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Table of Contents

Abstract

The transnational mobility of people, information, and resources is critical to the success of nonprofit international development projects. Ensuring effective transnational flows arguably takes on greater salience for grassroots international nongovernmental organisations (GINGOs), as these organisations and their leaders are unlikely to have a full-time presence in their intervention sites, instead tending to have short-term, episodic presences in the communities they serve. This is especially true among GINGOs active the health sector that provide healthcare services transnationally in the form of medical mission trips and temporary clinics. This paper presents findings from an ongoing interview-based project with health GINGO leaders, focusing on how they coordinate organisational activities from afar with local implementing partners in their chosen developing country intervention sites. I argue that GINGO leaders' level of medical expertise and immigrant status are important determinants of how interactions with local implementing partners take shape, which variously simplify or complicate transnational coordination of organisational activities. In making this argument, I apply a Bourdieusian relational framework to illustrate how these two factors shape their habitus and deployment of capital, which affect field-level interactions with local implementing partners.

1. Introduction

Private sector firms have experienced, and continue to experience, radical transformations in organisational activity as globalising forces create new means to connect with distant actors. The nonprofit sector is no different. Cheaper and easier access to international travel and advancements in information and communication technologies, for instance, have allowed formerly domestically oriented nonprofits to broaden their activities to reach distant populations abroad, create new initiatives to meet their needs, and establish partnerships with organisations located outside the United States to coordinate activities.

These same globalising forces have also facilitated the emergence of grassroots international nongovernmental organisations (GINGOs), a nonprofit organisational form in which ordinary citizens who lack prior training or experience in international development and nonprofit management undertake small-scale aid projects in developing countries. Indeed, globalisation has increasingly allowed lay Americans to forge "global ties through immigration, tourism, volunteering, study, work, and adoptions," and these ties have resulted in "the multiplication of grassroots relief and development organisations that operate independently from established development institutions" (Schnable 2015, 310; 2021).

One of the key features, among many, that distinguishes GINGOs from traditional, mainstream international nongovernmental organisations (INGOs) is that their projects tend to be short-term and intermittently implemented according to their leaders' available time and energy. In other words, for many GINGO leaders, their activities in developing countries do not constitute full-time work and instead are largely passion projects. This creates unique tensions with respect to coordinating organisational activities since, unlike mainstream INGOs that operate year-round in their intervention sites, GINGO leaders must remain in contact with local implementing partners and beneficiaries in developing countries while simultaneously attending to the demands of their full-time careers and personal lives in the United States. How do GINGO leaders, then, engage in effective transnational coordination with local implementing partners? And what accounts for differences in the strategies that GINGO leaders deploy in such coordination efforts?

This paper analyses how GINGO leaders maintain relationships with local implementing partners when they are unable to be physically present in their chosen intervention sites by examining four cases of GINGOs that provide healthcare services abroad. Drawing on interviews with these GINGOs' leaders[1], I find two factors have especially profound effects on how transnational project coordination and implementation unfold: the extent of leaders' medical expertise and whether leaders themselves are natives of the countries they support. I situate and present these findings within a Bourdieusian relational framework, borrowing Bourdieu's concepts of field, habitus, and capital, to demonstrate how medical expertise and immigrant status variously enable and constrain GINGOs' ability to work effectively in their intervention sites.

1 These cases were purposefully selected from a separate, broader, ongoing interview-based project on GINGOs active in the health sector, in which organisations were randomly sampled from IRS databases.

2. Background

2.1 Grassroots international nongovernmental organisations (GINGOs)

Grassroots international nongovernmental organisations (GINGOs) – sometimes also referred to as "private development initiatives" (e.g., Kinsbergen, Schulpen, and Ruben 2017; Kinsbergen, Tolsma, and Ruiter 2013; Kinsbergen et al. 2013) and "citizen initiatives" (e.g., Schulpen and Huyse 2017) – have many defining characteristics, primary among them being their founders' lack of prior background, experience, or expertise in development (Schnable 2021). Detached from the professionalised, mainstream development field, GINGO leaders follow a different approach to aid delivery, one that emphasises "expressive" over "instrumental" strategies and outcomes in the provision of aid (Frumkin 2002; Schnable 2021). This expressive approach is reflected in GINGO leaders' and volunteers' desire to "connect" and establish emotionally rewarding interpersonal relationships with beneficiaries, which oftentimes takes precedence over instrumental goals like enhancing project efficiency and effectiveness (Fechter 2012; Fechter and Schwittay 2019; Kinsbergen, Tolsma, and Ruiter 2013; Schnable 2021).

GINGOs' insulation from the professionalised, mainstream development field is also apparent in their funding sources. Rather than securing grants from bilateral and multilateral aid agencies, private foundations, and large corporations, GINGOs are largely self-financed and depend on donations from personal networks of family, friends, neighbours, coworkers, and other community members to sustain their activities (Schnable 2021; Schnable, Appe, and Richardson 2022). This reliance on personal networks for revenue is compatible with GINGOs' expressive aid approach, as leaders and volunteers regularly communicate the emotional rewards they experience in the aid delivery process to potential donors, who become enamoured by such stories and subsequently offer donations. Since these funds, however, often come from individuals' contributions, GINGOs operate on small, shoestring budgets of typically less than USD250,000 per year (Schnable 2021).

Running on meagre budgets, GINGOs' projects tend to be small-scale and emphasise direct service provision and meeting basic needs. Indeed, a recent survey of small-sized international nonprofits found that these organisations are most likely to implement such projects as providing school supplies and scholarships, donating medical supplies and equipment, and building structures like schools, clinics, and orphanages in their intervention sites (Schnable, Appe, and Richardson 2022). These project types are amenable with expressive modes of aid delivery since their effects are directed at the level of individuals, thus facilitating the interpersonal contact that GINGO leaders and their supporters seek. In contrast, professionalised, mainstream INGOs are more likely to implement projects that elicit effects at the community and societal levels. Their work is therefore characterised less by service provision and more by advocacy initiatives and multi-stakeholder collaborations. These interventions are more likely to address the structural sources of underdevelopment rather than its immediate, tangible effects on beneficiaries.

Clearly, GINGOs differ from mainstream INGOs by way of their expressive approach to aid delivery, funding sources, and small-scale projects. Concerning issues of transnational coordination, however, two additional characteristics that distinguish GINGOs from mainstream INGOs play a more central role. The first is the kinds of skills, interests, and expertise that GINGO leaders bring to their organisations and aid activities. The leaders of mainstream INGOs are quite homogenous in their skillsets and stocks of expertise due to their shared forms of training (e.g., graduate degrees in development- and managerial-related fields). GINGO leaders, lacking a professional identity and expertise in these fields, instead have unique skills and expertise that reflect their heterogenous occupational backgrounds, which often get put to

use in their aid activities (Schnable 2021). For example, teachers from developed countries often establish GINGOs to deliver education projects in developing countries, and GINGO leaders with medical credentials and expertise in their home countries frequently organise medical mission trips and establish clinics in the developing countries they serve. The latter examples of medical personnel establishing GINGOs to deliver healthcare services abroad will appear in the forthcoming GINGO cases I describe and analyse. Within these cases, however, GINGO leaders vary in their levels of medical expertise, which subsequently affect how they interact and coordinate activities with local implementing partners in their intervention sites.

The second distinct GINGO characteristic that bears relevance for issues of transnational coordination is how their leaders select intervention sites. Mainstream INGOs' choice of intervention sites, as well as the kinds of projects they deliver, is largely determined externally by their donors. That is, donors are the agenda-setters, identifying projects they seek to fund, and then disburse funds to INGOs that have the technical capacity and accountability infrastructure (i.e., monitoring and evaluation [M&E]) to effectively and responsibly fulfil their vision (Banks, Hulme, and Edwards 2014; Swidler and Watkins 2017). Put differently, professionalised, mainstream INGOs align their projects with donors' preferences, and such alignment includes not just project type but also invention site.

GINGOs, on the other hand, choose their intervention sites according to past experiences with international travel, including vacations, study abroad, business trips, and volunteering with other international nonprofits (Schnable 2021). These countries tend to be poor but reasonably stable, and are most commonly located in sub-Saharan Africa, Latin America, and the Caribbean (Schnable forthcoming; Schnable, Appe, and Richardson 2022). When GINGO leaders are immigrants living in developed countries, however, they are likely to deliver projects in their home countries of origin. For example, Appe and Oreg (2019) study the case of "Lost Boy" refugees who immigrated to upstate New York from South Sudan and subsequently established nonprofit organisations to support their homeland communities. This form of immigrant-led aid delivery, in which immigrants transfer private donations, services, and other resources back to their home countries, has been referred to as "diaspora philanthropy" (D. W. Brinkerhoff 2008; J. M. Brinkerhoff 2011; Doherty Johnson 2007; Espinosa 2016; Flanigan 2017; Newland, Terrazas, and Munster 2010). The diaspora philanthropy literature notes that immigrant organisational leaders have unique reasons to give back to their home countries, including a sense of obligation from having attained a better quality of life elsewhere (J. M. Brinkerhoff 2011), emotional longing for the homeland (Flanigan 2017), status purposes (e.g., fame and recognition from acts of giving) (Sidel 2008), and a desire to transfer knowledge and skills that diaspora communities have come to attain (J. M. Brinkerhoff 2008; Sidel 2008), among other motivations. These unique motivations create qualitatively different kinds of relationships between immigrant-led GINGO leaders and their local implementing partners and beneficiaries, which, as my analysis will reveal, affect project coordination from afar.

In summary, GINGOs are a unique organisational form that allow ordinary citizens without experience or expertise in development to participate in international aid delivery and altruism. They differ from mainstream, professionalised INGOs, as they abide by an expressive aid approach, rely on individual donations from personal network connections, operate on scanty budgets, implement small-scale projects, draw upon heterogenous skills and forms of expertise, and choose projects according to previous international travel experiences and connections to former homelands. While all these characteristics affect how GINGOs conduct their day-to-day activities in developing countries, the latter two are particularly consequential for how GINGO leaders maintain relationships and coordinate activities with local implementing partners when

they are unable to have a full-time presence in their intervention sites. I make this argument by highlighting differences in four GINGO leaders' levels of medical expertise and immigrant status and situating these differences within a Bourdieusian relational framework. But first, I describe Bourdieu's relational sociology and its three main components: field, capital, and habitus.

2.2 Bourdieusian relational sociology

In Bourdieu's relational framework, "field," "habitus," and "capital," all dynamically interrelate to explain social processes, especially when issues of power, status, and inequality are at stake. These concepts appear variously throughout Bourdieu's writings (e.g., 1977, 1986, 1989, 1990, 1996), and when applied together, capture "the inner logic of a particular domain" of social life (Rojas 2017, 37).

"Fields" have an extensive history of being conceptually deployed in organisational analyses, especially within the new institutionalist and neoinstitutionalist traditions (see, e.g., DiMaggio and Powell 1991; Scott 2014). Among institutionalists, fields constitute "a recognized area of institutional life" (DiMaggio and Powell 1991, 64), which include all relevant social actors with which the focal actor interacts. In the context of INGOs, this might include the focal INGO, its donors, its local implementing partners, other INGOs with which the focal INGO interacts and competes for funding, and regulatory bodies such as states and professional associations. In organisational analyses, this understanding of fields predominates and has proven to be a useful concept for understanding organisations' environments.

Bourdieu's conception of fields, however, differs from institutionalists' in at least two respects. First, Bourdieu (1993, 72) describes fields as "structured spaces of positions (or posts) whose properties depend on their position within these spaces and which can be analysed independently of the characteristics of their occupants (which are partly predetermined by them)." This definition of fields, unlike the institutionalists', suggests that fields "must be conceptualised as a configuration of relationships *not* between the concrete entities themselves – e.g., the specific organisations at hand – but rather, between the nodes those entities happen to occupy within the given network or configuration" (Emirbayer and Johnson 2008:6, emphasis their own). In other words, Bourdieusian fields emphasise the centrality of actors' positions within fields and the forces that bind them together. An analytic payoff to this conceptualisation is that Bourdieusian fields are especially capable of capturing power relations within fields and the structural tensions that characterise dynamics between the powerful and powerless (Emirbayer and Johnson 2008).

Second, in a Bourdieusian relational approach, the field concept cannot be deployed without reference to its attendant forms of capital and its various actors' habitus. Indeed, with respect to capital, Bourdieu claims "capital does not exist and function except in relation to a field" (Bourdieu and Wacquant 1992, 101), where capital refers broadly to the resources associated with a field that can be put to use to pursue particular ends (Bourdieu 1986). Capital, in other words, is "a power resource in arenas of struggle" that becomes "both the objects and instruments of struggle in fields within and across organisations" (Swartz 2008, 48).

Bourdieu (1986) describes several types of capital, chief among them being economic capital (e.g., money and material assets), social capital (i.e., relationships within networks and membership in groups), cultural capital (e.g., credentials, titles, tastes, dispositions), and symbolic capital (e.g., honour, prestige, recognition). For INGOs, economic capital might include donor funds and the material goods necessary for project implementation;

social capital might consist of connections to donors, other INGOs, state actors, and local implementing partners; cultural capital might comprise knowledge about development trends and familiarity with intervention sites' local contexts, languages, and sociopolitical conditions; and symbolic capital might appear as an INGO's perceived legitimacy or authority vis-à-vis other development actors.

Within a Bourdieusian relational framework, the distribution of these various forms of capital among field actors, and the value ascribed to them, are contingent on their past and present uses. Importantly, capital can be used as "both weapons and as stakes in the struggle to gain ascendancy over…fields"; thus,

> Within the configuration of power relations that constitutes a field, particular positions or roles, including those that mark the dominant and dominated poles of the field, can be rigorously analysed in terms of the distinctive profiles of capital associated with them. (Emirbayer and Johnson 2008, 11)

In simpler terms, the volume, content, and distribution of capital determines the "rules of the game" within a given field, and those with highly valued forms of capital (i.e., those with dominant field positions, roles, or posts) have a vested interest in enforcing the field's rules.

The final component of Bourdieu's relational sociology is the habitus, or "systems of durable, transposable dispositions, structured structures predisposed to function as structuring structures" (Bourdieu 1977, 72). Hallett clarifies this definition by explaining that

> The habitus is *structured* by the *objective* conditions in which the individual develops (their position in social space). These objective conditions inculcate dispositions and tastes that reflect the individual's position in objective social space. These tastes and dispositions *structure* the individual's subjective actions and experiences (emphasis his own). (Hallett 2003, 130)

An actor's habitus thus reflects its socialised position, both past and present, within a field. In the case of INGOs, a leader's habitus might reflect his or her previous educational and occupational experiences, past and current social class, leadership position within the organisation, and histories of interactions with other relevant field actors.

Given its focus on internal dispositions and subjective tastes, accounting for habitus provides a social psychological component that is often missing from other approaches to studying social life (Rojas 2017), one that assists researchers with making connections between micro and macro levels of analysis (Emirbayer and Johnson 2008; Vaughan 2008). In the forthcoming analysis, drawing upon the habitus concept will elucidate GINGO leaders' rationales for action because, as Hallett (2003, 130) writes, "in completing organisational tasks, people act on the basis not only of formal organisational rules, but also of the habitus." That is, the habitus informs individuals' practices within organisations.

3. Methods

3.1 Sampling strategy

I identified grassroots international nongovernmental organisations (GINGOs) by downloading Business Master Files (BMFs) for the years 2018, 2019, 2020, and 2022 from the National Center for Charitable Statistics (NCCS)[2]. The BMFs contain information on organisations' location, finances, employer identification number (EIN), and National Taxonomy of Exempt Entities (NTEE) code. Organisations are assigned NTEE codes according to descriptive characteristics such as sector of work, organisational activities, and organisation type. I used NTEE codes to identify INGOs that conduct international development and relief projects in the health sector (Q30 International Development, Q33 International Relief, and Q39 International Health Development).

The BMFs also contain information on organisations' reported annual income. Following previous research (Schnable 2021; see also Kinsbergen and Schulpen 2013), I operationalised GINGOs as those organisations with a mean annual income of USD250,000 or less across the four years for which I have BMF data, as INGOs tend to begin rationalising their structures and professionalise after surpassing this income threshold. Among the remaining organisations (7,491), I randomly sampled 500 and checked whether (a) they have a website or social media profile with contact information and project descriptions; (b) project descriptions indicate that the organisation provides healthcare services (e.g., primary care, surgical care, maternal and reproductive care, etc.) since these interventions require credentialed forms of medical expertise (e.g., MD, DO, RN, and NP degrees, among others), unlike other health-related interventions like donating and distributing medical supplies; and (c) these healthcare services are being delivered to low- and lower-middle-income countries, as defined by the World Bank (2021). I contacted GINGOs via email or telephone if they met these criteria; all others were discarded. The total number of eligible organisations in my sampling frame has yet to be determined since I am still actively locating and contacting organisations. At the time of writing, I have contacted 104 eligible GINGOs and conducted 17 interviews; 298 GINGOs have been discarded. I intend to conduct additional interviews, aiming for a final analytic sample of 25-30 GINGO leaders. The current analysis focuses on data collected from interviews with leaders from four GINGOs that provide healthcare services to developing countries.

3.2 Analytic strategy

The interviews with my four health GINGO cases were conducted over Zoom and lasted from 75 to 120 minutes. Following a semi-structured interview protocol, I asked leaders about when and why they established their GINGOs, how they chose their projects and intervention sites, sources of funding and fundraising efforts, whether and why they collaborate with state actors and other development organisations, whether and why they view their GINGO as distinct from other kinds of development organisations, and the roles and responsibilities that leaders, board members, and volunteers assume. Interviews were audio recorded and subsequently transcribed.

I read and re-read transcribed interviews with the recorded audio while searching for themes related to expertise (e.g., applications of expertise, claims to expertise, seeking out missing expertise) and transnational migration (e.g., frequency of visits to the intervention site, which organisational members migrate between the United States and the intervention site, how resources travel between countries). Exploring these topics introduced other meaningful

2 No BMFs were available for the year 2021 from the NCCS, hence its omission.

themes, such as the centrality of local implementing partners in coordinating and implementing GINGO activities and how communication is maintained between these locally-situated actors and GINGO leaders in the United States.

From these and other themes, I developed codes and applied them to my interview transcripts. The codes and their application were simultaneously informed by grounded theorising and published findings in related literatures. For instance, I read and drew heavily upon ideas from the literatures on GINGOs (e.g., Appe and Telch 2020; Haaland and Wallevik 2017; Kinsbergen and Schulpen 2013; Kinsbergen et al. 2017, 2013; Schnable 2015, 2021, forthcoming; Schnable et al. 2022), transnational professions and professionals (e.g., Abbott 1988; Harrington and Seabrooke 2020), diaspora philanthropy (e.g., Appe and Oreg 2019; Brinkerhoff 2011; J. M. Brinkerhoff 2008; Doherty Johnson 2007; Espinosa 2016; Flanigan 2017; Newland et al. 2010), expertise (e.g., Carr 2010; Eyal 2015), and critical postcolonial studies (e.g., Biehl and Petryna 2013; Brada 2011; Hanrieder 2019). This analytic approach closely resembles what Timmermans and Tavory (2012) refer to as abductive analysis, in which researchers iteratively move between empirical data and existing research to identify surprising insights and generate theory.

Through this abductive approach, I identified four GINGO cases that exhibited marked similarities and differences in how leaders maintained their organisation's activities despite only being present in their intervention sites for brief, intermittent periods. I found that significant axes of comparison hinged on leaders' levels of medical expertise and immigrant status. Drawing upon Bourdieu's relational sociology, the forthcoming analysis suggests that these factors fundamentally shape health GINGO leaders' habitus and access to, as well as current stocks of, various forms of capital. Leaders' habitus and capital affect how they go about designing, implementing, and managing health projects from afar in the field of amateur, citizen-led international aid.

4. Findings

This section begins by introducing the four cases of health GINGOs, their leaders, and how leaders manage issues of project coordination and implementation from afar. I then apply Bourdieu's relational framework to these cases to demonstrate how health GINGO leaders' extent of medical expertise and immigrant status shape their habitus, affect access to and use of different forms of capital, and produce varying manifestations of healthcare service delivery in intervention sites.

4.1 GINGO cases

4.1.1 Surgical solutions

Dan is a plastic surgeon who began Surgical Solutions in 2005 to provide surgical care, primarily cleft lip and palate restorations, to communities in various developing countries. He was inspired to establish his GINGO after operating on a Mexican child who travelled to the United States to receive surgical care. One of his colleagues, Jill, who had experience organising medical mission trips abroad suggested that he get involved in this kind of international outreach:

> So, with that [patient from Mexico], that was my start in this. Then, [Jill] came to me and said, 'Well, you did one case up here. If you go down there, you can do a lot of cases in a short amount of time.' I went down in 1991 to Guatemala with a team from [mainstream health INGO]… and I got hooked on it. (Interview)

The above quote reveals that Dan joined an already-existing medical mission trip organisation to deliver healthcare services abroad. He quit the organisation and began his own GINGO, however, because "We just thought we could do it better. We had a lot more control." The "control" Dan is referring to is with respect to budgeting and conducting activities in intervention sites. He boasted his GINGO's ability to run on virtually no overhead costs and being able to perform surgeries on patients until as late as midnight. These points of pride were unrealisable in his work with the mainstream health INGO; thus, starting Surgical Solutions provided Dan and his volunteers greater autonomy in the provision of healthcare services abroad.

Dan has extensive medical expertise as a plastic surgeon, but practically no expertise in international development and aid delivery. Lacking these forms of expertise, Dan described facing challenges when beginning Surgical Solutions, which appeared in such instances as registering as a 501(c)3 with the IRS, getting permission from local governments to practice surgery, and making arrangements for lodging, meals, and transportation in intervention sites. Nevertheless, "After we had done it a couple times, we kind of figured it out…We had done enough trips where I kind of had an idea on how to do it."

Although Dan acquired experiential expertise when it comes to carrying out activities in his intervention sites, this expertise does not extend to managerial tasks like developing local partnerships. Dan coordinates activities with local implementing partners, including, for instance, a local Lions Club chapter in Nicaragua, but is unsure how such partnerships formed. He explained such partners "reached out to us, and word would get through somehow," and later stated, "I wish I knew how some of these people heard of us." These partnerships, however, are not trivial; they are imperative for successful operations across Surgical Solutions's intervention sites. The Lions Club in Nicaragua, for example, "would arrange for us to have patients" by going

> Down the river, go[ing] down the *rio* to these little villages and find kids with cleft lips or cleft palates or the people that needed our care, and would help arrange to bring them, so that they would meet us. They would be there when we got there. (Interview)

In the absence of local implementing partners, Surgical Solutions would have no patients to treat.

Moreover, Dan lacks relevant cultural knowledge about the communities he serves. For instance, despite offering healthcare services in Spanish-speaking countries, he has minimal Spanish language skills:

> Other than *"buenos días"* and *"gracias,"* most of them [Surgical Solutions's volunteers] don't [speak Spanish]. I can fake Spanish. I'm sure that when I leave the room there are people rolling on the floor laughing at what I actually said rather than what I thought I said. Couple of these places, I would go on TV or on the radio, the local radio, and I learned the trick was to ask them ahead of time what questions they were gonna ask, and no matter how many times we did that, by about the third question, there would suddenly be something they didn't ask, and I had no idea what they were saying. But I can fake it. I can get my ideas across. (Interview)

Despite having to "fake it," Dan explained that many local implementing partners, especially those with medical expertise, speak English, and that he has never experienced difficulties conducting organisational activities due to language barriers. He remarked, however, that some local doctors "resented us being there" and "were not happy [that] we're infringing on their [patients]."

Dan reported seeing about 100-120 patients and operating "on about 35 to 45 people each trip." Performing these operations "feels really good," especially when he receives "credit as being able to do something that is not all that miraculous." Dan also enjoys the opportunities that his surgical missions provide for encountering medical cases that are atypical in the United States:

> One of the trips, we were in Honduras, and we did a cleft lip on a little, about a six- or seven-year-old girl, and she started coughing in the recovery room…And apparently, she had tapeworms. When you give anaesthesia – this is something I learned on the fly – when you give anaesthesia, it agitates the tapeworms, and she would, she had opened her mouth and all these tapeworms started crawling out. And down there, they were used to it. They just knew that you let the tapeworms come out and put them in a little waste basket. They would put them in as they came out. If that tapeworm would have come out in the middle of the operation, I'm not sure if I would have known exactly what you're supposed to do, and we never really covered it in medical school…So, you learn. (Interview)

In addition to these learning opportunities, providing healthcare in developing countries allows Dan to refine his surgical skills, as he explained that when working in low-resource environments,

> You don't have tests, you don't have a CT scanner, you don't have an MRI scanner. You have to learn how to trust your judgment, and you kind of learn that what your instincts, your gut feeling is probably much more important than any tests that you can order. (Interview)

Ultimately, despite lacking relevant knowledge in international development and nonprofit management, Dan and his team of volunteers are able to apply expert medical knowledge from the United States to developing countries and provide life-changing surgical treatments. Dan is committed to sustaining his GINGO's activities, but also acknowledges that Surgical Solutions is not a full-time job: "It's…just something we kind of do as a hobby." After all, as Dan explained, "I've got a busy practice that takes up most of my time."

4.1.2 Caribbean Care Medical Missions

Tracy founded Caribbean Care Medical Missions in 2000 after assisting with a cardiac medical mission trip in Haiti during the late 1990s. Tracy is not a cardiologist but was a registered nurse (RN) at a well-resourced university hospital in New England. At the time, she recalled being "very intrigued by the idea of outreach for international" health and, through two colleagues at the hospital, learned about a Catholic nun in Jamaica who helps organise medical mission trips throughout the country. Tracy recounted the first medical mission trip she coordinated:

> So, we hadn't ever done this on our own. And so, in 2000, we went down, the six of us, and we set up clinics throughout the inner city and came back, you know, loved it. And we didn't have a lot of medications. We just had basics. And really, everyone loved the experience, the mission of going down there. (Interview)

This quote suggests a lack of expertise in international development and aid delivery ("we hadn't ever done this on our own," "we didn't have a lot of medications"), but like most GINGO leaders and their staff, the experience was emotionally rewarding ("everyone loved the experience").

Following this trip, other hospital staff members expressed interest in making additional mission trips to Jamaica, resulting in increases in the number of participating volunteers and the frequency of trips to Jamaica. Tracy explained:

> It grew to, we had probably, I don't know, ten physicians and nurses going on these trips. It became more than once a year. It became every six months. We had a partnership with Yale University Medical School and their surgical team would come down with us once every year. So, throughout the year, every six months when we were down there, we started to have dedicated communities that we were caring for. And over the 22 years that we've been going there, we go every six months, we have charts on everyone. We have, you know, generations of families now that we've taken care of. (Interview)

The partnership with the surgeons at Yale, coupled with Tracy's connection to the Jamaican Catholic nun, allowed Caribbean Care Medical Missions to increase the breadth of services it provides and the range of communities it serves.

Tracy repeatedly emphasised the importance of returning to previously served communities. Aside from the medical benefits of ensuring continuity of care, returning to the same communities year after year strengthens the interpersonal connections that she and other volunteers made with beneficiaries:

> They know us. They all know us. They know we're coming. They know where they get free surgery. It's just an amazing relationship, and as I said, I see the grandparents, the parents, and now their children, so three generations of people that we're taking care of, which is fabulous. (Interview)

Tracy also emphasised the critical role the local Catholic nun plays in orchestrating the medical mission trips and her organisation's dependence on this local implementing partner. She explained, "As you start to build something like this, you really depend upon partnerships. And so, we had a partnership with…this woman who is in Jamaica. She happens to be a Catholic nun." According to Tracy, the nun runs a health outreach program in Jamaica's inner cities and rural areas that seeks US-based organisations like Caribbean Care Medical Missions to come and provide care. The nun and her "core group of workers" perform a great deal of in-country preparatory work prior to the arrival of these US-based organisations, including scheduling trips, finding places to serve as temporary clinics for the incoming medical teams (e.g., schools, churches, tents), publicising the arrival of incoming medical teams to local communities, and registering patients to receive treatments. Tracy's relationship with the nun grew to a point where

> …[You] could tell her you're coming tomorrow, and she'd be, "Ok, we're ready," you know, "Whatever you can do to help us." …It became a, I don't want to say a routine, but a scheduled thing. We knew where we were staying, you know, who was driving us. (Interview)

Tracy also advanced up from her RN position in the university hospital to eventually becoming the dean of the School of Health Professions and Nursing at her respective university. This greatly impacted Caribbean Care Medical Missions's activities in at least two key ways. First, it broadened her access to healthcare personnel who might be interested in participating in her GINGO's medical mission trips. Indeed, through these new connections, Caribbean Care Medical Missions expanded from providing only primary care services to also offering psychiatric, surgical, and speech and hearing services. Some new personnel also provided connections and opportunities to provide healthcare in other countries. For instance,

> There is a physician that I worked with, a very kind gentleman, I've worked with for many years, and he was Sri Lankan, and he said, you know, "Could you bring your team? We really need someone." And I said, you know, "I have to make one phone call," and then we had the whole team of eight ready to go. (Interview)

Tracy's colleague, a Sri Lankan immigrant to the United States, thus facilitated the expansion of organisational activities by providing an opportunity for the GINGO to serve his home country. Interestingly, though, not all of Tracy's medical colleagues from developing countries viewed their countries of origin as needing the GINGO's services. Tracy provided such an example:

> [The psychiatrist is] actually Jamaican. So, the funny thing is that the two of us work together and we have gone, I don't know, three or four times, and I saw him in an elevator, and I said, "How come you don't come to Jamaica?" I said, "You're Jamaican." He said, "I'm a psychiatrist. What am I gonna do down there?" (Interview)

The psychiatrist, however, did eventually participate on a medical mission trip, and he now leads the psychiatric team of providers who make return visits.

The second key consequence of Tracy's promotion to a high-level administrative position within the university is that she integrated Caribbean Care Medical Missions's activities into the curriculum of several universities' undergraduate and medical training programs. Tracy explained:

> After I think maybe three or four years, we started to bring down nursing students and nurse practitioner students, and we built it into the curriculum of these universities, that it was part of their coursework. So, it wasn't that people were coming down and volunteering. They were coming down participating in a course and had, you know, I don't wanna say homework, but they had debriefing in the evenings and patient presentations, and they were graded for that week, and they work clinical hours that were allocated. (Interview)

With the GINGO's integration, Tracy will step down from her leadership role, but is confident that the organisation she founded and cultivated will continue its original mission:

> The foundation is there. The structure is there. The people who are going to be overseeing it now have been there for years. So, I feel confident and, you know, it's something like I'm handing it off, but, you know, it's been a part of my life for so long, but I do feel comfortable that this is going to continue. So, there's not much more that I can do. (Interview)

Caribbean Care Medical Missions thus represents a case in which an individual with little expertise in international development acquired a great deal of experience through her own organisation's activities in Jamaica. Her activities in Jamaica were possible due in large part to a local implementing partner, a Jamaican Catholic nun, who makes all in-country arrangements for the visiting medical teams. The number of medical personnel and range of services they provide grew greatly as Tracy assumed higher administrative positions within the medical field in the United States. It allowed her draw upon the expertise of primary care physicians, surgeons, psychiatrists, and speech and hearing pathologists, and export their expertise to Jamaica and other developing countries. Despite the GINGO being subsumed by a group of universities, its activities will continue to rely heavily on local implementing partners and US-residing immigrant medical personnel to identify new communities to serve.

4.1.3 Dental dream missions

Carl started Dental Dream Missions in 2012 to provide dental care to inner-city and rural communities in Jamaica. Unlike Dan and Tracy, however, Carl is neither US-born nor has medical (in this case, dental) expertise. He instead relies on his daughter-in-law, Mariah, a certified Doctor of Dental Surgery (DDS), to provide dental treatments and conduct organisational activities that require dental expertise, such as ordering medications and supplies for dental mission trips. Carl explained,

> [My son] went off to college and brought back a wife who is a dentist. She's not Jamaican. Neither my son. My son was born here, and we figured that we'll go to Jamaica and we'll focus on dentistry because she would have the technical ability to do what we want to do, and I would be the organiser raising the funds, providing the leadership. (Interview)

He later added, "If I didn't have Mariah as the chief dental officer, I couldn't, I don't think I could [run Dental Dream Missions]."

Carl has an undergraduate degree in pure and applied physics, which does not prove practical for his GINGO's activities. He did, however, acquire some nonprofit organisational skills from having previously participated in medical mission trips:

> So, I went once with them [a medical mission trip organisation], and I was learning the ropes and how this thing went, and then I started going with them for about four or five years…They would go do all the logistics in terms of booking the flights, booking the places we're supposed to stay, and then we branched off. After that, we branched off and started doing it on our own in terms of getting the legal authority to do it, and then carrying the team, and going to [Jamaica]. (Interview)

Carl thus learned how to operate a nonprofit by observing the ins and outs of an established organisation's routines, which gave him the confidence to begin his own GINGO.

Carl is aware of his limited organisational and absent dental expertise. He explained,

> I don't know anything about dentistry…When we're there [in Jamaica], I just sort of see what I can do in terms of supplying their [volunteers'] lunch and make sure that they're comfortable, you know? So, I'm like the CEO who doesn't know the technical things of the ministry because we are mainly focusing on dentistry, which is a professional thing. (Interview)

Despite lacking these forms of expertise, Carl described himself as having a profound passion for helping others and viewed this personality quality as necessary for successfully running a GINGO: "You've gotta have what's called grit. And, plus, you've got to have this deep desire to help folks…I'm not a perfect person, but it takes a certain grit and grind…"

Passion alone, however, does not motivate Carl to provide aid transnationally; he is also driven by his Christian faith and its values of helping the needy: "This is my Christian values, you know? People start ministries and they're not Christians, but for me, that's what drives me to do it." Although his GINGO does not explicitly or deliberately evangelise, Carl does little to separate his religious motivations from organisational activities:

> A person with a tooth ache can't hear about the love of God, the love of Jesus until that tooth ache goes away, you know? You're almost wrapping your arm around them, show them that you care, then you can say, "This is what, the reason why we're doing this, and we love you." (Interview)

Carl also described his experiences of growing up in "abject poverty" as an additional motivator for beginning Dental Dream Missions: "I was born in abject poverty, and the Lord has blessed me tremendously. So, I think it's time for me to give back."

Having an immense passion for international altruism is common among GINGO leaders and was evident in my interviews with Dan and Tracy. Unlike Dan and Tracy, however, Carl has more extensive connections to local beneficiaries, and this is due in large part to both his status as a native-born Jamaican and his Christian religious identity. In fact, Carl returned to Jamaica in 2012 for a family member's funeral, and while attending the church service, he learned that it occasionally hosts dental clinics for the needy:

> I was born in Jamaica, by the way, and that's the church that I spent ten years of my life, and I went there for a funeral for my uncle, and when I went there in 2012 for the funeral, I went across what is called a fellowship hall, and I saw they have a dentistry there, and I said, "What's going on here?" They said, "Yeah, the government has set up a dental clinic here, and they give us some support, but when they don't, we're in trouble." So, that's why we started going to [name of church] mainly, and then we go to other sites, and that's what we do. (Interview)

Clearly, Carl's connection to a local church, which stems from both having grown up in Jamaica and his Christian identity, provided a fortuitous opportunity to first begin arranging dental mission trips to his home country. Carl's upbringing in Jamaica also provided opportunities to assist in non-religious settings, as he later described supporting a clinic that he visited as a child in Jamaica: "There's some clinics, especially-, there's one in a town called [name of town] where I grew up, and we purchased supplies and give to them because I remember when I used to go there when I was living, you know?" These quotes suggest that Carl's native-born Jamaican status provides advantages when identifying locations to offer dental services and send supplies, a task that might be more difficult if he lacked such connections with local communities.

Carl's native-born Jamaican status also provided advantages when expanding his GINGO's activities. For instance, Carl described having and mobilising connections with Jamaican universities to incorporate additional expert dental personnel:

> There's a second dental school which we are working with, UTech [University of Technology, Jamaica]. I know the leader there, and I know the leader at UWI [University of West Indies], and I know some other dentists who would come on board and help us when we're down there. (Interview)

These "other dentists" are, like Carl, native-born Jamaicans. Their ad hoc work with Dental Dream Missions enhances its technical capacity, as they enable the GINGO to see and treat more patients than would be possible with Mariah alone. Additionally, these contacts help Carl continue his organisation's activities when he is away from Jamaica: "It's a little bit more difficult to do it [dental missions] when we are not there, so we find it most convenient and easier when we work through the university system."

In summary, Carl does not have traditional training or experience in international development, aid delivery, and nonprofit management. He was inspired to begin his own GINGO that conducts

dental mission trips after having participated on similar medical mission trips, through which he "learned the ropes" about how to run an international nonprofit. With these rudimentary organisational skills and a strong, Christian-informed passion for international altruism, Carl was able to draw upon his daughter-in-law's dental expertise and his local connections in Jamaica to begin and expand activities as a GINGO providing dental healthcare services.

4.1.4 Care where it counts

Care Where It Counts is similar to Dental Dream Missions in that its leader, Hank, is an immigrant rather than US-born and delivers aid to his home country, Sudan. Like Carl, Hank does not have medical expertise, but he and his wife, Pearl, have more background experience with international aid initiatives despite lacking formal training or credentials. The pair lived in Yemen during the 1980s and describe having witnessed "a lot of development projects." Moreover, in addition to Hank's native-born Sudanese status and the couple's experiences living in Yemen, Pearl formerly had an academic career in Middle East studies, thus endowing her with a locally-relevant forms of knowledge. For instance, at several points in the interview, Pearl referenced how the legacy of colonialism is evident in Sudan's deteriorating infrastructure, which creates additional needs for the GINGO to meet.

Hank and Pearl first began delivering aid by implementing water projects in Hank's home village in 1994 to honour his mother who passed away that year. These projects were funded by grants from Rotary International and its local chapter in Khartoum, Sudan. Hank and Pearl decided to formally establish Care Where It Counts as a 501(c)3 about a decade later once they started working in the health sector, as Pearl explains:

> I think it was in the winter of either 2004 or maybe early 2005, we wrote a grant to start a clinic, to do a clinic project in [village], and we wrote it to Rotary International, and we had a plan for a clinic that a local doctor and medical professor had, uh, was able to supply us with, and we got the grant, which was to equip and supply the clinic, but because of Rotary International's rules, they do not build buildings. They have kind of a no brick-and-mortar rule because you don't know how buildings might be used in the future. So, we had this large grant to equip a clinic, but we had to build the clinic. So, at that time, we started Care Where It Counts and started fundraising. (Interview)

After building the clinic, Care Where It Counts mobilised local medical professionals to volunteer at the clinic and provide free healthcare. These mobilisation efforts were largely facilitated by the doctor and medical professor that Pearl mentioned in the above quote, who grew up in the same village as Hank:

> The clinic is overseen by a doctor who also grew up in that village. He's a medical professor in the nearby provincial capital, and he has helped organise free healthcare days. We've been doing three or sometimes four a year where basically volunteer medical specialists from the nearby provincial capital come out and treat people for free. (Interview)

Hank, like Carl, is able to exploit his local connections from having grown up in the village he serves; however, unlike Carl, his dependence on locals is stronger since neither he nor Pearl has medical training, whereas Carl can rely on Mariah, at minimum, to provide dental care in the absence of local implementing partners.

Since all of Care Where It Counts's medical expertise comes from local sources rather than from its leaders or Western volunteers, it is able to incorporate local medical practices into its healthcare services rather than strictly import Western biomedical models. When speaking about financial support received from an acquaintance in the United States, Pearl stated,

> The funding he provided allowed for there to be hired two midwives as opposed to one. And so, they have one midwife who's very much the traditional doula, and then they have another midwife who has had midwifery training, either in the provincial capital or in the national capital. (Interview)

The traditional doula therefore provides an alternative form of care alongside the midwife that was trained in a metropolitan center. This dual model, according to Pearl, is "kind of like keeping the best of both worlds."

Additionally, Hank and Pearl's complete dependence on local implementing partners to provide medical care makes transnational communication essential for organisational success. This dependence has only grown stronger in recent years, as Pearl explained that she and Hank "went there [to Sudan] once a year for thirty years" "until about five years ago," and that other board members have only been to Sudan once or twice, most recently for the clinic's opening ceremony in 2012. Fortunately, "because Hank had grown up in the community, it was very easy for him to interact with members of different local cooperatives," and Hank has been able to maintain these interactions despite his and Pearl's inability to continue travelling to Sudan through digital means:

> Hank gets both English and Arabic WhatsApp messages from community members about Care Where It Counts or about other things that are happening, you know? Somebody is getting married. Somebody just had a baby, you know? He's getting that all the time… The fact that Hank is in such constant communication with the different communities that we deal with, and again, it's communication that isn't all about Care Where It Counts. It's about their life. It's about him being part of the community life even though he's living across the world. (Interview)

As this quote indicates, Hank not only keeps in touch with community members to ensure successful project implementation, but also to remain up to date about the more quotidian aspects of community members' lives. In this way, his connections with local implementing partners serves both instrumental and expressive purposes, and according to Pearl, this makes their organisation distinct from professional INGOs: "That is something that makes us a little bit different, that we're a little bit more, uh, I don't want to say intimately involved, but more closely connected with the communities that our projects are in."

Hank is further able to advance his GINGO's activities by mobilising the support of Sudanese Americans living in the United States. Pearl recounted how Hank's affiliation with a US-based Sudanese American organisation resulted in its members, primarily first- and second-generation immigrants, donating small sums of money to Care Where It Counts to provide oxygen tanks to clinics in Sudan during the height of COVID-19 pandemic. In fact, "one of the Sudanese American women went there [to Sudan] and saw that it [the delivery of oxygen tanks] happened." Pearl views these women as potential heirs to Care Where It Counts, as she remarked,

> Hopefully in the future some of these Sudanese Americans, you know, as Hank and Troy [a board member] and I sort of fade away and die off, you know, it'd be nice to have that community involved in the ongoing Care Where It Counts because it's gonna keep going. (Interview)

To summarise, Care Where It Counts represents another immigrant-led GINGO that delivers healthcare services to its founder's country of origin. Despite being unable to continue returning to Sudan, Hank and Pearl are able to maintain organisational activities from afar due largely to Hank's strong connections with a range of local community members, including

medical professionals. Hank maintains these connections with local implementing partners by communicating via email and instant messaging about both organisationally-relevant matters and mundane day-to-day happenings. The importance of having local contacts and their committed involvement cannot be overstated, as Pearl also commented that she and Hank "tried to get a project started in the Gambia" but were unable to do so because "our contact there died." Moving forward, Hank and Pearl intend to continue Care Where It Counts but hope to enlist US-residing American Sudanese immigrants to assume organisational roles when they eventually step down as GINGO leaders.

4.2 Applying Bourdieu's relational sociology

The above four cases all operate within the emerging, but still loosely defined field of amateur citizen aid. GINGOs represent just one of other organisational forms that allow lay folk to get involved in international altruism. For instance, this broader field also includes diaspora philanthropy, online crowdfunding platforms, and religious mission trips that combine aid provision with proselytisation. The four cases, however, also operate within their own, internal fields that each have unique dynamics, stakes, and logics.

It follows that since GINGOs are situated within the broader, semi-autonomous field of amateur citizen aid, there should exist some structural similarities across the individual, autonomous fields within which the four GINGO cases are specifically embedded. One key similarity is that each of the four GINGOs' fields include local implementing partners as consequential field-level actors. How a given GINGO interacts with local implementing partners depends on its leader's habitus and stocks of capital (which will be discussed in subsequent paragraphs), and local implementing partners' play essential roles in ensuring the GINGOs' activities at the intervention sites are successful. Indeed, the local Lions Club chapter for Surgical Solutions, the Jamaican Catholic nun for Caribbean Care Medical Missions, the various Jamaican dentists and university personnel for Dental Dream Missions, and the university medical professor for Care Where It Counts all variously assisted with identifying locations to provide healthcare services, publicising the GINGO's activities to community members, attracting community members to the GINGO, inviting local medical personnel to assist with the provision of healthcare services, and other logistical tasks. Without these local implementing partners, the four GINGOs' ability to fulfil their missions of providing healthcare services would be greatly reduced, if not rendered completely impossible.

Largely absent from all four GINGOs' fields are state actors. Aside from obtaining permission from local governments to provide care, as Dan mentioned, and working alongside local healthcare personnel who otherwise work in publicly-run healthcare facilities, as Carl mentioned, state actors have minimal effects on GINGOs' activities within their respective fields. A caveat might be cooperation with local village leaders who constitute a more grassroots form of governance. For instance, Hank and Pearl explained that "the different villages we serve, they do have active community cooperatives" and that their "projects [are] based on what community leaders express as being what they need." Beyond these village authorities, however, Hank made it clear that his GINGO does not interact with national-level state actors and makes deliberate efforts to avoid such interactions: "We keep them away and ask them to leave us alone. That's, like, a blessing in disguise." He and Pearl justified this avoidance with fears of corruption and malfeasance.

At baseline, then, the four GINGOs' embeddedness in the semi-autonomous field of amateur citizen aid creates some patterned similarities across their distinct, individual, autonomous fields: local implementing partners are central, consequential actors, whereas state officials are

peripheral, inconsequential actors. Aside from these commonalities, each GINGO's field has unique characteristics. Some have additional key actors, like Caribbean Care Medical Missions's close relationships with multiple New England-based universities. The presence of additional actors and the nature of relationships between them, GINGOs, and local implementing partners are conditioned by GINGO leaders' habitus and stocks of capital. I argue that two factors that influence leaders' habitus and access to and use of capital are their levels of medical expertise and immigrant status.

4.2.1 Levels of medical expertise

When Dan enters the field of amateur citizen aid by performing cleft lip and palate operations in developing countries, he brings with him his habitus, or "durable, transposable dispositions" (Bourdieu 1977, 72), developed from the United States medical education and healthcare fields. He has high levels of medical expertise, one that privileges the Western biomedical model of healthcare provision. He conducts surgeries in developing countries as he would in the United States, notwithstanding his minimal access to technologies and resources that he is accustomed to in US hospitals. He likes the challenge of working in resource-poor settings and is able to do so despite experiencing resentment from local doctors.

Dan's fraught relationship with these local doctors reflects his low stocks of local social capital. So, too, does his lack of knowledge about how local implementing partners like the Lions Club learned about his GINGO and contacted him. Despite having somewhat tense and weakly-formed relationships with local implementing partners, Dan's high levels medical expertise allow him to fulfil his GINGO's mission of providing surgical care in developing countries. Interacting with local implementing partners is still crucial, as they are responsible for locating patients and bringing them to his GINGO; however, he can depend upon his medical expertise and his fifteen-plus years of experience organising surgical mission trips to achieve organisational goals, which thus influences how he coordinates his activities with local implementing partners from the US and in his intervention sites.

Tracy has some medical expertise from her work as an RN but relies more on the medical expertise of her colleagues at the various university hospitals in New England. Her connections with primary care, surgical, psychiatric, and speech and hearing specialists exemplifies strong US-based social capital, which she deploys by inviting them on medical mission trips to Jamaica. The services these physicians render is indicative of a Western biomedical habitus, as evidenced by the Jamaican-trained psychiatrist who initially did not see the need for his services in his home country (e.g., "I'm a psychiatrist. What am I gonna do down there?").

Tracy also has strong Jamaican-based social capital – she works closely with the Jamaican Catholic nun and cultivates long-lasting interpersonal relationships with beneficiaries (e.g., "I see the grandparents, the parents, and now their children"). Having high stocks of US- and Jamaican-based social capital is worthless, though, unless it is highly valued within the context of the field. Tracy's social capital is indeed valuable, as it simplifies her coordination efforts with local implementing partners (e.g., "…[You] could tell her you're coming tomorrow and she'd be, 'Ok, we're ready'…It became a, I don't want to say a routine, but a scheduled thing").

Meanwhile, Carl has no dental expertise but can depend upon his daughter-in-law and connections to local dentists and university personnel to provide the care that he is unable to deliver himself. Hank and Pearl face a similar situation – neither have medical expertise, but Hank maintains close relationships with Sudanese medical personnel (e.g., the medical school professor), community members, and Sudanese American immigrants. These GINGO leaders

thus have rich local social capital, which compensates for their absent expertise in healthcare provision and facilitates coordination from afar. Carl explicitly stated how his connections to the Jamaican universities reduce coordination complexities when he is not present in Jamaica (e.g., "It's a little bit more difficult to do it [dental missions] when we are not there, so we find it most convenient and easier when we work through the university system"). As for Hank and Pearl, who are both unable to make return trips to Sudan, they effectively coordinate their organisation's activities from the United States by means of communication technologies (e.g., emails, WhatsApp) and the Sudanese Americans who continue to visit Sudan and support their clinic (e.g., delivering oxygen tanks during the COVID-19 pandemic).

4.2.2 Immigrant status

Clearly, Carl and Hank have abundant social capital, and this social capital proves valuable when these GINGO leaders are unable to be physically present in their intervention sites. This social capital stems in large part from their identities as immigrants from the communities they serve. Indeed, Carl's return to Jamaica for a family member's funeral opened the door to providing dental services in the church and, later, the clinic that he attended as a child. And while Carl conducts dental mission trips throughout Jamaica, Hank more narrowly focuses his GINGO's activities on his home village in Sudan. Hank knows practically all members of his village and remains in contact with them from the United States.

We can also appreciate the social capital advantages that accrue from one's immigrant status through Caribbean Care Medical Missions. Although Tracy is from the United States, her Sri Lankan-born colleague provided her access to conduct a medical mission trip in his home country. In the absence of local social capital then, GINGO leaders can draw upon US-residing immigrants' in-country connections to organise and coordinate activities in new intervention sites.

Serving one's country of origin also endows GINGO leaders with valuable forms of cultural capital. For example, Hank is intimately familiar with the leadership structure of his local village (e.g., "because Hank had grown up in the community, it was very easy for him to interact with members of different local cooperatives"). Although speculative, having this kind of knowledge likely facilitates coordination efforts both in-country and from the United States. Less speculative are the payoffs to speaking the local language – another indicator of cultural capital. Hank and Pearl both speak Arabic, unlike Dan who has to "fake" his Spanish while working in Spanish-speaking countries. Although Dan insists "I can get my ideas across," his poor communication skills likely do little to assuage local doctors' resentment of his organisation's activities.

Hank and Pearl's superior cultural capital is also apparent through their clinic's provision of both traditional and biomedical midwifery services. Having both models of care benefits patients seeking reproductive care by offering them more diverse treatment options, especially if beneficiaries prefer one form of care over the other. Dan and Tracy, on the other hand, can only import Western biomedicine and its corresponding treatments into the communities their GINGOs serve. Hank's awareness of and sensitivity to different forms of care is likely a byproduct of his immigrant status.

Immigrant status also comes to bear on GINGOs leaders' motivations for providing healthcare services transnationally. Consistent with research from the diaspora philanthropy literature that suggests immigrants have unique reasons to give back to their countries of origin (e.g., Appe and Oreg 2019; Brinkerhoff 2011; D. W. Brinkerhoff 2008; Flanigan 2017; Sidel 2008),

Hank's immigrant status influenced his decision to serve to his home village in Sudan, as Pearl explained, "Hank is from Sudan, and at the time of his mother's death in 1994 he decided that he wanted to honour her by doing projects in his village." Likewise, Carl's experiences of having been raised "in abject poverty" in Jamaica motivated him to give back to underdeveloped communities in his home country. Hank and Carl, then, can be said to have an immigrant-specific habitus, as their unique social origins and trajectories create motivations for aid provision that differ from their US-born counterparts. Indeed, Dan and Tracy developed an interest in conducting medical mission trips only after having been introduced to international health outreach through US-based acquaintances.

Immigrant GINGO leaders, then, have a particular habitus that motivates aid provision, and once aid provision is underway, they can deploy extant stocks of highly valuable social and cultural capital to coordinate their activities with implementing partners in intervention sites. US-born GINGO leaders, in contrast, must acquire and cultivate these forms of capital on their own. For Dan, this is challenging since his primary commitment is his surgical practice ("I've got a busy practice that takes up most of my time"), and since he does not remember how his partnerships with local implementing partners initially formed, he will likely face coordination challenges if he ever needs to identify new ones. Tracy is also heavily dependent on local implementing partners like the Jamaican Catholic nun, but unlike Dan, she has invested more energy into developing interpersonal relationships with local implementing partners and beneficiaries, which facilitates transnational organisational coordination.

5. Conclusion

This paper investigated two empirical questions – How do GINGO leaders engage in effective transnational coordination with local implementing partners? And what accounts for differences in the strategies that GINGO leaders deploy in such coordination efforts? – through a Bourdieusian theoretical framework and found that leaders' levels of medical expertise and immigrant status affect their habitus and stocks of capital. Differences in leaders' levels of medical expertise and immigrant status (and, correspondingly, differences in their habitus and stocks of capital) combine to differently facilitate or complicate transnational coordination efforts with local implementing partners in the field of amateur citizen aid.

These findings emerged from an abductive analysis (Timmermans and Tavory 2012) of semi-structured interviews with leaders of four GINGOs that are active in the health sector. The small analytic sample limits the extent to which the patterned findings are empirically meaningful and generalisable to other GINGOs; however, additional interviews are currently being conducted and transcribed to determine whether these preliminary patterns persist more broadly. Additional interviews may yield data that corroborate the important roles of GINGO leaders' levels of medical expertise and immigrant status in shaping their interactions with local implementing partners, or perhaps new data will reveal complexities and contingencies that qualify the hitherto observed relationships.

Another limitation stems from the interview methodology itself. Jerolmack and Khan (2014) famously raise the issue of attitude-behaviour consistency whereby interviewees' stated responses (e.g., their beliefs, intentions, descriptions of behaviour) conflict with performed behaviours in relevant, situated settings. In the present study, my respondents' descriptions of their interactions with local implementing partners may differ from how they actually transpire both locally and transnationally. While observational data on GINGO leaders' relationships and interactions with local implementing partners would provide additional evidence to strengthen

my claims, the interview data presented here are nevertheless valuable by illuminating the imagined meanings that GINGO leaders assign to their interactions with local implementing partners, their perceptions of their own roles as organisational leaders, and their perspectives about their organisation's activities more broadly.

Finally, while my relational application of Bourdieu's concepts of field, capital, and habitus revealed differences in interactional processes and outcomes between GINGO leaders and local implementing partners, it remains unclear as to whether Bourdieu's framework provides additional leverage or clarity than what might be possible by adopting a different theoretical lens. For instance, a resource dependence perspective (Pfeffer and Salancik 1978), given its attention to how focal organisational actors adapt and respond to relevant external pressures, may generate useful insights about coordination efforts and outcomes with local implementing partners that are obscured when strictly adhering to a Bourdieusian approach. After all, if, as Pfeffer and Salancik (1978, 2) write, "The key to organisational survival is the ability to acquire and maintain resources," and since, as my data show, local implementing partners are key actors in helping GINGOs acquire and maintain resources (e.g., accommodations for travel and lodging, sites to erect and operate temporary clinics, patients to treat, etc.), then perhaps adopting this perspective can better capture the environmental factors that determine the circumstances under which interacting with local implementing partners is most advantageous for organisational survival and the external dynamics that influence how such interactions unfold. Exploring the potential insights to be gained from alternative theories, then, is a necessary direction for future analysis.

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