Short-Term Medical Missions: Enhancing or Eroding Health?

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This paper analyzes two case studies of short-term medical missions to Latin America. Its conclusions suggest that when such projects are evaluated in terms of their impact upon the health status of the local population or health care delivery systems, they are found to have insignificant and even negative consequences. The shortcomings of these short-term efforts reflect the cultural assumptions that inform their design and implementation, rather than local health realities. Recommendations are suggested to increase the effectiveness of these missions in terms of the health needs of local populations.

Short-term medical missions have become increasingly popular as an alternative or supplement to traditional medical missions. Mission agencies, denominational bodies, local churches, and para-church organizations organize and sponsor these projects. Typically, they involve sending fully-equipped volunteer teams of health professionals to mission sites for one or two weeks to provide medical and dental services for underserved, poor populations mostly in the so-called developing countries. Participants hope to alleviate suffering and to contribute to the improvement of the health of local peoples. Yet sponsoring groups generally do not undertake the systematic evaluation required to assess the actual impact upon local health status and health care delivery systems. That this evaluation is not being done is significant, since the projects represent sizable investments of financial and personnel resources which, if properly utilized, have the potential to make a positive contribution to the health needs of the world's poor. Yet as the following discussion illustrates, they can have insignificant or negative consequences.

In this paper, I analyze two case studies of short-term medical missions to Latin America to demonstrate the need to evaluate the impact of these projects on local health status and delivery systems, underscoring the issues their assessment should address. In conclusion, I will propose recommendations that would facilitate a more positive contribution by such missions. My analysis is based upon information gleaned from informal on-site observation, interviews with leaders and participants, and the too-often experience of being contacted for a post-mortem consultation to discover why a project did not produce the anticipated results or encountered "unexpected" difficulties. I would like to emphasize that the quality of the medical and dental care provided is not what is at issue, at least for the cases discussed here. In both, the practitioners were licensed and board certified in various fields of medicine, nursing, and dentistry, and any non-medical volunteers worked directly under their supervision. What is at issue, however, is the appropriateness of the delivery model; it can erode as well as enhance health.

While short-term missions have a long history, they seem to have become more common in recent years for a number of reasons. First, religious organizations have discovered that one way to increase constituents' interest and support of their mission activities is to provide those individuals opportunities for first-hand observation and hands-on participation. (Health projects are usually one of a number of short-term activities, such as construction and renovation of buildings, or more directly evangelistic efforts through participation in things such as drama or sports teams, available to participants.) Second and relatedly, the participants enjoy such projects, because they give them a chance to see tangibly how their financial support has been used and to "be a missionary" without the multi-year or lifelong commitment of traditional missions. The projects also provide a means to see other countries and cultures. In this way, they function as religious tourism. Third, organizations find that it is easier to recruit highly skilled professionals for shorter periods of time. Volunteers often use vacation benefits to release them from their usual job responsibilities. And fourth, such projects are often cost-effective, because participants usually pay their own expenses and bring or provide finances for equipment and supplies.

Not all of these projects originate from an organization's leadership. Some are initiated by members who, often as a result of a vacation or visit to an impoverished region, become inspired to "do something for the poor." Furthermore, short-term medical missions are not restricted to religiously affiliated organizations. Some professional medical and dental associations sponsor similar efforts by their members, and many others are sponsored by private individuals.

Case A is of a plastic surgery-dental team from a religiously affiliated school of medicine which worked at a former Protestant mission hospital in Central America. The hospital is now administered and staffed by local physicians, nurses, and administrators and maintains its religious orientation. Similar teams from this medical school have periodically visited the hospital, and the one described here seems to be fairly representative. Other teams from other organizations also regularly visit this hospital.

The volunteer team included plastic surgeons and operating room nurses, dentists and dental assistants, and medical and dental students. Most team members did not speak Spanish and relied on translators. To my knowledge, the team received little cultural orientation, and members were genera1ly unaware of non-biomedical health belief or delivery systems.

The hospital staff publicized the team's visit throughout the surrounding communities and set appointments in advance, though walk-in service was available. The news of the foreign doctors and the hope of free care brought hundreds of individuals with a host of medical difficulties. In the short period the team was present, they literally saw scores of patients. The charges for the services were token or gratis. Ideally, the staff physicians also participated in the surgeries as a form of continuing medical education, enhancing their skills or learning new techniques.

The plastic surgery team largely repaired congenital malformations such as cleft lips and palates. Occasionally, they also did burn repair and other related surgeries. Those cases requiring multiple operations or post-surgical rehabilitation are difficult to treat, because the hospital often does not have the appropriate staff or equipment. In those that require more than one surgery, individuals may have to wait for the next team to finish the process.

The dental team also saw large numbers of patients. They usually do checkups, prophylactic cleanings, fillings, and many extractions. Extractions become a treatment of choice either because the problem is so serious that no other alternative remains or because the necessary repair work exceeds the time limits and the funds of the team or the individual.

Case B, the second example, is another medical and dental team which is a part of a comprehensive short-term mission program organized annually by students from a non-denominational Christian college. The program includes a variety of activities, such as children's Bible classes, sports teams, prison visitation, construction projects, and health services. Since the early 1980's, groups of students and volunteer professionals have traveled to the same area in Mexico during spring break. In the past two years, the overall project has been coordinated with a committee of local Mexican pastors from various Protestant churches. The pastors encourage the project's yearly visits because they supply advertisement and public relations benefits for their congregations.

The medical-dental team works with a local physician who has committed a part of his practice to providing services for the poor. This physician spends one half of each week traveling to outlying communities and holding clinics. His practice has been subsidized by this student project as well as by church groups in the United States through construction of a clinic building, donations of medical supplies and equipment, and some monetary support.

The team usually includes about 40 individuals of which 20 are students and the remainder are health care professionals, including physicians in non-surgical specialties- due to lack of adequate operating room facilities- and dentists. A few of the students and health providers speak Spanish; most need translators. The teams bring their own supplies obtained through donations or fund-raising activities; however, all medications used are purchased in Mexico.

During the week period, the health team holds daily dental and medical clinics. The sites are chosen by the committee of pastors, and the clinic rotates to each site for a day. Before the team arrives, the local churches advertise throughout the communities in the area. The pastors also visit anyone they know in need of care and will frequently arrange transportation to the clinic if necessary. The medical and dental components combined see 120-150 patients per day for a five-to-six-day period. The care and the medication are provided free of charge. At the end of each day, the team finds itself turning people away due to lack of time and exhaustion. If these individuals have an immediate need, arrangements may be made to get them to the next day's clinic site.

Like case A, the services are largely curative, though in the waiting areas, preventive information is provided through demonstrations, skits, or puppet shows that the students perform in Spanish. The typical medical problems seen are parasites in children and adults, dehydration in children, infections, heart disease, and hypertension, as well as an array of dental problems. The dental team also does many extractions for the reasons given in the above case. While the student participants receive some basic orientation to the culture issues, they and the professionals receive none regarding cultural health beliefs and practices or regarding the underlying causes of many of the health problems they see.

The above descriptions provide a brief overview of the major characteristics of these two short-term missions. My observation is that they are "standard issue" projects. The discussion will now turn to an analysis of the effects these teams have on local health status and delivery systems.

If the success of these teams is measured in terms of the number of patients seen, successful surgeries, or prescriptions filled-which is how the participants tend to evaluate them-they are highly effective. If one, however, assesses

their contributions in terms of a change in the incidence and prevalence of disease or a long-term improvement in access to medical services, their effectiveness is less clear-cut.

Neither of these teams undertook the kind of evaluation that would gather this type of information. The type of evaluation that did occur tended to focus on the participants' experience and on logistical issues. My preliminary assessment is that such projects do little to improve overall health status or health care delivery even though some individuals may be provided access to surgeries and other treatments they might not otherwise receive. Such efforts can, in fact have a negative impact.

Several issues must be considered to determine the influence of these teams on local health status. Many of the problems the teams see are rooted in public health matters. While surgeries and dental treatment repair some of the consequences of poor health conditions, little, if any, preventive care is given that would affect the incidence or prevalence of these conditions or, in some cases, would prevent them from occurring or recurring. Thus, according to medical anthropologist Patricia Townsend, much of the curative efforts in both cases merely delay morbidity or mortality rather than reduce them (personal communication 1992). For example, while it is important to repair individuals with congenital malformations, such as cleft palates, the number of cases needing surgery could be radically reduced through improved prenatal care and nutrition. If short-term missions devoted more of their budgets to supporting preventive measures, over time, the need for the services they provide would be reduced or even eliminated.

Still, it must be emphasized that short-term groups, which by definition do not have long-term relationships with local peoples or adequate, in-depth knowledge of local conditions, are probably inappropriate providers of preventive care. Rather, providing support to local individuals or organizations would be more appropriate. The preventive information that is given in case B operates from the assumption that good health is largely a matter of knowledge and does not incorporate cultural sensitivity. This ignores the reality that poor individuals often have neither the resources nor the living conditions in which to implement that knowledge, and many of the problems would take care of themselves if general standards of living and income improved. Furthermore, if treatment or preventive information is being provided with no acknowledgment of local health beliefs and practices, their efficacy is questionable.

In individual cases, there may even be an erosion of health status if the person waits for the foreign physicians and free care and medication before seeking medical attention, resulting in a deteriorated condition that could have been avoided with more timely attention. In case A, the hospital physicians were concerned that this was occurring. In the Mexican case, the local physician believes that the clinics bring some individuals into the medical system that he otherwise would not see. It is uncertain whether this is true of all or most of the patients. The local pastors occasionally will visit those needing continued care to see that they are able to attend the physician's regular clinics. In both cases, the data has not yet been gathered to validate the physicians' assessments.

The effects of short-term missions on health care delivery must also be considered. While these teams provide temporary but sporadic access to health care, overall, they do not improve long-term access and they may, in fact undermine existing services. It is unclear whether the short-term projects are treating only individuals who under current circumstances would have absolutely no access to medical care because of an inability to pay for it, or if they are diverting some otherwise paying or potentially paying patients from local practitioners and facilities.

Local practitioners who must earn a living in the community cannot compete with the volunteers who donate their services. Furthermore, they cannot provide the same volume of free care over sustained periods and remain financially viable. Because the patient population in both of the cases has not been closely analyzed, it is difficult to assess the precise impact on the local health care delivery system. If these groups actually do compete with local providers, the possibility exists that they could be put out of business, further restricting access to health care.

In case A, the visits of these teams are sometimes disruptive to the hospital routine. Nurses and other hospital personnel must assume care of extra patients while still meeting the demands of the normal patient load. So while such missions may be "cost-effective" for the sending institutions or organizations which use volunteer help, they may not be for the local health care delivery system. In case A, however, the overall shortage and maldistribution of plastic surgeons in the country and the expense of those surgeries may make the volunteer teams the only reasonable access most have to this type of care under present circumstances.

The question still remains regarding the desirability of individuals being dependent upon outside resources and personnel for their health care. A more lasting solution would be the provision of support to train additional providers and efforts to improve patients' financial access to that care. Certainly these groups and others like them remove some pressure from the national and local governments to provide and respond to health needs with long-term solutions. In this way, short-term medical missions may cosmetically mask deeper ills of social, political, and economic inequities.

One often-cited advantage of these teams is the opportunity they provide for the continuing medical education of local physicians. In case A, at least the reality did not live up to the ideal. Some of the hospital physicians felt that the visiting surgeons viewed them more as orderlies rather than as colleagues to engage in active teaching and discussion. Customs laws often make the importation of specialized medical equipment difficult hindering the local physicians' implementation of some of the new techniques they do learn. Teams are allowed to bring the equipment in duty free only if they take it with them when they leave. While the costs of actually importing equipment may add considerably to the budgets of these teams, doing so could enhance the day-to-day health care devices of the location, assuming plans are made to provide for equipment maintenance or replacement.

These potential or real disadvantages and shortcomings of short-term medical missions have little if anything to do with local health conditions or delivery systems, but everything to do with worldview and cultural assumptions about health, poverty, and assistance that inform their design and implementation. These are not unique to Christian groups. Rather they reflect a larger American middle-class worldview, which Stewart and Bennett (1991) have described thoroughly, that has informed decades of development and relief efforts. Many development and relief analysts have recognized the inherent shortcomings of these assumptions (Bodley 1982; Cernea 1985; and Lappe, Collins, and Kinley 1980). Below, I describe the major cultural assumptions of these short-term missions as reflected in their design, promotional literature, and discussions with participants. For further discussion of each assumption see Stewart and Bennett (1991).

First is the emphasis on short-term, quick-fix solutions rather than on a longer term, preventive approach. The very model of the short-term project precludes long-term planning and assistance. As such, the focus is on immediate rather than on underlying or ultimate levels of causation. This short-term approach often engenders the use of professionals, such as surgeons, whose "to cut is to cure" training causes them to focus too narrowly, thus perpetuating the model. This short-term perspective also fosters a "technique orientation or formula approach" with mission planners often looking for a project design that can be applied generally rather than investing the time and effort in locally appropriate designs.

The second characteristic is the need for tangible results; achievement and doing are more valuable than being. Participants often comment that they need to see, quite literally, that they made a difference; otherwise, they are reluctant to volunteer time and money. More intangible results, such as knowledge transfer or an increase in participants' understanding of the local culture, health conditions, and beliefs, or the building of relationships, are not perceived to be as much of a legitimate way of helping people as being able to count the number of patients seen, faces repaired, and teeth extracted. Furthermore, the efforts of preventive work are often not immediately apparent. Thus, the participants' need to serve or desire to be needed, coupled with the organizations' need to involve constituents, is confused with the health needs and realities of the populations ostensibly being served.

Some advocates for short-term missions often justify them in terms of the inspiration or the awareness they provide for participants. Indeed, a few do commit to lifelong service as a result of their participation. Christians should carefully examine this type of means-ends reasoning. Is a model for servanthood which essentially is oriented to the needs of the server rather than to the served the biblical model of servanthood? Is a mode of service which is informed by ethnocentricity an appropriate one with which to socialize potential missionaries?

The third characteristic of short term missions is both naive realism and ethnocentrism which assumes that approaches suitable in one setting are appropriate in another. Project designers often assume that if their own situation does not have the same problems as the ones they are encountering in another, then the solution is to duplicate their own situation. These attitudes also manifest themselves through an assumption that no special planning or localized knowledge is needed and participants frequently have a lack of awareness and training regarding other medical systems, beliefs, or practices. Sometimes local beliefs and practices are ridiculed and, therefore, discounted and not taken seriously. Since the projects are present for such a short period of time, participants are often ignorant of the possible conflicts between health beliefs and practices that may result in miscommunication or noncompliance.

The fourth cultural assumption is the American predilection to explain behavior and circumstances in terms of personal qualities of individuals rather than in terms of larger cultural patterns and structural issues. This results in an inattention to or a discounting of the impact of social structural issues of injustice or inequality as being critical factors determining health and poverty. Teams are not challenged to confront the question of why the people they treat do not have access to medical services and sanitary conditions in the first place. This assumption feeds a middle-class explanation of poverty which assumes that the victims of poverty are to blame because of their lack of knowledge or immoral character, rather than because of underlying relationships of power. This orientation also tends to obscure for participants the inherently political nature of their activities.

In conclusion, I would like to offer some observations about what could be one to increase the effectiveness of these teams in terms of the health needs of local populations. Given the discussion thus far, the temptation is great to conclude that they have little if no positive contribution to make. In both cases, however, these teams are filling gaps in the health care delivery system in each of these locations, but they are not the most appropriate delivery models. Such teams certainly should not be providing the only medical services accessible to local populations; if anything they should be supplementary to local services. The short-term nature of the program works against the long-term planning and commitment that improving a community's health status and delivery system requires. Despite these problems, the participants and planners are often sincerely motivated to assist others, and these groups can serve as a conduit for the transfer of skills and resources. The following changes in their design and implementation might improve their contribution to health conditions:

1. The effects of these short-term missions must be thoroughly assessed in terms of their influence on health status and the local delivery system. Often project designers and participants need to be educated about what does or does not constitute a contribution to health status or health care delivery.

2. Emphasis must be placed on educating participants regarding local health realities and their connection to cultural, political, and economic conditions and less emphasis on providing service. Participants need to be confronted with questions of why people do not have medical services or why they live in poor conditions, and then given suggestions about where they may be able to provide constructive, long-term assistance. This could motivate participants to allocate funds for preventive care and the training of local providers.

3. More emphasis needs to be placed on location-specific projects and less upon widely applied general formulas. All efforts should be closely coordinated with existing services.

4. More emphasis needs to be placed on skill and equipment transfer and less emphasis on patient volume. More time could be spent on continuing medical education, especially in the surgical areas. If appropriate, funds could be provided to promote the training of additional local practitioners.

5. Impacts on the local health care delivery system and providers must be assessed and coordinated. Issues of potential increases in patient load or compensation for local health care providers must be addressed. These short-term missions must also be aware of their potential political impact.

6. Project participants must ask, "Whose needs do these projects ultimately meet?" For Christian groups, their belief system provides the rationale, especially in the concept of servanthood, for reorienting their activity toward meeting the needs of the people they serve. Moreover, the recipients, not the short-term participants, must be the ones who define and determine the needs to be met.

With this type of reorientation, short-term medical missions could become a more positive tool in the improvement of health and health care delivery systems. Certainly the sizable financial and personnel resources that are currently expended on these projects could be used more effectively.

Notes
I. I know of no data that calculate the total costs of all short-term medical projects conducted annually. Based on my knowledge of the monies spent for a handful of projects, I would estimate that the direct financial outlays represent hundreds of thousands of dollars.

2. A related example from another Central American country is of a mainline Protestant denomination which built and equipped an eye clinic and yearly had volunteer teams of ophthalmologists and related personnel come to perform eye surgeries and other treatments. Many of these cases needed follow-up, yet within the country there was only one ophthalmologist. Initially the teams anticipated that he would do the follow-up at no charge which would have doubled his case load at no remuneration. Understandably, the local ophthalmologist was reluctant to do so.

3. I am not suggesting that the only or most appropriate solution to health care needs is reliance on technology. Certainly the cost of high-tech medicine in the United States has contributed to the lack of access to care that many in this country face. I know there are examples of places where donated equipment sits unused in mission hospitals because of lack of personnel, need or funds to use it I am suggesting that when appropriate, on-sire equipment should be made available.

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