5-10-2019

Healthcare Providers´ Experience With Wellness Seeking Refugees In Clarkston, Georgia

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HEALTHCARE PROVIDERS EXPERIENCE WITH WELLNESS SEEKING REFUGEES IN CLARKSTON, GEORGIA

by

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ABSTRACT

Currently, little information is available on free clinics and the volunteers who work in them. Ferris (2011) has observed that "most of what is known about these clinics comes from the clinics themselves, from journalists, or from general observers of the humanitarian world", and Bennington (2017) argues that the volunteer population has been documented at large, but that the medical and the free clinic environments have yet to be explored. While volunteering at the clinic I observed the work of other volunteers from different angles and this motivated me to place the question "Aside from the good experiences, which challenges do volunteers must face in order to open and work in a successful free clinic?". In the attempt to answer this bigger question, what I look for is to be able to add some literature knowledge on volunteers and their points of views.

INDEX WORDS: Volunteering, Free clinics, Humanitarianism, Faith, Third sector, Culture

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A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Master of Arts

in the College of Arts and Sciences

Georgia State University

2019

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College of Arts and Sciences

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May 2019

DEDICATION

There is a saying that states that it takes an army to help build an individual, and I could not agree more. I want to start by dedicating my work to my mother, Nitza. Thank you for always believing in me, even when I stop believing in myself.

I also want to dedicate my work to my best friends from Puerto Rico, Alexandra and Elizabeth. Thank you guys for always remind me my potential, for always listening to me, and for always pushing me forward.

Last but not least, I also dedicate my work to the friends that Atlanta gave me, Laila and Rachel. Thank you guys for never letting me fall, and for always being there no matter what.

Because of all of you I was able to do this, and I thank you from the bottom of my heart.

ACKNOWLEDGEMENTS

I want to start of by thanking Georgia State University and the Anthropology department for giving me the opportunity to further develop my anthropological skills. At the same time, I want to thank Dr. Papavasiliou for being patient and for guiding me through the whole process. I also want to thank Dr. White, not only for her advise during my process, but also, for introducing me to the Grace Village Medical Clinic, where I conducted my fieldwork. Furthermore, thank you Dr. Ruprecht for always making time in your schedule to help me with my research.

Last but not least, I want to thank Michael Sorrells, the Executive Director of the Grace Village Medical Clinic for letting me conduct my research there; and a big thank you to all the volunteers who never hesitated to participate in my study.

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1 INTRODUCTION

My first day as a volunteer at the Grace Village Medical Clinic was on a Saturday in September at 8:30am. At 9:00am patients were allowed to come into the clinic, so we had to prepare every corner of the house to make it look like a regular clinic. This mainly means opening seats to simulate a waiting area, opening tables at the entrance so the patients could register, and getting all the medical equipment in order. At 8:55am, the executive director directed a short prayer and after that the patients started coming in to the first station which was the registration tables. Never before had I witnessed so much cultural diversity in one same room: patients from Ghana, Iraq, Afghanistan, Lebanon, among others. Different cultures, different religions, different stories, all in the same place because of the same issue, not being able to afford to go to a regular clinic in the United States.

Currently, little information is available on free clinics and the volunteers who work in them. Ferris (2011) has observed that "most of what is known about these clinics comes from the clinics themselves, from journalists, or from general observers of the humanitarian world." and Bennington (2017) argues that the volunteer population has been documented at large, but that the medical and the free clinic environments have yet to be explored. While volunteering at the clinic I observed the work of other volunteers from different angles and this motivated me to ask the question "Aside from the good experiences, which challenges do volunteers face in order to open and work in a successful free clinic?". In the attempt to answer this bigger question, what I look for is to be able to add to the literature on volunteers and their points of views when it comes to refugees in the United States, the U.S. healthcare system, and their experiences while working at a free clinic.

Georgia´s communities receive 2,500 – 3,000 newly arriving refugees annually (Coalition of Refugee Service Agencies 2017). Grace Village Medical Clinic is in Clarkston, Georgia which boasts being "the most diverse square mile in America", with 31.8% of the population being foreign born (City of Clarkston 2018). This community has received over 40,000 refugees over the past 25 years (The Guardian 2017). The Grace Village Medical Clinic is funded by the Grace Snellville Church, which is a Christian church. Before opening their official clinic in Clarkston, members of this church traveled to places like Kosovo and Peru to help communities with health-related issues, but they decided to build a clinic here because they also wanted to help people in need in a local scale. According to the Georgia Department of Public Health, they can only treat people that have little to no income, are documented, and have no health insurance (Georgia Watch 2002).

When the Grace Snellville Church started this project, they were not focusing on a specific community or group, they just wanted to provide healthcare to people that could not afford it; however, as it turns out, 90% of the patients that frequent this clinic are refugees. The clinic attracts people because one of their main goals is to be able to help patients without them spending any money, and so far, they have achieved that. As of today, the Grace Village Medical Clinic is the only clinic that is completely free in the Clarkston area and depends solely on volunteers. The clinic runs every other Saturday for 5 hours, and recently the volunteers started opening the clinic every other Wednesday, for 5 hours as well.

The theoretical framework used in this research is mainly clustered around different theories that serve as major elements that set up the conditions for and guide de realities of free clinics. This section includes literature on neoliberalism, the third sector, humanitarianism, and faith-based humanitarianism. The turn toward neoliberal politics has led to the reinvention of the

government and the scaling back of services with the concomitant rise of the NGO form (Evans and Shields 2000, 8). At the same time, this reinvention of the government is changing the ethics of many nonprofit organizations and the roles they play within society (Evans and Shields 2000, 9). Furthermore, according to Castañeda (2011), the work of the third sector is governed by particular tendencies or ideologies, frequently discussed as a juxtaposition of human rights versus humanitarian approaches. As in today, faith-based humanitarianism exists from small-scale efforts, by religious communities to more professional operations which are the non-governmental organizations (Ferris 2011, 606), but because of the lack of information on them, they tend to get homogenized. By doing research on these topics I intend to show the connection that they share and their influence on the work that volunteers do at free clinics today.

By ethnographically examining the workings of the clinic and the perspectives of volunteers I argue that their work as intermediaries between the state and the community plays a key role when it comes to offering services that, in this case because of low income, people would not be able to afford otherwise. Beyond just giving these people a voice their position as intermediaries itself deserves attention because they materialize the ideological, moral and legal structures of the state, through the situated interpretive vision of a church. However, formally, they themselves are neither representatives of the state, nor necessarily of the church. As such, my work does not just document their work and voice their perspectives but illuminates the processes and complexities to be found at the very point of contact between the abstractions of legal status and humanitarianism and the concrete realities of people seeking and providing healthcare in this messy, neoliberal, globalized, but increasingly polarized environment.

The methods chapter presents the procedures that were implemented to conduct the research and the challenges that I encountered during my fieldwork. In this project I employed

participant observation, which involves immersion in the field of study to gain a systematic and methodical view of daily processes, and ethnographic interviewing, which illuminates the range of perspectives, understandings and meanings of social actors. Furthermore, I conducted informal interviews with healthcare providers. In the context of my volunteering, I was present in the waiting area of the clinic observing volunteers complete their daily duties and interactions. For the purpose of this study, participant observation was conducted during clinic days for 3 months. Additionally, I spoke with 10 staff members.

All the workers in this clinic are volunteers (physicians, nurses, and registration staff), meaning that they are not steady workers, and they keep rotating. Since space is limited at the clinic, they can only accept approximately 10 volunteers each Saturday, and there is a core of 10 people who regularly volunteer (around 4 physicians and 6 other volunteers) while the rest tend to be temporary. The number of ethnographic interviews therefore aims to capture the voices and perspectives of all the regular volunteers, and a sample of rotating volunteers.

The ethnographic section consists of three chapters. The first chapter is titled "Refugees and Free Clinics in the United States" and examines refugee policy and experience because even if the main focus of the research is on volunteers, it is also important to know about the people that these volunteers are seeking to help. The second chapter is titled "Religion and Humanitarianism in Free Clinics." Because the Grace Village Medical Clinic is a Christian-based clinic it is important to observe the role that religion plays on humanitarian work. Lastly, the third chapter is titled "Research in the Grace Village Medical Clinic" were I explain my different experiences at the clinic while I was gathering information through participant observation and informal interviews with other volunteers.

This research provides an ethnographic account of the Grace Village Medical Clinic in Clarkston, Georgia. The broader impact of my research is to elucidate the potential limitations and the achievements that free clinics in a context such as Clarkston when it comes to bringing healthcare to the refugee community. This research might help upcoming free clinics around the United States that are interested in helping the refugee community by not just documenting the achievements of a particular clinic, but also exposing challenges and the things that need improvement. At the same time, healthcare providers that volunteer at free clinics will have a chance to voice their struggles in order to work in a successful free clinic, which connects them to larger frameworks, like state policy and economic systems, and they will also get a chance to propose possible solutions to those struggles.

2 THEORETICAL FRAMEWORK

Much contemporary anthropology is centrally concerned with the larger structural and political factors of late capitalism, which are connected to the emergence of free clinics. Accordingly, this chapter provides a critical discussion related to the emergence and establishment of late neoliberalism using the dynamics of the "third sector". Furthermore, it questions if people´s identity plays a role on the amount and the quality of help they receive, in this case, how coming from a Muslim country might add challenges to the refugees that are seeking asylum. Another important part of the frame of this research is to examine how power dynamics between the state and grass roots community-based organizations create challenges for people that are trying to open free clinics, but also, how they also affect the ones that are already opened. The aim of this study is to build a broader theoretical framework, which allows the holistic interpretation of free clinics, the volunteers in them, and how their work creates a positive impact in the middle of a worldwide social crisis.

2.1 Neoliberalism and the Third Sector

Neoliberalism has provided a framework for competitive globalization by promoting and imposing far reaching programs of state restructuring and establishment across national and local contexts (Gledhill 2004, 332). Its premises also fixed the ground rules for global lending agencies operating in the economies of Asia, Africa, Latin America, and the Soviet Union (Gledhill 2004, 332). It is crucial to emphasize that these economies were torn by crisis at that time and that new forms of "free market" had been constructed. Since then, the virtues of free trade, flexible labor, and active individualism have become a part of contemporary politics (Gledhill 2004, 332).

David Harvey defines neoliberalism as "the intensification of the influence and dominance of capital; it is the elevation of capitalism, as a mode of production, into an ethic, a set of political imperatives, and cultural logic" (2005, 23). He also states that capital is not just properties and money, but it is an organizing principle of modern society. At the same time, "neoliberalism values market exchange as an ethic in itself, capable of acting as a guide to all human action and substituting for all previously held ethical beliefs" (Harvey 2005, 23). It emphasizes that the social good maximizes by increasing the frequency of market transactions. In simpler words, its main goal is to lead all human action under the domain of the market.

Neoliberalism has put pressure on the government, forcing it to re – invent itself and this has magnified the attention towards the role and place that nonprofit organizations have in society (Evans and Shields 2000, 8). It was with neoliberalism that the third sector got a key role as an agent of the state by producing and delivering "public goods" (Evans and Shields 2000, 2). This developing relationship between the state and nonprofit organizations is transforming the third sector by moving it away from its primary mission, also by commercializing their operations, and by compromising its autonomy (Evans and Shields 2000, 2). To be more specific, Evans and

Shields (2000) argue that the third sector´s core mission is to provide a number of services to the community, including areas like health and things like food, shelter, among others. The services are usually provided through grassroots community-based organizations and this makes the experience a bit more intimate, as this type of organizations tend to be close to the communities they serve and know their concerns. According to Evans and Shields, "the third sector is strategically situated, located between state and market, to facilitate a long-term strategy of marketization of public goods and services" (2000, 17). What they mean is that the third sector assumes a new role as producers and suppliers, and this compromises their autonomy as they move on to work more like agents of the state. These transformations have deep implications not only for inclusive citizenship, but also for the health of society, the development of capital, and enhancing social cohesion (Evans and Shields 2000, 2). In short, one of the main goals of neoliberalism is to downsize the state by slashing state support programs and by placing various human activities on to a market-based footing, and this includes nonprofit organizations (Evans and Shields 2000, 9).

In 1945, the IMF and the World Bank were established, and the United Nations was created. After this happened, a new framework for international development assistance emerged and later became key to a broader system of global governance (Georgeou 2012, 28). These international regimes played a key role in the institutionalization of volunteering in the 1970s (Georgeou 2012, 28). According to (Georgeou 2012, 28), along with the United Nations, the IMF and the World Bank have an emphasis on the interdependence of countries, and they are interested in the value that is given to equality and global responsibility in order to relieve poverty. This emphasis guided bilateral and multilateral donors to step in. The role of volunteering and the third sector is only reinforced with the shift away from the original Bretton Woods system to the flexible

system of neoliberal capitalism, which mistrusts the government and emphasizes private and individual agency. Before this, volunteering was viewed as an informal activity in which young people built friendships with others from different communities (Georgeou 2012, 29). As of today, volunteering has become a form of development practice involved a broader system of global governance (Tvedt 2002).

The term third sector is used to refer to various kinds of organizations like charities, nongovernmental organizations, social enterprises, self – help groups, among others that are not included in the state or market categories (Corry 2010, 11). It is implied that the third sector is positioned side by side with the state and the market, but they are not equals (Corry 2010, 15). "Nongovernmental organizations fill a service gap for welfare states; the social economy covers for failings in the market economy" (Corry 2010, 15) and this is the main reason why the third sector is accused of being a controlled sector under the power of other societal forces, particularly neoliberalism (Kaldor 2002).

According to Scott, "third sector/nonprofit organizations exist primarily to serve others, to provide goods or services to those in need and exhibit some aspect of voluntary action, behavior or shared commitment of purpose"(1992, 35-36). To compliment this statement Evans and Shields (2000) state that these organizations often interact with the public sector and tend to work in favor of the public good. The third sector delivers various services, both tangible (e.g. food, health) and intangible (e.g. counseling). These services are often provided by grass roots, community-based organizations that are or supposed to be highly aware of the issues and concerns of the communities that they serve. It is important to clarify that the organizations of the third sector can be highly variable, from top-down, heavy bureaucracy to bottom up, small, grassroots action. According to Stout (2010), people who are involved in grassroots organizations are committed to organizing

and educating themselves, so they can strategize to keep the powers accountable; by powers he is talking primarily about the government. Stout (2010) also believes that by utilizing a bottoms-up grassroots democratic style of organizing changes in America take place. He also states that this way of solving problems or making change is slow, tedious, and it must be detailed in order to be successful. According to Kenny (2002):

> Contemporary community-based interventions draw on ideas of engagement and self-determination located in the activist framework; at the same time, you find them on the individualistic idea of self-determination in the market framework, where competition and leadership are important, and where individuals, left to their own resources, become resilient. (p. 296)

As an example of how grassroots organizations work, Stout (2010) elaborates on the Obama campaign experiences before the election and explains why they were effective. Obama started with a small seed to plant and spread quickly, like grassroots, throughout the United States. In simpler words, Obama organized his way to presidency. Stout also explains how Obama used his presidency to mobilize grassroots organizations after the election, but this strategy did not work. To be more specific, Obama was a community organizer who worked with various citizens groups on Chicago´s far South side, and he emphasized how crucial it was that citizens were active and involved in working to bring about social change. The problem was that after he got elected as President, he shifted from being involved with grassroots organizing, to working in broad – based organizing, and he did not involve others in his decisions as much as some would have wanted.

The third sector also contributes to a non-stop public policy dialogue (Cappe 1999, 2). It is important to remember that voluntary organizations are formed by citizens and that as expressions of their communities they represent their issues and concerns (Phillips 1995, 4). By doing this they maintain “political spaces in democratic discourse for their constituencies”

(Phillips 1995, 4). Also, in the representational capacity, third sector organizations have two types of knowledge. They have the technical expertise of the people they represent and the service they provide, and popular knowledge about the concerns and history of the community they serve (Phillips 1995, 4). At the same time, according to Brown & Korten (1989), for a long time NGOs have been idealized as institutions where people can help others putting profit and politics aside. Fisher (1997) argues that this way of idealizing the NGOs as completely apolitical organizations has led theorists and practitioners to develop higher expectations for these institutions.

Development agencies and International NGOs tend to support local NGOs because of how effective they are when it comes to pursuing the goals of a new policy agenda that combines neoliberal economics and liberal democratic theory (Robinson 1993). At the same time, local NGOs already have the skills and can provide the training to prepare individuals and communities to compete in various markets; also, to provide welfare services to those that get affected by the market; and can contribute on the democratization and growth of a strong civil society (Fisher 1997). It is important to point out that all these skills that local NGOs possess are crucial for the success of neoliberal economic policies (Fowler 1991). Some analysts believe that NGOs are important as new political actors making valuable contributions to politics in general (Clarke 1996). On another hand, observers tend to disagree with the kind of impact that NGOs can have as some focus on the transformational impact on political structures and processes (Fisher 1993); whereas others focus on the NGOs impact on public policy and legislations (Edwards 1996). Fisher (1997) argues that as of now, there is no consistent evidence that shows any storyline talking about good NGOs against evil governments. In the end, we have to remember that the relationship between NGOs and the government is not static and this makes it difficult to mention definite impacts that they may have on each other.

In recent years there has been significant cutbacks in the financial support given from the government to nonprofit organizations and as a result the third sector has been experiencing fiscal stress (Evans and Shields 2000, 9). As beneficiaries of outside funding, this issue puts NGOs in a vulnerable position where they might not want to advocate positions that run against the agencies that are funding them or their local governments (Fisher 1997). It is a reality that well-funded NGOs are able to provide more and better opportunities to their workers, and at the same time these NGOs tend to attract more qualified individuals; this can be an inconvenience for NGOs that still want to focus on empowering communities and creating social movements (Pearce 1993). Evidently, NGOs are often connected with their home governments and their relationships can be, as Chazan (1992) says, dynamic, positive, sometimes controversial, and sometimes that relationship can be all these things at the same time. Bratton (1989) argues that governments often see NGOs as a threat to state hegemony and that is why they have always attempted to bring them under control through government agencies that are there to service them. According to Evans and Shields "The neoliberal´s interest is to cast the nonprofit sector as an independent third force, so they can obscure the role that many nonprofit organizations have historically played in close cooperation with government in creating and sustaining the welfare state" (2000, 9). When looking at the neoliberal restructuration in context, with the promotion of charity it becomes easier for the government to slip the responsibility for the poor by reassuring policy-makers and voters that no one will starve (Poppendiek 1998, 5-6).

2.2 Humanitarianism and Human Rights on Refugee Service Provision

According to the Geneva Convention (1951) a refugee is a person who has a "well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion". An individual that has refugee status is a legal resident, has the right

to work legally and can apply for citizenship after five years (Global Village Project 2011). There is a difference between being an immigrant and being a refugee, starting with the fact that an immigrant leaves their country of origin willingly, while refugees are forced to flee their home countries. Men, women, and children are forced to leave their homes only with the possessions they can carry (Global Village Project 2011). Refugees are not only forced to leave their belongings and their homes behind, but they may also have to endure gruesome journeys that might take them through forests, jungles or dangerous war zones (Global Village Project 2011).

In the United States, if a family arrives under the refugee status, a case worker has 90 days to arrange for an apartment with furniture, help the adults find a job, enroll the children in school, and discuss relevant topics like the available resources for language learning, healthcare, social service assistance. This is also the time frame settled to sign up refugees for social services like Medicaid, among others (Global Village Project 2011). After resettlement, adult refugees encounter some challenges that include dealing with trauma, learning everything in a new language, being isolated, fitting into American culture, finding a job; at the same time another issue that they must endure is having to re-build a sense of identity for themselves and adjusting to new family roles (Global Village Project 2011). In addition to these challenges, younger refugees struggle to succeed in school partly because of an interrupted education; at the same time, some of them encounter issues related to peer pressure and bullying (Global Village Project). Parents tend to become dependent on their children as cultural negotiators and translators because most of the times children are able to learn the language quicker; inevitably, this changes the power dynamics of the family (Global Village Project 2011).

Refugees experience conditions of vulnerability, marginalization, and poverty aside from the high stress of their displacement; this seriously affects the health of these populations (Langlois

et al. 2016, 319-321). Even though, most welcoming countries do offer some kind of medical screening upon arrival, many refugees do not benefit from these services as the quality of the screenings is considered questionable and often overlooks mental health problems (Langlois et al. 2016, 319-321). Legal restrictions also play a role in preventing refugees from gaining access to healthcare, as asylum seekers are typically granted restricted access to it, often limiting the medical care for emergencies only, pregnancy and childbirth care, and immunization services (Langlois et al. 2016, 319-321). At the same time, host countries often impose significant waiting periods before they grant refugees access to healthcare services (Langlois et al. 2016, 319-321). As a consequence of this delay, per-person health expenditures may increase for the refugees (Langlois et al. 2016, 319-321).

As of today, there is still some evidence that suggests that acculturation, immigration, and discrimination – associated stress are just some of the causes of various diseases within the community (Inhorn and Serour 2011, 939). According to Inhorn and Serour (2011,939) Arab - Muslim refugees that come into the United States face poverty and this affects their ability to seek higher education, improve their way of living, and even to access affordable healthcare. In a study that was carried out in Dearborn, Michigan most of the Arab refugees had "extremely challenging barriers to healthcare access, including lack of health insurance, lack of well-paid employment, or any form of economic support to pay medical bills" (Inhorn and Serour 2011, 939). Through interviews in the same study, Muslim refugees expressed how most had to leave their countries post – war and were unable to afford healthcare in the US medical system, and for many of them returning to the Middle East was not an option (Inhorn and Serour 2011, 939).

According to the United Nations High Commissioner for refugees, currently, there is an estimation that shows that 23 million people have the refugee status and around 65 million people

have been forced to leave their homes worldwide (Today 2018). Since 2017, the number of refugees that are entering the United States has reduced dramatically, primarily because of the current president Donald Trump, who gave executive orders to limit the number of refugees that come into the country even more. I say even more because it is important to point out that this is something that all presidents have done in the past starting in 1980, including Barack Obama, but Donald Trump made that number even lower. Not only this, but Donald Trump also banned people to enter the United States as refuges if they came from seven specific countries, five of them with Muslim majorities. For 2018, Trump set the limit of refugees at 45,000 which is officially the lowest limit on refugee admissions since 1980 (Today 2018).

In the late 1800s the city of Clarkston started growing as it was one of the stops on the Georgia Railroad (Today 2018). At that time the majority of the population in Clarkston was white until they started moving to the suburbs in the 1980s (Today 2018). It was in the 1980s that the city started to become a refugee destination. In that year, people were fleeing from Vietnam and other Southeast Asian countries that were repressed started coming into Clarkston (Today 2018). Ted Terry, the Mayor of Clarkston, stated that during that time "a lot of leaders were saying that they could not take Vietnamese refugees because the communists could infiltrate the ranks and spread communism" (Today 2018). Even with these people´s opinions against accepting refugees into the state, in the past 25 years, Georgia has resettled 37,000 refugees with an average of about 2,500 to 3,500 each year (Today 2018). Now, regarding the refugees directly, Ted Terry, said that new arrivals have typically spent seven to 10 years in a refugee camp before entering the United States. Not only this, but he assures that usually they come into this country with skills that help them find jobs quicker. He also mentions that 89% of the refugees that come into the United States

through Clarkston become self-sufficient in six months, and in that same time frame they stop depending on the government (Today 2018).

It is a reality that on most cases primary care clinics are the first access point to healthcare for refugees, and the healthcare barriers are well documented (Kotovicz et al. 2018). Some of the known challenges that refugees and healthcare providers must endure are communication and language barriers, acculturation challenges, divergent cultural beliefs about health, and difficulty establishing trust (Kotovicz et al. 2018). At the same time, healthcare providers notice how often refugee populations are unfamiliar with concepts like prevention and long – term treatment of asymptomatic conditions and they agree that a greater amount of time for health education is crucial (Kotovicz et al. 2018). "Lack of knowledge of the healthcare system and reduced ability to negotiate and advocate for themselves creates barriers to access services, comply with medical recommendations, and succeed within the social context, making resettlement more difficult" (Kotovicz et al. 2018).

NGO work does not function in an ideological vacuum but tends to follow particular perspectives, most often casting work as humanitarian or rights-based. Their perspectives, in turn, affect not just the work they perform and the methods they use but the access and role they play in specific places. Humanitarianism´s main purpose is to alleviate people´s suffering; at the same time, it tries to depoliticize aid, while Human Rights approaches, by contrast, are more overtly political (de Torrente 2004). As Gottlieb, Filc, and Davidovitch state, "human rights organizations play an important role in advocating for migrants´ rights, but in many cases, they represent a legalistic and individualized conceptualization of the right to health that limits their claims for social justice" (2011, 839). It was between the 1960s and the 1970s that human rights organizations that shared the same principles of humanity and universality as humanitarian

organizations emerged (Gottlieb, Filc, Davidovitch 2011). The only difference between these two types of organizations was that instead of putting politics aside and focusing on providing assistance, human rights organizations were questioning the legitimacy of states that systematically violated human rights. By questioning and challenging these states, their goal was to modify political contexts that permitted violations of human rights and possible humanitarian crises.

According to the Advocates for Human Rights organization,

> Human rights law provides an important framework for guaranteeing the rights of all people in all countries, yet, human rights standards generally do not become enforceable in the United States unless and until they are implemented through local, state and/or federal law. (2019)

Since this is how the system works, the best way to improve human rights in the United States is by fortifying domestic legal protections for human rights (Advocates for Human Rights 2019). This can be done by passing laws that recognize those rights, and after, ensuring that they get recognized and implemented by the government and United States courts (Advocates for Human Rights 2019). As of today, the United States possess a mixed record on human rights. Unlike many nations is the world, the United States has not ratified several of the human rights most important treaties (Advocates for Human Rights 2019). Some experts argue that "the U.S policy does not always respect human rights and the government also fails to protect key human rights domestically, especially economic and social rights (Advocates for Human Rights 2019).

During the first half of the 20th century, the United States was very active by proposing and establishing a universal human rights system (Advocates for Human Rights 2019). In 1948, they were actually one of the leading countries that helped create the Universal Declaration of Human Rights (Advocates for Human Rights 2019). In the 1950s, the United States started opposing to the newly established international human rights system and eventually they just stopped

participating. At that time, the United States had domestic reasons to back away from the international human rights law; many states were practicing legally-sanctioned discrimination against racial minorities, covered by the Jim Crow laws (Advocates for Human Rights 2019). It was not until the 1960s and 1970s that the United States came back to the international human rights system, by signing various human rights treaties, such as the International Convention on the Elimination of All Forms of Racial Discrimination, the International Covenant on Economic, Social, and Cultural Rights, among others (Advocates for Human Rights 2019). Like mentioned before, it can not be said that the United States, in the present, is fully committed to the international human rights system. It was not until 2009 that the United States rejoined the UN Human Rights Council. As of today, two important treaties that have not been ratified by the U.S are:

> The International Covenant on Economic, Social, and Cultural Rights, that was created in 1966 and it is the only covenant that forces governments to protect such rights as health, education, social protection and a descent standard of living for all people; and The International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, created in 1990 and it protects migrant workers and their families from abuse and inhumane treatment and conditions in the countries that they work. (Advocates for Human Rights 2019)

The first treaty that was mentioned currently have been ratified by more than 150 countries. Interestingly enough, the second treaty has not been signed by any industrialized, migrant-receiving country. It was during the 1980s and the 1990s that the United States became active in humanitarian interventions and to indict crimes against humanity.

Tracing the challenges of humanitarianism and health care provision in Germany Castañeda points out that over the past decade the climate in the United States, similar to the one in Germany, has become more restrictive and hostile and this has increased support for laws to criminalize medical aid and even to require that authorities must be notified if people that come into their

clinics are illegal immigrants (Castañeda 2011, 7). According to Castañeda, "the reporting guidelines generated significant confusion and anxiety among human rights advocates and state workers and forced them to serve as both as gatekeepers as well as be subject to criminalization themselves" (2011,7). At the same time, it is a reality that these clinics face difficult conditions as they often have inadequate equipment or do not have the necessary equipment, they often deal with irregular funding and recordkeeping, among other situations (Castañeda 2011, 8). Even by enduring all these issues, these organizations provide key services that would not be available for people in need otherwise, and that the people who decide to volunteer step in where the state has "forgotten" to fulfill its legal obligations (Castañeda 2011, 8). Even if the connection with my research might not be clear at first, throughout her work, Castañeda lays out how "universal notions of a right to health for unauthorized migrants operate together with incongruous state an international policies" (2011,1). Instead of being anchored by policy, the medical care for unauthorized migrants tends to be left at the mercy of NGOs. Even if the volunteers that participated in my study are not allowed by the state of Georgia to treat unauthorized migrants, some of the struggles that volunteers who participated in Castañeda's (2011) study in Germany had to endure, were also brought to my attention during my semi-structured interviews. Castañeda (2011) explored the various motivations that encouraged physicians to bring care to marginalized populations; this included political, religious, and humanitarian motivations. In her study, the volunteers´ engagement with the cause came as a result of the outrage that unethical state practices caused (Miraftab 1997). But in the end, as Kamat (2003) states, by filling the gaps in the service delivery area NGOs practices enter a complementary relationship with the state, and at the same time they allow the expansion of neoliberal practices; this happening by the government controlling what goes on in these institutions from a distance.

Free clinics in the United States have existed since the late 1700s, as dispensaries started providing free health care to the poor in cities in the northeast (Starr 1982). Now, Katz (1996) argues that in the early 1900s these dispensaries started disappearing throughout the United States because of the institutionalization of academic medicine in universities. As a consequence of this institutionalization, Katz (1996) also states that private physicians kept trying to undermine free clinics. At that time, dispensaries did disappear, but the population still needed access to healthcare, so in order to fill this gap, new institutions emerged (Hossler 2012, 102). Weiss (2006) acknowledges that today, free clinics are using the clinics that were organized by the Black Panther Party, Young Lords and the counter-culture movement of the late 1960s as models. Back then, these clinics were created as a response to the racism that prevented racial/ethnic minorities from getting proper health care (Hossler 2012, 102). It has been estimated that currently, there are 1700 free clinics actively operating in the United States (Isaacs and Jellinek 2007). It is possible that this number has been underestimated, as many free clinics operate in basements, churches and community centers (Hossler 2012, 103). Sometimes, these clinics are only known by the community that they serve.

2.3 Faith-based Humanitarianism

Throughout the years, the relationship between humanitarianism and the Christian theology specifically has been tense. During the colonial period, Christian missionaries went on humanitarian trips with the idea that their main duty was to "go into all the world and preach the good news to all creation" (New International Version Bible, Mark 16:15). The first religious aid agencies were created with the help of the Protestant evangelical movements (Thaut 2009). Aside from spreading the Gospel, these agencies were looking forward to assisting poor people economically and ideologically (Barrow and Jennings 2001). Michael Barnett and Thomas Weiss

(2008) state that in the present it is the Christian-based organizations the ones that have had a lot of influence on the humanitarian actions that we see today. Barnett and Weiss (2008) go as far as saying that for the Western world, the New Testament of the bible works as a charitable guide.

As of today, not much academic research has been done on faith-based organizations in the humanitarian arena. "Most of what is known about these organizations comes from the organizations themselves, from journalists, or from general observers of the humanitarian world who have not explored the particular orientations of faith-based organizations" (Ferris 2011, 621). It is evident that the world of faith-based organizations is full of variety, but because of the lack of information on them, they tend to get homogenized (Ferris 2011, 621). Furthermore, to be more specific, research needs to be done on the funds that are raised and moved through these faith-based organizations as these data currently do not exist, except for few international NGOs (Ferris 2011, 622). With research being conducted in this area, the public will be able to understand the movement of the resources and this could lead to better access to international funds and more support to local communities (Ferris 2011, 622).

Local churches tend to provide significant support to people that need it in their communities (Ferris 2011, 610). As of today, "differences between faith-based and secular organizations appear to center on the extent to which religious activities such as worship, prayer, and evangelical activities are integrated into these organizations´ humanitarian work" (Ferris 2011, 616). This categorization raises questions about how many faith-based organizations implement neutrality and impartiality when engaging in humanitarian work (Ferris 2011, 616).

Faith-based organizations do have some advantages over the secular organizations when it comes to humanitarian work. First, faith-based organizations have or at least may have some unrestricted funding from their own communities, and this gives them the freedom to carry out

more activities without the donations of the government, meaning that they can have other donors without any objections (Ferris 2011, 617). Most secular NGOs rely on government funds almost exclusively which restricts them to the priorities of their donors and limit their opportunities to carry out more activities and to develop diverse programs (Ferris 2011, 617). A second advantage that faith-based organizations have over secular ones is that most of them build networks of local partners in their communities and this adds strength to the organizations (Ferris 2011, 617). Faith-based organizations also suffer from a few disadvantages, starting with their problematic relationship with neutrality, a humanitarian principle. "Advocacy for justice is never neutral, nor is much of either Christian or inter – faith peace work" (Ferris 2011, 617). Surprisingly for some, various secular organizations suffer from the same disadvantage, but religious agencies tend to get called out more on this topic. "The fact that some large faith-based organizations receive a significant portion of their funds from governments can raise questions about the extent to which they are independent humanitarian actors" (Ferris 2011, 617). Another disadvantage that some faith-based organizations must endure is that they can have problems within their faith communities. For example, "while churches set up church – related agencies precisely to carry out charitable work on their behalf, the interests of the church may differ from those of the specialized agency" (Ferris 2011, 617). The problem with this is that the situation evidently creates unnecessary tension within the broader church constituency.

Many humanitarian organizations have religious motivations and are actively involved in missionary work (Walker and Maxwell 2009). At the same time their humanitarian notions of altruism go hand by hand with the moral teachings of world religions (Walker and Maxwell 2009). Humanitarian efforts have been greatly influenced by faith-based efforts, and as a result, the boundaries between apolitical service work and the commitment to social justice and advocacy

have been blurred (Taithe 2004). In the study of Tiedje and Plevak, they observed how "faith-based medical humanitarianism combines its traditional notions of human compassion and Christian solidarity and apolitical service work with that of social justice and human rights advocacy in the rural U.S" (2014, 360).

Many experts have pointed out that as of today, very little is known about how Christian beliefs shape the principles and how these organizations operate. Thomas Jeavons (2004) emphasizes that:

> We cannot understand these organizations well, we cannot fully comprehend either what they are or what they should be -at least from the point of view of the traditions that gave them birth, and that they claim to represent- if we do not see how the religious belief system that undergirds them also encourages the integration of service and witness, faith and works, preaching and practice." (p.46)

At the same time, Barnett (2008) states that "we actually know very little about the connection between religious identity and organizational structure, where an organization is willing to act, who it is willing to help, and what kinds of assistance it is willing to provide and under what conditions" (p.249). Not being able to fully comprehend all of this brings concerns, as it raises the question "Has contemporary humanitarianism truly broken with its roots in nineteenth century colonialism and Christian missions? Meaning, having the saving power in one hand and the bible in the other?" (Thaut 2009, 326). It can be argued that Christian-based organizations do employ some sort of religious imperialism, as they may see people in need as opportunities to capture an audience to spread their message, even if in the end the people do not need to become Christians to receive aid (Thaut 2009, 326). In the end, according to Thaut (2009), faith does play a key role in these organizations, but that role varies among them and its is determined by the organization´s individual theological tradition and how they make use of the humanitarian practice.

There has been a significant increase in the number and visibility of religious organizations that are involved in development and humanitarian aid (Petersen 2010). Through history we have witnessed how some religious organizations as Catholic hospitals, Islamic foundations, Buddhist monasteries, among others have provided aid to the poor (Petersen 2010). As of today, religious NGOs are a diverse group of conservatives and progressives (Petersen 2010). The history and the connections to religious institutions of many of these organizations might facilitate their relationship with local communities by providing them information related to the context, and by giving these organizations possibilities for building relationships of trust that were already established (Petersen 2010).

Darnell (2010, 946-953) suggests that policymakers and other safety net providers must acknowledge that free clinics have an important role to play, and that by integrating free clinics into the safety net there is potential to strengthen the healthcare system overall. Most free clinics are independent entities, affiliated with other clinics and hospitals (Darnell 2010, 946-953). At the same time, most operate as medical clinics, generally in buildings that are rented; only few of the clinics have their own buildings (Darnell 2010, 946-953). According to (Darnell 2010, 946-953), free clinics tend to receive funding from private charitable donations, civic groups, churches, foundations and corporations, while federal, state and/or local grants support the operating costs of only few of them.

Georgia is one of the top six states in refugee resettlement, and most of the refugees that are currently living in this state are usually settled in the Clarkston/Stone Mountain area (Global Village Project 2011). The Grace Village Medical Clinic is an openly Christian based clinic, and I suggest this plays an important role in how they operate. The clinic is intrinsically linked with the Grace Snellville Church, to the point that the church provided the money to buy the two houses

in which the clinic operates today in Clarkston. Most of the non – medical staff are active members of this church. The clinic is also in partnership with the Christian Medical & Dental Associations of Atlanta. The mission of the clinic is to provide quality healthcare to people that would not be able to obtain it otherwise. This ideal can be associated with the Christian focus on charity.

3 METHODOLOGY

This chapter presents the methods I utilized during my research and examines what procedures were used and what challenges I encountered while doing my fieldwork in Clarkston, Ga at the Grace Village Medical Clinic. Before entering the field, I considered possible challenges and difficulties related to my positionality in this sector. The first challenge being attempting to focus my research on a vulnerable population. After careful consideration, I decided to focus my work on volunteer care givers. I prepared semi-structured interviews for the volunteers at the clinic and decided to audio record these interviews to maximize data fidelity. Additionally, I took fieldnotes and actively participated within the Grace Village Medical Clinic´s environment for 3 months.

My biggest concern before starting my research was to figure out the best way to approach other volunteers without making them feel coerced to participate in the study. The executive director of the clinic gave me permission to conduct my research there. Therefore, I made sure that even with the volunteers knowing that he knew about my study, they did not feel compelled to participate in it. A limitation of my research is that it does not include refugee voices, which I had to omit for pragmatic and ethical considerations. I lay out the methods I employed in more detail and the chapter ends with a discussion on the limitations and opportunities that emerged from my methodological choices. The chapter underscores the importance to understanding the perspectives of healthcare providers, especially the ones who decide to volunteer.

3.1 Methods in Anthropological Research

When conducting anthropological research, there is a variety of methods that allow the anthropologist to collect qualitative and quantitative data. Some of these methods that are pertinent to this research include participant observation, field notes, and semi-structured or open-ended interview questions. Participant observation is a research framework in which the ethnographer gets actively involved in the lives of the people that are being studied (Bernard 2006, 291). The main method of documenting and analyzing day-to-day experiences for most people is through field notes. Person – centered interviews are a combination of informant and respondent questions and probes (Bernard 2006, 337). According to Bernard "A probe is an intervention to elicit more information, not necessarily in the form of a question" (2006, 337). Another pertinent method in this research is audio recording which contains various kinds of information that allows the interviewer to make interpretations about the interaction with the interviewee (Bernard 2006, 353).

The ethnographer must be aware that with each of these methods there are different concerns that will emerge. For example, participant observation raises the highest number of ethical questions. The first issue has to do with preserving the anonymity of the people that participate in the research (Bernard 2006, 273). The second issue is directly related to field notes, as the researchers must acknowledge that these notes are constructed by them, and as humans we are all biased in some ways (Bernard 2006, 271). Also, one of the main concerns when conducting semi – structured interviews is to fall into what is called cognitive distortion, which Bernard defines as "a misunderstanding of what is going on, based on the interviewer´s prior intellectual experience with other types of people and contexts" (2006, 347). With audio recordings the biggest concern is that there is always a possibility that the files can be misplaced, and this cannot happen, because the ethnographer must protect the identity of the interviewee. Even with this said,

it is a positive when an ethnographer makes use of a combination of multiple methods as that might help to increase the data validity.

3.2 Methods during Fieldwork

The bulk of this ethnographic research started in September 2018 and ended in November 2018. I obtained formal acknowledgement and permission from the clinic´s executive director. I started volunteering at the clinic on April 2018, which gave me time to get to know the volunteers and for them to get to know me. It was because of this development of relationships that they trusted and welcomed me. While I was developing my relationship with the volunteers, I must admit that I was nervous, because of the uncertainty of not knowing how they would react to a female, black, Puerto Rican, graduate student coming into their working space to observe and conduct research; plus, to be honest, compared to the number of volunteers that work at the clinic, just few of them accepted to participate in my study, and most of them were women. Starting in September 2018, I gathered qualitative data through semi – structured audio recorded interviews, and field - note taking through participant observation in formal and informal conversations with the volunteers of the clinic. I spoke with at least 10 volunteers in the clinic, as I understood that this number was enough for me to gain insight and understand the needs, challenges and possible solutions that emerged from these people that volunteer at the Grace Village Medical Clinic.

All the workers in this clinic are volunteers (physicians, nurses, and registration staff), meaning that they are not steady workers, and they keep rotating. Since space is limited at the clinic, they can only accept approximately 10 volunteers each open clinic day, and there is a core of 10 people who regularly volunteer (around 4 physicians, and 6 other volunteers) while the rest tend to be temporary. The number of ethnographic interviews therefore aimed to capture the voices and perspectives of all the regular volunteers, and a sample of rotating volunteers. What I looked for

with these semi-structured interviews were to explore the healthcare providers point of view on topics related to public service, refugees, politics, and migration. Verbal consent scripts were handed out as flyers in the waiting area as I explained everything related to the research before the volunteers started to work with the patients. A consent form was given to the volunteers that wanted to participate in the research and all of them were already notified that participation was voluntary. Participants were assigned pseudonyms. No identifying information was collected from the participants, but pseudonyms will be used to refer to them in publications or presentations.

My interview questions started with demographic information (such as age, ethnicity, and religion). Then I moved on to asking the participant´s history of volunteering. After, I asked about how the participant got to know about the clinic´s existence and what motivated the participant to volunteer in it. I also wanted to know the participant´s point of view on immigration and refugees in the United States (which are different). I believe that the deepest question that I had refers to the fact that since 90% of the patients that attend the clinic are refugees, what are some significant challenges that they must face when it comes to healthcare, as the participant volunteers saw them?

I also asked if at the end of a clinic day, they think that they had gone home with any lessons. Another question that can be a bit complicated to answer, but I felt that it was necessary is if they believed that the United States healthcare system is efficient for refugees. Also, there are questions related to what is a typical day at the clinic? and have you encountered any remarkable experiences at the clinic? At the end, I simply asked if they believe that volunteering at this clinic will open doors to new opportunities. These questions can be seen as very open-ended, but I employed this technique, so the participant could feel more comfortable and talk about their experiences clearly, with less inhibitions.

3.3 Ethical Challenges in Research with Vulnerable Populations

Even though I decided not to focus my research on the refugees/patients that attend the Grace Village Medical Clinic, my intention initially was to do so. I already knew beforehand that this community was considered vulnerable for many reasons, but it was not until I went to the clinic for the first time that I realized that starting with the fact the realities of this vulnerability, starting with the fact that most refugees have endured several hardships, and it is extra difficult for them to trust people, especially when their English is not fluent. This is when I started thinking about the time frame available for my research (considering analyzing information, classes, work, writing time, etc) and I decided to focus field work within a three-month period. The problem with this was that in order to gain somebody´s trust, a descent amount of contact is highly required, and if I decided on focusing on refugees/patients, the time I had available for building rapport, relationships and trust would not be tenable. I also acknowledged that most refugees that frequent this clinic had a hard time with English, so this was another limitation for my research, because at the same time you hear multiple languages in that waiting room. Although, I am certain that if I had maybe one or two more years to work on this research, I would have included them without a doubt.

Some ethnographers do not see obvious vulnerabilities until they start conducting their research (Lphofen 2015, 49). Ethnographers´ perception of vulnerability is going to depend on their cultural preconceptions, but it is also regulated by localized legislation (Lphofen 2015, 49). After acknowledging certain vulnerabilities, ethnographers need to be careful on how they phrase questions that are related to the topic; at the same time, the ethnographer must be prepared for any emotional response (Lphofen 2015, 49). For (Birman 2005, 155) to define ethical responsibilities for a researcher is difficult when they work with vulnerable populations

and diverse cultures, as sometimes they encounter conflicting definitions if what being ethical means. Researchers must be familiar with the ethical issues of the culture that they are studying, as this is going to help them understand their perspectives better (Birman 2005, 175). Focusing my study on the volunteers of the Grace Village Medical Clinic allowed me to circumvent some of the thornier ethical considerations by not including populations that are considered vulnerable, but it still gave me the opportunity to offer invaluable perspective on how refugee care actually materializes through their experiences.

3.4 Opportunities and Limitations of Research´s Methodological Choices

For this research I decided to combine various methods that are useful for collecting relevant qualitative data. I used participant observation and field notes, followed by semi-structured/open-ended interviews. When using participant observation at the clinic, I got the opportunity to observe everything that is happening around me without having to interrupt the normal day-to-day activities/dynamics of the volunteers, and this gave me insight on the context in which I am immersed myself. When using field notes, I got to remember the details of important observations that I would probably forget eventually. Participant observation not only helped me guide interviews, but it also faded some of the stress that we encounter in structured/formal interviews, for example, the interviewees got the opportunity to speak their minds without feeling that they must constrain or limit themselves to answer something too specific. This was also a good opportunity for me because with participants´ answers I got to start questioning more things related to my research as well. Since the interviews were audio recorded, I had the opportunity to listen to these recordings as many times as I needed to, meaning that I got all the details that I may might have missed while the interview is taking place.

Every method that I decided to implement into my research came with its limitations. For example, with participant observation I need to be aware of my positionality as a researcher in the clinic and acknowledge that this might influence the way volunteers carry themselves around me. Writing field notes in front of everybody can be awkward and since I was aware of this, trying to find the perfect time to write data can feel limiting at times. One limitation of working with semi – structured/open – ended interviews is that the participant might start answering the question and suddenly move on to something that is important to them, but it is completely irrelevant to the research. As an ethnographer you are called to not interrupt the participant, but you need to come up with innovative ways to re-direct the interview back to where you need it to be. Following the line of limitations that came with conducting interviews, I have to mention that even if I said that every volunteer at the clinic was welcomed to participate in my study, most of the volunteers who ended up participating were females; this for me was frustrating at first because I wanted to get, if possible, an equal amount of males and females. At the same time, most of the physicians who volunteer at the clinic are males, so I only got to hear the experiences of few of them. Also, since the interviews were audio recorded, the biggest limitation became the preservation of anonymity, and with this making the decision of where to store the recollected data safely. I felt that I needed to give the interviewees pseudonyms so they could address the topics that they wanted to freely, without having to think that they would be exposed. Now, speaking about the clinic per se, I did not utilize a pseudonym for it because as of now it is the only free clinic in the Clarkston area and exposing it will help spread the word.

Another thing that I saw as a limitation while conducting my research was acknowledging that the environment of the Grace Village Medical Clinic was complex; by this what I mean is that there is health involved, policies, religion, among other interesting components that make this

clinic what it is today. I saw this as a limitation because my main focus was on the volunteers and their experiences with refugees at the clinic, but if I had more time to work on my research, I would have investigated the religious aspect of the clinic, all the policies that can affect the clinic, among other components more in depth. During the interviews these components did emerge, and I could perceive through my participant observation that they are there indeed, but as an anthropologist I had to acknowledge that I could mention these components and explain what I witnessed in the clinic the best way that I could but in the end these areas would need to be looked at more in depth in further investigations. At the same time, my limitation was not only the amount of information that I could include in my study aside from the volunteers´ voices and experiences, but also how much could I critique this side components. In the end, I realized that I could still make valuable critiques on, for example, the religious component of the clinic as long as I acknowledged that the critiques were based on what I witnessed while conducting my research at the clinic and the information that I got from my interviews.

4 FINDINGS

There are several studies that focus on refugee healthcare experiences; however, the perspectives of those who provide healthcare, particularly in such humanitarianism-based contexts, are important to understand as well; Healthcare providers are the ones that struggle with a variety of problems and barriers in order to offer refugees the care they need. Studying volunteer providers is significant because since they do the bulk of this work, we need to understand how, they shape, are shaped by and are enabled and constrained by larger cultural frameworks. Some of these frameworks, like state policy and even economic systems, enable and constrain providers in different ways. These larger political frameworks are constantly shifting, thereby hindering the success of such clinics. For instance, state pre-requisites and rules regarding the makeup and

characteristics of the populations that free clinics may serve and the types of services they may provide are constantly subject to change (Georgia Watch 2002). This causes additional difficulties, both practical and affective, to healthcare provider´s work, and impacts them as well as their clients. Therefore, this study aims to understand the needs, challenges and solutions of volunteer healthcare providers in the Grace Village Medical Clinic, to develop recommendations for improving cultural communication and support providers' work.

4.1 Grace Snellville Church and the Emergence of The Grace Village Medical Clinic

In the Fall of 1983, Buddy Hoffman held the first Grace Fellowship Church meeting in a daycare center un Tucker, which is a suburb outside Atlanta. A few years later, the church bought a small building located in a town called Lilburn. By 2000, the church grew in size, to the point that they had to relocate the church to a new building in Snellville. In 2001, "the leadership team committed 15% of the total budget to missions from the church´s inception" (Grace Snellville 2017). In 2010, a third Grace Church was created in a small town called Monroe. In 2013, another Grace Church opened in Athens. As in now, what started as just one church became a Family of Churches that share a common elder board and a central service team, but each church has their own local leadership, live preaching, and they are mostly financially independent (Grace Snellville 2017). The financial and administrative support of each church is handled by a team of central services (Grace Snellville 2017).

The Grace Snellville Church is a Christian church that believes that God sent Jesus, his son, to earth as a man to announce his kingdom. Even if they do not call themselves that way, their beliefs fall into the non-denominational category. For them Jesus, invited a new group of followers, called the disciples to imitate his life and to love God and others as much as they love themselves. They also believe in the death and resurrection on the third day of Jesus, and that he

is now by his father´s side in heaven. Today, as a congregation, they believe in the Bible and pursue what the disciples did in the past, to imitate Jesus life as much as possible and to love God and others. Members of this church are encouraged to do charitable work and they seek to alleviate the suffering of people in need; yet, they believe that it is important to develop meaningful relationships with others through their work, no matter what religious beliefs the others may have.

Before 2001, the Grace Snellville Church was already working with multiple partners around the world on various trips and projects (Grace Snellville 2017). At that time, it is said on the church´s online page that their leadership team committed 15% of the total budget to missions planned by the church. According to the church, these relationships developed organically because of the connections of people within the congregation. After September 11, 2001, when the attacks on the World Trade Center and the Pentagon took place the church sent a team to New York, and it was after that moment that Buddy Hoffman along with other leaders of his team decided to shift their primary occupation to the seeking of reconciliation with the Muslim community (Grace Snellville 2017). As they state in their online page since the church shifted their primary occupation, they "have been prayerfully and intentionally trying to learn the best ways to build relationships and share their faith with the Muslim communities around them" (Grace Snellville 2017).

The concept of the Grace Village Medical Clinic started in 2013 with a truck; which someone donated to the Grace Snellville Church. Prior to this, active members of the church had traveled to places like Kosovo and Peru to assist communities in those locations with health-related issues. The church members saw the truck as an opportunity to help people in need on a local scale; this is how the idea of having a "clinic on the road became a reality". As Dr. King,

who is the medical director of the clinic, explained to me "Most of these new Americans, we were told, had no health insurance so we started visiting Clarkston apartments to help, initially once a month but later every other Saturday." After only a few months they realized that the idea was not very effective, mainly, because when you are dealing with vulnerable communities that have had to endure so many difficult situations it is very hard to gain their trust, and by not being in a steady place, this became an issue. In November 2017 they became steady in a house located in Clarkston, Georgia. As of today they operate only two Saturdays a month, and nobody gets paid, because they are all volunteers. According to the Georgia Volunteer Health Care Program of the Department of Public Health, the physicians in the clinic can only treat people that have low income, are documented, and do not have any health insurance. When they started this project, they were not focusing on a specific community or group, they just wanted to provide healthcare to people that could not afford it, but it so happens that 90% of the patients that frequent this clinic are refugees.

4.2 Christian Medical and Dental Associations

The Christian Medical and Dental Associations (CMDA 2019) is an organization that "provides resources, networking opportunities, education and a public voice for Christian healthcare professionals and students". The organization was founded in 1931, and according to their official website (CMDA 2019):

> They promote positions and address policies on healthcare issues; conduct overseas medical evangelism projects; coordinate a network of Christian healthcare professionals for fellowship and professional growth; sponsor student ministries in medical and dental schools; distribute educational and inspirational resources; provide Third World missionary healthcare professionals with continuing education resources; and conduct academic exchange programs oversees.

This organization is a 501(c)3, which under the terms of the (IRS 2019) means that they are a charitable organization that is eligible to receive "tax-deductible contributions", according to the Code section 170. It is important to mention that in order to be recognized as a 501(c)3 organization, they can not be seen as an action organization. According to the (IRS 2019), "these organizations may not attempt to influence legislation as a substantial part of its activities and they may not participate in any campaign activity for or against political candidates." In simpler words, these organizations are restricted in how much involvement they may have in political and legislative activities. The organization itself is governed by a Board of Trustees and House of Delegates, who are elected every three years by district (CMDA 2019). Today, there are approximately 75 employees that form the staff of the CMDA in the national office and U.S field offices. Also, it is important to mention that to become a part of this organization you must become a member by paying an annual fee. The organization has various membership deals, the cheapest one starts at $64 for a year, which is usually the one that they offer to healthcare professionals who already retired, and the most expensive one costs $387 for a year, which is usually the membership that they offer active healthcare professionals. According to their official website, members of the organization have the benefit of having access to resources such as videos, articles, audio files, and presentations related to faith and practice. Members also have access to various ministries that were designed for Christians in healthcare, such as malpractice and support among others. At the same time, members have the benefit of getting assistance from placement services to find a practice from their large network of "like-minded healthcare professionals" (CMDA 2019). They also get the benefit of free continuing education on topics like ethics, family issues, and the challenges of working in healthcare. Last of not least, the annual dues for CMDA are tax-deductible to the fullest extent allowed by law.

Dr. King is a member of the Christian Medical and Dental Associations and the medical director of the Grace Village Medical Clinic. In the clinic he monitors other physicians, nurses, and medical students as they receive patients. At the same time, being a member of the CMDA, he is always in contact with other physicians within the organization to check their availability, so the clinic is not left unattended. The non-medical volunteers of the clinic are typically members of the Grace Snellville Church or students from various universities in Georgia. These students learn about the clinic because of professors that know about the clinics´ existence and encourage them to volunteer. Today, Emory´s IM residents rotate through the clinic thanks to the initiative taken by physicians. Also, sometime in 2019, the Grace Village Medical Clinic will have an MOU in place with Georgia State University´s Nursing and Health Professions Program to have both faculty and nursing students rotate through the clinic.

4.3 Work in the Grace Village Medical Clinic

As of today, the Grace Village Medical Clinic opens every other Saturday, from 9:00am to 1:00pm, and every other Wednesday from 10:00am to 2:00pm. Since I used to have classes on Wednesdays, I went to the clinic on Saturdays. A typical Saturday at the clinic starts at 8:30am, which is the time that the executive director suggests that the volunteers start arriving, so we can help get everything organized and ready. After unpacking, all the volunteers get together at the waiting area and the executive director says a prayer, before the clinic officially opens for the day. During weekdays they engage in different activities with refugees to help them get adjusted to their host country; this is separate from the health clinic but hosted by the same church. These activities include different kinds of workshops to help them gain more skills, so they can have more job opportunities; clinic volunteers also provide counseling to help refugees cope with their

transition and possible traumas and it is important to mention that all these services are offered free of charge.

A busy/successful day at the clinic consist of seeing up to 50 patients, and "slow" days consist in seeing at least 30 patients. Volunteers feel satisfied when they receive lots of patients, primarily because for the providers this means that the word is spreading around the Clarkston community and refugees/people with low income are learning about the clinic´s existence. As Frances, a current volunteer of the clinic stated "If you don't tell people, they won't come. Our most attended clinic days, are when we can get the word out properly through the various micro communities here in Clarkston."

New patients have to sign a form with personal information, which is required to assure that they meet the requirements stated by the Georgia Department of Public Health. Most of them meet these requirements; and they move onto getting their vitals taken by a nurse. First time patients are then led to the waiting area, where a file is created for them as they wait. Returning patients have their files pulled and updated by the nurse. While the patients are in the waiting area they do have some refreshments for them, and they usually do not have to wait too long to be seen by one of the doctors. After the doctor examines them, the patient has some bloodwork done, or walks to the pharmacy section to get a prescription. If nothing else has to be done, the patient will return the file, and will then be able to leave. Since I am a non-medical volunteer, I typically help finding files, updating them, or even getting the refreshments out. After every patient has been attended, all volunteers proceed to clean and organize, and the files of the people who got bloodwork done are given to the medical director of the clinic. After taking the bloodwork with him, Dr. King takes it to a laboratory that is associated with the CMDA and gives the Grace Village Medical Clinic a discount so they can continue providing this service to their patients for free. I

was told by the CMDA´s Atlanta director, who is present at the clinic almost every Saturday, that for 2018 the church arraigned a monthly budget of $300 just for laboratory work. He also explained that the church prepared a different budget for prescriptions, but that he was not sure how much money they gave for that purpose. When the bloodwork results are ready, Dr. King files them and brings them back to the clinic. Instead, the other files get stored in their initial location.

Everyone is allowed to volunteer at the Grace Village Medical Clinic. However, since the space in the clinic is limited, in the beginning of every month the executive director of the clinic sends online signing sheets to the people that have volunteered there before, so they can enlist themselves in case that they desire to help in any of the elected clinic days of that particular month. By using this method, they attempt to have some control on the number of volunteers that show up in one clinic day. While conducting my research I did notice that as weeks started passing, more people would start to show up unexpectedly, mostly because they were told about the clinic´s existence by friends or professors. The problem with this was, and I know that is still is, that since the Grace Village Medical Clinic is practically a house that has been turned into a clinic, space is limited. Still, the executive director has expressed that even if a person did not sign up in the online sheet, but still desire to volunteer, they can do so, and they will find something for them to do in the clinic, because for them it is better to have "extra" volunteers than to "lack" them.

First we have the executive director who makes sure that everything runs in order in the clinic, lists the things that need to be restocked (like medicines) and other things that the doctors believe that can be useful for better a quality healthcare experience at the clinic, and gets in contact with the people that provide to the clinic to negotiate and plan distribution strategies. Then we have the medical director who oversees the medical students that work as volunteers at the clinic.

Along with other doctors that volunteer at the clinic, they all recruit future doctors and nurses from universities like “Emory”, not only to add volunteers to the clinic, but also so these students gain experience in different tasks that they will most likely have to perform after they graduate. Not only this, but as doctors, mentioned by the medical director, “their main goal should be to improve healthcare and to end health disparities”. By giving these students the experience to witness the effects of poverty, the anguish that comes with it, and many other difficult situations that patients go through, specially refugees, the doctors in the Grace Village Medical Clinic hope that these students gain empathy and eventually go to work in their specific fields with a mindset full of compassion towards others. There are also people that volunteer as interpreters, because patients that frequent the clinic tend to speak various languages (Kurdish, Spanish, Korean, Arabic, Chinese, Swahili, etc) and some are not fluent in English. Other non – medical volunteers are included in the staff and they tend to help with paperwork, filing, and to distribute the refreshments.

4.4 Volunteers Motivations and Experiences

Through my semi-structured interviews not only was I able to capture volunteers’ motivations and experiences, but I was also able to witness how these varied depending on multiple factors like age and background. The first thing that I noticed while conducting the interviews was that volunteers who were 60 or older looked somewhat uncomfortable when questions related to the United States healthcare system, refugees and their status, and even when I asked if they thought that volunteering at the clinic could possible open new opportunities, of any sort, for them. Most of the volunteers who were 60 or older were white, American, Christians. As Brenda, a current 60 or older volunteer at the clinic, eagerly said when I asked her the new opportunities question “I am retired, and I just volunteered to help!” Brenda looked a bit annoyed with this last question and after analyzing the situation I concluded that by me questioning that to her, she felt

as if I was already assuming that she was volunteering because she was getting something in return. In the beginning of the interview she admitted that she was a Christian, and in this faith, you should help others without expecting anything in return. After putting this information together, what I concluded about this specific situation started to make more sense. Even when I analyzed why Brenda reacted in the way that she did, I kept thinking that in fact she was getting something in return, putting materialistic things aside, she was still getting an individual satisfaction from helping people in need, and at the same time she was getting a collective satisfaction that came from being a member of something bigger. This specific interview with Brenda caught my attention because it made me see how even in free clinic/volunteering scenarios you can still find individualistic motivations that are not so evident until you really look into them; yet, this does not mean that they do not share the desire to help others. What I am trying to show by using Brenda as an example is how she feels complete/happy just with the fact that she knows she is helping others, but when she was questioned about things related to the population that she was serving she either limited her answer or just evaded the question. For example, when I asked her "What are your thoughts on immigration in the United States?" she replied "I believe in legal immigrants only which must be vetted", practically ignoring the fact that the process for refugees to make it into the United States legally usually takes months, sometimes even years and as I witnessed through my participant observation, most of the refugees that frequent the clinic come from places that are considered war zones, meaning that there was an evident desperation to get out of those countries. The interesting thing is that I only got this specific type of reaction/response to these sorts of questions from volunteers who were 60 or older, younger volunteers did not even hesitate to answer the questions and if they thought that they were probably getting opportunities through the clinic they just said it without any sort of shame.

While conducting my study I also noticed that many of the younger volunteers at the clinic were pre-medicine students. Most of the ones I interviewed considered themselves as non-denominational Christians. A non-denominational Christian is a person who does not ascribe to a particular scripture interpretation or ritual practice. When I asked Katy, a 24-year-old pre-medicine student and former volunteer, what motivated her to volunteer at this clinic, she replied:

> I thoroughly enjoy the company of my fellow volunteers. I have spent almost three years with this clinic, and find the family feel among volunteers comforting. I enjoy the patients that come through and seeing their progress of care. I like the feeling of being a small part of something bigger than myself- of contributing to a community.

Most of the other young volunteers who are also pre-medicine students gave almost an identical response. Volunteers like Katy had a stronger stance when it came to answering the questions related to the United States healthcare system, the United States immigration policies, and refugees. For example, since at that point I already knew that 90% of the patients that frequent the clinic are refugees, I asked Katy what were some challenges that refugees had to endure in order to have access to healthcare in the United States? To which she replied:

> Healthcare is an exorbitant expense for American citizens. It is considered a luxury for many citizens, especially in regard to medication. People have to choose between paying for their medication or paying their bills, or for food. Many students have to choose between insurance and paying for college tuition. Citizens have an option of buying insurance, or some kind of insurance (Medicaid, which does not cover much at all.) With this comes deductible costs that can quickly add up. Imagine being a refugee, who has no source of income, no resources, nothing.

I believe it is important to point out that to this same question, Brenda replied that the only challenges that refugees had to endure were language barriers and cultural differences. Evidently, at this point I witnessed how the level of education played a crucial role in not only the way people see social problems, but also in the way they verbalize them. By any means am I implying that Brenda did not have any clue about all the struggles refugees have to endure besides the cultural differences and the languages, maybe she did, and for some reason she decided not to talk about

them; but this is just one of those moments in which things stay inconclusive, maybe she knew, maybe she did not.

The motivations expressed by most of the young volunteers/pre-medical students were all similar to Betty´s motivations, meaning that they all wanted to help others and feel that they were a part of something bigger. But like I mentioned before, there was a significant difference in the responses that I got from the young pre-medical volunteers versus the responses that I got from volunteers aged 60 and older regarding the reciprocity in volunteering. For example, when I asked Kristen, who is now a medical student who volunteers at the clinic, if she believed that volunteering at the clinic would open doors to new opportunities, she replied, "Yeah, definitely. They do missions every year and I've never been able to do one, but we love to go on one. Career wise it may open some doors for future work in Christian clinics, but otherwise I'm not entirely sure." Following a similar path, when I asked Katy that same question, she said:

> I hope so. I think that volunteering has widened my world view and my acceptance for others. It has introduced me to people and an organization CMDA that has already changed the course of my life since graduation. I hope to go on a mission trip with the clinic this year. I know I will continue to volunteer here, hopefully for years to come. I had lost my passion for why I wanted to enter medicine while studying in undergrad. This clinic has helping to renew that passion, and I foresee new relationships and opportunities coming because of it.

This is not a critique against the young volunteers who are also medical students. I also fall in that same category because by volunteering at the clinic I got to help others, while perfecting my research skills as an anthropologist at the same time.

Through the experiences of the volunteers, I also got to know stories about refugees struggles and stories of success when they were able to help. For example, Kristen told me that while volunteering at the clinic she has witnessed a large variety of pathologies and stages of disease that are not normally seen in the United States, but that to her surprise, most refugees that

come into the clinic also tend to suffer from hypertension or diabetes, which are pretty common diseases in the United States. This is valuable information for me on a personal level because eventually I would like to study the healthcare of refugees from their own points of view, and I would probably not had been able to get this information otherwise; plus, it comes from people that have witnessed these situations first hand, reinforcing my main statement that volunteers voices are important because aside from getting to know their struggles, you also get important information of the population that they serve and of the government and its power.

As I mentioned in the beginning of this section, the backgrounds of the volunteers also played a crucial role in their motivations and in the way they viewed and expressed their experiences at the clinic. For example, Frances, who is a 29-year-old volunteer at the clinic, was born and raised in the United States, but her husband is an immigrant who comes from a country where the majority of the population practices Islam; he too identifies as a Muslim. I use her as an example because she has witnessed first-hand how her husband has struggled to get everything he has today in the United states, as she states, "It took years to get him a visa. I am happy that we get the chance to live as a family in the US. I do wish, that the immigration to the US was more efficient. My husband's green card is held up because of a backlog of cases, and it is stressful." Because of these personal struggles, Frances has strong opinions when it comes to refugees, the United States immigration system, and the United States healthcare system.

Then there is Katy, whose father was born and raised in India. When I asked her what were her thoughts on the United States immigration system, she replied:

> The current political climate is worrisome. I am the daughter of an immigrant. Turning away immigrants who come to this country- illegal or not- is going against the core values this country was found upon. It also goes against my core values. America is the melting pot country. The blend of so many different cultures is what makes America unique. The families that are separated at the Mexican border, the Islamic travel ban, the incessant "need" for a bigger boarder wall- it all sends a message of bigotry and racism.

The personal and emotional attachments that Frances and Katy have with these topics are evident through their responses. On another hand we have Kristen. When I asked her what were her thoughts on refugees in the United States, she replied:

> It's a balance of security, while also helping those who are in unfortunate situations. I believe Americans are very opinionated/passionate on this topic. Personally, I want my retirement, security, etc to be preserved, but I know as a Christian I am called to lose my life to Christ. I believe Christ would be a friend to the refugees.

Kristen and Brenda share some similarities, starting with the fact that both are white females who were born and raised in the south area of the United States. Also, contrary to Frances and Katy, none of them mentioned to have a direct connection with an immigrant; meaning that there are no immigrants within their families or very close friends. It is important to point out that as Katy said earlier, "we are all immigrants in the United States, that is how this country was built in the first place." Throughout this study I had to face the fact that people have different opinions when it comes to saying who is an immigrant and who is not, and these opinions can be very diverse and complex. Furthermore, I wanted to draw attention to the responses of these four volunteers when it came to questions related to their motivations for volunteering, the United States immigration and healthcare system, and the refugee situation in the United States. The four of them shared the desire to help others and wanted the opportunity to become a part of something bigger. When the questions about refugees and the immigration and healthcare systems in the United States emerged, Frances and Katy showed emotion and commitment to let others know that the refugee community has to endure multiple challenges that can be even life-threatening for them; whereas, when this same questions emerged when I interviewed Brenda and Kristen, they opted for more technical responses. At the same time, I noticed that when I interviewed Brenda and Kristen, both always found a way to guide their responses back to their positionality as

Christians. People that consider themselves as members of Christian denominations should mimic Jesus life, as the 12 apostles did back in time, in order to be saved by God in the afterlife. This was hinted by Kristen during her interview when she said that her main reason for volunteering was "to show others the love I feel Christ has for me. I want to be the hands and feet of Jesus to those who are underserved. I feel it is the most important thing I can do in my life is serve."

4.5 Volunteers´ Challenges at the Grace Village Medical Clinic

Volunteering in free clinics benefit both, the patients and the volunteers. While the community gains access to healthcare, the volunteers get to practice their medical skills and expand their understanding on the issues that the population that they treat must face daily. As Dr. King stated "We have the privilege of training healthcare providers from all the schools in the Atlanta area. Nurse practitioners, physician assistants, physical therapists, nurses and doctors in training care and learn every time we are open." However, in order to provide free health care, volunteers must endure various challenges. At the Grace Village Medical Clinic, for Kristen, who currently volunteers there, the most notorious challenge that they must face is the evident language barriers, and this goes hand by hand with health literacy issues. As she says, "How can I explain your medications to you when you don't understand what they are for or what they are treating?" During my research period, various volunteers mentioned the language barrier issue; plus, they explained how when they move around the Clarkston area to promote the clinic, their flyers advise people to bring translators with them to the clinic. Katy, a former university student and regular volunteer at the clinic, states that "There is a significant lack of translators who speak languages such as Farsi, or Hindi in the normal healthcare setting." This is something that I witnessed firsthand, as most available translators at the clinic only speak languages such as Spanish, Chinese, among few others; however, I am aware that it is difficult to find people who can understand and speak

languages that are not common in our society, primarily, because these are usually not taught in schools or universities here in the United States.

Another challenge that must be acknowledged is the fact that these people are doing volunteer work, meaning that they do not get paid for their services. The executive director of the clinic was the only one who directly pointed this out as a challenge. He deeply appreciates all the volunteers in the clinic, but he is also aware that since we are all involved in the United States economy, we are in a constant battle to survive. This becomes a challenge for the clinic, because for example, physicians can not neglect their regular clinics as they need income. It is because of this issue that the clinic only opens on some Saturdays and Wednesdays in a month, because it is during those days that the executive director can bring in as many available physicians as possible to help. This issue goes hand by hand with another cultural challenge that is not uncommon to witness at the clinic. Since the clinic receives a variety of people from different countries and different religions, sometimes they have cases were based on their beliefs, female patients can only be attended by female physicians. Today, most of the physicians that volunteer at the clinic are males, so situations like this one become an issue.

A third but not less important challenge for volunteers at the clinic is related to income and expenses. The Grace Village Medical Clinic receives an amount of money from the Grace Fellowship Missions Budget. According to the executive director of the clinic, in 2018, the Grace Fellowship Missions Budget sent $5,000.00. Aside from this amount of money, they received monetary gifts from various places and people for a total of $4,505.00. The clinic started operating in October 2017 and up until December 2017, they treated 188 patients in total. Now, from January 2018 until December 2018, they treated a total of 954 patients. With the evident increase in the number of patients from 2017 to 2018, the anticipation is that the number of patients will rise even

more in 2019. As the number of patients seen rises, so does the associated cost for blood work, prescription/O-T-C medications, supplies, etc. At the same time, the executive director anticipates that for 2019 the clinic will need around $2,000.00 or $3,000.00 over the total that was donated last year, because with more patients coming into the clinic, more exam rooms need to be created.

4.6 Refugees Challenges in Clarkston

The focus of my research is not on the refugee population, yet during my interviews with the volunteers at the Grace Village Medical Clinic, many mentioned their concerns towards the challenges that the refugee population must endure in the Clarkston area. Frances, a current volunteer at the clinic, approached this topic by saying "For most refugees that are here in Clarkston, I am going to say the biggest challenge is actually a financial challenge. Getting good healthcare in America is possible, but it is very expensive." Kristen, another volunteer, added that an additional challenge for refugees that is related to the one mentioned by Frances is "to gain access to healthcare when the clinic is closed, or for procedures/exams we cannot provide." Along that same line, Katy, a third volunteer, added that "Many of the patients at our clinic require medications that they cannot fill or afford elsewhere." Katy also pointed out that a big challenge for refugees in the Clarkston area was the transportation issue, as many of them usually have to ask someone for a ride or else, they have to walk to the clinic.

During her interview, Kristen pointed out that the United States Healthcare system was inefficient for refugees because:

> The amount of time we give them care on their refugee status isn't enough for them to assimilate or adjust. A lot of their chronic health conditions are managed at first but lose continuity after they lose their benefits. Then the healthcare system as a whole is burdened, because they may end up in the ER with an exacerbation of some sort.

5 DISCUSSION

As mentioned before, neoliberalism is not just about properties and money, it is also a principle that reorganizes modern society. With neoliberalism, the third sector got a crucial role that consists on producing and delivering public goods. The third sector is in the middle of the state and the market, meaning that they do work as agents of the state. This sector fills the gap that the state purposely leaves unattended, knowing that these non-profit organizations will jump in and try to fix situations. The Grace Village Medical Clinic is a non-profit organization that attempts to fill the healthcare gap that currently exists in Clarkston. In order to be able to operate, the clinic had to be registered in the Georgia Department of Public Health. According to this department, physicians in the clinic can only treat patients that have little to no income, are documented, and have no health insurance (Georgia Watch 2017). The mere act of having to register the clinic in the Georgia Department of Public Health shows how even when the executive director said that they do not receive any money from the government, the state still has an impact in the way they operate. To be more specific, the state attempts to have control of what happens inside the clinic from a distance. First, by enforcing the registration of the clinic they get to know about the clinic´s existence and its location; and last but not least, they enforce rules that the clinic must follow in order to be allowed to operate "legally". By using the term legally, I am referring to the physicians, because if they start seeing patients in clinic´s that do not follow the states regulations and a patient gets badly injured or dies, the physician will get in trouble with the law and lose its license.

Before I started conducting my research, I thought that in the clinic I would encounter a clear image of both, humanitarianism and human rights. While conducting my research I found that as of today, the Grace Village Medical Clinic focuses on the humanitarian side of the spectrum, as humanitarianism´s main goal is to alleviate people´s suffering, while attempting to depoliticize aid

(de Torrente 2004). Since I did some general research before starting my fieldwork, at that time, most of the literature that I got to read on NGOs pointed out their importance as human rights advocates. When I got my hands on more reading materials and eventually started conducting my fieldwork at the clinic, I realized that there are various types of NGOs, with different goals. It can be said that the Grace Village Medical Clinic is a very recent project, and maybe when they become stronger and better known they'll attempt to advocate in favor of the rising refugee population in Clarkston; or maybe not, maybe they´ll stay on the humanitarian side of the spectrum, providing free care to people that can´t afford it, only time will tell.

At the same time, even if my research was geared towards the volunteer's voices and their experiences at the clinic, I could not leave religion out of the equation as the Grace Village Medical Clinic is Christian-based organization. Most of their income comes from the Grace Snellville Church, and they get most of their physicians and nurses through the Christian Medical & Dental Associations. Ferris (2011, 616) and many others have raised the question, how many of these faith-based organizations are actually implementing neutrality and impartiality when they engage in humanitarian work? This is a question that I have asked myself multiple times. From my observations at the clinic I must admit that the religious, specifically Christian, aspect of the clinic is evident. Before letting patients into the clinic, they all get together to pray, and that prayer is directed to God and Jesus. I must admit that the first time that I went into the clinic I did not know that it was a faith-based organization and much less that it was a Christian organization; but, after that first group prayer, when I started noticing the words and phrases that the volunteers constantly used to communicate with each other, it was more than clear to me. Almost after every conversation between volunteers you would hear a "this is all thanks to God", "Praise to God", "God blessed us today", among others. I think it was easier for me to get this right away probably

because of my background, as I was raised Catholic and there are several similarities between Catholics and other Christian denominations. Even with the evident and strong Christian presence at the clinic, they never asked me neither if I was Christian, nor if I was affiliated to any religion in particular. At the same time, 90% of the patients that they treat are refuges and as the volunteers told me during their interviews, almost half of them are openly Muslims. During my fieldwork, I never witnessed any patient not being treated because of their affiliation with a different religion, nor I witnessed volunteers trying to convert these patients while treating them. In this aspect, I believe that as of today, the Grace Village Medical Clinic has showed a decent amount of neutrality while providing medical services.

For this study, I used participant observation and semi-structured interviews as methods to gather data. With these methods I did encounter some challenges and limitations while conducting my study. The first challenge that I had to deal with was that I had to train myself to be less concerned with my positionality as a female, black, Puerto Rican, graduate student and how this could have an impact on how the volunteers would react to me being in the clinic, doing fieldwork. In the end, I understood that even if my positionality did have an impact on the way volunteers acted around me or in the way they responded to my questions during the interviews, this is all part of being an ethnographer. Now, a limitation in my study is that I did not as get as many male voices as I wanted to. The main reason why I wanted to include more male voices because I already had several female voices in my study. At the same time, I wanted to include more male voices because most of the physicians who volunteer at the clinic are males. The reason why I did not get as many male voices in my study simply was because even when I reached out to all the volunteers equally, only few of the males reached back and showed their desire to participate. Another limitation in my study came when I acknowledged that the Grace Village Medical Clinic

is a complex organization. By this what I mean is that this organization has various components that are intertwined with each other to make this clinic what it is today. My issue with this was that my research is focused on the volunteers of the clinic, their perspectives and experiences. In this clinic you have the health component, the policies involved, the religious aspect, among others. This fact intrigued me, but because of the time that I had to conduct my fieldwork, I found this limiting because I could not look into all these components in depth. With this last limitation I felt that I had to limit the amount of information related to these topics because they were never my main focus. Yet, while analyzing the data I realized that these topics were brought up to my attention in every interview that I conducted and that I did witness, to an extent, the impact that these components have on the clinic, especially in the way that they operate; so with this in mind, I had to write about them, because like I said before, they are all intertwined.

As mentioned before, the Grace Village Medical Clinic is a Christian based organization. This clinic is primarily funded by the Grace Snellville Church. The church only has the Christian label, but based on their practices and beliefs, I think that they fall into the non-denominational category. They believe that God sent his son, Jesus, to earth as a man to announce his kingdom. Members of this church also believe that Jesus invited 12 men, called the 12 disciples, to imitate his life and to love God and others as they love themselves. They also see themselves as disciples of Christ, who believe in Jesus resurrection on the third day and in the bible. Members of the church are encouraged to do charity work and to build relationships with the people that they work and the people that they serve, regardless of what their religious beliefs are. Before 2001, the Grace Snellville church was already working with multiple partners around the world on various trips and projects (Grace Snellville 2017). After the September 11, 2001 terrorist attacks on the World Trade Center and the Pentagon took place, Buddy Hoffman, who is the founder of the church, and

his partners decided to shift their primary occupation to seeking reconciliation with the Muslim community (Grace Snellville 2017).

The concept of the Grace Village Medical Clinic emerged on 2013 as some members of the Church, who at that time had already participated in mission trips to places like Kosovo and Peru, wanted to be able to help people on a local scale as well. It so happens that a member of the church donated a truck, which they started using to move around different places in Clarkston, as they already knew that this community lacked affordable healthcare. Since Clarkston is well known for having an up and rising refugee population, the idea of the truck had one big limitation. Some refugees have gone through very traumatic experiences from the they that they were forced to leave their homes. For this clinic to work, they had to build trust within the community, and by having a truck going around and not having a steady place for people to reach them, this was a challenge. It was in November 2017 that the Grace Snellville church gave money to the executive director of the clinic as they agreed to the idea of buying a house to transform it into a clinic; eventually, the church gave enough money for them to buy the house next door as well.

In the beginning, most of the non-medical volunteers were members of the Grace Snellville church. The medical director of the clinic is a member of the Christian Medical & Dental Associations in Atlanta; so, through him physicians started coming into the clinic to help, and he is in charge of doing this to this day. Because of the physician's availabilities they started opening the clinic two Saturdays in a month for five hours, and eventually they added two Wednesdays for five hours as well. When I concluded my fieldwork, they were about to add a third Saturday and a third Wednesday in a month. This is a positive thing, because it shows that the number of patients is growing, which means that the word is spreading around Clarkston and people are getting to know that there is a place that they can go and get the care they need. Even when the whole

purpose of this clinic is to help as many people as possible, the fact that the word is spreading so quickly can be bitter-sweet. I say this because with more patients coming in, the volunteers will need more resources to cover the patient's needs, and this requires money. The Grace Snellville church sends a certain amount of money to the clinic, but as the executive director of the clinic told me, for 2019 as they expect the number of patients to keep rising, they are planning on expanding different areas of the house so it does not get too crowded on open-clinic days; this requires construction work, so they´ll need more money than the amount that the church gives them, so they opened an online page that anyone can go to and donate to the clinic in an anonymous way. In terms of medical equipment, the good thing is that aside from seeing patients at the free clinic, if physicians have some extra medicines or equipment at their regular clinics, they do bring them as a donation.

Most of the medical staff of the clinic is brought in by Dr. King, who is the executive director of the clinic and a member of the Christian Medical & Dental Associations. This organization "provides resources, networking opportunities, and a public voice for Christian healthcare professionals and students" (CMDA 2019). In order for people to become members of this organization, they must pay an annual fee. In exchange for paying this fee, members have access to various benefits. Personally, I believe that the biggest benefit that they offer is geared to pre-medical/medical students directly as they state that through placement services, the organization can help these students to find a practice. In the United States, the medical field is a very competitive one, so for pre-medical students to get into medical school is a challenge, and for medical students to get accepted in hospitals to do a practice is also a struggle. As mentioned before, as of today, Emory´s IM residents rotate through the clinic thanks to the initiative taken by physicians. Plus, as I was ending my fieldwork the executive director told me that for 2019 the

Grace Village Medical Clinic will have an MOU in place with Georgia State University´s Nursing and Health Professions Program to have both faculty and nursing students rotate through the clinic.

After analyzing the interviews that I conducted, I realized that it is impossible to homogenize the volunteers, as everyone makes sense of their own agency in their own way. Even with this said, based on their reactions and responses I was able to group them. For example, I used Brenda as an example of the volunteers who are 60 or older. Katy and Kristen were used as examples of the volunteer/students' group, as Katy is a pre-medical student and Kristen is currently a medical student. Last but not least, I used Frances as an example of the group of non-medical volunteers who are members of the church and under 60 years old. I also got to interview the executive director and the medical director of the clinic. To be more specific, Brenda was very open about feeling extremely motivated to help in the clinic, but when I asked her questions related to the refugee situation and the United States immigration and healthcare system looked uncomfortable. Not only did she looked uncomfortable, but in the way she answered these questions it was evident that at times she went around the question and in other times she simply did not answer at all. Her answers were short, and she always managed to turn the conversation back to where she explained that her biggest motivation to volunteer was that she got to help others. I used her interview as a representation of the volunteers who are 60 or more at the clinic because, to my surprise, the others who participated in my study reacted almost the same way to the same questions and managed to give very similar answers. Brenda and the others within this same age group are all Christian, white, born and raised Americans. In my interviews with them, the question that seemed to start making them uncomfortable was if they thought that volunteering at the clinic will open doors to new opportunities for them. After analyzing their reaction to this question and what remained of their interviews I started thinking about their positionalities as Christians. Jesus always said that

you should love others as you love yourself and help others without waiting for anything in return. So, from my interpretation, I could see why they would get a bit defensive, as the question may come off as if I was already assuming that they were getting something in return. At the same time, I was curious looking at how their answers showed little to no knowledge about the bigger social problems outside of the clinic, meaning the refugee crisis, immigration in the United States, the healthcare system. This, once again, made me think about the impact of my positionality. Me being a female, black, Puerto Rican, graduate student maybe they just did not want me to know how they felt about these issues in depth as maybe they did not trust me enough.

Within the group that included pre-medical/medical student volunteers, in which I used Katy and Kristen´s interviews for representation, I was able to observe and analyze how even with me separating the volunteers in three initial groups, these were not enough. Even if these group of volunteers labeled themselves as non-denominational Christians, through their interviews it was evident that they all had different levels of connection with Christianity. For example, Kristen, like Brenda, through all her interview eagerly expressed her Christian values, even when she mentioned from the beginning that she labeled herself as a non-denominational Christian. This for me was unexpected, as I thought that people that considered themselves non-denominational anything would do so in order to maintain some distance with denominations, in this case, Christianity. Kristen embraced her Christian roots, and this was one of her biggest motivations for volunteering. In this same group we have Katy, who also labeled herself as a non-denominational Christian, but different from Kristen, she did mention that one of her biggest motivations to volunteer was that she got the chance to help others, but after saying this she never moved on to saying something like "it is because I was raised Christian that I learned the value of helping others…" I used these two women as a representation of this group because I noticed that

when I interviewed other pre-medical/medical student volunteers, their responses were similar either to Katy or to Kristen´s answers. Now, this group was completely different than the 60 or plus group when it came to talking about the refugee crisis, the United States healthcare and immigration systems, and even about the doors that they thought would get opened for them after volunteering at this clinic. This group was very forward, very open and clearly showed concern when they spoke about these issues. They also were extremely open and detailed when it came to talking about their personal experiences at the clinic, and this was a response that I did not get from anyone in the 60 or more group. In this case I also had to think about my positionality, specifically as a graduate student, because in this group they are all students as well, so I believe that they may have a broader understanding of the positives and the challenges that come with conducting research; therefore, because they could relate to me in that sense, I think that it was easier for them to trust me. For the third initial group, which are the younger than 60, non-medical volunteers who are also members of the church I did not get many participants; but to represent this group I used Frances´ interview, who I consider has a unique positionality in the topics that were brought in the interview as she is a Christian who married a Muslim man who came into this country as a refugee. Of course, she talked to me about all the personal struggles that she has had to endure with her husband in order for him to get the correct paperwork and services in the United States.

CONCLUSION

Neoliberalism´s main goal is to increase the profit of capitalists. It has created a policy agenda that has increased the power of finance capital (e.g. banks); this at the expense of consumers, workers, borrowers, etc. The state has its own agenda and purposely leaves some gaps unattended, because they do not find them as important, as other situations in which they

can gain profit. At the same time, they know that organizations from the third sector will jump in and try to fill these gaps that were left un attended. The problem with this is that even when the third sector is doing a favor to the state, most of these organizations lack necessary resources to decently provide the services that these communities need. Yet, it is interesting that even if the state does not help these organizations directly, they still want to keep some sort of surveillance from a distance. I use the Grace Village Medical Clinic as an example of a clinic where I got to see how this whole dynamic between the state and the third sector works, and how complex and limiting this relationship can be for the volunteers of these organizations.

I believe that the Grace Village Medical Clinic is a very recent non-profit organization that has been developing quickly, but it still has a long way to go. Their number of patients and volunteers has been rising non-stop, and like I said before this is a positive thing, but this also means that there needs to be more money involved; first, to get all the proper equipment in order to be able to treat the patients; second, to make all the proper adjustments in the houses that they own so there is enough space for everyone in the clinic. I also see as a positive thing that as of now, the clinic has never received money from the state, and I hope that with the need for more income they do not have to move towards this direction. I say this because even if I mentioned before that it is clearly seen that the state has certain amount of control on the work that is done in the clinic, by making them register the clinic and by implementing some rules that dictate who they can treat and who they cannot treat; I believe that by receiving money from the state they would be allowing the state to be more involved and to make decisions in the clinic. This has happened before, for example, the Grace Snellville church sends money to the clinic, but, in case that the volunteers of the clinic decide that they need to do some construction work to add more space in the clinic, they must notify the church and wait for their approval.

Regarding the volunteers, through the interviews I was able to hear their motivations to become volunteers, their experiences at the clinic, the challenges that they endure at clinic; while at the same time I got to hear their points of views when it comes to complex topics like the refugee crisis, and the United States healthcare and immigration systems. Furthermore, the clinic can be seen as a band-aid to alleviate the hardships of people that have been affected by the refugee crisis, and the inefficiency of the United States healthcare and immigration systems. Even with this said, I was not expecting the complexity of each volunteer. In the end, with them I concluded that each of the volunteers backgrounds, levels of education, ethnicities, religious beliefs, and even if they have someone close to them who is an immigrant or not play a crucial role in how they relate and how emotional they can get when topics like the refugee crisis, and the United States healthcare and immigration systems come up. On another hand, they all agreed when they said that one of their biggest motivations to volunteer was their desire to help others. For some, like the 60 or older group, the satisfaction of being able to help others while feeling that they were part of a group that attempts to do some bigger good was enough. But, the experience of volunteering at this clinic for the pre-medical/medical student volunteers gave them the opportunity, not only to help people, not only to have a nice-looking volunteering experience on a resume, but also to attempt to move a step forward in their academic/professional careers, with the help of the CMDA.

For future research I would like not only to include more volunteers into the study, but also to add the voices of the refugees that frequent the clinic. At the same time, I think that for the future is also important to study the role that religion plays in this clinic more in depth, and to see if even as time passes they are able to maintain the descent level of neutrality that I witnessed during my fieldwork. Furthermore, I think that it is very important to get to study the CMDA

and their relationship with the clinic, as for what I witnessed during my fieldwork, the CMDA helps the clinic by bringing medical staff and equipment when needed; while the clinic becomes a recruiting place for the CMDA as many of the volunteers that frequent the clinic are pre-medical/medical students. I use the word recruitment, as I witnessed every Saturday how the director of the CMDA would approach specifically students who are in the medical field to talk to them about the organization, its benefits and to give them his testimony; this to the point that once he told a student "maybe you can come volunteer with us as well", referring to the CMDA.

The volunteers mentioned the language barrier that they have with refugees as a challenge. Personally, I think that in this case the most viable solution would be to do a study on the top five languages spoken by patients at the clinic, and then proceed to find around five people that are fluent in these languages and pay them an amount of money. Why not bring them as volunteers? Well, as mentioned before, the reality is that most patients that frequent the clinic do not speak European languages, such as Spanish, English, French, Italian, etc. In most American universities they tend to teach European languages, and sometimes they would add a language such as Arabic. What I mean with this is that in the end, most likely, they will find translators that are fluent in both English and the foreign language, but there is a big possibility that the person is also a refugee or an immigrant. Since the executive director and other volunteers at the clinic have expressed that they would like to help refugees more, and they started doing so by providing free care, I believe that by paying a bit of money to these refugees or immigrants for their translation services is another way to help them. Of course, I am aware that this cannot be done right now because members of the clinic must find more steady donors besides the church first.

As of today, the Grace Village Medical Clinic is a Christian-based organization which work depends solely on volunteers. In the present their work falls more into the humanitarian dimension, as they focus on providing care to people that cannot afford it otherwise. Volunteers at the clinic and the executive director have expressed that they would like to be able to help the refugee community in other aspects as well, bringing the advocacy aspect to the table. Their desire is clearly there but, as mentioned before, this clinic became steady recently and they still have some work to do before they can decide if they would want to add the advocacy dimension to their work, or if they just want to keep providing for the people in need. With advocacy comes more responsibility, and of course, involvement in political scenarios so in the end is a very personal decision that eventually members of the clinic will have to make. In the present, I personally believe that the volunteers of the clinic are doing a remarkable work worthy of admiration. I say that it is worthy of admiration because they keep pushing forward and even when they do not have all the equipment they need or enough space for everyone in the clinic, they move around in order to get what they need and they never leave any of their patients unattended.

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