to studying up as they are often utilized by working professionals as part of social networking. Self-disclosure not only allowed me to demonstrate my working knowledge of the work culture but also gave me an opportunity to "brand" and locate myself as a "competent" young professional with relatable traits to generate conversation and familiarity.

Knowing that participants in this study would have a higher socio-economic status, I attempted to perform similar socio-economic status and life-experiences with participants through my appearance. As I was meeting most participants after work, I wore professional but versatile clothes that consisted of dress pants, a T-shirt, and a semi-formal cardigan that allowed me to match my participant's clothes. However, in an era where audits often seek to evaluate the performance of employees, I was extremely careful to maintain a non-threatening disposition to members of the organization. By projecting a pleasant disposition, I offered to buy my respondents coffee or light snacks, a gesture that was appreciated by many. I was also ready to help the organization in various ways, including offering to do casual labour, such as vacuuming the floors or rearranging the tables for a meeting, which would otherwise be inappropriate roles for professional

auditors. In addition, I disclosed personal information in-person that might be relevant such as sharing that some of my family members are involved in the medical industry in Singapore. I used self-disclosure as a strategy to build on familiar understandings and enable a bi-directional flow of affective sentiments and experiences (Holstein and Gubrium 2011; Pacholock 2012). Thus, I was able to portray myself as a "competent" young professional who is a professional and reliable scholar, but also an "idiot" who is unfamiliar and removed from the Canadian medical industry and hence unlikely to be perceived as a threat.

2.3.2 Negotiating power as a competent idiot

Drawing from Holstein and Gurbrium (2011), who posit that an active engagement and production of an "identity," or persona, is needed to encourage participates to share, I felt I consistently had to maintain the persona of a competent idiot to prove my non-threatening disposition. Within the context of studying up, this includes navigating the power dynamics between me and my participants. For example, I describe in my fieldnotes the challenges I faced to show both competence and ignorance:

> Harry had suggested the location. The café is a beautiful, open concept styled place. I arrived earlier and picked a more private spot with a small table between us. However, the table was very low, and my interview questions and notes were left largely exposed. At various points of the interview, I felt like Harry was looking at the notes that I have written. It made me extremely self-conscious and uncomfortable. At times Harry would look straight at me and he was watching my hands and the notes that I was writing. I was not sure if he could read upside down. There were moments when I felt that I had to hide what I was writing. But other times I was also conscious as to not cover everything that I had written to give a sense that I was not criticizing what he was saying.
>
> Fieldnotes, 10th September 2019

Although the act of looking at my notes from across the table could be interpreted as an act of curiosity, this scenario illustrates how studying up a gated institution does not imply that power is fixed between the knowledgeable doctor and me as a lowly researcher (Odendhal and Shaw 2002). Rather, power is can be fluid and shifting (Hill Collins 2002, 287). Although Harry was a doctor who had the power to disclose or withhold information, I could also put Harry in a vulnerable position using the information he had shared with me through my work. Therefore, by glancing at my written notes, Harry sought to discern what my intentions were. I recognized that withholding my notes could breed distrust and ruin the rapport that I sought to foster. To maintain my persona as a competent idiot, as an act of deference, I made a conscious decision to display my notes to Harry to demonstrate that I had no hidden agendas or ulterior motive. Doing so, I proved that I was a reliable person and credible scholar. This persona was essential in enabling me to build trust and rapport with the organization and its members. In fact, Harry became central to my successful recruitment over the course of the study.

My persona as a competent idiot was not static and it evolved throughout the research process. It became apparent when I returned for the second time to conduct my fieldwork that my persona needed to evolve to reflect my research process and findings. In other words, with each time I returned to Mission Smile, I could no longer play the same "competent idiot" that I was during my previous field trip. Participants expected my questions to reflect my understanding of the organization, which I reflected on after the second field trip:

> Another problem I encountered this time was the assumption that I am now no longer a "competent idiot." I feel that same questions I asked, "describe a medical

> mission" is now no longer an appropriate question. In fact, when I asked Liz, "Is there any questions you want to ask me, or is there anything you feel that I should have asked?"
>
> She paused for a while before she replied, "Do you get any sort of idea on what we do from talking to us?" To which I replied by telling her what I know. This made me feel like I am expected to know how Mission Smile works. I am expected to understand the system/goals of the organization.
>
> Fieldnotes, 15th September 2019.

The expectation that I ought to reflect "insider" knowledge revealed that I had successfully negotiated access within the organization. Yet, my failure to demonstrate my previously learned knowledge could cause the organization and their members to scrutinize my competence and credibility as a researcher. The role reversal of having a participant in the study asking me a question when I should be doing the asking revealed the relationship that I had established with the organization was extremely fragile. Therefore, my access to the organization could be withdrawn at any time. Consequently, maintaining my persona as a competent idiot required constant and careful negotiation to maintain access and rapport.

2.4 Methodology

Given the fact that an ethnographic study of an organization lacks a "proper" field site, this research partakes in what Hugh Gusterson calls "polymorphous engagement" that involved "interacting with informants across a number of dispersed sites, not just in local communities, and sometimes in virtual form; and it means collecting data eclectically from a disparate array of sources in many different ways [such as] . . . formal interviews . . . extensive reading of newspapers and official documents" (Gusterson 1997, 116). For my research, I employed multiple data collection methods: narrative-interviews

of 12 participants, three participant observation events, media analysis, and grey literature analysis, which I describe below.

2.4.1 Studying up: conducting interviews

> "Everyone has been eager to hear about [our most recent medical trip overseas]. It dominates party conversations. Like, I don't talk about this because I don't talk about what I do at all. But if people ask I will, I'll tell them, and everyone's interested. Everyone's supportive. I have people donate to Mission Smile after hearing me rant about it for 20 minutes." - Sherman, MD (volunteer)

In her ethnography on Wall Street, Karen Ho (2012) points out that interviews are often the most accessible form of evidence in "studying up" especially when there are limited opportunities for participant observation (Ho 2012, 30). There were limited meetings and social gatherings where employees or volunteers at Mission Smile would gather. When meetings were scheduled, it was also challenging for me to gain access to all of the meetings. Compared to participant observation, interviews could be arranged at a participant's convenience allowing for an ease of access to information. Moreover, in the quote above, Sherman showed that talking about one's experiences is intrinsic to the volunteering experience and it is also a means for volunteers to build social capital, promote the organization, and fundraise. As Michel de Certeau (1984, 77) points out, "If the art of speaking is itself an art of operating and an art of thinking, practice and theory can be present in it." Therefore, I paid attention during the interviews and in analysis to both the content and form of talking. Specifically, I paid attention to how the organization's narrative or orientations (form of talking) were embedded in individuals' narratives and how one's narrative (the content of the talk) translated to social practices, actions and discourse (Certeau 1984; Gubrium and Holstein 2012). As Briggs and Mantini-Briggs's ethnography, *Stories in the Time of Cholera* (2003) illustrates,

narratives produced within the domain of global health can legitimize access or deny medical care to certain individuals.

To identify the various humanitarian discourses volunteers and Mission Smile use to legitimize the moral and social need to provide CLP surgery, I conducted narrative interviews to allow interviewees to elaborate on their emotional experiences (see Appendix C). 12 semi-structured interviews were conducted, which lasted between 40 minutes to 2.5 hours each. Following the active interviewing technique outlined by Holstein and Gubrium (1995), at the start of the interview, I emphasized that I was interested to learn about how Mission Smile operates and their experiences as employees or volunteers within the organization. Questions transitioned from general questions, such as participants understanding on the social and physiological impacts of CLP and recruitment, to specific questions that drew on their experience and practices on patient safety and being fiscally responsible when operating in resource-poor conditions.

I attempted to implement an interactive approach by paying attention to both body behaviour and linguistic patterns. This proved to be challenging as conversations were often fast paced and participants tended to use general descriptive words such as "privileged," "blessed," and "gratifying" to describe a rather complex situation and their affective experience. To get more detail on their meaning behind the use of these terms, I had to encourage participants to elaborate. This allowed me to gain a deeper understanding of the participants' worldviews and affective experiences, I became more attentive to their speech and paid less attention to their body behaviour. I observed consistencies in the various discourses they used around their need to help, their views of a clefted body as abnormal, and ways they equated volunteering as work, which are

major themes that I observed during the interviews. This allowed me to speak more clearly to how volunteers recognize the significance of their work and the way they go about to help, which will be discussed in later chapters.

2.4.2 Interviews conducted over video calls

I invited participants to participate in interviews via video call when they were unable to meet in person. Three interviews conducted by video call lasted between 2 to 2.5 hours. Having the interview in a comfortable and familiar location with increased privacy facilitated participants to be more responsive in sharing (Hanna 2012; Seitz 2016). Moreover, I allowed for a longer pause after participants finished their sentences to avoid talking over them also meant that I was less likely to interrupt. By using Callnote, a third-party software which captures videos and audio of the calls, I could record their body language which was not available in phone interviews.

Unfortunately, due to a poor internet connection during one of the interviews I was unable to see the participant, but he was able to see me. As Sally Seitz (2016) points out, internet glitches can lead to the loss of non-verbal information and intimacy during the interview. To maintain a friendly disposition, I continued to display attentiveness towards the participant by looking at the camera, nodding, and asking questions for 1.5 hours until the end of the interview. As I viewed my relationship and rapport with Mission Smile and its members to be fragile, I decided to actively perform the role of a competent idiot even though I was unable to see the respondent.

2.4.3 Participant observation

As an ethnographic technique, participant observation views the study of the everyday lives of individuals that are embedded with cultural meanings, social norms and power relationships (Hammersley and Atkinson, 2007). Conducting participant observation at Mission Smile allowed me to witness how the organization *talks to* their volunteers and how participants *talk about* their recipients and the work that they do. This enabled me to locate the organization's relationship with their volunteers and recipients, and to understand the organization's values and goals. I conducted participant observation at three events: a volunteer appreciation dinner and two volunteer meeting sessions.

Following the methodology suggested by Orne and Bell (2015), during these events, I focused on emplacement, embodiment, and emotions to discern how individuals engaged with space, observe their body language, and their feelings and sentiments during the event. When possible, I collected handouts such as promotional brochures which I analyzed. Combining methodologies was important for triangulating research results (Uwe 2018; Hammersley & Atkinson 2007). Specifically, I used participant observation to triangulate aspects of monetization of humanitarian care, the language of work, and affective sentiments of volunteering which were topics raised in both interviews and on the websites.

2.4.4 Film and media analysis

Last, I gathered information about Mission Smile's media profile. As a small organization, the practices that Mission Smile employ appeared to be influenced by their larger counterparts. To understand Mission Smile's values and goals in providing surgical

intervention required unpacking discourses commonly used by dominant organizations to portray children with CLP. Nead defines discourse as "a particular form of language with its own rules and conventions and the institutions within which the discourse is produced and circulated" (Nead 1988:4). In other words, discourse produced and circulated by CLP organizations is tied to projects of governance, as the language used by these organizations is embedded with meanings to create a specific representation of the world (Fairclough 2003; Starks & Trinidad 2007). Discourses can be expressed or embedded in different media such as verbal interactions, practices, and visual images. To identify dominant discourses that are produced and circulated among CLP organizations, I conducted discourse analysis on the websites of Mission Smile and Operation Smile, and on a documentary titled *Smile Pinki* that was commissioned by Smile Train, another CLP NGO. As two of the industry's most prominent organizations in providing CLP treatment, Smile Train and Operation Smile widely circulate promotional materials and discourses that are used by other CLP organizations like Mission Smile.

Situating Mission Smile within the larger structures of CLP organizations allowed me to investigate the extent to which Mission Smile perpetuated these discourses and how surgical intervention sought to address the problems associated with CLP. In Chapter 4, I identify the discourses used in Smile Train's documentary *Smile Pinki* to justify the need for surgery. I discuss how those discourse found in the documentary is internalized and utilized by Mission Smile volunteers.

2.4.5 Additional literature

In addition to the documents collected during various outreach events, a few participants in this research shared materials they believed would be of interest to me. This included a journal entry of a medical mission and scholarly articles. Some participants showed me personal pictures of the patients they had treated. As I was never given copies of these images, I described the images and the conversation I had with participants in my fieldnotes.

2.5 Analysis and data management

Ewick and Silbey (2003) argue that although narrative research acknowledges that each experience is unique, it also recognizes that individual narratives can reflect a much larger collective experience. Given the diverse professional occupation and experiences of participants, I was concerned about accurately identifying collective experiences and values of participants at Mission Smile. Thus, I approached analysis as an iterative process (Hammersley & Atkinson 2007) where I constantly developed and redeveloped analytical themes and categories throughout my fieldwork. I transcribed all interview and participant observation data and input the data into MAXQDA qualitative data software to code. I analyzed the data through a combination of methods including using word counting of key phrases across all interviews, using codes to identify significant themes, and using the software to retrieve and reorganize those themes. The themes identified from interviews allowed me to foreshadow and anticipate significant themes from other data sources such as participant observation, media analysis, and additional literature. By triangulating different data sources and putting those through a similar iterative process, I ensured that themes and data presented here are representative and valid.

2.6 Reflexivity

Maintaining my reflexivity by recognizing how my orientation as a researcher is shaped by my socio-historical location, including my values and interest, has remained challenging (Hammersley and Atkinson 2007, 15). I recognize that playing a competent idiot is effective in building rapport and enabling participants to share their experiences and worldview to me. Yet, central to having a conversation with an idiot is to enlighten and educate the fool. Consequently, I found myself quickly immersed in my participant's worldview and the organization's cause. Moreover, as playing the role of a competent idiot required me to demonstrate that I was a non-threatening intruder, I rarely challenged the worldview of my participants. This was rarely an issue as I found participants to be rather convincing. I attributed their ability to persuade me of the value of their volunteerism to our shared sensibility of having a post-secondary education, that enabled participants to not only deploy discourses around humanitarianism found in scholarly work, but also communicate about them in an eloquent and convincing manner. As Marcus and Holmes have observed, "it is perhaps disturbing to think that we [anthropologist] are more like some managers of capitalism or some politicians than we would like to admit" (Marcus and Holmes 2005, 250).

In playing the "idiot," participants often sought to convince me of the importance of their work by inviting me to imagine myself in the position of a child with CLP. This exercise often involved inserting myself into the situation that used my personal experiences or imagination. I reflected on my emotions when Sherman invited me to engage with his justifications:

> Sherman: Everyone's going to get ridiculed in childhood, everyone's going to get teased right? You don't need a reason, but if you know, if you take away [the cleft], that thing that makes them different, then you just change their lives, it's

> one of the best things you can do. Children are innocent, they didn't do anything. If you can do something to help them then, why wouldn't you do it?
>
> *Just listening to this part of the interview, I can feel the passion, the drive, and the need to help and fix a child that Sherman feels - it also makes me feel very emotional.*
>
> Fieldnotes, 28th October 2019

As a charismatic person, Sherman invited me to empathize with children with CLP by drawing on my personal experience as a child, as "everyone [was] ridiculed in childhood." At the same time, he reminded me that "children are innocent" and therefore do not deserve any reason to be teased. By tapping on my own experiences and utilizing a shared moral discourse, that suffering should be alleviated, Sherman persuaded me that children ought to be helped: as reflected in my fieldnotes, I agreed with him. Therefore, participants were able to align me with their cause by leveraging on normative values and discourse that we were expected to share. Thus, I risked reproducing the very hierarchies and assumptions that I sought to discern (see Ho 2012, 36).

At the same time, studying up highly educated and knowledgeable participants meant that participants could anticipate and mitigate various criticisms encountered by international medical missions. For example, Michael addressed a common criticism where CLP organizations were accused of imposing western standards of beauty onto children with CLP in the Global South:

> I know it's controversial, why do our society put those [beauty] pressures on? What is our western agenda? What is our aesthetic of beauty, [and] why are we putting that on them? Why can't they live with a cleft lip? Well... you know what? *You* try living with something different!
>
> **It's not our judgement.** It's not that we're saying you're ugly. You're something, let's help you. It's not like we're picking them off the streets. **Because they come voluntarily.** It's not us saying, your mouth, you're deformed right? It's the fact that this can be fixed, let's just do it (Michael, Administrator) [Emphasis added]

Participants like Michael were not only quick to justify and defend their cause and beliefs, they also practiced reflexivity that I employ as a scholar. Like an anthropologist, Michael claims to suspend his judgement. By further demonstrating that recipients exercise their agency when seeking treatment, Michael was able to defend his claim that he and the organization do not impose western standards of beauty on their recipients. In this way, it is not unusual for participants to practice reflexivity and "analyze" the volunteering that they do. Consequently, this made it challenging for me to maintain *my reflexivity* as a researcher, and I struggled throughout to maintain a level of distance from my respondents' values that I thought would be most productive for an anthropological study.

Yet, as Karen Ho and other scholars who focus on studying up point out, a major aspect of studying up is to destabilize and analyse the normativity of the powerful, rich, "specialist" NGOs (Ho 2012; Nader 1972; Wright 2004). To maintain my scientific rigor and reflexivity throughout the research process, my fieldnotes and transcript included a component where I reflected upon my emotional and moral reaction towards my participants' views. In doing so, I attempted to understand how and why I was swayed by particular informants and their point of view. In addition to self-interrogation, I consulted my peers for their opinions especially on their affective sentiments on web materials to get an external perspective. Where possible, I triangulated my findings with participant observation and discourse analysis. Finally, I put alternative and competing discourses using various scholarship to question or challenged these knowledge claims that were put forth by participants in this study.

2.7 Conclusion

In this chapter, I have described and demonstrated why studying up is an effective and suitable approach for conducting a qualitative inquiry at Mission Smile. I have demonstrated that playing the role of a competent idiot was an effective strategy in building rapport to learn about Mission Smile's practices and the affective experiences of their volunteers. I also highlighted the limitations of playing the competent idiot and how I attempted to ensure the claims I make in this study are valid by practicing self-reflexivity and triangulating my findings.

I have described respondents in terms of their professional status and their character attributes to not only to fully develop the arguments in the later chapters, but to also prevent dehumanizing participants. Participants' affective experiences are embedded in their professional careers and form the crux of humanitarian discourse in the need to help, which is central to the argument presented in Chapter 5. In the next chapter, I begin by describing Mission Smile as a grassroots organization. I focus on the values and practice of Mission Smile as an organization. I show that in spite Mission Smile's attempts to enact values of charity, neoliberalism continues to permeate the organization. In particular, I problematize the conjugation of the organization's moral desire to help with performance indicators.

Chapter 3: “Doing as much as possible”- when performance indicators and humanitarian goals conjugate

In this chapter, I describe the NGO Mission Smile and review how volunteers talk about their activities. This chapter shows that in spite of efforts to enact values of charity, neoliberal rationalities continue to undergird Mission Smile’s values and practices. This thesis argues that neoliberal rationalities, or an economic framework, have become intrinsic to how volunteers understand the organization and the work they do.

The first half of this chapter describes Mission Smile as an organization. I describe how Mission Smile and their volunteers respond to the moral need to help children with CLP, and how specialized treatment the organization provides challenges neoliberal rationalities. The second half of this chapter looks at the ways neoliberal rationalities permeate the organization’s practices. I look at how Mission Smile’s aim to provide help for children in need of surgery becomes entwined with performance indicators. I point out Mission Smile’s attempts to make legible their moral commitment towards their donors and recipients ironically enabled neoliberal rationalities to permeate the organization’s values and practices. In particular, I highlight how market rationalities are internalized by employees and volunteers in how they talk about their work. I begin with an overview of the organization’s informal grassroots structure, which is central to Mission Smile’s identity.

3.1 Mission Smile

Founded in the late 1980s by Dr. Z, a pediatric plastic surgeon, Mission Smile is a secular organization that specializes in providing cleft lip and palate surgery and burn reconstruction surgery to children who cannot afford it. Mission Smile organizes one to

two “medical missions” a year. Each mission is usually 10 days long and involves 20-30 medical volunteers who typically have experience in pediatrics. These missions rely on a team of highly trained medical professionals from North America who go to countries in the Global South to do short-term biomedical surgeries on children who do not have access to surgery. Mission Smile partners up with local hospitals in various countries to provide surgeries. Whenever possible, the organization also provides CLP surgery to adults. To date, Mission Smile has performed medical missions in more than ten countries.

As an organization, Mission Smile works to remove barriers to access. The organization arranges transportation for families who cannot afford to travel to the hospital and back home. All children who arrive at the hospital are screened by anaesthesiologists, pediatricians, and surgeons. The child is scheduled for surgery when all three doctors have certified that a child is healthy enough to undergo surgery. Mission Smile ensures that accommodation and food are provided to the child and their caregiver during their entire stay, which averages four to five days. Because partner hospitals often lack the resources to provide post-operative care to children at night, caregivers are trained by Mission Smile nurses to care for their child at night. Children are discharged on the third or fourth day after surgery and are encouraged to return on the last day of the mission, known as Clinic Day, for a final checkup. To ensure a positive surgical outcome, nurses often remind parents on post-operative care procedures, such as keeping hands away from their child's mouth and massaging their wounds to make sure the incision site remains soft. Whenever possible, Mission Smile returns to the same hospital to conduct follow up checks and provide additional surgical revisions to patients who need it.

Mission Smile is described as a grassroots organization with an informal structure. Volunteers, like Emma, have expressed pride that the organization directs "100% [of our donation] towards our equipment, towards our supplies, [and] towards our missions." To keep their cost low, Mission Smile hires six part-time staff[2] who oversee the organization and they rely on their dedicated volunteers for various functions.[3] In addition, volunteers who participate in a medical mission pay several thousand dollars to covers the administrative costs and the costs of their participation such as flights, food, and accommodation. This allows funds raised from charity drives, such as blind auctions, to go directly towards their medical programs.

As a surgeon who has volunteered in various organizations, Ron described Smile as a "bootstrap organization" as he compared Mission Smile with other NGOs who provide CLP surgery:

> There's lots of NGOs that do CLP surgery…they're a little bit more politically oriented, a little more business oriented. Mission Smile is really a boot strap operation…Whereas in large cleft NGOs, you basically drop into the organization, which is highly organized, highly funded. You sort of slot into a round hole, if you're a round peg. Mission Smile is not that way. It's very much more grassroots. It's - basic is not the word I'm looking for. But it's a much simpler, much simple organization. (Ron, MD)

Ron compared his experience in a large organization akin to that of a peg which "sort of slot[s] into a round hole" in a large piece of machinery. Therefore, volunteers are treated in a highly economic fashion as easily dispensable and replaceable parts within a larger organization. In a similar vein, Nancy compared the structure of these large organizations

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[2] All the six part-time staff are paid in a small stipend for their contribution. All of them have other employment. They often meet after working hours to discuss matters pertinent to Mission Smile.

[3] Volunteers are recruited for various administrative and operational tasks. For example, assisting the program coordinators as part of a mission planning committee, or ordering and packing medical supplies for the mission.

to a "franchise like McDonald's." The structured approach of a large cleft organization is highly efficient and effective but does not enable volunteers to have a personable experience among other volunteers or with their patients.

In contrast, Nancy described Mission Smile as a "boutique artisan shop" comprised of a passionate community with a sense of camaraderie among their volunteers. To maintain a sense of community, the organization mostly recruits new medical volunteers through recommendations from existing volunteers. Harry, who has recruited a few of his coworkers, explains how volunteers tend to recruit other co-workers who they know are "good people to work with or who you know are good [at their job]." Michael, an administrator, explains the importance of "knowing" new volunteers by having a character referee from existing members of the organization:

> I want to keep it, that I know someone,[4] I want them to be accountable for them. I want to know them; I want to know what their skill sets are and much more. Because, it's like your family. You have to be able to count on your family. […] I have to feel that they can trust me, and I have to feel that I can trust them to perform at their best. (Michael, Administrator)

Michael views volunteers as part of Mission Smile's family. Before recruiting new volunteers, he wants to "know" that volunteer and to foster a relationship based on "trust." This vetting process is also important to avoid potential malpractice overseas. The lack of an international governing body that regulates medical professionals means that humanitarian NGOs have to vet their volunteers or risk their reputation. By recruiting through existing social networks, both the organization and new volunteer can tap on pre-

[4] This is in contrast to large cleft NGOs where any certified medical professional from all over the world can apply to become a volunteer. Michael say this gives the organization a "grab bag" of volunteers with different character, goals, and skills.

existing social relationships to build a personal relationship. However, this relationship is also used to encourage volunteers to "perform at their best." Despite the differences between a "boutique artisan shop" and a "franchise," Nancy refers to both types of NGOs as businesses where products are sold. Nancy's and Michael's perspective on the goals and values of Mission Smile entwine the moral desire to help while using business language. This chapter explores the connection between humanitarianism and neoliberalism by looking at Mission Smile's practices.

Before exploring the ways in which neoliberalism is present in the practices of Mission Smile, I look at how cleft NGOs, like Mission Smile, generate the moral call to action that Mission Smile volunteers respond to. I begin with the moral discourses that are found at Mission Smile and other cleft NGOs, which portrays CLP surgery as lifesaving.

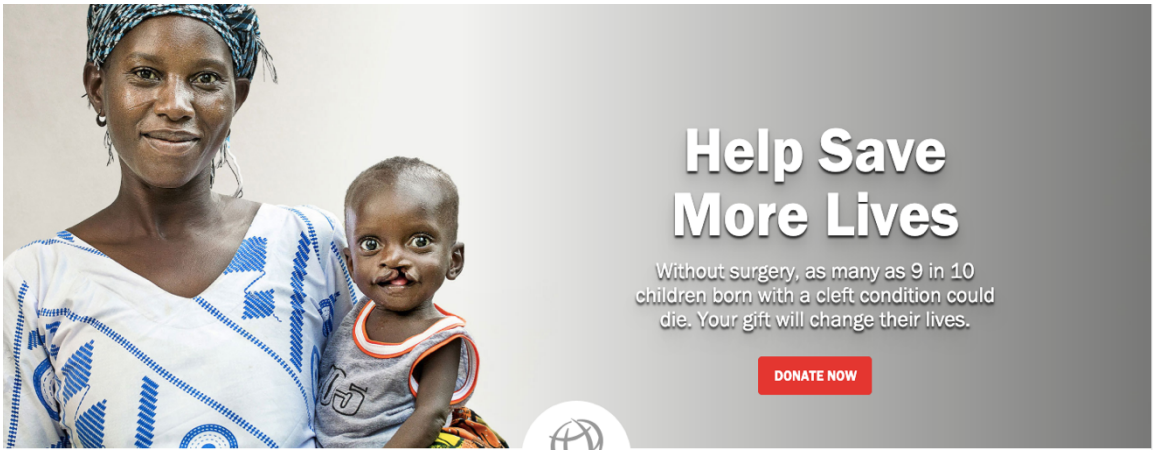
3.2 Mission Smile's goals: helping those in need

Visitors to Operation Smile's website, another CLP organization and one of the dominant international agencies, quickly learn about the dire need to provide life-saving surgeries to children with CLP.[5] The organization explains, "without surgery, as many as 9 in 10 children born with a cleft condition could die." Accompanying the text is an image of a young mother carrying her baby with CLP who will likely die without that surgery (see figure 1). While volunteers at Mission Smile would likely find Operation Smile's statistics to be inflated, as they see many adults with unrepaired cleft lip and palate who are alive, the same volunteers will agree that CLP surgery is a life-saving

[5] An analysis of Operation Smile website is shown here instead to protect the anonymity of Mission Smile.

procedure. Participants at Mission Smile explain that death from starvation is possible as feeding children with CLP can be challenging.

Figure 1: **Operation Smile homepage illustrating physiological implications of CLP**



To Mission Smile volunteers, surgery is viewed in lifesaving terms that enables a child to survive and to live well (Redfield 2013; See also Agamben 1998). Participants were concerned with children's immediate survival and improving their quality of life through surgery. Children's inability to consume food is seen to threaten a child's life. In a word count, volunteers mentioned the words "eat" 60 times, "feeding" 62 times, and "development" 42 times. In addition, volunteers were also concerned with the long-term social impact of having CLP. Although volunteers described the effects of CLP to be "stigmatizing" seven times and "isolating" eight times, volunteers raised concerns on other aspects of children's social life. Participants highlighted barriers to attending school 33 times and finding a marriage partner 16 times. To participants, CLP surgery that mitigates the threat to life and suffering is seen as a life-saving procedure.

Participants recognize the importance of closing the cleft for children to grow and develop. Liz, a pediatric nurse, explains the importance of closing the cleft in the mouth as that is: "where the nourishment goes in. That's where your source of sustenance is [and] it affects them. Like, oh my god, how is this child going to survive with no proper, you know, mouth to eat food properly?" The inability to consume makes CLP a life-threatening condition. Five participants shared an extreme story of a severely malnourished baby girl, Hoa, in Vietnam. Michael recalled his thoughts when he saw the one-year-old baby:

> She came in really small, [and] grey. We thought she was going to die. She was like one year old. I think she was six kilos. She was very, very grey… when I saw her, I was like, "holy shit, this child is going to die." (Michael, Administrator)

Specialized bottle feeders and technique are used to nurse children with CLP. Given that parents in rural Vietnam lacked access to healthcare, they did not have access to those resources to nurse their child. Volunteers say that malnutrition can impair the child's growth and development and in cases, like Hoa, children can die. Although Hoa was too malnourished to receive surgery, Eddie, an administrator points out, "nurses come up with a strategy for [parents to feed their baby]. A lot of time, that saves lives." Volunteers view feeding as a basic physiological function that is essential to survival. They understand the surgery and health education services related to caring for a child with CLP that Mission Smile provides as lifesaving.

Besides threats to a child's physical survival, as a facial abnormality, CLP is often entangled with social stigma (Talley 2014). A surgical fix for CLP that promises to eliminate social discrimination is another dominant theme among cleft NGOs. Themes of social isolation and exclusion are apparent in websites of NGO. For example, Operation

Smile features a young boy with CLP who is alone in a junkyard. In the picture (figure 2), the boy is compared to the unwanted scraps of plastic and junk that he is crouching over. Accompanying the image is the title, “As if he didn’t have a name,” which suggests that having CLP reduces the boy to scrap materials that have no social value. This image problematizes society’s treatment of children with CLP was waste materials that can be thrown away, which reveals the deadly effects of having CLP (Talley 2014).

Figure 2: Image from a patient story illustrating social exclusion of children with CLP

Participants in this study highlight the moral urgency to provide surgery to “fix” a child’s body and protect them from unnecessary suffering that arises from CLP. Employees and volunteers at Mission Smile who witnessed children who were “thrown away” by their parents, also view CLP to have socially deadly consequences. Harry, a doctor in his early forties, expresses his shock:

> We ended up actually working on a couple of female babies with cleft lips that were adopted by other families. [The family] said they literally found the babies in the gutter because someone had thrown them away, which is really striking coming from North America and thinking that, that's screwed up. That someone would have [so] little respect for life that they would just throw it away. (Harry, MD)

As Harry suggested, in the Euro-American tradition, children embody the sanctity of life who are excluded from the messiness of politics (Bornstein 2003; Fassin 2011b; Malkki 2015). To "throw away" children is a moral transgression. As Sherman remarks, "[Children] weren't asked to be born, they haven't done anything, they're innocent." With no real agency to fend for themselves, volunteers view children as helpless and innocent victims (Barnett 2013; Bornstein 2003; Fassin 2011b; Talley 2014). The feelings of horror volunteers feel towards a child who is thrown away like trash reveals the moral failure of humanity (Kleinman and Kleinman 1997, 6-7). Cleft NGOs like Mission Smile respond to this moral call to help and protect children, and surgery is viewed as a "fix" that addresses the physical and social consequences of having CLP.

In the next section, I look at how Mission Smile enacts these moral values around life, stigma and childhood to provide specialized medical care to children. I describe how Mission Smile's informal structure challenges neoliberal rhetoric as the organization provides a high standard of care, not only attending to a child's needs but also supporting their volunteers with the resources and freedom to perform their best.

3.3 "Providing patient-centred care" – ensuring good patient outcome

Mission Smile and their volunteers claim that they are motivated by the moral desire to help children in need. Rather than allocating fixed resources to each patient,

Mission Smile attempts to challenge neoliberal rationalities by providing medical care based on the specific needs of the patient. As a volunteer in a passionate organization, Emma explains that Mission Smile aims to provide "the best, safest, care possible" to their patients. In a word count, the word "care" was used 112 times, "safety" was used 55 times, and "standard" was used 23 times when referencing the quality of medical treatment Mission Smile provides. Michael, an administrator who oversees the allocation of resources, explains that the organization provides specialized care to children. Patients have various resources at their disposal that is necessary for a good surgical outcome:

> I really like the fact that we specialize each child's treatment in their particular deformity. …We do [a] specialized surgical plan for each child. So, if [a surgeon] spends 3 hours on a lip, I'm okay with that. It's not like everybody gets one hour, gets 3 packs of suture, gets this, and off you go. It's whatever it takes for that particular child. Because we've seen Dr. Z do a complete lip, looks at it, "nehhh," not too happy. Take it all down, start again. Because we give him that freedom and he's the physician. So that whole thing about specialized care, we really do walk that talk. (Michael, Administrator)

According to Michael, care is delivered based on what the child needs. Michael and other respondents are committed to the idea that Mission Smile's informal structure provides the surgeons with more flexibility, freedom, and resources to provide the best possible care. As Michael adds, "I can't give them the world, but I'll give them whatever they can give their best practice with." Volunteers can request specific tools like sutures or tapes or use their preferred methods.

In comparison, Sherman feels that the technocratic, top-down approach that other CLP organizations implement can be counter-productive in providing the best possible care to their patients (see also Farmer et al. 2013). He explains that some organizations require their volunteers to use a specific surgical technique that he is uncomfortable with, causing him to question his ability to help. Sherman express his concerns, "I don't really

know if I'm doing a service here." He feels the use of an unfamiliar surgical technique can lead to experimentation on patients and result in substandard care. Ron gives a clear insight into what he considers as surgical experimentation:

> In the less developed countries, we should never do something we would not do at home. There's never a reason to experiment on people, this a reason to do the very best you can. (Ron, MD)

Defining surgical experimentation as doing something different from home reflects Mission Smile's deep-seated value to replicate not only similar practices, but also standards and patient outcomes typically encountered in North America. The organization's practice of providing volunteers with familiar surgical tools such as sutures and tapes to limit experimentation and guarantee success exemplifies volunteers' desire to provide the "best possible care" and "best possible outcome."

Mission Smile's goal to provide the best quality of care and surgical outcome towards their recipients is facilitated by the organization's informal structure. The flexibility of the organization allows their volunteers to enact their best practices and aim for a positive and successful surgical outcome. Sherman points out the success of the structure that Mission Smile has implemented:

> Mission Smile has never lost a patient, no one has died. And people know that. And there's a reason, that's not luck, that's not coincidence. (Sherman, MD)

Mission Smile's commitment to their patients' safety has influenced various aspects of their organization from volunteer recruitment to patient selection. However, Mission Smile's informal and flexible structure means that the organization does not create a specific standard or procedure by which volunteers have to abide. As Nancy explains:

> There's a certain amount of joy and freedom and being accountable to your own conscience, and the best you can do. […] We're answerable to patients that we serve and our donors. (Nancy, Administrator)

Mission Smile's informal structure deviates from highly corporate and bureaucratic structures adopted by larger CLP organizations. This freedom, however, is a double-edged sword. On the one hand, the autonomy and the provision of resources enables volunteers to believe they can provide the best possible care. Their standard of care is enacted based on perceptions of an individual's moral responsibilities. In doing so, volunteers attempt to disrupt marketization as marginalized groups are treated as equal and objects of love, rather than a statistic (Muehlebach 2013, 455). Yet, Mission Smile's flexible structure also means that the quality of care is at the discretion of the same volunteers as there are few structures to ensure that surgeons meet minimum standards of care as established by wider medical bodies. Mission Smile believes it mitigates such challenges through careful recruitment of volunteers and by fostering a positive work environment and culture.

In the following section, I contextualize these claims about the priority of care in Mission Smile practices by showing how, contrary to what volunteers say, neoliberal rationalities permeate throughout the organization. I show how the provision of care is shaped by performance indicators that seek to illustrate the good work done at Mission Smile. In addition, I highlight how market rationalities are internalized by employees and volunteers in how they talk about their volunteer activities.

3.4 "Trying to do as much as possible" – Counting social good

Like other cleft NGOs, Mission Smile seeks to demonstrate to their donors and volunteers that their time and money translate into social good. The use of indicators is key in demonstrating fiscal responsibility, measuring success, and maintaining their

reputation. Numbers are used as a tool to render the translucent performance of individuals and organizations "legible" as evidence of "good work" (Scott 1998). Through the use of numbers, Mission Smile demonstrates the positive social impact of their volunteer activities.

On Mission Smile's website, performance indicators are often used to communicate the production of social good. For each medical mission, the organization provides a summary of the number of patients seen and the number of surgeries completed. This demonstrates how the use of metrics is conjugated with ideas of helping children with CLP. Moreover, Mission Smile employees often use performance indicators to talk about the organization's accomplishments. For example, William used numbers to describe the organization's accomplishments:

> So, I'm proud to be part of the team. It's an amazing 20 years. We did over 2000 people. So, it's quite an achievement. (William, Administrator)

According to William, Mission Smile's "achievement" lies in the organization's ability to perform surgeries on "over 2000 people." The quantity of surgeries rather than the high quality of care forms the foundation of the organization's reputation. However, why is the number of surgeries performed used as evidence to the production of social good?

In a context where the lack of access to healthcare has created a huge demand for reconstructive surgery, supplying free surgery to those in need is interpreted as meeting a humanitarian demand. As Emma explained, "we're trying to provide [surgery] to those who have limited access." Emma's use economic language of supply and demand to describe the places Mission Smile operate. This perspective interprets the need for surgery by looking at a numeric demand rather than alleviating suffering. Taking this perspective further, the completion of each surgery meets a humanitarian demand. In

other words, the more surgery Mission Smile performs, the closer they realize their humanitarian goal. Harry, a volunteer who has taken on additional responsibilities at Mission Smile, explained to me that the goal in a medical mission is "to help as many children as possible." The provision of surgery is equated with helping children with CLP. All participants in this study expressed a desire to "do as many [surgeries] as possible." Consequently, participants conflate performance indicators with the production of social good.

The importance of performance indicators is internalized by employees and volunteers. Mission Smile's determination to perform as many surgeries as possible caused the organization's decision to break a partnership with a local hospital. Michael explained to me during an interview, "[the partner hospital] is limiting me to five patients a day… I can do 12 a day. I'm not going to bring a team of 30 at a cost of 70 thousand dollars, for 15 children." By sharing how much each mission costs, how much the local partner hospital was charging, and limitations on the number of surgeries performed each day, Michael used the language of cost-benefit analysis in his decision to partner up with a hospital. Michael is articulating hidden targets in interventions, of a minimum of "12 [patients] a day" as a cost-effective and optimal surgical schedule for the organization. The amount of social good Mission Smile produces relies on a logic of cost-benefit analysis and performance indicators. To Mission Smile, demonstrating moral accountability to their donors and volunteers includes a responsible use of funds and performing an appropriate number of surgeries. The use of metrics and numbers is a framework for Mission Smile to ensure that the production of moral good for their

patients is also morally sound to their donors. In the next section, I problematize the provision of humanitarian aid parsed in numbers and the consequences on care practices.

3.5 “But we can't do that in a short period of time” – Thinning out dimensions of health outcomes

Here, I build on the previous section, where participants conflate the provision of surgery with generating social good. As participants seek to “help as many children as possible,” a positive surgical outcome serves as a proxy that renders the organization’s good work legible (Merry 2011). Mission Smile’s focus on generating surgical outputs inevitably treats surgery as a fungible product that fulfils the values of humanitarianism, which removes the social and medical complexities for a child with CLP to achieve a state of physical and social health.

My interview with Theodore, a volunteer surgeon, illustrates how numbers alone do not reveal social complexities associated with providing CLP treatment:

> We always want to do as much as we can. There's always much more need than we have capacity. So, you might screen 150 people can only operate 50. So, you try to choose the people with the greatest need and your ability to care for them. (Theodore, MD)

Theodore reiterates the theme of volunteers conflating humanitarian practice with performance indicators. It is easy to assume that the 50 patients operated on were “care[d] for” by Mission Smile. This use of metrics is a “thin description” where numbers function as self-evident indicators that imply a child’s needs are attended to (Porter 2012). The superficial understanding of metrics provides does not reveal a child’s health outcome. For example, performance indicators do not reveal if a child was able to

completely regain normal physiological function, or if social suffering caused by CLP was actually ended or reduced as a result of surgery.

In addition to "thinning" health outcomes, the use of metrics also condenses multiple aspects of CLP to only focus on surgery. Harry explains that Mission Smile "goes [to a country], does a mission and then we leave. And we're not there to provide long-term, follow up with speech therapy and stuff like that." The short-term medical missions Mission Smile conducts means that the organization do not provide holistic care to their patients. The focus on performance indicators led to the "thinning" of Mission Smile's practices as the organization focuses on providing surgery as a fungible product to humanitarianism.

Other components of CLP treatment that are not easily measured through numbers are not provided. Without access to those forms of care, Emma explains the health outcome patients can expect from Mission Smile:

> We [can] improve their appearance, we [can] improve their ability to eat [*sic*]. Rarely can we improve their ability to speak, that is the closure of the palate helps, but in N. America, there would be speech therapy… We try to reinforce, that if [the patient] can access through [their] system, through [their] school system..~~.~~ So a perfect success would be a perfect line of the lip… the gum and teeth that have been aligned, [but] that's dental work, we can't do that. Like I've said, the speech, if we could optimize the speech as much as possible, that would be perfect. But we can't do that in a short period of time. (Emma, RN)

Emma describes the surgical outcome as an "improvement" a child's appearance and physiological function, rather than attaining a state of health. Long-term medical care such as speech therapy and orthodontics are important contributions to social aspects of healing and social integration, but these are not provided (Taylor-Alexander 2016, Talley 2014). Children's health outcomes are interpreted through performance indicators instead of discussions of what constitutes care or how a patient's quality of life can be improved

through surgery (Taylor-Alexander 2016, 386). Mission Smile's attempt to convey both fiscal and moral accountability to their donors through performance indicators, becomes an ideal fungible humanitarian product that is readily made legible through performance indicators. Numeric indicators can oversimplify varying components to children's health. This leads to a narrow discussion on what kind of medical options and support Mission Smile ought to provide to ensure the well-being of children with CLP.

In the next section, I discuss how economic calculus are used by volunteers to justify the type of care given to recipients. Discussions about care reveal how volunteers internalize neoliberal rationalities. I show the encroachment of neoliberal rationalities not only influence the organization's goals, but also influence volunteers' values and decision in distributing surgical care to children with CLP.

3.6 "Do I do three kids, or do I do six?" – A utilitarian approach to humanitarian aid

In this section, I describe how volunteers attempt to distribute humanitarian aid. I show that volunteers have to grapple with the ethical implications of providing medical care to as many people as possible rather than working towards the best interest of their patients. As volunteers equate the distribution of humanitarian aid with the provision of surgery, they distribute CLP surgery in a utilitarian fashion. Volunteers problematize their effort to maximize the greatest amount of social good for the most number of people is done at the expense of a patient's needs.

This priority of providing the greatest number of surgeries over other forms of care is characteristic of Mission Smile practices. Ron recalls what he calls his first "lesson" on his first medical mission with Mission Smile where ideas of being a good organization are focused on metrics rather than helping a patient. He explained that he

had just agreed to remove a tumor growing on a 17-year-old boy's face when the anesthesiologist said no to that case:

> The anaesthetist said, "no you won't be able to do that case, we bring drugs here for anaesthesia, we bring it based upon the pediatric population. If we are to do an adult sized person, although he was 17, we would not be able to do 3 or 4 children" and so we had limited resources and we can't do that. (Ron, MD)

Although surgery is unable to provide a cure, it is able to significantly improve the quality of life for this young person. However, as Ron demonstrates, the organization's goal to help as many patients as possible overrode the volunteers' compassion to help those in need. Although Ron saw the patient as a child at 17 years of age, the patient is seen as an adult based on the amount of resources needed to perform the surgery. Ron explains that the patient is viewed in terms of the resources of time and amount of anaesthesia required to perform the operation. Consequently, the selection criteria for surgery at Mission Smile takes on a utilitarian view that strives to maximize the greatest good for the greatest number of patients, which does not necessarily keep an individual patient's best interests in mind (see Redfield 2003). This practice is similar to triage, in selecting patients whereby claims to political, social, and religious criteria are rejected in favour of "life, health, efficiency and fairness, the last understood as a procedural and distributive good" (Redfield 2003, 169). Volunteers echo utilitarian values about efficiency and fairness in how they talk about their time on medical missions.

Michael, an administrator explained the dilemma of helping as many children on the one hand, while attempting to remain cost efficient and productive on the other. He explains:

> It's very difficult to refuse somebody. Like for example, you have a two-year-old that's come in with a bilateral lip and a big palate. That ideally you should fix the palate because of the speech development. **But if you don't have the time, you just have to do the lip, so you sacrifice the speech.** But I would ideally do what I could. But sometimes depending on how bad it is, that could be up to a 4-hour surgery. Which is, you know, if we don't have a lot of patients, then that's like great! Right? **But if you don't - do I do three kids, or do I do six?** (Michael, Administrator). [Emphasis added]

As administrator, Michael is responsible for allocating resources, he attempts to distribute surgery using the "ethic of fairness as a procedural and distributive good" (Redfield 2003, 169). He is confronted with a dilemma to provide specialized care based on the needs of each individual child on the one hand, and to help the many children who have travelled long distances to seek surgical treatment on the other. As an organization, Mission Smile attempts to maximize the greatest number of good for the greatest number of people. However, this pragmatic focus also entails loss or a sacrifice of sorts (Redfield 2003). Michael has to contend with sacrificing various aspects of care: choosing to close the cleft lip is viewed to be more emergent but leads to the "sacrificing" of speech; or foregoing specialized care to three children so another three children need not return home "empty-handed." This utilitarian approach, although recognized not to be ideal, is viewed to be a fair and ethical solution to distributing surgery in places with high demand.

This reveals how neoliberalism, the extension of economic practices and calculation, can function as a mode of judgement and action. Despite the fact that the provision of care using a utilitarian approach does not always meets a patient's best interest, under the circumstances Mission Smile operates in, this approach in distributing surgery is viewed to be an appropriate response to a humanitarian need. However, the application of a utilitarian approach is not without consequences. The utilitarian language

used to describe humanitarian work reveals how neoliberal rhetoric is internalized by volunteers and employees at Mission Smile. Michael's and many other volunteers' language to "*do* three kids", "*do* the lip", or "*do* that case", among many other examples, reflects an impersonal and business-oriented attitude. Volunteers' choice of verb of "*doing* as many children as possible" does not place the children's interest at the center of attention. Instead, "do" refers to the distribution of aid to children in technical and impersonal terms, in contrast to other verbs like "care," "operate," or "help" that might suggest a more personal or humanitarian element. The adoption of a utilitarian perspective reveals how neoliberal practices that uses economic calculation is internalized by volunteers and employees at Mission Smile. These findings show that Mission Smile's care practices is intertwined with neoliberal economical calculations by which the organization is managed and organized. Mission Smile's attempt to produce healthy numeric indicators, shapes the goals of the organization, and impacts the way care is made available to their recipients.

3.6 Conclusion

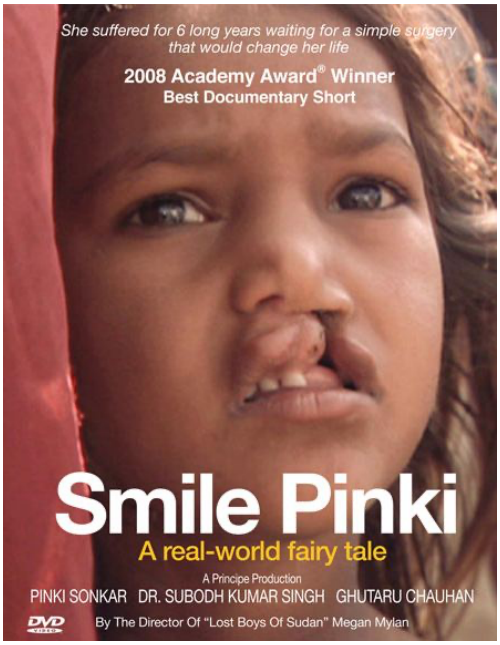
I have provided a description of Mission Smile as an organization that attempts to emulate values of humanitarianism by providing a personalized and high standard of care to those in need. Despite Mission Smile's claims to resist economic rationalities to impose a top-down vertical intervention by empowering their volunteers through the provision of resources and tools to ensure the best surgical outcome, I showed how neoliberal language and neoliberal rationalities continue to percolate the organization. In particular, the organization's application of performance indicators shaped volunteers' ethical understanding of what it means to be financially and morally accountable in the

provision of humanitarian aid. The organization's desire to perform as many surgeries as possible has led to volunteers adopting a language which suggests they view utilitarian practice based on time and numerical goals as ethically and morally sound medical actions.

In the next chapter, I disentangle the moral discourses and neoliberal rationalities involved in providing surgery through a close look at bodies of individuals with CLP. In particular, I discuss how volunteers understand what it means to have CLP in developing countries and what surgery can offer, which shows how surgery can be perceived as a form of investment in a body as it attempts to restore a child's body and future back to equilibrium.

Chapter 4: "A real-world fairy tale" - Surgery as an investment in a child's future

Figure 3: Promotional poster for the 2008 documentary *Smile Pinki*



Volunteers at Mission Smile pointed to the devastating impact CLP has on the lives of children. Participants in this study explained that CLP "affects the child in all aspects of life" and is "exceedingly debilitating." Other cleft NGOs often echo similar sentiments. The award-winning documentary,[6] *Smile Pinki*, describes a six-year-old girl who has "suffered 6 long years waiting for a simple surgery that would change her life" (Figure 1, 2008). The film hails the free CLP surgery provided by the NGO Smile Train as "a real-world fairy tale." The discourse surrounding children's experiences of CLP that label the bodies of children with cleft palates as abnormal and therefore in need of a

[6] Smile Pinki is the 2008 Academy Winner for Best Documentary Short. The documentary was commissioned by Smile Train, one of the key organizations that provide CLP surgery (Youtube, 2018).

surgical fix is widely circulated among cleft NGOs. While the theme of a "normal" body is identified as necessary for a child's physical and social wellbeing, this chapter speaks to the ways Mission Smile volunteers understand the ways surgery is able to improve the lives of children with CLP. I posit that Mission Smile volunteers view surgery as a biomedical antidote to social and economic exclusion, where a normal body is a valuable currency which allows children to gain social and economic access.

To Mission Smile volunteers and employees, a body with CLP is abnormal; one that is unhealthy, socially isolated, and houses an unproductive subject. Biomedicine becomes a technology that physically and socially transforms a child into a healthy, socially included, and productive citizen. The CLP surgery that normalizes a child's body serves as an investment in a child's future. The body is part of an individual's flexible collection of assets, or human capital, which enable children to practice self-management of their lives, and to seek employment (Wickström 2010).

Volunteers' ideas of normality and abnormality are rooted in a larger cultural construction, intimately associated with the social, political, and moral order (Lock 2015). Although there is a tendency to establish abnormality as a deviation from a statistical norm, there is a need to recognize that a normal body is constructed based on what is socially "normal" (Canguilhem 1989). In that context, the body of a child with CLP is abnormal because it does not conform to social norms. Hacking (1990 in Lock and Nguyen 2010, 46) argues that ideas of normality transverse the gap between what the body "is" and what it ought to be. Hacking's conceptualization of "normal" as what the body ought to be often implies normality is a static state when achieved. This is implied in *Smile Pinki,* that Pinki's "fairy tale" transformation of what her body ought to be is

accomplished through CLP surgery. However, I suggest that discourses of a normal body used among Mission Smile volunteers on what a body ought to be are closer to what Shillings (1993, 161) terms a "civilized body," which includes maintaining physical control and regulation over one's body. In other words, for volunteers, being normal is an embodied experience, shaping an individual's lived experience of having and being in a normal body (Lupton 2000). Therefore, becoming normal includes having "normal" physiological characteristics and managing one's body and future (Lupton 2000; Shillings 1993; Wickström 2016).

How do volunteers label bodies with CLP as abnormal and what allows them to legitimize the need to perform surgery? What are their understandings of normal bodies? Answers to these questions become especially clear in the documentary *Smile Pinki* and in the narratives of volunteers from Mission Smile, which reveal how these cleft organizations understand the impact of CLP on the lives of children.

To protect anonymity of the participants and the organization in this study, I present a discourse analysis of the documentary *Smile Pinki* which has generated significant public interest. *Smile Pinki* is the 2008 Academy Award Winner for Best Documentary Short. The documentary was commissioned by Smile Train, one of the key NGOs that provide CLP surgery (Youtube, 2018). *Smile Pinki* functions as an information commercial, or infomercial that educates the public of the importance of providing CLP surgery to children while garnering public support towards their organization. The film educates the public about the importance of providing treatment for children with CLP and lends legitimacy to the organization's work. This widely circulated film demands a closer analysis to identify the discourses of children with CLP.

The discourses presented here were triangulated with data obtained from the web materials from Operation Smile, as presented in Chapter Three, and Mission Smile's website. This allowed me to identify the dominant discourses surrounding the bodies of children with CLP among the three cleft NGOs.

There are two parts to this chapter. The first part of this chapter will investigate how cleft NGOs, like Mission Smile, understand the bodies of children with CLP to be in need of a surgical fix. I identify the social meanings and discourses attached to the bodies of children with CLP and how bodies with CLP are constructed as abnormal. The second half of this chapter investigates how Mission Smile volunteers understand CLP surgery to be a transformative process, and the ways in which normalization of children's bodies functions as an investment towards their future.

4.1 "Can you count up to ten?" – Embodying an abnormal body

Smile Pinki illustrates the pervasive effects of having abnormal body. Similar to the patient stories on Operation Smile website mentioned in the previous chapter (see figure 2), the documentary identifies the bodies of children with CLP as stigmatized and socially excluded. The documentary hints at the long-term consequences of experiencing social exclusion from a young age. This prevents children with CLP from participating in social activities, such as attending school, which is essential to developing their human capital. In this way, abnormality is an embodied process of having and being a body that deviates from the expected and acceptable norms.

The film features a six-year-old girl, Pinki Kumari, who is portrayed as living in poverty in rural India. Pinki is depicted as suffering socially from having a cleft lip and palate. When recruiters enter the school of a remote village promoting Smile Train's free

surgeries, the students do not refer to Pinki by name but instead refer to her as "Anjulata's little sister who has a cleft." Despite being of school-going age, Pinki is found at home instead of playing with her peers. Pinki's father later reveals that "[Pinki] used to ask to go to school, she'd grab her book bag, but then the kids started calling her cut-lip." The documentary shows how having an abnormal body can define a child's identity. Instead of referring to Pinki by name, she is referred to as "cut-lip" or as a sister "who has a cleft." Without a normal body, Pinki becomes disempowered from pursuing her interest in attending school. The documentary illustrates how Pinki embodies abnormality: by having an abnormal body and being in an abnormal body.

The documentary hints that children with an unrepaired CLP remain in a state of stasis. Excluded from participating in various rites of passage, such as going to school, children lack the skills needed for self-management associated with adulthood. Consequently, children with CLP are portrayed to remain in a state of infancy. For example, the documentary features another child, Ghutaru, an eleven-year-old boy. While screening Ghutaru, the doctor from Smile Train asks:

> Doctor: Does he go to school?
> Father: No, he used to go to school, but not anymore.
> Doctor: Why doesn't he go?
> Father: He can't speak properly, so he doesn't go.
> Doctor: What's your name?
> Father: Say your name
> Boy [barely audible]: Ghutaru
> Doctor: Can you hear properly? Can you count up to ten?
> [Ghutaru shakes his head]
> Doctor: You don't know?
> [Ghutaru looks down in shame, he shakes his head]
> Doctor [talking to another staff]: Pankaj. An earlier date [for the surgery] will be better. Pankaj, try to admit him now.
> [to the boy] So once it's fixed, will you go to school?
> [Ghutaru nods his head]
> Doctor: Ok, he'll go. Admit him.

Ghutaru's social exclusion from education has prevented him from learning how to count from one to ten, something that a "normal" eleven-year-old boy is expected to do. It is important to stress how going to school ties into ideas of normality, especially since Ghutaru's lack of knowledge and promise to go to school appear to be a condition for receiving surgery. By agreeing to go to school, Ghutaru demonstrates his desire to practice self-management. In exchange for surgery that normalizes his body, Ghutaru is expected to be able to manage where his body should be, and what his body should do: studying in school. All three children with CLP and their guardians featured in the documentary agree that after receiving surgery they will go to school. School, in turn, can be viewed as an institution that moulds children's bodies and their sense of self in preparation for the labour market, and reflects the larger neoliberal value of self-management (Kerstetter 2016).

The documentary ends with a scene of Ghutaru in school during the attendance call with his new smile. This scene juxtaposes the opening scene in a classroom where Pinki's presence was absent and her name was never uttered. Like other children, Ghutaru knows to stand up when his name is called (see figure 4). Instead of playing alone, forgotten in the village, Ghutaru is seen and his presence is registered. With surgery that normalizes the appearance of children with CLP, Smile Train demonstrates children are able to acquire and develop human capital by attending school. Children like Ghutaru can practice self-management of their attitudes, actions, and body where they are expected to become a productive member of society and a manager of their own success and well-being (Wickström 2012, 294).

Figure 4: Ghutaru standing up during his attendance roll call in school

Smile Pinki depicts a common experience of stigma, social isolation, and exclusion among children with CLP. Beyond the urgent response towards a child's suffering, the documentary asserts an undertone of concern that innocent and vulnerable children can be transformed into dependent and unproductive adults (see Fassin 2011a). The undertone of such fear creates a sense of urgency to normalize children with CLP by providing surgery. In doing so, these children can build their human capital by practicing self-management of their attitudes, actions, and body and hopefully become a productive member of society.

In the next section, I look at how participants from Mission Smile understand children with CLP as abnormal. Volunteers at Mission Smile offer a more nuanced perspective by look at the symbolic meanings attached to CLP. However, referring to CLP as a "hole" in the body, volunteers discuss the social meaning associated with having a hole in the body, the loss of autonomy, and even the loss of humanity.

4.2 "They're hideous looking"- the perceived loss of humanity

During my interview, Sherman attempted to explain to me the physiological and aesthetic problem associated with CLP. He went on to explain: “it is a little insensitive to call it a hole in the head, but that's essentially what it is.” By describing to CLP as a “hole,” volunteers referenced a body that is breaching in its boundaries, leading to the “leaking,” “shooting,” or “slobbering” food. The loss of bodily control in the movement of substance is accompanied with a perceived loss of humanity as the body returns to the chaos of infancy (Lupton 2010). As the body is viewed to be part of an individual’s human capital, that must be managed. Otherwise, children with CLP incur the loss of human capital due to their inability to assert control over their body and be active agents by successfully acquiring skills through school or utilizing their skills from employment (Brown 2006; Rose 1990).

Eddie is a non-medical volunteer who has never seen a child with CLP before his first medical mission with Mission Smile. In the excerpt below, Eddie describes his initial reaction and feelings of unease that stem from the breaching of boundaries caused by the cleft:

> Some of them are really, really deformed. They're serious deformities. You look at them and you want to look away, because some of them, all of their teeth are out…I'm trying to think of a word right now that's politically correct, but the first word is that they're hideous looking. Like they're really deformed in the mouth. And you do want to look away […] They got a different laugh. Their laugh goes this way instead of this way. When they laugh, maybe some spittle comes out. [Eddie, Administrator]

Eddie’s description further highlights the embodied experience of having CLP. The “hideous looking” deformity is not a static image. The interaction with children also reveals other abnormal aspects of having CLP, such as having a “different laugh” or having “some spittle come out [*sic*].” Lupton refers to this feeling of unease Eddie

describes as “liminality disgust” (Lupton 2015, 8). She explains that the presence of a cleft, a split in one’s lips, revealing the inner and outer parts of the mouth, corresponds to a “the transgression or indistinctness of cultural boundaries” (Lupton 2015, 8). The absence of a boundary such as lips, revealing the teeth or the splashes of spittle is a transgression of cultural norms. Children’s inability to regulate their appearance and their bodies renders them in a liminal, or even an unregulated and uncontrolled state, traversing between the boundaries of sickness and health, between a child and a deformed monster.

In an extreme example, Emma, a nurse, reflected on the impact of CLP as an orifice. She details the dehumanizing consequences of losing of control over one’s body:

> So, if I compare [CLP] to women who had babies at a very, very, young age, 11-year-olds. And they have a lot of vaginal tearing, a lot of rips between the bladder and vagina, so they leak urine all the time. That's not a visual but it is life limiting. Because there's odor associated, there's the moisture, there's the odor. Same idea. They can't get husbands, they can't get jobs, they can't go to school. (Emma, RN)

The “leaking” of urine, moisture, and odor in social spaces is a physiological impairment that turns a private matter into a public affair (Livingston 2008). This also underscores the unruliness of the human body (Livingston 2008). The inability to dispense bodily substances in socially acceptable ways and spaces becomes what Mary Douglas (2002, 44) would term “matter out of place.” This constant leaking renders the bodies of individuals as unruly and distasteful and leads to the cutting off of sociability with others. Emma further suggested that the body’s uncontrolled state results in the loss of human capital as the abnormal body, that is part of an individual collection of assets, is seen as “defective.” In other words, both children with CLP and the women in Emma’s example lack human capital to engage in relationships that further develop their human capital by

going to school or offer usable skills, traits, or marketable capacities for employment or finding a marriage partner.

Mission Smile volunteers draw attention to the mouth as an orifice and a medium to express one's self. They problematize that the inability to expresses one's self further signals a loss of humanity. The socially inappropriate oozing of bodily fluids, coupled with the inability to communicate, demonstrate the body's loss of rational control and a state of bodily chaos of infancy (Lupton 2010, 10). Harry, a surgeon, who is an advocate for international medical missions, explained his perception of the social life of CLP patients based on his clinical tours:

> The people with unrepaired cleft lip and palate, they tend to be isolated, because they don't look like everybody else, their speech doesn't develop as well. Then because they have improper speech, then a lot of people then automatically assume that they have some, you know, mental dysfunction or mental retardation because they don't speak properly. Then these people are treated like they have a lower IQ or have developmental delay (Harry, MD)

Harry pointed out that because a child's cleft inhibits their ability to communicate, it is assumed that the child has a mental disability. In Harry's perspective, children are not only unable to control their body, they are also limited by it. Children with CLP are unable to assert their autonomy (to express their will) and to manage their body (to produce speech). The child's failure to act as an active agent over their body is seen as a loss in humanity. If a normal body is associated with the practice of self-management of one's human capital that is continuously nurtured, managed and developed (Martin 2000, 582), the failure to self-govern is associated with a state of infancy. This signals the erosion of the self that is marked by the assumed loss of cognitive function.

Thus far, I have shown that some volunteers at Mission Smile use discourses of abnormality to describe a body with CLP. For most volunteers, the cleft as a hole in the

body that leads to an uncontrolled leaking, slobbering, and shooting of substances signals the loss of autonomy and the loss of human capital. As scholars have noted, global health initiatives (such as providing CLP surgery) can function as projects of governance that seek to transform the bodies, behaviours, and aspirations of their recipients to adhere towards a self-governing neoliberal subject commonly found in the Global North (Briggs and Mantini-Briggs 2003; Keshavjee 2014; Pandolfi 2008; Redfield 2005; Timmer 2010). Surgery as a biomedical tool attempts to normalize the bodies of children with CLP, in support of a larger project of self-management and self-governance. The discourses employed thus far are not related to the social or physical well-being of a child. In the next section, I explore how "health" is used as a foil to justify medical intervention that attempts to normalize the bodies of children with CLP.

4.3 "It's fixable anatomical difference" – Surgery as a normalizing project

Insofar, the therapeutic objective of biomedical intervention seeks to normalize a child's appearance and capabilities for self-management. Zola (1972) observes that health is used to justify medical intervention that seeks to discipline, modify, and restore bodies into a state of normality. Although Mission Smile volunteers recognize the threat to life in extreme cases (like the story of Hoa in Chapter Three), volunteers like Harry have pointed out that CLP is "not life threatening as there are many [children that] … had unrepaired CLP and they live to adulthood." Instead of solely focusing on a child's physical health, volunteers locate a child's facial abnormality as a barrier to attaining a state of social wellbeing.

All the surgeons in this study attributed children's experience of social exclusion to the facial disfigurement associated by CLP. Consequently, surgeons described one of their surgical goals as "to give the best possible aesthetic result [we] can" and "to do the best you can to almost call it a perfect smile." Sherman described the correlation between improving a child's appearance through surgery and increasing a child's social well-being:

> I want to try to take away the visual stigma that makes them different from others… it's fixable anatomical difference between them and the kid next to them that subject them as victims of ridicule. (Sherman, MD)

According to Sherman, "visual stigma" that subjects children with CLP to "ridicule" stems from a "*fixable* anatomical difference [emphasis added]." By attributing social exclusion to a physiological abnormality, Sherman evoked the notion of "need" based on a child's suffering (Edmonds 2013). The domain of biomedical intervention has legitimized and promoted aspirations for normalized appearance as necessary to attain social well-being.

Improving a child's appearance becomes a synonym for normalization. Harry explained how he expected improving a child's appearance to enable a child to build their human capital through the practice of self-management of their attitudes, actions, and body:

> From a cosmetic standpoint, their facial features and their lip will be more normal in appearance. So that will carry all the social implications, so better socialization, more acceptance into regular society etc. (Harry, MD)

According to Harry, the normalization of a child's appearances has positive social implications for "socialization" and social "acceptance into regular society." From this perspective, biomedical intervention attempts to normalize a child's body and life from

an embodied perspective. Surgeons view the importance of having a physiologically normal body to be normal. This implies that a normal body becomes a currency, or a prerequisite, for social and economic participation. In other words, the objective of the surgery is not to improve a child's appearance but rather the life of the child. As Daniel, an administrator, explained to me that the surgery that Mission Smile provides "is not just a cosmetic surgery, it is a life-altering surgery."

It is important to point out that volunteers do recognize the physiological impacts of CLP such as challenges to feeding and its associated implications with growth and development (see Chapter Three). While I acknowledge the physiological implications associated with CLP, the point that I want to make here is how cleft NGOs use physical and social aspects of health to legitimize the need for biomedical intervention. For example, Ron told the story of a woman who was at the hospital to get her granddaughter's CLP treated. Ron explained how the woman's life was not was severely affected by CLP:

> We did a 65-year-old lady who had a complete cleft of the primary palate. In other words, her nose was badly deformed, her lip was wide open, and the tooth baring portion also had a little cleft in it. […] It took about 45 minutes and she looked like an entirely different person. And the next day we went to see her, the nurses were in tears because she was so beautiful and they say, "you look absolutely beautiful, what do you think of it?" and she sort of shrugged, held her palms up and kinda like: it is what it is (Ron demonstrate how she shrugged by lifting his shoulders). So, it wasn't a big thing for her. It was a bigger thing to be involved in her care I must say. But the point is, she lived her entire life totally functional, just that aesthetic problem. (Ron, MD)

For the elderly woman with an unrepaired CLP, getting married and having a granddaughter suggested that CLP did not have devastating effects to her physical and social well-being. In Ron's perspective, the woman "lived her entire life totally

functional, [CLP was] just that aesthetic problem." Despite the woman's stoic reaction to her surgery, Mission Smile volunteers were emotionally moved when they witnessed her transformation into an "absolutely beautiful" person. This suggests that Mission Smile volunteers attached meanings to the physical appearance of their patients.

Mission Smile volunteers expect the aesthetic transformation of patients with CLP to accompany other aspects of normalization. Emma, who described CLP surgery as a transformative process, further demonstrated how normalizing a child's appearance can influence other aspects of the child's life:

> I don't think we take an ugly child and make them beautiful child, not at all! I just think we take a child and support them in such a way that they can then eat, grow, speak, go to school, you know. (Emma, RN)

A normal appearance is premised on an orifice with normal physiological function that enable a child "eat, grow [and], speak" properly. The normalization of a child's body enables a child to lead a normal life such as "go[ing] to school." As a technology, biomedicine is an effective tool that seeks to modify the physical body and restore the social life of children with CLP into a state of normalcy.

In the final section of this chapter, I look at how volunteers' effort to normalize a child's body is tied to a larger project of neoliberalism. I briefly look at why Mission Smile targets children with CLP to be the prime recipient for humanitarian aid.

4.4 "A child has much more opportunity to benefit" – Surgery as an investment

When Mission Smile volunteers talk about the benefit of providing surgery to patients with CLP, they often refer to children. Children are viewed as ideal candidates

for surgery as their young age is viewed as an asset that allows them to benefit from the surgery. Theodore explained how children are expected to receive greater net benefit from the surgery compared to adults:

> A child has a much longer potential to realize any benefit. I mean, if you had infinite capacity, you would treat everyone. But a child, has much more opportunity to benefit. Just in terms in years if nothing else. (Theodore, MD)

Theodore viewed surgery as an investment in two ways. Firstly, children are expected to be able to get a longer mileage from the physiological fix "in terms of years if nothing else." Secondly, Theodore pointed out that children also have a "longer potential to realize any benefit" from their surgery. This includes "secondary" benefits where a normal body enables a child to attend school and to invest in other areas of their human capital that may not be available to adults.

Some volunteers admit that they do not know how children's lives are changed by the surgery. Despite that, volunteers with Mission Smile do not distinguish biomedical interventions from productivity outcomes. As a long-standing employee of Mission Smile, William explained that the goal of the surgery is to help children "go to school, educate themselves, and become good citizens." William equated receiving an education that prepares children for the workforce to being "good citizens." Implicit in volunteers' aspirations for recipients is not only to become economically productive, but to also achieve upward mobility.

Michael shared a rather unexpected incident when he and another doctor, Dr. B happen to see sex workers who were recipients of CLP surgery. In the quote below Michael's highlights some of the implicit goals of upward mobility associated with providing free CLP surgery:

> There's a couple of time where we have seen prostitutes with cleft lip scars. And it always disturbs Dr. B immensely. I'm like: she's a hooker, she's been able to look after herself, don't judge her lifestyle. I mean, she's pretty enough now so that people will pay for her. But Dr. B gets upset about it. And I'm thinking, "oh that's a good repair." That's how I think of it. I don't judge that part of it, I know Dr. B gets upset about it, because all this work and who knows what these little girls' lives will end up. Well, hey, it's a job. Life- you know, it's employment. (Michael, Administrator)

Michael empathized with Dr. B's disappointed when they saw former recipients of CLP surgery doing sex work. As Michael explained, volunteers put in "all this work" as an investment in hopes that children will attain a better state of social, physical, and economic wellbeing in their future. Yet, implicit in Michael's and Dr. B's disappointment is the view that the provision of surgery ought to be, what the documentary *Smile Pinki* describes as, "a real-world fairy tale." Sex work that is associated with poverty signals a failure of the organization's humanitarian program as it was unable to adequately normalize children's lives to become what William describes above as "good citizens."

Michael, on the other hand, considers the provision of free CLP surgery to be successful. Even though sex work is considered to be an undesirable "lifestyle" for recipients, surgery is still considered to be essential to transform the bodies, behaviours, and aspirations of their recipients to adhere toward a self-governing and productive neoliberal subject. Michael recognizes that surgery alone does not ensure secondary investment in human capital, such as attending school, which enables children to accumulate enough human capital to escape poverty. Despite that, Michael points out that a good surgical repair is an investment on a woman's body and her appearance, which makes her "pretty enough" such that "people will pay for her." To Michael, CLP surgery continues to function as a normalizing project that enables women to practice self-

management. Despite the undesirable connotations attached to sex work, Michael points out, “it's a job… it's employment.”

For William, Michael, and other volunteers, the therapeutic object is not only a child’s physical cleft but extends to the child’s future socio-economic potential. Surgical intervention is entangled with neoliberal rationalities wherein surgery constitutes an investment in children’s bodies as assets that are “normal”, and that will allow the children to administer long-term, adult forms of self-management over their physical, social, and economic wellbeing.

4.5 Conclusion

In this chapter, I have shown how children with CLP are perceived to be abnormal in their ability to practice self-management of their attitudes, actions, and bodies that are required to become productive members of society. The first half of this chapter looks at how abnormality is an embodied process of having and being in an abnormal body. I illustrated how Mission Smile volunteers perceive an abnormal body that is breaching in boundaries to represent the loss of autonomy and humanity. As the exertion of agency is perceived to be central to practising self-management of social and economic well-being, volunteers anticipate children with CLP to remain unproductive.

In the second half of this chapter, I showed that Mission Smile volunteers view CLP surgery as an investment in a child’s future. Despite claims to alleviate a child’s physical and social suffering caused by CLP, I discerned that the real therapeutic objective of CLP surgery is to normalize children with CLP. Volunteers perceive

normalization as essential to practising self-management that enables a child to attain social and economic well-being.

The next chapter looks at the affective experiences of volunteers. I show how neoliberal rationalities is extended into Mission Smile's relationship with their volunteers. By engaging in a business-like relationship with their volunteers, I investigate how Mission Smile encourage volunteers to become morally and fiscally responsible for their patients. Although volunteers' affective desire to help children in need can be used towards neoliberal ends, I also show that volunteers continue to articulate their affective experiences in the form of communitas, which for them, appears to reside outside of the influence of neoliberalism.

Chapter 5: “They have been zapped by Thor’s hammer” – the generative joy of helping children in need.

While I was conducting participant observation at a volunteer meeting, a discussion arose about a previous failed mission. In the fall of 2019, Brazil introduced policy changes on foreign NGOs which led to a series of bureaucratic delays that in turn led Mission Smile to cancel a medical mission. An air of disappointment filled the room. After an update on various events that had taken place since the last meeting, a volunteer abruptly asked, “Do we have an agenda for this meeting if we don’t have a mission to talk about?” In an effort to console the volunteers, the chair of the meeting quickly explained that even though “we don't have a mission this year, the work doesn't stop.” The organizers shared the ongoing “background work” that was taking place to make the next mission materialize. Feelings of disappointment nonetheless remained strong in the group, as volunteers had been looking forward to leaving for Brazil the next month.

This scene gives an indication of the emotional work Mission Smile does as an NGO in order to maintain volunteer engagement. It reveals the various practices Mission Smile uses to manipulate the affective sentiments of volunteers. Maintaining their volunteers’ engagement is essential since the organization depends on the skills and financial resources volunteers offer. In other words, Mission Smile is able to govern the actions of their volunteers towards an economic end by manipulating their affective sentiments. This chapter explores the role of volunteers’ affective desire to help children in need, and its impact on volunteers’ experiences. It investigates the extent to which volunteers moral desire to help can be explained using neoliberalism as a cultural framework.

This chapter argues that neoliberal rationalities can converge with values of humanitarianism. In particular, volunteers' affective desires to help those in need can be used towards neoliberal ends. However, I also reveal that volunteers often articulate their affective experiences in the form of communitas that for them is external to economic calculation. The first half of this chapter reveals the extension of neoliberal rationalities into Mission Smile's relationship with their volunteers. Specifically, I show that Mission Smile engage in a business-like relationship with their volunteers as the organization uses affect as a strategy to generate free labour (Adams 2013; Muehlebach 2012) and to bear the fiscal cost associated with participating in a medical mission. The second half of this chapter explores the emergence of communitas. It reveals how the moral relationship volunteers develop as they attempt to provide healthcare as a right serve as a foundation for the magical and joyful quality of communitas to emerge.

The term affect needs elaboration. The majority of emotion studies in anthropology investigate how emotional states such as love or shame experienced by individuals are constructed socially (Lutz and White 1986). While an individual may feel compassionate towards a child in need, it does not necessarily lead to action (Hardt, 2007). This chapter is concerned with actions rather than emotions per se, and affect theory offers a useful avenue for exploring actions volunteers take.

Unlike emotions, affect refers to relations practised between individuals, or to have an effect on. Derived from the same Latin root, *afficere*, to be affectionate is to both feel and direct a sense of affection towards an individual. I use Richard and Rudnyckyj's definition of affect, "the way people conduct themselves and others that makes certain avenues of action possible, while foreclosing others" (Richard and Rudnyckyj 2009, 59).

In their discussion of affect, the authors highlight the use of affect to facilitate economic transformation in domains previously excluded from neoliberalism. For example, Analiese Richard describes how a Mexican NGO was able to secure funding from their foreign partners by arousing feelings of connectedness. Affective sentiments were used to create business relationships between the NGO and their foreign partners. I suggest that a similar process is at play in Mission Smile where volunteers' affect are channelled towards specific economic ends for the organization. I suggest that Mission Smile views their relationship with volunteers as a business alliance that fulfills an economic goal (See Gershon 2011). Specifically, Mission Smile manipulates volunteers' affective desire to care to not only provide free specialized labour, but also to maintain the organization's fiscal health. In the first part of this chapter, I look at the various practices Mission Smile employs to manipulate volunteers' affective sentiments. I demonstrate the effectiveness of those strategies that appoints volunteers, rather than the organization, morally and fiscally responsible for their patients.

Mission Smile's business relationship with volunteers and the organization's manipulation of volunteers' affective sentiments towards an economic end demonstrates how neoliberal rationalities can be projected into social relationships. As Rudnyckyj highlights, neoliberalism is a "ubiquitous practice of making economic calculation a universal standard for the organization, management, and government of human life and conduct" (Rudncykyj 2011, 21). However, this approach is insufficient for understanding the full scope of volunteer experiences. Drawing from Ilana Gershon (2011, 546) who argues that "neoliberalism is too flimsy a set guideline for fashioning relationships," I explore the moral relationship volunteers engage in with their patients. Specifically, I

show that volunteers talk about this moral relationship as external to the economic calculation and neoliberal rationalization. I propose that an emergence of communitas, a generative feeling of collective joy (Turner 2012, 2) that occurs when volunteers are on a mission, means that volunteers are animated by their affective desire to help and do not demand any "returns."

Often described as feelings of bubbling joy, a group's pleasure in sharing common experiences, and a sense of togetherness, communitas is a "deep, rich substance" with a magical quality that "warms people toward their fellow human beings" (Turner 2012, 3-4). Communitas can function as a social glue that binds strangers together. The emergence of communitas among volunteers, shown in part two of this chapter, reveals that the relationship between volunteers and recipients are not enacted in economic terms. I explore how the emergence of communitas as an invisible spirit, that "not yet externalized and fixed in structured form" allows communitas to be external to neoliberal rationalities (Victor Turner 1968 in Edith Turner 2012, 3). I describe how the spirit of communitas briefly emerges in volunteers' bodily sacrifice in order to place the needs of their patients first.

In sum, this chapter argues that Mission Smile's use of affect is a mode of governance where volunteers conduct themselves and others (see Rudnyckyj 2011). The manipulation of emotional states to determine action makes affect a useful tool for economic gains. On the other hand, communitas is a generative force that emerges through group interaction and engagement. Unlike affect that seeks to foreclose certain actions, the spirit of communitas generates an action with an endless range of

possibilities. This enables volunteers to feel empowered and connected to the patients they seek to help.

In the next section, I begin by locating volunteers' affective desire to help. I discern that volunteers respond to a moral and apolitical desire to attend to children without access to surgery. Volunteers claimed that healthcare is a right and they seek to provide surgery to those who need it, regardless of nationality or global politics. Identifying participants' affective motivation to volunteer is important as it sets the foundation for the way in which volunteers' affect can be made mutable towards the economic goals of Mission Smile, which I will address later.

5.1 "You can't change the world, but you can help": Locating volunteers' affective call to action

This section identifies the origins of volunteers' affective forces that compel them to volunteer with Mission Smile. Thus far, volunteers in this study have justified the need to help children with CLP to cope with the physiological limitations associated with CLP (see Chapter 3), and to alleviate stigma and suffering caused by CLP (see Chapter 4). All volunteers explained that they are responding to a moral call to provide CLP surgery to children without access. According to Emma, "universal access to resources is an important principle. It shouldn't matter on your culture, gender, on your religion, on your financials, socio-economic status. [We should] try to achieve it." Volunteers recognize the unequal global access to health and they seek to address this inequality by providing CLP surgery to those who cannot afford it.

Volunteers reject the economic and political discourses used to determine how healthcare ought to be distributed or who deserves it. Sherman problematized the unequal

access to healthcare in the Global North and South caused by the expansion of neoliberal rationalities to the domain of healthcare, which transforms health into a commodity rather than a right. Sherman points out that parents in the Global South encounter barriers to accessing healthcare as parents have to travel to "get a consultation, [they] have to go back [home] to save the money and to go back again to pay for the surgery that you know it's not a charity. [Parents] can't get there." Sherman views the application of neoliberal rationality to healthcare that lead to an unequal and unfair distribution of healthcare between the rich and poor that ought to be addressed.

Sherman further problematizes the unequal distribution of healthcare between the Global North and South. He explains:

> A child is innocent. Why should a child have to live through that [suffering] right? … [An unrepaired cleft] is not accepted here. You cannot have a 6-year-old who was born in North America, with an unrepaired cleft lip. That just won't happen because we won't let it. In India or the developing countries…there's so much else that's happening…The parents can't get their kids [treated], so what are you going to do? (Sherman, MD)

Sherman viewed children as victims of the state and larger global political, social, and economic forces which rendered the child's access to care unattainable (see Fassin 2011). As Sherman bluntly stated, in North America, an unrepaired cleft will not happen "because we won't let it." For Sherman, while children in North America have access to care to mitigate physiological impairments and avert suffering, children in the global south become victims of their circumstances.

Volunteers view children to be victims of larger political forces and they act on their affective sentiments to provide CLP surgery directly to those without access. Eddie, who pays for his personal equipment for the medical mission, explained why he decided to volunteer:

> If there's a country with poor people and if their government isn't going to take care of them for whatever reason, we can. […] I'm going to help this person as long as it's going to help this person. I always thought you can't change the world, but you can help in the little corner you're sitting in at the moment. […] Hopefully some of these people were helped. Because it helps those people more than it helps us here. (Eddie, Administrator)

Volunteers like Eddie recognize on a personal and local level that individuals are deserving of healthcare regardless of larger political and economic discourses that suggest otherwise. Identifying the universal right to healthcare is central to volunteers' affective desire to help. In this sense, volunteers' affective call to action is not conceived in terms of personal benefits, but in providing recipients access to healthcare that volunteers feel the recipients deserve. Although volunteers tend to view their work on a local level by conceiving their situation in terms of the number of lives saved (Pandolfi 2008, 160), I suggest that volunteers choose to disengage with these political forces in order to attend to their recipients.

Volunteers' apolitical desire to provide surgery led them to participate in medical missions. In the following section, I explore the ways Mission Smile fosters teamwork and camaraderie as a social glue that encourages volunteers to produce both a high standard and high volume of patients.

5.2 "They mesh together and become one entity:" Teamwork as an affective social glue

This section looks at the various practices Mission Smile employs to sustain their volunteer's affect in a way that encourages volunteers to provide a high standard of care for a large number of patients. I describe how Mission Smile is able to motivate their volunteers by orienting volunteers' individual affective desire towards a communal team

effort, where one's affective desire is materialized in a healed patient. In other words, the communal goals of the team align with requirements of performance indicators, where one healed child is registered as one output.

As an administrator, Michael, explained that the medical mission is designed so that volunteers "hit the ground running." He explained how utilizing volunteers' excitement and affective desire to help can be maximized to ensure volunteers remain focused and productive:

> If we arrive into the country at eight in the morning, we are seeing kids by noon. Like it's boom, boom, boom. So, you're working. The whole philosophy of that is that if you're exhausted, you'll just go to bed at night and you revert because of the time change, and you start off the next day. I tend to exhaust the team right away. I don't let them come in and have a day off. When we can we go to the hospital, we're going there to set up. We're going to physically do something. If we arrive at two in the morning, breakfast is at six and we're starting, it's a full day. There is no day to time change, to acclimatize. It may seem cruel, but it has actually worked out best. Because everybody is super excited, there is momentum. **Everybody is excited because they want to see the kids, they want to start working. And it just charges your system,** you don't even think about your 12-hour time change, you just go for it. (Michael, Administrator) [Emphasis added]

Mission Smile manipulates volunteers' excitement that prioritizes their role as productive volunteers. By putting volunteers straight to work, this administrator takes advantage of volunteers' excitement because "they want to see the kids." This utilization of affect is powerful as it "charges [the volunteers'] system" in two ways. First, it reinvigorates volunteers' existing affective motivations to help children in need of surgery. Even more, volunteers' existing excitement is propelled into an intense momentum that sets the pace for the medical mission. Second, this manipulation of affect acts as a way to control volunteer's bodies by denying them the opportunity to adjust to the new time zone, and in doing so prioritizes their role as productive volunteers. Mission Smile designs their

mission in a way that immediately reaffirms their affective goals and controls volunteer bodies to ensure productivity. While Mission Smile is able to further generate volunteers' affective excitement, the organization also works hard to maintain their volunteer's affective desire to help.

Mission Smile actively attempts to foster what participants describe as "camaraderie" and "teamwork." This emphasis on group collaboration enables Mission Smile to heighten volunteers' affective sentiments that in turn increases the organization's productivity. Using the language of teamwork, Michael further describes other practices Mission Smile employs that are related to productivity:

> I make sure the flow is good. Intake is good, there is no kinks. We communicate by walkie talkies. Just to check that everything is okay… And at the end of the day we have to debrief. What we've done for the day and how we can better improve. What are our hits and misses, that sort of thing, and how we can continually improve. I hear about the team, if there's anything. Usually if it's interpersonal, they will come to me personally. If they don't like their roommate, they snore, you know what I mean? Like somebody didn't get a diet coke, somebody wants mangos, they didn't like lunch, so you got to deal with that. All the team problem, so I'm there to support the team. (Michael, Administrator)

Michael is concerned with two aspects of teamwork. The first is to ensure smooth communication between different groups of medical volunteers. The process of receiving CLP surgery is viewed as a highly structured process as the patient goes through different stations from patient intake, to screening, to pre-op etc. Open and clear communication is perceived to be essential to creating a "good flow." Communicating on walkie talkies and debriefing at the end of the day is a strategy that Mission Smile employs to maintain efficiency and productivity.

Secondly, Mission Smile attempts to foster interpersonal relationships among volunteers that fosters a sense of camaraderie among volunteers. For example,

volunteers' roommates are preassigned to prevent social cliques, particularly along occupational lines, from forming.[7] Additionally, volunteers attend nightly group dinners that function as a team building and social activity. As volunteers' schedule defers, waiting for a fellow teammate becomes an opportunity for group solidarity to occur. As Sherman explains, "everyone as a group goes to dinner. I love that. This is not we're done [doing our part for the day and we say] *adios*. We are all [in this] together."

These practices Mission Smile implements allow volunteers to recognize that providing that surgery is a team effort and not a personal pursuit. The fostering of camaraderie functions as an affective social glue that enables volunteers to place their collective work before their personal needs. Emma explained how teamwork is understood through the individual roles each volunteer has, in relation to the larger work the organization seeks to achieve:

> It's a real teamwork focus on this (helping the patients). Other times it's busy and there's long periods of waiting for the OR to finish. […] Something that's supposed to take 2 hours is turning into 3.5 hours. It would be really easy to "[pufff] this is ridiculous, why can't we go home?" Home is where our bed [is]. You know, we don't break up the team. We're here for the patients, we are here for the family, but we are also here for each other. I guess it is what athletic teams are: they bond, they become their own organism. They are dispirited bunch of people, but they mesh together and become one entity. (Emma, RN)

As Emma explained, teamwork is essential to helping their patients. This recognition enables a "dispirited bunch of people" to be made into "one entity" wherein affective sentiments flow and circulate between each volunteer. By aligning her goals with that of the group (i.e. to help children in need), Emma was required to place her personal needs

[7] As mentioned in Chapter Three, there are three main volunteer groups: surgeons, pediatricians, nurses, and anesthesiologists. As new volunteers are recruited through existing networks, often along similar occupations, Mission Smile actively attempts to encourage all volunteers to socialize.

or unease aside to maintain a positive dynamic for teamwork to help the children in need. In this way, affect is a medium that individuals circulate where volunteers are governed through their own affect but also that of others (Rudnyckyj 2009, 2011).

Mission Smile manipulates the actions and goals of their volunteers by tapping volunteers' shared goal of helping the children in need. Combined with feelings of camaraderie that glues together a team with different backgrounds, volunteers provide a high standard of medical care. The integration of those components is best expressed by Liz:

> To do the best you can in the surgery for the children, as many as we can, and as much as we can. You know, we work hard and do as many as we can. Basically, they will look [at the surgical slate] and it's kinda tight to fit it in, but the doctors say, 'let's do it, let's get it done'. [It is] a lot of teamwork. (Liz, RN)

As Liz and other volunteers have pointed out, to "do as much" and to "do the best you can" requires cooperation from the team. The circulation of affective sentiments to help "the children" binds volunteers into what Emma describes as "one entity," sharing the same goals and executing the same high professional practice. Mission Smile uses affect to sustain the affective goals of volunteers, and to transform volunteers into productive members who not only work for what volunteers describe as 10 to 12 hour workdays but also what is beyond the regular demands and expectations of paid labour. Through the pulling of their affective heart strings, volunteers at Mission Smile consent to working beyond what is considered to be fair labour practice.[8]

[8] In addition, some medical mission volunteers have also worked in poor conditions, such as in windowless storage rooms, or in places without proper running electricity.

In the next section, I develop the final thread of the argument exploring how volunteers' affective desire to help is used as a fiscal tool. I show how affective desire is a financial resource used to maintain the organization's fiscal health.

5.3 "Doing free charity work at cost:" The cost of volunteering

Mission Smile manipulates volunteers' action to attend to the fiscal health of the organization. Volunteers are not only responsible for generating positive performance indicators by doing as many patients as possible, but they also bear the financial cost of attending a medical mission. In doing so, Mission Smile orientates volunteers' affective actions towards helping the children in need and towards the organization which makes caring for the patients possible. Mission Smile's relationship with their volunteers can be understood in economic terms, specifically as a business relationship, albeit an unequal one.

Volunteers bear the financial and personal cost of their affective desire to provide access to healthcare in the global south. If volunteers want to go on a mission, they have to pay. The most obvious cost is a fee, approximately $2000, that volunteers pay to Mission Smile in order to participate. Ron explained, some of the cost associated with volunteering:

> When you go on these missions as a physician, and the nurses who go are on leave as well…most of the people are taking their holiday time to go. Nobody gets to go on the mission, in fact you pay to go on a mission. You pay for your own airfare, and so you have to be aware of the fact that's part of the whole thing. So, to volunteer is not also volunteering your time, but you're always paying to go. (Ron, MD)

Despite volunteers' attempts to provide a public good, these missions often come at one's personal expense. As Ron explained, volunteers not only pay to attend these medical missions, they also use their personal leave to donate their medical expertise on these trips.

In addition, surgeons in this study who owned a private practice revealed they have to shoulder additional costs associated with volunteering. As William aptly commented, "I got to pay all that (overhead of running a practice) and I'm not earning any money, plus I'm doing free charity work at cost." Providing "free charity work at cost" is an oxymoron as charity implies giving a donation, and yet William highlights that he pays to provide charitable services to those in need.

For volunteers with families, going on a mission means losing the opportunity to spend time with their families. William describes the impact of volunteering on her family life:

> [It's] very hard on your family, I have missed many birthdays. These are the things that you sacrifice in your life to make sure these things happen. So, it's hard on your family. Sometimes marriages break up because of that. (William, Administrator)

In this way, volunteers' affective desire to address global inequality in healthcare becomes a family endeavour as they also have to bear the cost of providing access. Despite the various costs associated with volunteering, all participants in this study have attended a medical mission with Mission Smile at least twice. This suggests that Mission Smile is highly successful in capturing and retaining the affective engagement of their volunteers.

Scholars have studied the insidious use of affect as a tool to generate free labour in NGOs (Adams 2013; Muehlebach 2013). However, participants' awareness of this

exploitation suggests for Mission Smile that the intrusion of neoliberal rationalities is normalized. My conversation with Eddie revealed how his affective desire to help normalized paying to going on a medical mission:

> It did seem odd at first (to have to pay for a mission). Well, we're doing it for free, right? We're not being paid for it. And there's still a cost to get you over there. Well, if I pay that fees then [Mission Smile] doesn't have to pay to get me there. […] After a certain point, the whole Mission Smile thing, is there's work to do. You forget that you're not getting paid for it.
>
> I make good money in my job so I can buy all the additional equipment and tools, and that's what the other volunteers do as well. If you look around the room, everybody's here but nobody has to be. It's not your job, nobody has a contract to be there. But they're there because they want to do it. And they (the organization) assigned work, and it is hard work. It's hard to explain unless you do it. Nobody will go, "neh I'm staying home today, I'm phoning sick today." Although do you do miss a few days because you get sick over there, but nobody's taken a day off because they're tired. It's weird how you just accept that's what you're going to do, or you wouldn't do it. (Eddie, Administrator)

Eddie revealed how the financial burden of volunteering becomes naturalized as part of the discourse of care. Relegating the financial burden onto volunteers enables Mission Smile to demonstrate accountability to their recipients, donors, and volunteers. As Eddie explained, by paying the fees Mission Smile does not "have to pay to get me there." Eddie incurred the cost of the mission so he can direct more of their proceeds towards the medical program. In this way, volunteers' affective desire to help is extended to maintaining the welfare of the organization. Volunteers seek to maintain the organization's fiscal health, demonstrate accountability, and produce social good. However, this means that volunteers are often left vulnerable as they participate in the medical mission at their own expense.

Wendy Brown highlights the large-scale problems of global health inequality, caused by the rolling back of public healthcare services, are sent down the pipeline to

individuals to cope with them technically, politically, or financially (Brown 2016, 9). Mission Smile passes the moral burden of power and authority onto their volunteers. Consequently, volunteers are not only responsible to their own personal welfare (managing the associated cost of participating in a mission) but they are also accountable to their patients, and even the organization itself, to conduct a high volume of surgeries and positive patient outcome.[9] In this way, Mission Smile sees their relationship with volunteers as a business partnership, albeit an unequal one, which mutually satisfies their respective goals (Brown 2016; Gershon 2011). In exchange for materializing volunteers' affective desires, volunteers have to become financially and morally responsible for their patients, the organization, and their own participation. However, as volunteers bear the various costs of participating in the medical mission, it also leaves volunteers vulnerable to other social and economic demands, such as maintaining one's private practice and managing one's family life and childcare.

Thus far, I have located volunteers' affective desire to help provide surgery to those who cannot afford it. I have identified how Mission Smile manipulates volunteers' affective sentiments in two ways. First, Mission Smile uses volunteers' affective sentiments to produce a highly productive team. Second, by engaging in volunteers' affective sentiments, Mission Smile shifts the financial and moral burden of providing healthcare onto volunteers. Yet, as Richard and Rudnyckyj (2009, 59) have pointed out, the possible courses of action predisposed by affective states can never be completely determined. In the next section I look at the volunteers' experience of communitas and I move beyond viewing affect as a means to expand on neoliberal rationalities into the

[9] See Brown (2016) concept of devolution and responsibilization

domain of humanitarianism. I explore the ways volunteer affective desire to help can sit within, and go beyond, the purview of neoliberal rationalities.

5.4 “Let's put this in perspective, and do your feet hurt now?” Humanizing medical care

After hearing about the long hours and trying conditions of volunteer missions, I found myself asking participants “so what keeps you going?” What emerged as a theme is solicitude, and a feeling of concern and passion, that motivates volunteers. In this section, I show that volunteers and recipients develop a moral relationship with their recipients, a relationship that Mission Smile volunteers describe as outside of economic calculation and neoliberal rationality and where the needs of the recipients are placed first.

The recognition of trust patients and their family place on the team is foundational to this moral relationship. The weight of this moral relationship is expressed by Sherman: “what we're doing [surgery] is akin to assault and battery. But because the patient is allowing us to do it, or is giving us consent, we have the privilege of giving them care and caring for them.” In a similar vein, Ron, who was mildly frustrated when having to explain to me the significance of a “one-to-one relationship” doctors build with their patients, told me firmly:

> What you have to appreciate is, it's a privilege to do this, okay. It's a privilege to have the skills to be able to do it, and to go out and have somebody have the trust to allow you to do it [perform surgery], and that must never be forgotten. It's very emotional. (Ron, MD)

Knowing that surgery is “akin to an assault” where physical pain is inflicted onto their patients, both surgeons described their ability to care for a patient as a “privilege.” Both

Sherman and Ron's narratives express strong feelings, or "privilege," with the trust that their patients confer to them. At the heart of the mission, "trust" and "care" animate and orient the work volunteers do. Providing surgery is not merely a cold, bureaucratic and technical fix to a physiological problem. Rather, volunteers' action is driven by moral values of care that enact the humanistic promise of medicine (Livingston 2012).

Volunteers' moral commitment towards their patient is reflected in the ways they choose to endure physical discomfort. As an administrator who has participated in many medical missions, Eddie has observed the way volunteers hold their feet to ease their physical discomfort caused by long hours spent in the operating room:

> I have [photos] of them (medical volunteers) standing in the operating room for hours and hours at the table. And they keep shifting their feet. You know when you have to stand forever? You see the doctors and the different ways they hold their feet. Just different combinations of it. They can't just walk away - their hands are in somebody's face! …. [they are in so] much discomfort while they are working. (Eddie, Administrator)

This physical pain and discomfort that volunteers endure from working for more than 10 hours a day reflects volunteers' commitment to providing care to their recipients. Moreover, volunteers' affective engagement comes at the expense of their body. Nancy, an administrator, reflected on her first medical mission, "I didn't expect to one day hit the wall. I think it was mid-way [into the mission] and they say, 'you don't look so well.' […] But generally speaking, people don't expect the exhaustion." Volunteers live out their affective values by choosing to endure physical discomfort.

Volunteers often see themselves as being part of a child's journey as they endure the physical discomfort to provide care. As a charismatic team player, Michael often encouraged his exhausted team by reminding them of their affective destination, to

witness a child's recovery. He encouraged them to hold on until "clinic day," when parents bring the children back for a check-up:

> You know, the bottom line, the reason why I do this is my ability to help the children. At the very, very end, even when people are exhausted, they just can't do it. People just cry, everybody just cries. And the males tend to get angry, the emotions are just "arghhhh!!!" And I just say, "just hang in there, hang in there for clinic day. When the kids come back almost healed, they look completely different, and you see the families how happy they are, you see the kid [transformed]." (Michael, Administrator)

Michael reminds volunteers that their technical skills give them the "ability to help the children" and the exhaustion they endure is integral to a child and their family's journey towards recovery. In this way, Michael encouraged volunteers to see themselves as part of a child's journey. This sentimental relationship that volunteers develop is best illustrated by Emma who developed a relationship with an 18-month-old girl and her parents. She told me, fondly and emotionally, about seeing the parents and the girl on the last day of the medical mission:

> I'm sitting on the bus and all of a sudden, I turn and look, there's the dad with the little girl. He's smiling at me and she's smiling at me. I blow kisses and she blows kisses back and I'm going to cry [Emma says that in an emotional voice as she laughs]. We had done something that caused discomfort and so often pain is for a short period of time, it's not nice, but we're going to pass this, we are going to do things that help you get past it. She's here and she's in her dad's arms, she's happy. (Emma, RN)

Like other volunteers, Emma recognized that surgery involves inflicting pain on the child. In recognizing and acknowledging a child's pain, Emma became part of the child's journey to "help [her] get past it." In other words, Emma was physically and emotionally moved to action by her empathy. For Emma, to be able to receive and give kisses from that little girl became a testimony of the sentimental work she had performed as she was

remembered as someone who has, quite literally, provided a personal touch to that child's care.

Volunteer's affective desire to help is at the center of the moral relationship they have with their recipients. In their desire to help, Mission Smile volunteers were physically and emotionally moved by the recipient's resilience and determination to have surgery. In this way, volunteers were moved to empathetic and practical action. This is best articulated by Michael:

> You know, you really want to- you really want to help somebody. You could be tired, because you've worked 14 hours. You want to sit down because your feet hurt. And then it's like this family just walked 200km to get their child fixed, **let's put this in perspective and do your feet hurt now?** And some people will say yes, and they don't care because they've shut down. Other people who are like-minded understand what that means, will go, "bring that child through." You've got to have the same drive, that same passion for - the same amount of passion for life, for what we do, I guess. That's what we want to do. We have the same amount of passion for that life. (Michael, Administrator) [Emphasis added]

Michael showed that volunteers center their action based on the needs and wellbeing of their recipients. Therefore, volunteers at Mission Smile put the needs of their patients and their family into perspective. This is in contrast to aid workers at the International Finnish Red Cross, whose actions, as described by Malkki, are centered on the volunteers' sense of self, or a "self-to-self" relationship (Malkki 2015, 4). Malkki explains that the actions of aid workers are based on the need for self-escape, self-pleasure, and a care of the self. As I have shown, volunteers at Mission Smile are focused on "them" – their patients. In recognizing their patient's laborious search for surgery and the trust they place on the team, the "self" is not at the center. Instead, volunteers are reminded to place their physical discomfort into perspective, and to ask themselves, "do your feet hurt now?"

5.4.1 “It’s magic”: The joyful and magical aspect to volunteering

As an emotional counterweight to the experience of pain and exhaustion illustrated in the previous section, volunteers repeatedly and consistently found “joy” and “magic” when witnessing a child’s transformation. I argue that providing surgery as a right to those who cannot afford to receive surgery challenges the commodification of healthcare, and forms the foundation for communitas to emerge. In other words, providing surgery to those who lack access is fundamental to the emergence of the joy and magic that volunteers experience.

For volunteers, a celebration of humanity is what the spirit of communitas encapsulates in their mission work. While volunteers perform the same duties they do at the hospital, volunteering at Mission Smile feels qualitatively different, as Theodore explained:

> When you go on a mission it's a feel-good opportunity, it's an opportunity for you to reconnect with why you do this work. A lot of times we get stuck - even though it's what we do all day every day is helping people; it seems a lot more like a job. When you're away and you're doing it. It feels like it gets to the core of the situation and the level of the potential opportunity you create for patients is much greater. (Theodore, MD)

Other volunteers often described children before and after surgery as “transformed,” “empowered,” “reborn,” and to have “possibilities.” Michael described volunteers’ emotions on clinic day: “you see the satisfaction of the team, that they realize, ‘holy shit we [did] something good here. This really was worth it!’” The grand emergence of a shared communitas, a collective joy with a magical quality, cushions the physical and material suffering that volunteers go through.

Volunteers also find communitas in the promise that surgery will transform children's lives. Volunteers view surgery as life-altering, causing a disjuncture between a child's past and their future. Volunteers often describe this disjuncture in magical terms. For example, Eddie compared parents' experience of waiting to hear if their child qualified for surgery to feelings on Christmas morning:

> They come from huge distances …, and they're the poorest and they come all the way down there. [It all comes down to] this is the decision, on literally on which way the kid's life is going to go, and the family. This is Christmas morning on whether you get socks or a rock. It's such an important thing. […] When you see the ones where you say: yes, we're going to be able to do this. Yes, we're going to fix the child properly. This is what we're here for, for your child - it's a good Christmas. And you see the joy, you can see the relief on the family. And their life is now changed, their whole family's life changed because of this. And that's what everybody's there for. That's just emotional. (Eddie, Administrator).

Eddie's story encapsulates the spirit of communitas where to receive surgery is a magical, life-changing gift especially when patients would otherwise be unable to access it.

Sherman described this promise of change as "empowerment" that is made possible with surgery. He animatedly described this transformation, particularly among older children, in magical terms:

> All of a sudden you can see that this child, **they have been zapped by Thor's hammer, there's this power in them**. There's this confidence and they're like: I'm good, I'm going to do something. And whatever that something is, it doesn't matter. But what it is [that matters], is that these kids now feel that they can do it. (Sherman, MD) [Emphasis added]

Sherman compared receiving surgery to being "zapped by Thor's hammer." This description confers the image of a child's body becoming empowered as they absorb the flash of light and energy from Thor's hammer, Thor being a hammer-wielding god of Germanic mythology commonly associated with power and strength. While volunteers aren't always sure of the extent to which surgery will change a child's life, the

communitas that transpires stems from the belief that “these kids now feel that they can do” whatever they want to do. Therefore, it doesn’t matter what a child does with this power, what matters is that the child has become empowered with the ability to do something which was not possible before. For volunteers, the joy and magic that arises from communitas is a celebration of human connections and relationship that goes beyond class, race, and nationality. Communitas is central to volunteers’ experiences. The feelings of exuberance drives and motivates volunteers to consider how care ought to be provided

As I have illustrated, a central component to volunteers’ engagement is to provide healthcare as a right. In their attempt to provide surgery to children regardless of ethnicity, nationality, economic status, or religion, Mission Smile volunteers actively choose to disengage with the political and economic discourses that influence the distribution of healthcare as a commodity. As Sherman, who previously commented that it is unacceptable to have an unrepaired cleft in North America remarked “we are all people, we are all the same. Why should one group have something and not the other?” This experience is best captured by Daniel, an administrator:

> HH: So why do you think people are interested in being part of Mission smile?
>
> Daniel: Well, so they can give back. The team members are really, really interested and they feel really happy when they see the difference. They know that we are making a difference in a child's life, and the family's life and the community. Not just a kid, it's their family, and everything else. I witness it through my camera, I see the care and love from the nurses and the doctors, the anesthesiologist and everybody who is involved. How they care for these kids, and how they give the best care they can, which is really gratifying because **we are so lucky here with our access to healthcare. And they don't have that there so we can give them what we have, to the best we can, right?** (Daniel, Media Administrator) [emphasis added]

The exuberant emotional force in the way participants, like Daniel, talk about the "care" and "love" they bring in order to "give the best care they can" is central to the emergence of communitas. Volunteers' joyful experience in "know[ing] that [they] are making a difference in a child's life, and the family's life, and the community" allowed volunteers to be proud to be human in a world fraught with inequality where there is little to be proud of (Turner 2012, 65).

Scholars such as Adams (2013b), Muehlebach (2012), and Rudnynkjy (2011) have argued that neoliberalism can accommodate seemingly oppositional practices and values that work to serve neoliberal ends. It can be argued that volunteers' moral commitment towards their patients and their experience of communitas does indeed align with the financial and moral goals of Mission Smile. Through their moral commitment, volunteers seek to provide a high standard of surgery to as many patients as possible. In other words, volunteers' experience of communitas can be interpreted as a form of self-government that renders one's self-interest irrelevant and the moral relationship that volunteers develop with their recipients were "harmonized" with the broader collective interest of the organization (Rudnyckyj 2011, 171).

However, I argue that the way respondents talk about communitas is at the same time external to the economic calculus proposed above. As Turner points out, the unexternalized spirit of communitas warms people towards their fellow human beings because it "overrides psychological and sociological constructs" and renders one's pride and social status irrelevant (Turner 2012, 3). Mission Smile volunteers who "give [the children] what we have" experience a collective joy as they attempt to provide healthcare as a right for all. This is in contrast to volunteers in Muehlebach's ethnography, whose

affective call to action is based on a generic expression of love, pity, and solidarity towards another citizen, which does not confer equal status to recipients (Muehlebach 2012, 46). Communitas, does not define itself in exclusion to others, rather it is conceived for everyone, for humanity.[10] For Mission Smile volunteers, their ability to provide healthcare as a right is accompanied with feelings of exuberance as children with CLP are poised for a new future. In other words, the ability to extend healthcare as a right to those without access and the provision of surgery in which child's life is "transformed," "empowered," or goes through a "re-birth" is understood by volunteers in magical terms where they promise, and deliver, the possibility of equal status to recipients.

5.5 Conclusion

In this chapter, I located volunteers' affective desire to provide children with CLP surgery which they would otherwise be unable to afford. I looked at the multiple ways Mission Smile uses volunteers' affective desire to help children in need can become imbricated with neoliberal rationalities as it is used as a tool to generate free labour (Adams 2013; Muehlebach 2012) but to also bear the fiscal cost associated with participating in a medical mission. In the second half of this chapter, I looked at how volunteers articulate their experience of communitas that goes beyond neoliberalism. I showed that volunteers engage in a moral relationship with their recipients that places the needs of their patients before their own physical comfort. Moreover, by providing medical care that would otherwise have been inaccessible, volunteers described their

[10] See Turner 2012 for comparison between communitas and Durkheim's solidarity that Muehlebach employs in her work on Moral Neoliberalism

patients, before and after surgery, in joyful and magical terms. The emergence of communitas reveals the relationship between volunteers and recipients is not viewed in economic terms.

At the beginning of this thesis, I described the ways in which the moral and apolitical nature of humanitarianism needed to be interrogated. Scholars such as Adams (2013), Redfield (2013), and Keshavjee (2014) have debunked the myth of a purely apolitical humanitarian relief. They have looked at the ways larger politics and economic forces undergird the provision of aid. In this chapter, I have showed that while neoliberal rationalities can converge with values of humanitarianism to serve a neoliberal end, volunteers articulate their affective experiences to be external to economic calculation. While volunteers' actions and experiences are shaped by neoliberal rationalities to "do free charity work at cost" or "do as many [children] as possible," these neoliberal practices do not diminish volunteers' moral desire to help. This is evident through the emergence of communitas, as volunteers experience joy as they see children transform like "they've been zapped by Thor's hammer." The coexistence of these neoliberal rationalities and the moral desire to help is best expressed Liz: "It gives me the joy that I was able to give a little bit of my time, my knowledge, and my skill to improve somebody's life and somebody's happiness, it's worth a lot."

Chapter 6: Conclusion

This thesis has revealed the ways neoliberal rationalities percolate throughout Mission Smile, a humanitarian organization that claims to be motivated by values of charity. I have shown how neoliberalism, as a cultural and moral framework, applies an economic calculus through a mundane set of practices into the domain of humanitarianism that was previously excluded from the market. Unlike many scholars (Adams 2013b; Kevshavjee 2015; Malkki 2015; Muehlebach 2012; Pandolfi 2008) who speak to the oppressive and exploitative effects of neoliberalism on volunteers and their recipients, I have shown how volunteers and employees at Mission Smile continue to be engaged in care and empathy as they navigate the various moral and ethical intricacies in providing surgery to those without access.

I showed how Mission Smile's effort to communicate moral and fiscal accountability to their donors, through the use of metrics, has made neoliberal practices the norm in other areas of the organization. The goal of the organization is construed through performance indicators to "help as many children as possible," which has led to the subsequent use of triage or a utilitarian approach to distribute care. Under the trying circumstances that Mission Smile operates, the organization's effort to maximize the greatest amount of good for the greatest number of patients do not always serve the best interest of their patients.

Neoliberal rationalities also influence the way Mission Smile views their recipients and volunteers in economic terms. Despite Mission Smile's claims on providing surgery to alleviate physical and social suffering associated with CLP, in reality, surgery functions as an investment in a child's future. In other words, Mission

Smile attempts to transform children into productive workers in the future. In addition, Mission Smile develops a business-like relationship with their volunteers. Through the use of affect, the organization manipulates the actions of their volunteers toward an economic end by engaging to help as many children as possible. Volunteers are encouraged to work beyond the regular demands of their paid jobs and endure physical pain in order to support the organization's performance.

However, this research reveals that the extension of neoliberal rationalities into new domains do not reduce all relationships and ethical dimensions of life to an economic calculus. While I have shown how Mission Smile uses neoliberal practices to demonstrate fiscal and moral accountability as a humanitarian organization, I have also revealed that the application of neoliberal does not fully explain the affective experience described by respondents. The emergence of communitas as an exuberant force is central to volunteer experiences. As an affective experience, the emergence of communitas is an uplifting and vigorous force that influences the way in which Mission Smile volunteers think, feel, and act. Future scholarship could explore the role of affect more fully, addressing the power of communitas in volunteer practice in order to shed further light on the place of neoliberalism within moral and ethical practices in the field of global health.

Limitations of research:

Unfortunately, this study lacked perspective of volunteers who are pediatricians and anesthesiologists. Therefore, there is potential to enhance and enrich the present study by including the perspectives of both groups of volunteers. Moreover, volunteers who agreed to participate in this study have volunteered at least twice with the

organization. As such, these participants have demonstrated their commitment to the values of the organization. A more diverse perspective of volunteers including those who did not return to the organization would allow for a more nuanced understanding of Mission Smile.

Future directions:

Future directions of research could include a more detailed ethnographic study, such as the study of medical missions to understand the various tactics volunteers employ to negotiate, resist, and challenge neoliberal logics and expectations that were imposed onto them. It would also be fruitful to include the perspectives of recipients to understand how patients and their families understand the provision of care provided by organizations like Mission Smile, and the extent to which power inequality between volunteers and recipients are challenged. Finally, a comparative study between large cleft organizations like Operation Smile and Mission Smile could reveal how neoliberal logics are embedded within both types of organizational structures. More importantly, it would be useful to understand how volunteers in large cleft organizations engage in the moral and ethical complexities of providing care in a highly bureaucratic, technocratic, and neoliberal environment.

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Appendix

Appendix A: Informed Consent Form

University of Victoria

Participant Consent Form

Providing Cleft Lip and Palate Treatment and Volunteer's Experiences

You are invited to participate in a study entitled "Providing Cleft Lip and Palate Treatment and Volunteers' Experiences" that is being conducted by Hilary Ho. Hilary is a graduate student in the Department of Anthropology at the University of Victoria, and you may contact her if you have further questions by email at ___. As a graduate student, Hilary is required to conduct research as part of the requirements for a degree in Anthropology. It is being conducted under the supervision of Dr. Leslie Butt. If you have any questions, you may contact her supervisor at__.

Purpose and Objectives
The purpose of this research project is to understand how international non-governmental organizations identify the need to provide cleft lip and palate treatment and what is the goal of treatment, as well as to understand volunteer's motivation in volunteering, their role, and their perspectives and feeling towards providing free cleft lip and palate treatment patients.

Importance of this Research
Your voices as employees and volunteers who run humanitarian programs often receive little attention. Your participation is important to understand the importance of delivering of cleft lip and palate treatment and to understand the process and experiences of delivering treatment to recipients.

Participants Selection
You are being asked to participate in this study because you are an employee or a volunteer at an international non-governmental organization that provides treatment to individuals with cleft lip and palate.

What is involved

1. **Interviews:**

If you consent to voluntarily participate in this research, your participation will include an interview that will last between 30 to 90 minutes. You will be asked about your views on

promotional materials for recruiting donors and volunteers, your views on the need to provide cleft lip and palate treatment, and your role and experience as an employee or a volunteer.

- ☐ I agree to participate in the interview

Audio-recording and note-taking for interviews:
With your permission, an audio recorder and written notes will be used to record your responses.

- ☐ I agree to have my responses recorded using an audio recorder for transcription purposes.
- ☐ I agree to allow notes, including observational notes, to be written down during the interview.

Inconvenience
Participation in this study may cause some inconvenience to you by taking time out of your schedule to take part in this interview.

Risks
There are no risks in your participation. However, if you feel uncomfortable about answering any question, we can take a break, skip a question, reschedule, or end the interview.

Confidentiality
Your confidentiality and the confidentiality of the data will be protected. A pseudonym will be used, personal identifiers will be removed, and details will be generalized to ensure that you cannot be personally identified anywhere in this research.

However, full anonymity of your participation in this study cannot be guaranteed if you were recruited through acquaintances. Nonetheless, your responses shared in this study will be kept confidential.

Voluntary Participation
Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study, all the data collected will be destroyed.

Dissemination of Results
It is anticipated that the results of this study will be shared with the University of Victoria as a thesis, which they will publish online through their library system. It is also possible that this research will be used in journal articles and scholarly presentations. In presentations and publications based on this study, quotations from interviews and observations from time spent together might be used. The data collected here may be used to prepare a report that will be sent to the organization involved in this study and to other non-governmental organizations who could potentially benefit from this research. Personal details will be changed so that while it is highly unlikely for others to recognize you, you may recognize yourself. If you wish, you can receive a summary of the study's main findings when it is completed.

Disposal of Data

No information about you will be made public. Data such as observations and transcripts will be removed of personal identifiers. All data from interviews will be stored on a password encrypted computer and hard drive. Data from this study will be disposed of once I have completed my thesis project and published results from it. Data from this study will be destroyed by 2025.

Contacts

If you have additional questions or concerns on the ethical approval of this study that cannot be addressed by me or my supervisor, you may contact the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca).

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researchers, and that you consent to participate in this research project.

Name of Participant	*Signature*	*Date*

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Appendix B: Recruitment Email

You are receiving this email on behalf of Hilary Ho. Mission Smile has agreed that the organization will participate. Your participation is completely voluntary and there are no negative impacts for declining or participating in this study.

***

Hello, my name is Hilary. As part of my master's thesis at the University of Victoria in Canada, I am doing a research project to understand how non-governmental organizations that provide cleft lip and palate surgery operate. I also seek to understand volunteers' motivation in participating with the organization.

If you are a medical volunteer or if you have volunteered in photography, social media, or event planning within the last five years and are over the age of 18, I would like to talk to you. I will talk to you about your interest in volunteering, your role as a volunteer, and your perspective and feelings towards providing cleft lip and palate surgery.

If you decide to participate, you will be interviewed. The interview will last 45 to 90 minutes. Participation in this project is completely voluntary, and there are no risks associated with your participation. I will ensure that your responses shared in this study will be kept confidential. However, due to the small size of the community, your participation in this study may not be kept confidential.

If you would like to participate in this study or if you have any questions, please contact me at _____.

Appendix C: Selected questions from interview protocol

1. Can you tell me what you do as a volunteer for Mission Smile?
    a. How did you become interested in paediatrics?
2. How you became part of Mission Smile?
    a. Were you involved in a similar NGO before this one?
3. In N. America, what do you think having CLP means?
    a. How do you think having CLP is affects a child in developing countries?
    b. What happens if these patients do not receive care?
4. how would you differentiate between CLP surgery as cosmetic vs medical treatment?
    a. Do you believe that it is important that surgery should be free?
5. Can you describe what a medical mission is like for you?
    a. What do you enjoy most about going on a mission?
    b. How is practicing your profession different N. America compare with in the host country?
6. Can you tell me about a patient that left an impression on you?
    a. If you could describe the transformation of a child before and after surgery with an adjective, what would it be?
7. What in your opinion what makes a treatment successful?
    a. Did families or recipients thank you for your work? How did you feel?
8. Knowing how transformative surgery can be, can you tell me what turning patients away is like?
    a. How do you tell the child's guardian that they were rejected?
9. I am also learning about Mission Smile's identity as an organization – in comparison to other NGOs. How is Mission Smile different from other NGOs?
    a. What are some of challenges you encountered on a medical mission?
10. Would you volunteer at a different NGO that does similar work?
11. Would you, or, why did you decide to go for another medical mission?
    a. Can you tell me what do you need to consider you need before going go on a medical mission?
    b. Do you foresee any reason that might prevent you from volunteering again?

That was my last question. Did I left out anything you think I should know? Do you have any questions for me?

Thank you for your time!