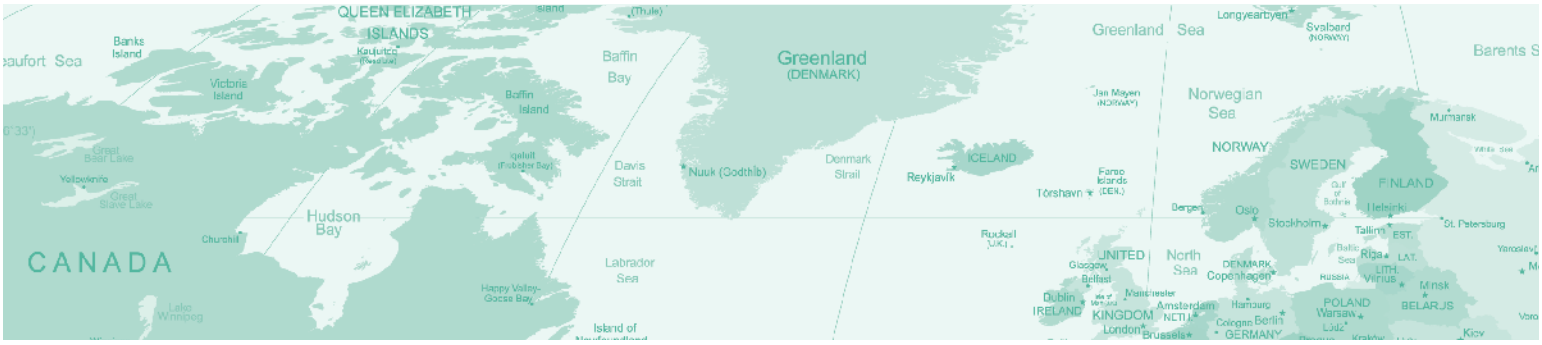

Short-Term Medical Mission Trips Survey Results

PHASE I: PRACTICES AND PERSPECTIVES OF U.S.-BASED PARTNERS

PHASE II: PRACTICES AND PERSPECTIVES OF INTERNATIONAL PARTNERS

CHA
Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

CHA advances the Catholic health ministry of the United States in caring for people and communities. Comprised of more than 600 hospitals and 1,400 long-term care and other health facilities in all 50 states, the Catholic health ministry is the largest group of nonprofit health care providers in the nation. Every day, one in six patients in the U.S. is cared for in a Catholic hospital.

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Introduction

The Catholic Health Association of the United States has conducted two phases of research on short-term medical mission trips — one from the perspective and practices of the U.S.-based partners, and the second from the perspective and practices of those who receive these trips in low- and middle-income countries. This book contains the detailed question-by-question survey results from both phases of research. This is a companion resource to the CHA resource, *Short-Term Medical Mission Trips: Recommendations for Practice*. You can find both of these resources at www.chausa.org/international.

PHASE I BACKGROUND

Gaining the U.S. Perspective

In 2014, CHA completed a study of short-term medical mission trips to understand the goals, best practices and perceived impact of these trips from the perspective of volunteers and trip organizers. Conducted by Fr. Michael Rozier, SJ, doctoral student, Department of Health Management and Policy, University of Michigan; Judith N. Lasker, Ph.D., the N.E.H. distinguished professor of sociology in the Department of Sociology and Anthropology at Lehigh University; and Bruce Compton, CHA senior director of international outreach, it included two phases: an online survey and in-depth interviews. The survey targeted employees of Catholic hospitals and health systems who had participated in or had overseen a short-term medical mission, but it was open to anyone who chose to respond. With the majority of over 500 respondents answering between 36 and 47 questions (volunteers and organizers, respectively) it was likely the largest database on short-term medical missions. The in-depth interviews were held with 18 individuals who had completed the survey and indicated their willingness to be contacted. These interviews provided additional information on the practices and perceptions of short-term medical missions.

PHASE II BACKGROUND

Gaining the International Perspective

In 2015, CHA conducted a follow-up, Phase II study on short-term medical mission trips, to understand the strengths and areas of improvement of these engagements from the perspective of the organizations in the developing world that receive medical mission trips. Conducted by Accenture Development Partnerships, and underwritten in part by Ascension Global Mission, the research, overseen by Bruce Compton, also included an electronic survey followed by in-depth interviews. Research began in the spring of 2015 with a 52-question online survey that was distributed by CHA and its members to persons at hospitals and clinics who received medical mission trips. Out of 82 survey responses, 49 representing 14 countries were included in the research. In-depth interviews via video conferences were conducted with 25 individuals, including 20 who had completed the survey or were affiliates of respondents, and five global health and medical mission subject matter experts.

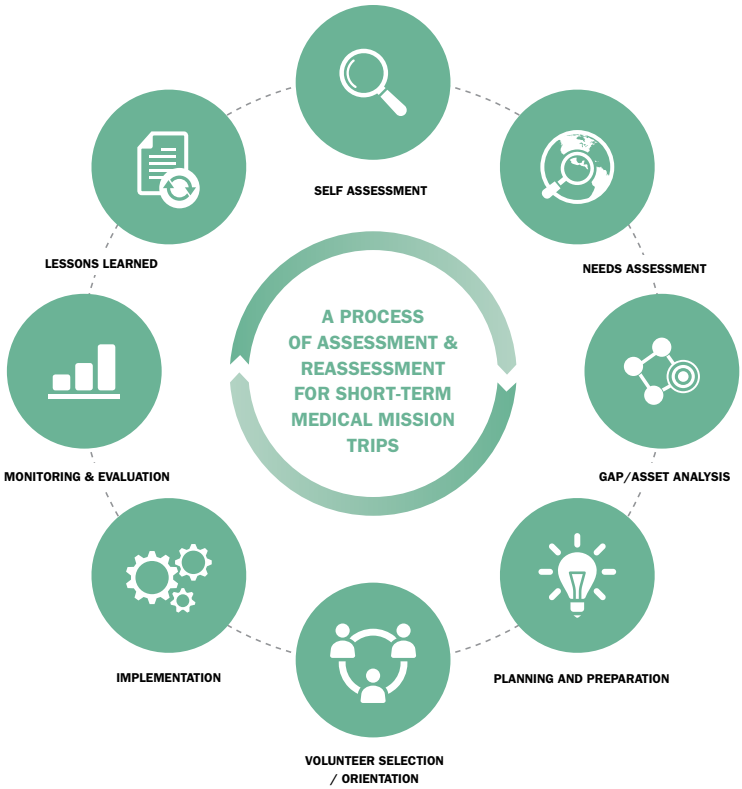
Based on the research findings of Phase I and Phase II, CHA developed the following 20 Recommendations for Practice.

They stem from the question-by-question Phase I and Phase II survey results which make up the remainder of this book. These 20 recommended practices are fleshed out in a companion resource, *Short-Term Medical Mission Trips: Recommendations for Practice*, which is available at www.chausa.org/international.

SHORT-TERM MEDICAL MISSION TRIPS: *Recommendations for Practice*

The desire to identify recommended practices is not just rooted in good professional practice. There is an ethical imperative that also drives the desire to improve short-term medical missions. If there are better ways to do this work than current practice and we are not intentional in pursuing them, then we are doing ourselves and the host communities a great disservice. While it may not be possible to prescribe what should always be done, we are able to take the perspectives from the U.S. and international partners to provide these Recommendations for Practice.

The recommendations are organized by way of a process for discerning your organization's current or future short-term medical mission trips programs and processes. This process takes into account a process suggested by the World Health Organization (WHO) in its report, "Partnerships for safer health service delivery: Evaluation of WHO African Partnerships for Patient Safety 2009 – 2014."



SELF ASSESSMENT

1. Understand your organization's history as it relates to international activities.
2. Ensure your motives are appropriate.
3. Identify the budgeted resources and the time frame for such support.

NEEDS ASSESSMENT

4. Ensure that you are working at the invitation of an international partner that is part of the local community where the interventions will take place.
5. Confirm that your international partner has done a needs assessment to determine their prioritized needs.

GAP ANALYSIS/ASSET ASSESSMENTS

6. Identify the in-country resources by conducting a local asset mapping which takes into account the resources of both the local partner and the local health community.
7. Ascertain the international resources available to build capacity where the local assets are weak or missing by doing an organizational asset mapping.

PLANNING AND PREPARATION

8. Determine whether the medical mission will be conducted virtually or in-person based on the local needs assessment and asset assessments.
9. Create a Memorandum of Understanding (MOU) with your partner.
10. Set specific goals and objectives for each medical mission.
11. Ensure that each volunteer position helps meet the overall mission goals and objectives.

VOLUNTEER SELECTION AND ORIENTATION

12. Ensure that you select volunteers with the competency, attitude and skills to fulfill tasks related to the prioritized needs.
13. Prepare volunteers for success through a well-developed, mandatory orientation that emphasizes capacity building and cultural competence.

IMPLEMENTATION

14. Ensure that you collaborate in a way that builds capacity of the local partner in a culturally competent manner.
15. Apply high-quality standards that follow international and local laws, guidelines and regulations.

MONITORING AND EVALUATION

16. Identify appropriate metrics which allow you to effectively assess the impact of your interventions on the local community.
17. Honestly communicate the impact of your interventions.

LESSONS LEARNED

18. Create a culture that provides regular opportunities for reflection to allow for honest two-way feedback on your medical mission interactions.
19. Communicate lessons learned — both positive and negative.
20. Use lessons learned to plan future interventions that lead to actionable improvement.

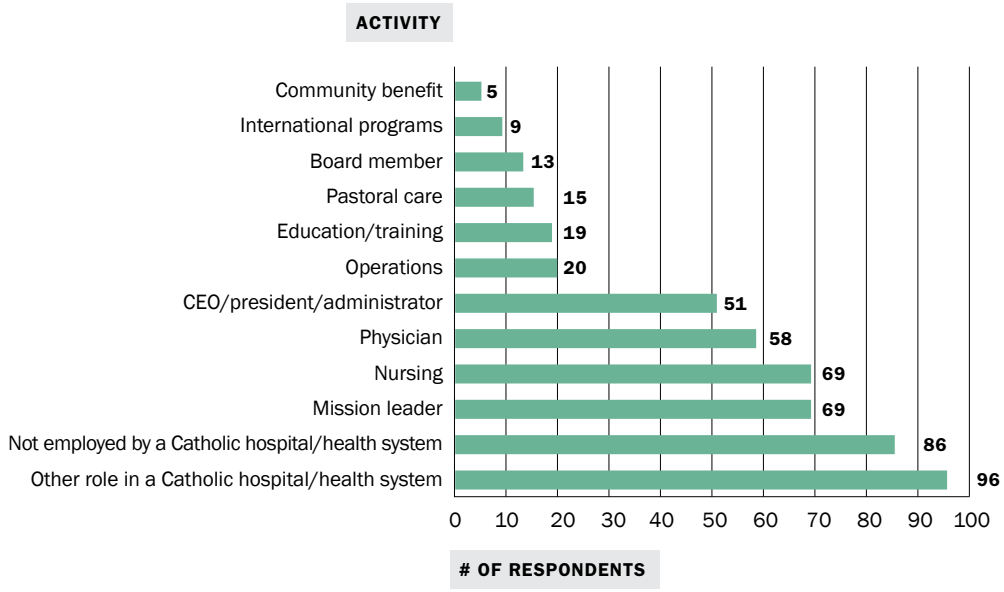
Section I

PHASE I RESEARCH

IDENTITY OF SURVEY PARTICIPANTS

The Catholic Health Association distributed an online survey to its members, asking that those who have overseen or participated in medical mission trips complete it. Many recipients forwarded the request to people outside of the CHA network who are involved in medical missions. There were 510 people who completed the survey, including 138 executives, board members and administrators in CHA hospitals or health systems; 286 people working in a large variety of other positions in CHA-member hospitals or health systems; and 86 people who work outside of the CHA network.

WHAT IS YOUR PRIMARY FUNCTION IN A CATHOLIC HOSPITAL / HEALTH SYSTEM? (N=510)



Survey participants played a variety of roles with regard to mission trips, and in many cases individuals are organizers as well as volunteers, reflected in the totals in the following table adding up to more than 100 percent.

WHAT ROLE HAVE YOU PLAYED IN INTERNATIONAL MEDICAL MISSION TRIPS IN THE PAST FIVE YEARS? (N=510)		
	NUMBER	PERCENT
I have organized and/or directed a mission trip in the past five years.	**157**	**30.7%**
I have been a volunteer on a mission trip organized by my employer in the past five years.	**121**	**23.6%**
I have been a volunteer on a mission trip organized by a group other than my employer in the past five years.	**203**	**39.6%**
I have supervised others who are involved in mission trips in the past five years.	**145**	**28.3%**
I have not participated in a mission trip as an organizer, volunteer or supervisor in the past five years.	**117**	**22.9%**

Organizers and volunteers were asked separate but related questions about many aspects of their most recent trips. If a person was both an organizer and a volunteer, he or she was asked questions about the most recent trip organized and is treated as an organizer in this report. There were 157 people who responded to questions for organizers and 205 to questions for volunteers.

ROLE OF CATHOLIC HEALTH ASSOCIATION MEMBERS IN SHORT-TERM MEDICAL MISSIONS

Sixty-five percent of the organizers and 60 percent of the volunteers participated in trips sponsored by organizations that are not CHA network members. Even among those who work within the CHA network, experience with medical missions was more likely to be in relation to a non-CHA organization (106 Catholic health employees work for and traveled with a CHA member versus 137 who work for a CHA member but traveled with an outside organization). Notably, many of the outside organizations are religiously affiliated.

It should also be noted that about half of organizers of CHA member-sponsored trips indicated that some of their volunteers come from outside the CHA network. These volunteers were recruited for specialized medical skills or joined as family members or friends of CHA member staff going on the trip.

The survey findings lead us to the likely conclusion that many CHA member hospitals and health networks do not directly sponsor medical mission trips. This was confirmed by a number of people we interviewed who are leaders in such institutions and expressed regret that their own employers do not offer opportunities for overseas work. Explanations for not sponsoring overseas trips included a desire to focus on mission to local communities and changes in leadership causing disruption to programs. One interviewee said, "Our Chief Operating Officer says, 'Why on earth will we go across the world to help the poor? The poor are right here.'"

Nevertheless, interview participants described a number of ways in which the CHA member hospitals and health systems do provide support for medical missions. For example, a nurse who works for a Catholic hospital and has organized service programs said,

"The Sisters fund a scholarship for people, because they want this opportunity available to everyone who is an employee of [the health system], whether you be a valet or a heart surgeon, because they feel that this is valuable."

The president of a foundation affiliated with a Catholic health system, who has also been a volunteer and supervisor of other volunteers, described the system's support as follows: "Generally we offer prayer support. We are vocally supportive of them. We bless them. We encourage them. Our senior leaders are generally supportive of physicians who want to take time away to go do this." He made it clear in his comments that he would prefer the support to take a much more tangible form.

A hospital administrator who has also been an organizer and a volunteer, working with organizations outside his hospital, told us, "If there's real opportunity for learning, and there's a truly underserved situation, then we support the use of Paid Time Off (PTO) and voluntary PTO. We do what we can to help them go, because I just think it's a wonderful opportunity."

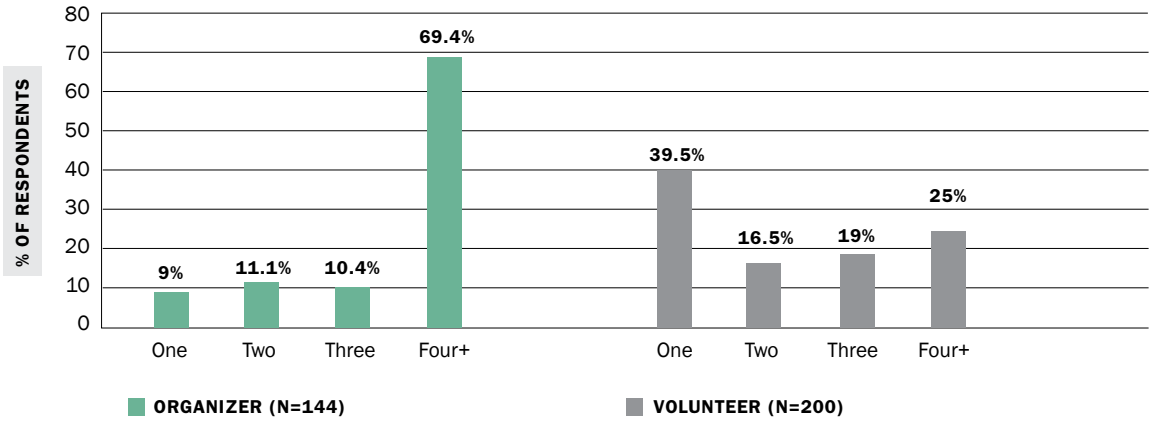
When asked on the survey if they received support from their hospital or health system, 42 percent of organizers responded that they received equipment and supplies, 32 percent reported that the support came in the form of freeing up staff to spend their time for planning and administering a mission trip, 26 percent received a financial subsidy and 21 percent reported that the employer pays staff for the time spent on mission trips. Twenty-nine percent received no such support.

Here are some basic facts about trips as described by survey participants, including their size, cost and destination.

HOW OFTEN DO PEOPLE GO?

Just over one-fourth of the people who were either organizers or volunteers had been on only one trip in the past five years. Almost 30 percent have gone on two or three trips, and 44 percent have gone on four or more trips. As would be expected, organizers reported a higher average number of trips than did volunteers. The answers from organizers and volunteers, when added together (and using the most conservative estimate of four trips in the calculation for those that checked "four or more") reflect experiences on a minimum of 949 medical mission trips in the past five years.

HOW MANY MISSION TRIPS HAVE YOU BEEN INVOLVED IN OVER THE PAST FIVE YEARS?



WHERE ARE PEOPLE GOING?

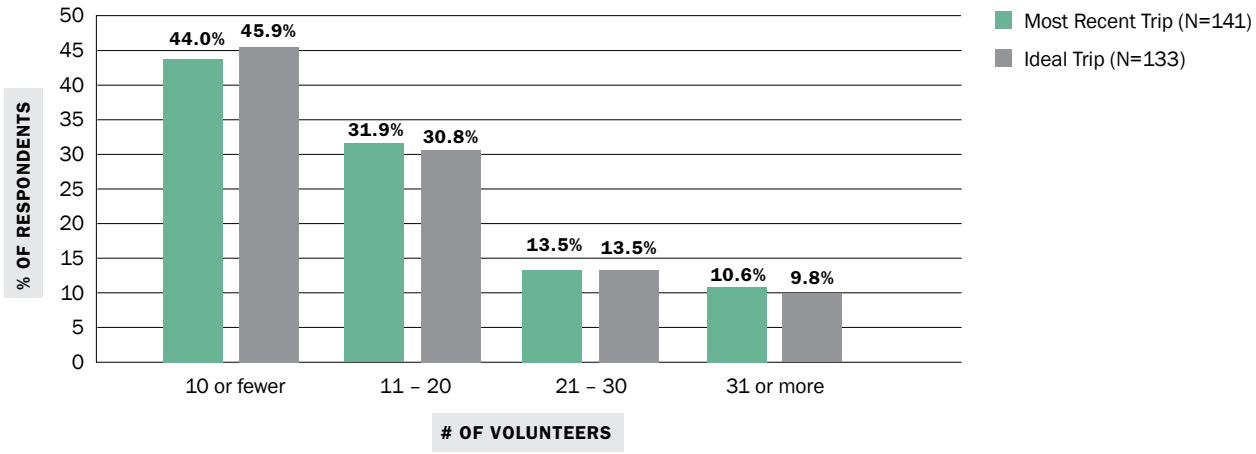
Organizers were asked what countries they visited on their most recent trip. They cited 45 different countries. The most commonly mentioned country (by 40 people, 28 percent of the 143 organizers who listed specific destinations) is Haiti. The other countries in the list of top destinations, in order of number of mentions, are Guatemala (31), Mexico (22), Dominican Republic (19), Honduras and Peru (18), Kenya (12), Nicaragua (11), El Salvador (10). Fewer than 10 organizers mentioned each of the other 36 countries. Interestingly, with the exception of Kenya, all of these top destination countries are in the Western Hemisphere, primarily in Central America and the Caribbean. This is almost certainly, in part, because of ease of travel.

TOP COUNTRIES VISITED

HOW BIG ARE THE TRIPS?

The number of volunteers participating in mission trips averaged 16.5, with a range from one to 95. Forty-four percent had 10 or fewer, 32 percent included 11–20, 13.5 percent had 21–30, and 11 percent had 31 or more volunteers. On their most recent trip alone, organizers in the survey reported taking a total of over 2,300 volunteers. Responses to the question about an ideal trip, when compared to the most recent trip, demonstrate that organizers were overall satisfied with the size of their teams.

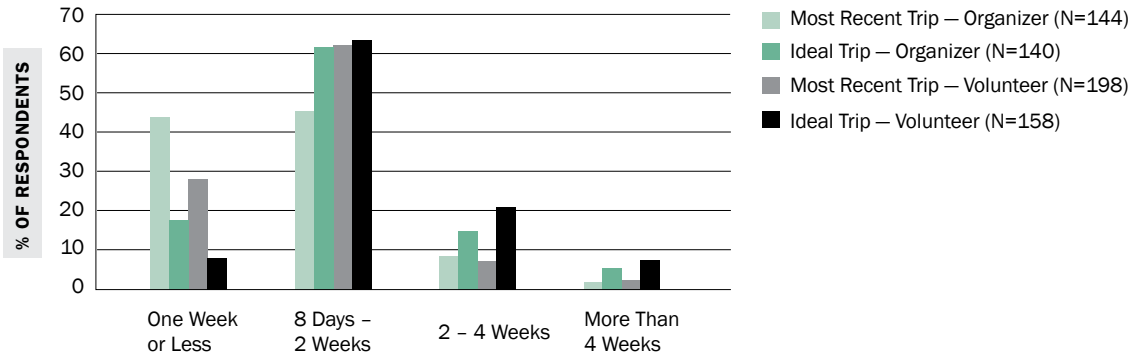
HOW MANY VOLUNTEERS TRAVELED WITH THE MISSION TRIP? WHAT IS THE IDEAL NUMBER?



HOW LONG DO THEY STAY?

Thirty-four percent of organizers and volunteers combined spent one week or less on the most recent volunteer trip, 55 percent stayed between one and two weeks, and just 11 percent stayed more than two weeks. Many would ideally like to stay longer in the country. Forty-four percent of organizers, for example, report spending less than a week, but only 18 percent consider that ideal. More than three in five organizers and volunteers consider the ideal length of stay between eight days and two weeks.

HOW LONG DID YOU STAY IN THE HOST COUNTRY? BASED ON YOUR EXPERIENCE, WHAT WOULD BE THE IDEAL LENGTH?

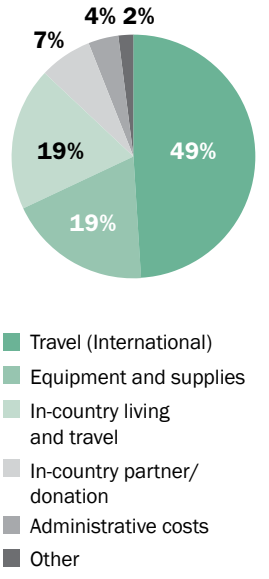


WHAT DOES IT COST?

The most frequent cost to volunteers, including airfare, was between $1,000 and $2,000 (41 percent), followed by 24 percent who paid over $2,000, 21 percent who paid less than $1,000, and 13 percent who did not pay anything at all. With an estimated 2,300 volunteers going on the "most recent" trips, at an average cost of about $1,500 per person, the cumulative cost of the most recent trips described in the survey represent an estimated expenditure of $3.45 million.

We asked organizers to estimate what proportion of total trip costs went to each of the kinds of expenses listed on chart at right. Their estimates indicate that international travel is by far the largest expense, consuming nearly half of the total direct costs. Taking up the next largest piece of the pie, approximately 26 cents of every dollar is spent in the host country for living and transportation expenses and for payments to partners.

OF THE TOTAL DIRECT COST, WHAT PERCENTAGE WENT TO THE FOLLOWING AREAS?



IS THERE A DIFFERENCE BETWEEN RESULTS FROM CHA MEMBERS AND NON-CHA MEMBERS?

There was no difference between CHA member sponsored and non-CHA member sponsored trips with regard to actual length of the most recent trip, the number of volunteers included, or how many trips were undertaken by the survey participants. However, CHA member-sponsored trips are significantly less expensive for the volunteers, with 51 percent of volunteers and organizers reporting either no personal cost or under $1,000 per person, compared to 22 percent of non-CHA member-sponsored trips. Other comparisons are noted elsewhere in the report.

GOALS

We asked all of the participants what they considered to be the most important goals of international medical mission trips; they could select three possible responses from a list of 13. By far, the most commonly selected option (73 percent) was "improving access to medical or surgical care for residents in the host country," followed by "providing volunteers with an opportunity to serve" (38 percent). About one in three selected missionary work as one of the most important goals.

MOST IMPORTANT GOALS OF INTERNATIONAL MEDICAL MISSION TRIPS (N=511)		
	NUMBER	PERCENT
Improving access to medical or surgical care for residents in the host country	371	72.6%
Providing volunteers with an opportunity to serve	196	38.4%
Improving public health conditions (e.g., water supply, sanitation) in host countries	177	34.6%
Carrying out missionary work	166	32.5%
Building partnerships in other countries	141	27.6%
Building capacity in host country medical facilities	130	25.4%
Providing an educational experience for the volunteers	110	21.5%
Continuing the tradition of our sponsors	65	12.7%
Comments or other	37	7.2%
Providing disaster relief	35	6.8%
Providing financial support for host country organizations	17	3.3%
Enhancing the reputation of your home hospital/health system	8	1.6%
Conducting research	5	1.0%

VALUE TO VOLUNTEERS

Ninety-one percent of all survey participants indicated that they consider international medical mission trips to be "extremely valuable" for the volunteers. This rating did not differ by trip sponsorship (CHA/non-CHA members) or by whether the person answering had been an organizer or a volunteer.

When asked to explain their rating, the most typical responses were grouped into the following categories:

» Fosters solidarity — provides an opportunity to develop mutually beneficial relationships with other volunteers and people in the host countries.

» Offers personal and/or spiritual fulfillment/ growth/transformation.

» Provides learning experience — volunteers broaden their worldview, gain a better understanding and appreciation of people from other cultures, religions, etc., and of the needs and conditions faced by those in developing countries.

» Gives volunteers opportunities to serve those in need that they may not have otherwise had.

» Inspires continued work to resolve international health care problems and a reinforced commitment to service and missions.

» Helps put volunteers' lives in perspective, including a greater appreciation of what is available in the U.S. (resources, health care, etc.).

Some of these same themes are also seen with regard to the specific benefit to the individuals who participated in the survey. We asked both organizers and volunteers an open-ended question, "Looking back, what was the most valuable part of your experience?" The most common themes identified in the responses were:

» Helping/serving those in need through medical treatment, health education, and capacity-building.

» Gratitude from patients/host community.

» Greater appreciation of/perspective on privileges that volunteers have that people living in the host countries do not.

» Personal and/or spiritual fulfillment/ growth/transformation.

» Experiencing a different culture, gaining a better understanding of global health care needs and situations in other countries.

» Building relationships with host country staff, host community, and fellow volunteers.

» Seeing change/growth/fulfillment in volunteers (organizers only).

We also asked, "What changes, if any, has the experience of an international mission trip made on your outlook, beliefs, life plans, or professional practice?" The most common responses focused on several key themes:

» Support, promote, and continue to go on (or wish to go on) more mission trips.

» Increased gratitude for what we have in the U.S. (resources, health care, etc.).

» Gained a new perspective in life which has led me to become or want to become a better person.

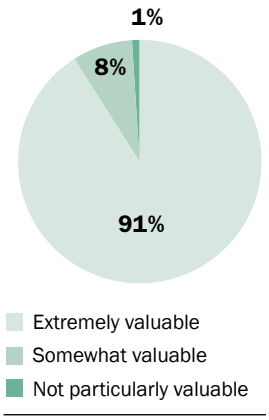
» Deeper commitment to service both abroad and at home.

» Greater appreciation/understanding of those from other cultures and religions.

» Led to adopting a less materialistic, simpler way of living.

All three questions about the value to volunteers generally and to the individual responding to the survey specifically reveal a consensus. There is a strong perception that participating in medical mission trips can provide individuals with greater appreciation of what they have, greater understanding of the world, personal fulfillment and satisfaction and a desire to serve others further.

IN YOUR OPINION, HOW VALUABLE ARE INTERNATIONAL MEDICAL MISSION TRIPS FOR THE VOLUNTEERS?



VALUE TO CATHOLIC HEALTH CARE

Seventy-eight percent considered international medical missions to be "extremely valuable" for Catholic hospitals or health systems.

When asked to explain their answers, the dominant themes that emerged are summarized in the following statements:

» They help to fulfill the mission of the institution and extend it on a much broader scale than otherwise possible.

» They provide an opportunity to fulfill Christ's command to service. It is our duty/responsibility to share our gifts and care for those in need.

» They provide an invaluable learning experience for employees of Catholic hospitals/health systems to develop their passion and skills (such as teamwork, leadership, cross-cultural skills, etc.), leading to stronger, more engaged and more committed staff and physicians.

» They build relationships with those in other countries and foster a sense of solidarity.

» Catholic health leaders interviewed agreed that medical mission trips by their employees have benefits for the home organization.

VALUE TO HOST COMMUNITIES

Seventy-five percent of respondents considered medical mission trips to be "extremely valuable" for host communities, while 24 percent said they were "somewhat valuable." There was no difference on the rating of value to host communities between organizers and volunteers, between people who participated in CHA member-sponsored trips and those involved in trips sponsored outside of CHA members, or between CHA hospital employees and those not working for a CHA-member institution. Within CHA hospitals/health system members, administrators rated the value to host communities lower than did non-administrative staff.

When asked to explain their answers, the responses were categorized into three dominant themes: the trips are definitely valuable; the trips are potentially valuable but only if done right; and the trips have the potential to cause damage. Among the three questions about the value of mission trips (to volunteers, to Catholic health and to host communities), only this last one elicited such differences. What follows are descriptions of the main themes:

DEFINITELY VALUABLE

» They provide needed care that otherwise people could not get.

» They give hope to the communities, who learn that people love and care for them and that they are not forgotten.

» They provide valuable resources, services and knowledge.

POTENTIALLY VALUABLE BUT ONLY IF DONE RIGHT

» The value of the trip is dependent on preparation, goals and execution.

» They are valuable if they bring long-term, sustainable care, build capacity and involve the hosts.

POTENTIALLY HARMFUL

» Trips can lead to dependency and damaged relationships.

» Trips can have negative economic and/or cultural impact.

» Trips can cause possible harm to health without follow-up.

The potential for medical harm is noted in many critiques of international medical mission trips. For example, short-term missions that are not part of continuous care often include participants who are unaware of patients' history and previous treatment. They sometimes introduce expired or inappropriate medications or perform surgical procedures without the possibility for monitoring and correcting complications and side-effects. Lack of language fluency can increase the chances of miscommunication and inappropriate care. These possibilities worried some of the study participants.

"It would be nice if we had more collaboration with some of the local doctors in terms of the pre-op and the post-op. That's really from a surgeon's perspective, but it's hard for us to walk away and not be sure how our patients are doing.

So it's nice that we do have one doctor who's willing to check in on those patients and make sure that they aren't infected and that they're doing well. But I wish that was more reliable," said a physician, worried about the lack of follow-up for surgical patients after the team's departure

Others worried that the trips offer little value to hosts: "In some cases, we're more bother than we're worth. And we're tremendously disruptive to their ordinary workday, and they've got to take care of us, they've got to pick us up at the airport. They smile and they're very nice, but, oh my gosh, we're a huge disruption to their lives. And the least we can do is just be gracious, you know?" said a Catholic health system administrator, organizer; volunteer; supervisor of other volunteers, worried that a mission group may simply be "in the way" of local staff accomplishing their work.

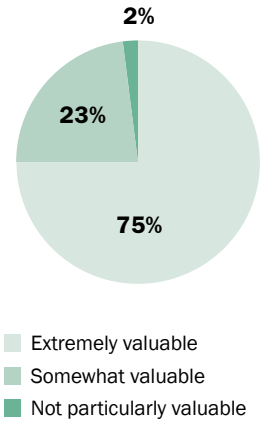
A number of study participants expressed the worry that medical mission trips undermine host populations by creating dependency on the arrival of outsiders — outsiders who are temporary and often unprepared to make a lasting difference.

These concerns were expressed in many comments on the survey when participants were asked to explain their rating of the value to host communities:

- "Only if it creates partnerships, not a dependent relationship."
- "Unless the foundation is built and developed to make the host systems self-sustaining, mission trips are often just a Band-Aid to a much larger problem."
- "If done well, and not furthering dependency or being a drain to the hosts, the missions can be valuable."
- "If the trips come alongside the communities to empower the communities. If it is just handouts without including the community then it can be harmful."

In sum, there is an almost unanimous belief that medical mission trips are valuable for the volunteers, somewhat less valuable for Catholic health, and there is the least support for their being extremely valuable for host communities. Even so, 75 percent do agree on the value for communities, and many specified that they could be even more valuable if they adhere to specific guidelines.

IN YOUR OPINION, HOW VALUABLE ARE INTERNATIONAL MEDICAL MISSION TRIPS FOR HOST COMMUNITIES? (N=501)



ESTABLISHMENT OF PARTNERSHIPS IN THE HOST COUNTRY

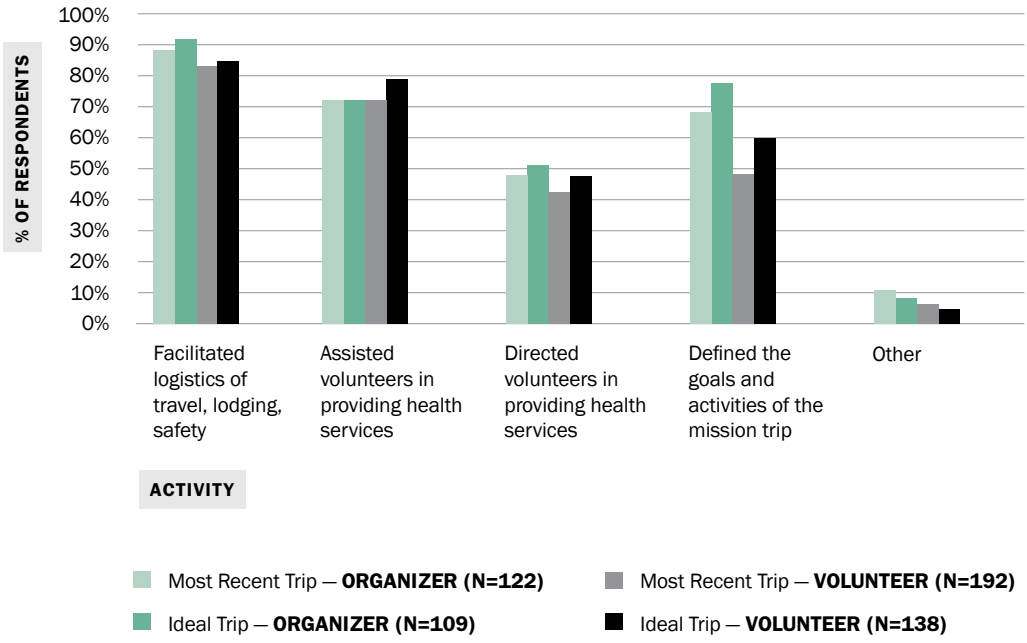
When asked to classify their primary partner, the majority of organizers indicated that it was either an NGO (non-governmental organization), a church or a hospital. Others referred to religious congregations (e.g., Sisters of Charity) or leaders based in the host country, or to multiple partners, as seen in the following comment: "We have a number of partners equally represented — the NGO that is our primary on-the-ground partner in all projects helps coordinate, but we also worked with the local hospital where our teaching occurs and the public health clinic where our mentoring program takes place. We also worked with the Catholic Doctors Association and the local medical society."

Nine percent of organizers and three percent of volunteers indicated that there was no in-country partner involved in planning or carrying out the medical mission trip. Yet when the organizers who responded "no partner" were asked whom they relied on for planning activities, they usually referred to in-country missions or their country-based organization. Indeed, many of the in-country partners are not independent of outside organizations.

Most partnerships were established as a result of personal connections (70 percent) or connections with the hospital's religious sponsor organization (15 percent). This is both advantageous and precarious for the long-term success of these trips. In one sense, personal relationships and trust are essential between partners. In another, trips that require a long-term relationship in order to be effective should not be dependent upon a single personality within a hospital or health system.

The most frequently cited role of a partner was facilitating logistics (88 percent), followed by assisting volunteers in their activities (72 percent). The in-country partner was reported to define the goals and activities of the trip 69 percent of the time, and to direct volunteers in their activities 48 percent of the time. Organizers reported being very satisfied (88 percent) with the partner. The biggest gap between actual and ideal trips with regard to the partner's role, for both volunteers and organizers, was a desire for partners to be more involved than they are in defining the goals and activities of the trip.

WHAT ROLE DID IN-COUNTRY PARTNERS PLAY IN THE TRIP? WHAT ROLE SHOULD THEY PLAY?



Interviewees almost uniformly emphasized the importance of the partner relationship to the success of a mission trip. They gave a number of reasons for this. One hospital employee who had both organized and volunteered on mission trips emphasized the relationship and its public relations function: "I think a successful trip is one that first and foremost builds a sense of collaboration and partnership and compassion between the host community and the visiting organization. Medical missions have to be marketed within the sponsoring organization or they won't survive financially, so the trip has to be perceived by the people who make the financial decisions as worthwhile and worthy of continuing. That's big — it's life and death for the trips."

On the other hand, the executive director of a medical mission organization emphasized the safety aspects and the importance of partners agreeing on the purpose of the trip: "I think it's very important to have a partnership. Don't go unless you have one. Without an in-country sponsor, it's incredibly dangerous and you aren't responding to their request or their need, and you don't have protection. So number one, you've got to have a partner. And then number two, is your partner an organization whose mission and vision are in line with your own?"

For a hospital administrator who has been both an organizer and a volunteer, the partner's role is critical to a trip's effectiveness: "We have little or no difficulty getting the donated supplies and equipment, but having somebody on the ground that you can trust to receive the equipment and to get equipment into country and avoid excessive and abusive taxes and fees that pretty much go to pay bribes, that's the challenge, the real challenge ... you can't overemphasize the importance of having trusted partners."

A health system administrator who has volunteered frequently spoke of the importance of working with partners over a period of time to define the goals and activities of the visiting group: "The first step in forming any sort of partnership is as much as possible listening to the local community, listening to local leaders, listening to the needs of your partners. The building of relationships is fundamental to building a healthy partnership. So we've spent the past 18 months building our relationships before we developed this plan. And I think that those 18 months are really what's going to make us successful over the next four years."

He continued to explain why this kind of relationship-building is often avoided by sponsoring organizations: "As large organizations from the U.S., we can go in and push an agenda and throw down some money on the table, and any organization is going to jump to collaborate. But I think that a sign of a good relationship is when someone says, 'Wait a second. That's not exactly what we're trying to do.' We've allowed space for that pushback so that we can have some real fruitful conversations about what is realistic."

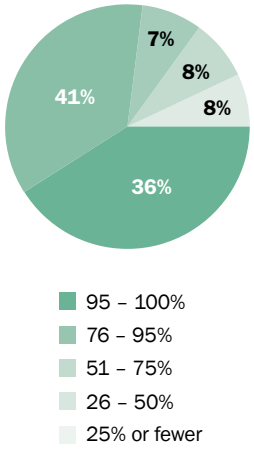
Building an effective and mutually beneficial partnership takes time and effort and a focus on meeting the needs defined by responsible community leaders, not by the sending organizations.

Yet the most common roles of partners appear to be as assistants to the visitors, helping with logistics and helping with services, rather than as the ones who define what is needed and are assisted by the visitors.

One potential mechanism for establishing good relationships and avoiding possible misunderstandings and disappointments is to develop a Memorandum of Understanding (MOU). Based on the interviews, the majority of partnerships appear to be informal, without specific contractual arrangements formalized in MOUs. As one organizer, a faculty member in a Catholic nursing school, noted: "We really at times were a little bit hampered by not having more formal agreements for some of the activities that we performed. Those agreements were often not as airtight as they could have been and there did develop a couple of times some serious misunderstandings which somewhat detracted from the collaboration and the credibility between the in-country people and us."

Many study participants expressed concerns about fostering dependency; the work of creating equal partnerships is very important in avoiding that pitfall.

WHAT PROPORTION OF APPLICANTS DID YOU ACCEPT INTO YOUR PROGRAM? (N=133)



RECRUITMENT AND SELECTION OF TEAM MEMBERS

When asked about the greatest challenges to creating effective medical mission trips (results reported in Section 5), almost one in four organizers selected "volunteer recruitment and commitment," and 23 percent picked "managing volunteer expectations." This suggests the need for attention to how volunteers are selected and prepared for their trips.

Almost two-thirds of organizers indicate that they use application forms and/or interviews with potential volunteers as part of the selection process. Just over 40 percent carry out reference or background checks, but nine percent do no screening at all. And almost everyone who applies is accepted; 41 percent of organizers report having accepted more than 95 percent of all applicants on the most recent trip. An additional 36 percent of organizers accepted between 76 and 95 percent of all applicants. It may be that the lack of selectivity among applicants results in some cases from problems in recruiting sufficient numbers of volunteers for the needs and schedules of specific trips. The most common reason for rejecting applicants was inadequate space on a trip, followed by poor adaptability to the team or negative attitude.

CHA member-sponsored trips are somewhat more selective, with 30 percent accepting over 95 percent of applicants, compared to 49 percent of non-CHA member-sponsored trips. When asked about reasons for rejecting applicants, non-CHA organizers were twice as likely to say that they do not reject any.

We asked organizers, "What specific skills or qualifications were most important when you recruited for the most recent mission trip?" They could select up to three items from a list of eleven possibilities. The most commonly chosen were, in order of preference: primary care training (56 percent), character and personality (e.g., flexible, outgoing, compassionate — 55 percent), medical specialty or surgical training (42 percent) and cultural sensitivity (37 percent).

In selecting the qualifications for a future trip, organizers would prefer to have more volunteers with primary care training and somewhat fewer with specialty medical or surgical training, or with no specific qualifications at all.

We asked volunteers if they believed their skills were well-matched to the needs of the trip. Eighty-three percent believed that they were very well-matched and 17 percent partially matched.

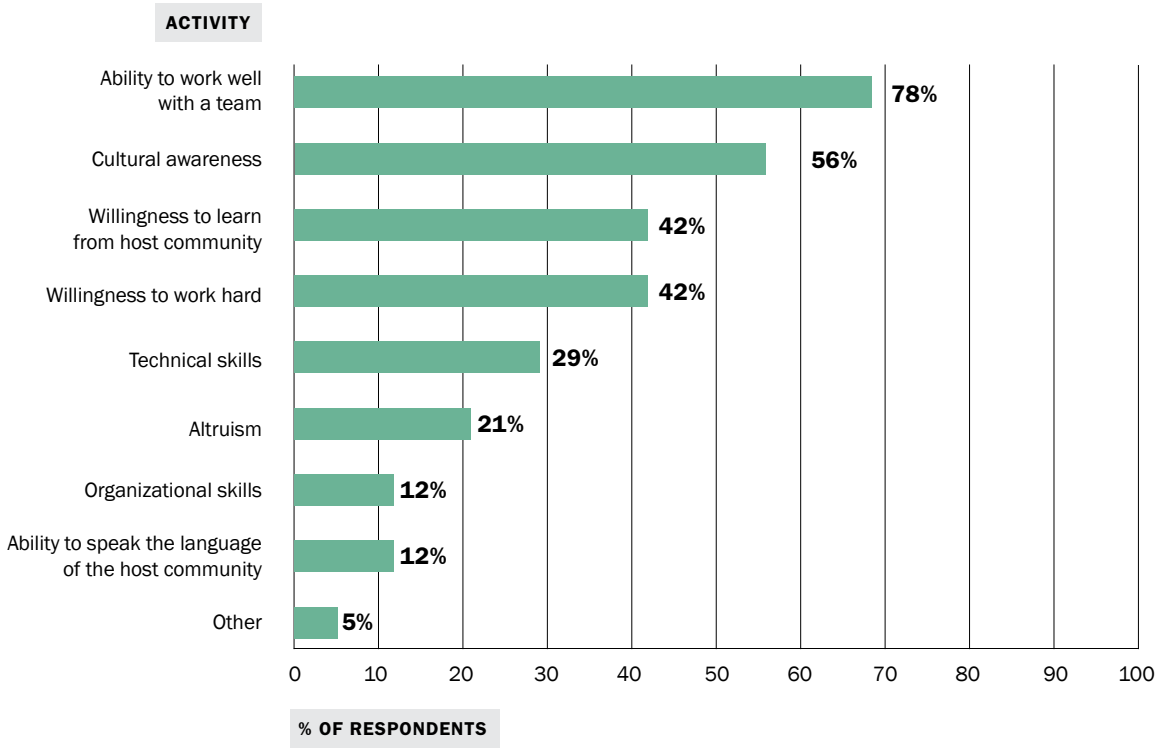
Organizers would like to screen potential volunteers more rigorously; the largest gaps in the entire survey between responses regarding recent and ideal or future trips are seen in this domain. Compared to the most recent trip, organizers would ideally reject applicants who are non-compliant with the rules, who have physical or mental health issues, poor recommendations, poor adaptability or who are theologically incompatible. These differences were quite dramatic, as included in the charts that follow:

REASONS FOR REJECTING APPLICANTS	PERCENT WHO SELECTED ANSWER	
	MOST RECENT TRIP	FUTURE TRIP
All were accepted	28.0%	5.6%
Non-compliant with rules, paperwork	22.7%	52.8%
Health issues (mental health, substance abuse, physically unable to complete required work)	23.5%	68.0%
Poor recommendations (criminal history, malpractice)	11.4%	50.4%
Poor adaptability (cannot work in team, negative attitude)	29.5%	64.8%
Theologically incompatible	1.5%	11.2%
Inadequate skills	23.5%	39.2%

Some organizers we interviewed referred to occasional problems with team members. For example, one said, "When people weren't a good fit, it was because they really didn't embrace the basic values that were driving our trips, and so there were some situations where there was a lack of integrity." Another cautioned, "Not everybody is cut out for the kind of conditions that they're going to encounter, and so you just can't take prima donnas, you know, people who want to be served by others. You're looking for people who are serving."

We asked survey participants what they considered to be the qualities of ideal volunteers.

WHAT DO YOU CONSIDER TO BE THE QUALITIES OF THE BEST VOLUNTEERS? (TOP 3 CHOICES ALLOWED) (N=351)

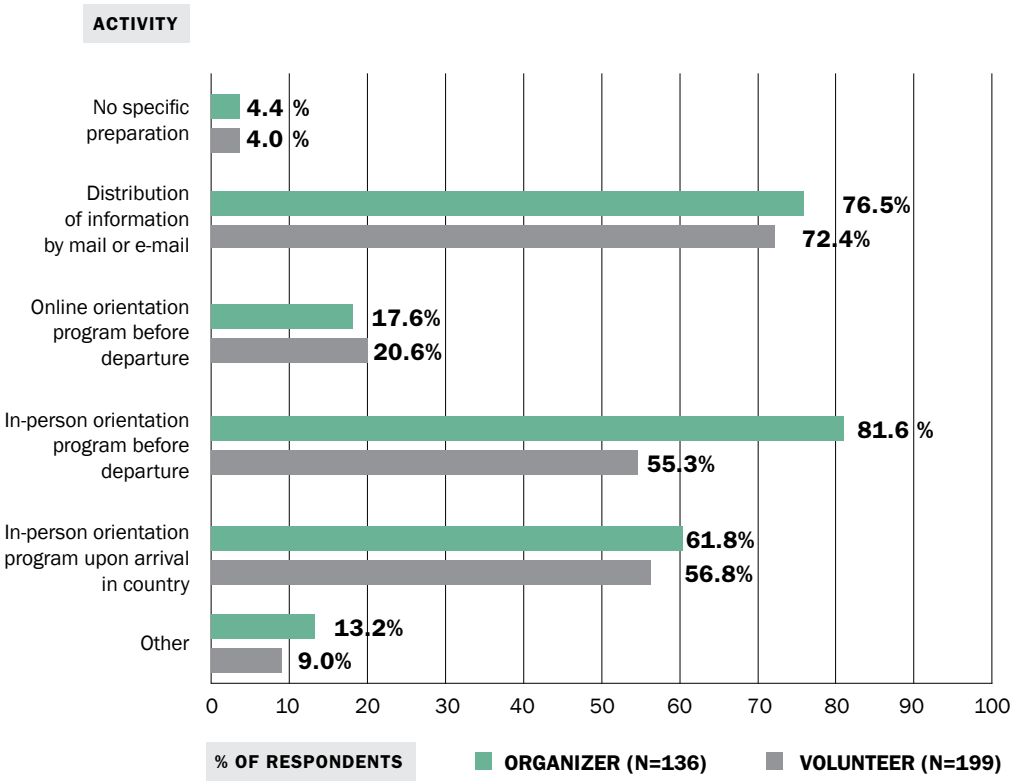


The most common response under "other" was flexibility.

Interestingly, both in the ideal selection of volunteers and in assessment of best qualities, specific skills are considered less important than the kind of personal qualities that facilitate team work. These qualities are more difficult to assess in advance of a trip but are clearly very important. Cultural awareness and willingness to learn from the host community are also rated highly and can be included in the orientation of volunteers, although, as results show, they are not often emphasized.

PREPARATION OF VOLUNTEERS

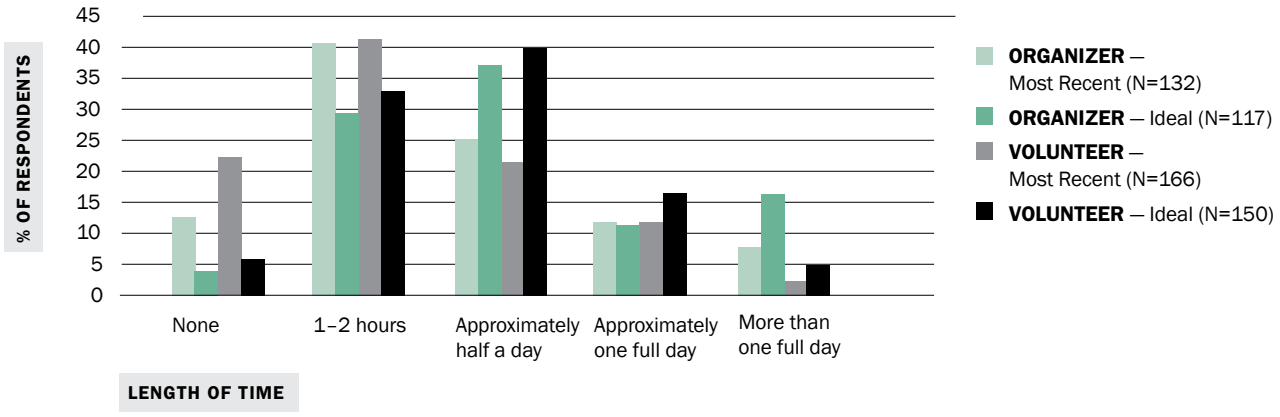
WHICH OF THE FOLLOWING KINDS OF PREPARATION DID YOU RECEIVE FROM THE SPONSORING ORGANIZATION IN ADVANCE?



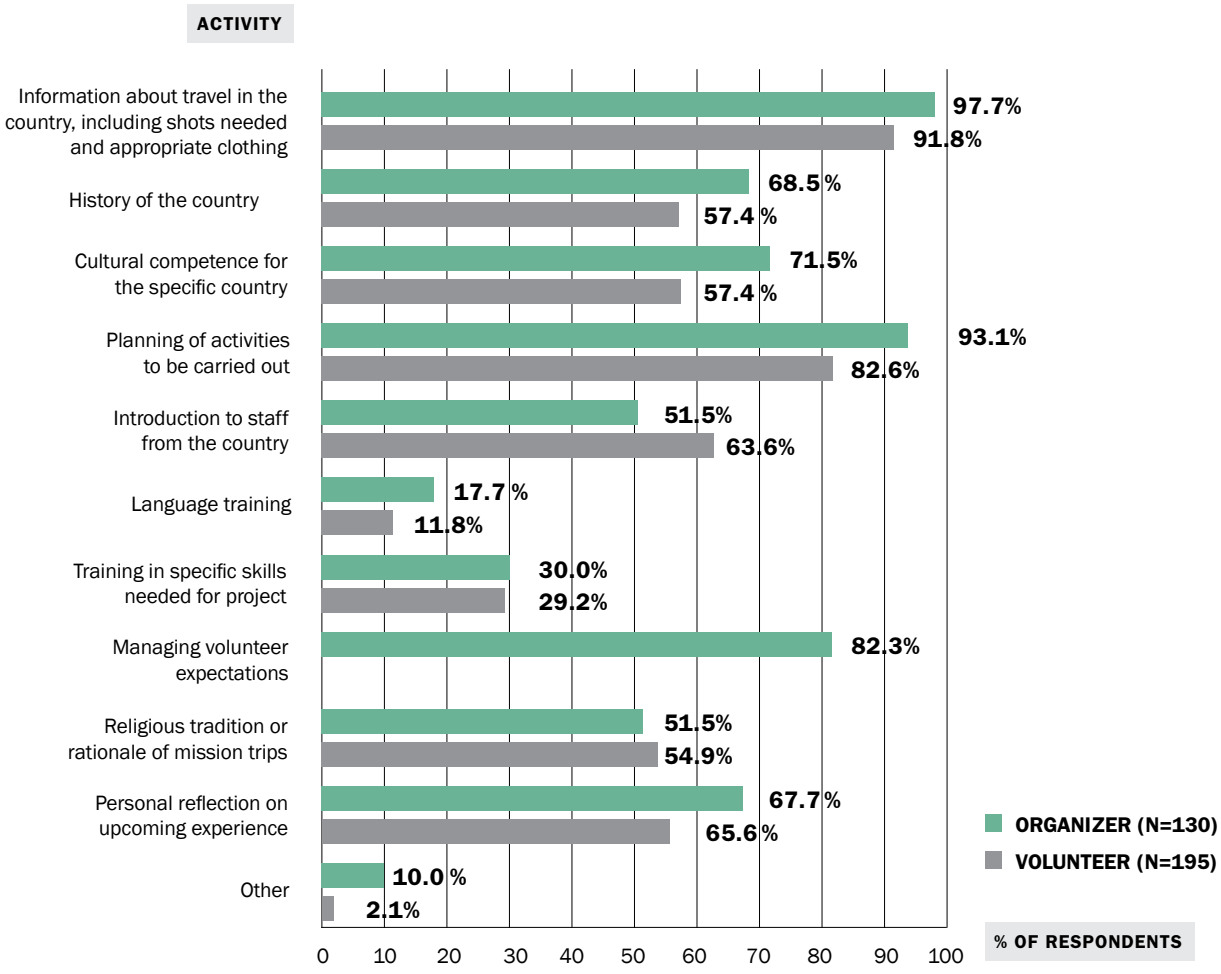
The challenge of having to "manage expectations" cited by almost one in four organizers, speaks to the issue of volunteer preparation, which is often brief. Eighty-two percent of organizers indicated that they had held an in-person orientation in advance of the trip, although only 55 percent of volunteers said that they had such an orientation.

Orientation, as reported by organizers, typically (41 percent) lasted between one and two hours, although one in four reported half a day and one in five a full day or more. When organizers and volunteers are combined, they would ideally like to have a longer orientation; the length of time selected as ideal by most people is half a day.

IF THE GROUP HAD AN IN-PERSON ORIENTATION IN ADVANCE OF THE MISSION TRIP, HOW LONG DID IT LAST? EVEN IF THERE WAS NOT AN IN-PERSON ORIENTATION, GIVEN YOUR EXPERIENCE, HOW LONG WOULD IT IDEALLY LAST?



WHICH OF THE FOLLOWING ELEMENTS WERE INCLUDED IN THE PREPARATION OF VOLUNTEERS IN ADVANCE OF THE MOST RECENT TRIP?



Most volunteers wanted to be better prepared for the activities in which they would be engaged. They wanted more knowledge of their host's culture, language and national history. They wanted both a personal and group reflection on the trip. They were largely satisfied with the other topics.

ORIENTATION TOPICS	RECENT	IDEAL
Information about travel	91.8%	85.5%
History of the country	57.4%	78.0%
Cultural competence for the specific country	57.4%	80.5%
Planning of activities to be carried out	82.6%	76.7%
Introduction to staff from the country	63.6%	66.0%
Language training	11.8%	59.1%
Training in specific skills needed for the project	29.2%	52.2%

Some of the organizers we interviewed referred to manuals, books and videos that they use to introduce volunteers to the country they will be visiting. For the most part, however, the emphasis in preparation is on logistics of travel and packing. Orientations are brief, if held at all. When volunteers live in widely scattered locations, organizers rely on materials distributed by email or mail and on in-country orientations. Increasingly, however, there are materials available on the Internet and group orientations can be held with video conferencing tools.

When the volunteer team is located in one region or consists of students at a specific university, there are more opportunities for in-depth preparation. For example, the director of international programs at a Catholic medical school described the orientation for students before they go overseas, including the challenges they'll face: "The best part of the preparation comes through the reflection that we do. We ask them to do fundraising to try to articulate, for themselves, why this is important for their own growth and development. And then we do some educational pieces to get them aware of the situations in the various communities."

"I think the biggest barrier is we still don't do a good enough job at dispelling stereotypes, so students still come with their sort of first-world understanding of what it is to be effective, [to do] effective service. It's so hard to prepare students to get out of that mindset. The other thing it's hard to prepare them for is to not expect the same kinds of conveniences."

The majority of mission trips do not provide much preparation for volunteers, often leading to their feeling unprepared for visiting the country. The emphasis on flights, shots and packing is understandably essential. But the value of a trip is likely to be greatly increased, both for the volunteer and for hosts, if there are educational materials about the country, realistic reflections on the role of the volunteer, and preparation for the work to be done.

PLANNING AND CARRYING OUT ACTIVITIES

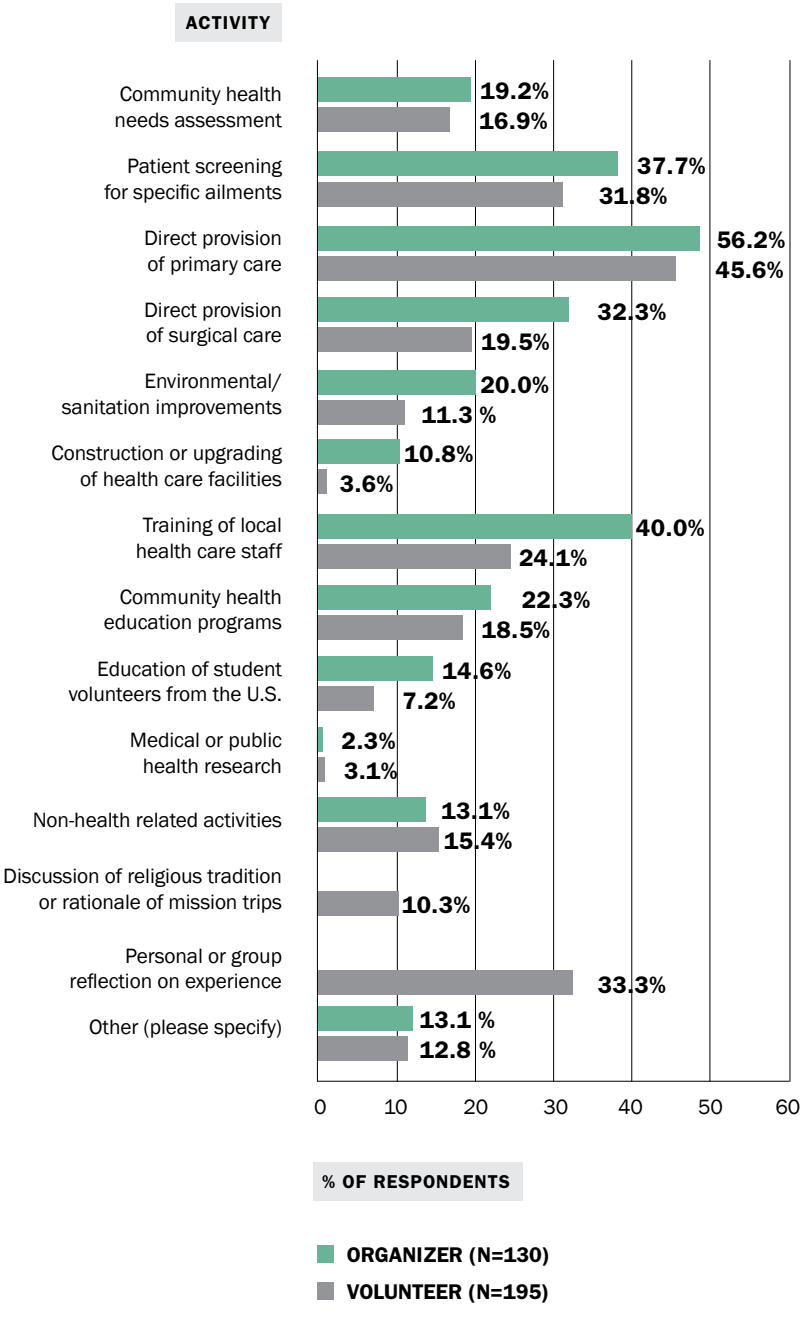
We asked both organizers and volunteers about the major activities they engaged in. There were some important differences in responses between the two groups.

There is consistency between organizers and volunteers in the focus on screening and treatment of patients. Organizers were more likely to mention the training of staff. The volunteers were also given the option of selecting "personal or group reflection" (33 percent) and "discussion of religious tradition or rationale of mission trips" (10 percent), as major activities.

Some survey participants added specifics such as "strengthening of hospital's IT system," tooth extraction, equipment repair, distribution of eyewear, translating and "demonstrated desire to assist host community" as their major activities.

The majority of activities apparently involve short-term interventions. They provide what are often very valuable, even life-saving, services to people who are suffering. Given the concern expressed earlier, however, about fostering dependency, there seems to be very little attention to capacity building in the form of training or improvement of facilities.

WHAT WERE THE MOST IMPORTANT ACTIVITIES YOU PERSONALLY ENGAGED IN?



EVALUATION AND DEBRIEFING FOLLOWING THE TRIP

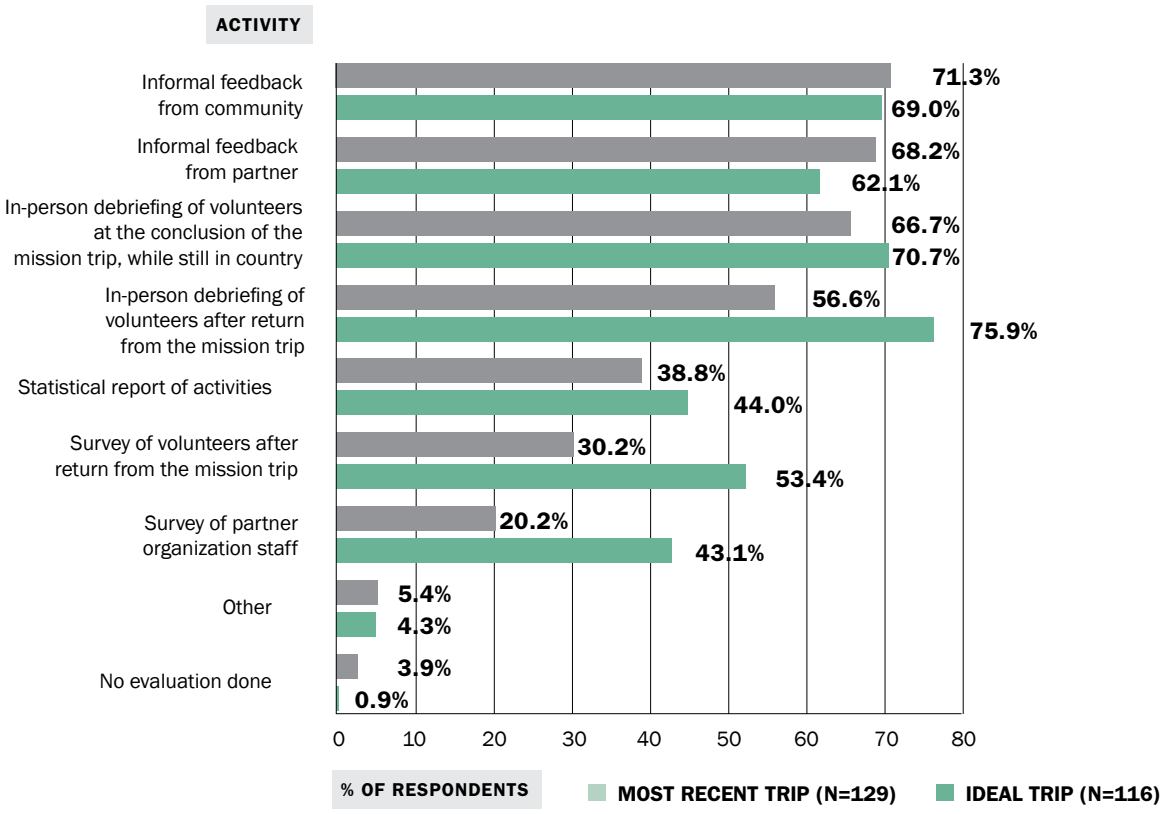
Both organizers and volunteers were asked what kinds of evaluations were used to assess their most recent medical mission. Almost all organizers reported carrying out some kind of evaluation, and three-quarters of volunteers were asked to evaluate their trips. The most frequent topics for evaluations were the benefit to volunteers (88 percent of organizers and 74 percent of volunteers) and the logistics and organization of the trip (87 percent of organizers and 74 percent of volunteers). Just over 60 percent in each group said they evaluated the benefit to the host community.

We then asked organizers what methods they used to carry out evaluations. Only four percent indicated that they had not done any evaluation. The most frequent types of evaluation involved informal feedback from community members, partners and volunteers.

Organizers were also asked to compare their actual evaluation procedures to what they ideally would do. The main differences were that organizers expressed a strong desire to do more in the way of surveying host country partner staff (43 percent on ideal trip compared to 20 percent on most recent trip) as well as debriefing and surveying volunteers after their return (76 percent would ideally debrief compared to 57 percent who did; 53 percent would survey volunteers after return compared to 30 percent who did).

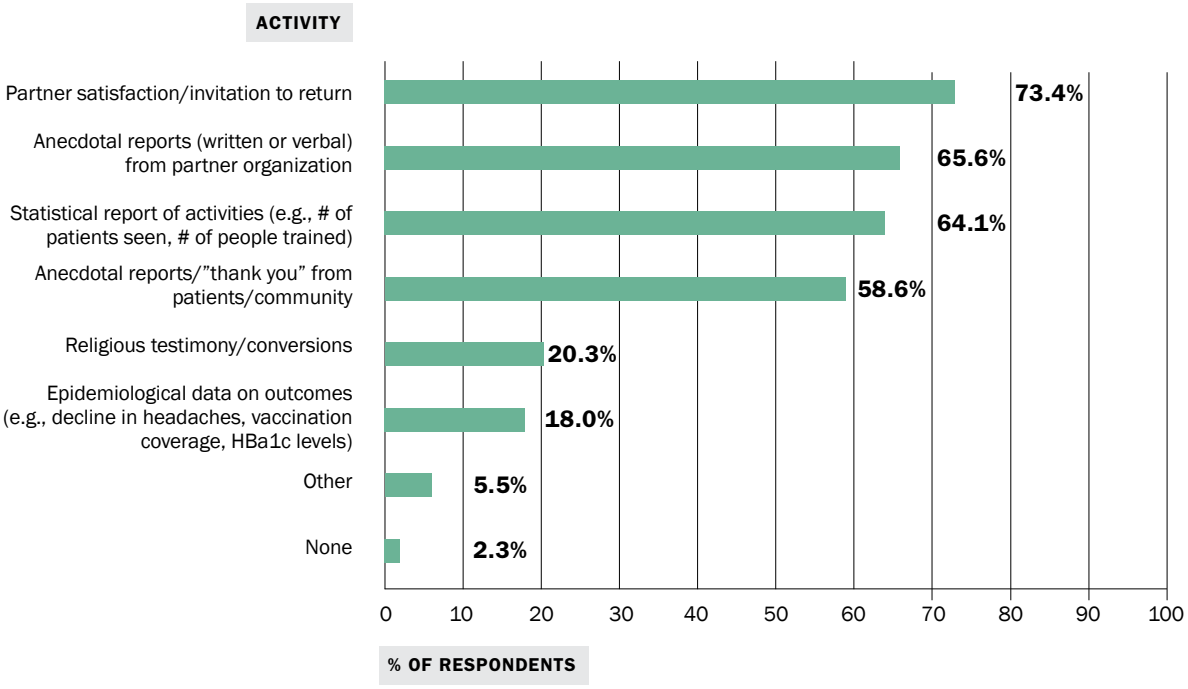
Said one health administrator, who is also an organizer of missions trips and volunteers, "We think, we have our own definition of success. We think, 'Well, that went well. You know, there were no major hiccups or disasters, so that went well!' Then we don't take the time to evaluate for improvement. That's an important thing that's often overlooked."

WHAT METHODS DID YOU USE TO EVALUATE THE MISSION TRIP? GIVEN YOUR EXPERIENCE, WHAT KIND OF EVALUATION DO YOU THINK SHOULD BE DONE?



We also asked a question about evidence of benefit to host communities.

WHAT EVIDENCE DO YOU HAVE, IF ANY, OF THE MISSION TRIP'S VALUE TO HOST COMMUNITIES WHERE VOLUNTEERS SERVED? PLEASE SELECT ALL THAT APPLY. (N=128)



Some specific examples of evidence were offered by survey participants, such as: "Ministry of Health has requested a formal partnership with our organization and an expansion of our health education efforts"; "Ongoing education of the public and beginning an extensive donation program that is continuing to supply income to the missions in need"; "Ongoing relationship with the host country diocese and hospital; the hospital is now open and operational."

When asked about evaluating evidence of benefit, several people we interviewed offered anecdotal examples of positive responses:

» A nursing educator and volunteer said, "Knowing that we served a lot and you got a lot of patient satisfaction from a smile on their face that somebody decided to listen to them and treat them."

» A director of international programs for a Catholic medical school who is also an organizer, volunteer and supervisor said, "Our host communities, they just say really good things. They're so grateful. I'm not sure that we get a good, honest picture of the impact that we're making other than to say they want us to keep coming back."

» A health system administrator and volunteer said, "They're so appreciative to even have a physician present or nurses present to meet their needs or at least try. So, in any case, that's to me the most valuable feedback. So, yeah, it's soft. I don't keep a spreadsheet on that or anything."

But other interviewees revealed some important concerns about the lack of adequate evaluation. For example, a health system administrator who has served as both an organizer and a volunteer noted: "We see 1,000 kids in a two-week mission. So what happened to those kids? Did they just go home, take their medicine like they're supposed to and now they're all better? Or did the medicine never get given, it got sold to somebody else, it only got half taken, they ended up back in the hospital? It's the outcome issues that are the hardest to collect the data on."

A foundation president who has been a volunteer and also has supervised other volunteers voiced similar worries about impact: "If we go and take a dental team, do we teach them how to floss? Do we leave them the floss that they can't get their hands on? Do we set up a system by which they get more floss? And do we have the teachers in that little village doing it themselves and teaching the children to do it? OK, that's beginning to see an outcome, right? And so, you can quantify that, and you can narrate that. Without evaluation, you'll redo the bad trips over and over."

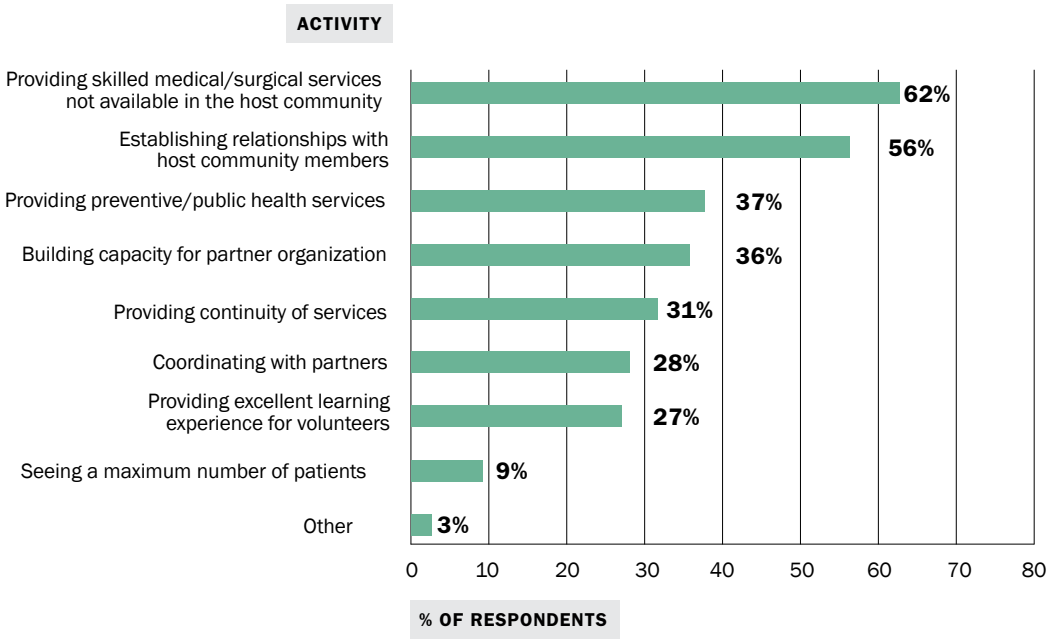
The responses about evaluation paint a very clear picture: The major focus of evaluation is on the volunteers' experience and the logistics of the trip itself. There is hardly any systematic assessment of the impact of medical service trips for host communities. Smiles and appreciation are valuable, counting patients seen is important and observing patients' pain alleviated or surgical conditions repaired is very gratifying. It is sometimes obvious when lives are saved or dramatically improved. But much more often we do not know the results of a primary care encounter or a health education lesson, a staff training session or a patient screening, and these are the major activities of medical mission trips.

Many who are involved in medical missions are aware of this fundamental problem, but good assessment is difficult and expensive to carry out. It is an important challenge to sponsoring organizations and their in-country partners as they endeavor to make their efforts as useful as possible. Some are satisfied with anecdotal information. But in an era of evidence-based medicine, and with the enormity of needs, we require more and better assessment to justify and to direct the huge financial and human investment in medical mission trips. Even though it may look like there are more pressing tasks, every group should devote time and resources to measurement and evaluation.

Near the end of the survey, we asked what people think are the keys to success and the greatest challenges of short-term medical mission trips.

WHAT ARE THE CHARACTERISTICS OF THE BEST TRIPS?

WHAT DO YOU THINK ARE THE CHARACTERISTICS OF THE BEST MISSION TRIP? (TOP 3 CHOICES ALLOWED) (N=352)



The largest number of organizers and volunteers selected provision of direct care services, followed by the establishment of relationships with host community members.

When we asked in the interviews what defines a "successful medical mission trip," there were quite a variety of responses. Some focused on the smooth functioning of the volunteer team, as seen in the following comment from a health system administrator who had both organized trips and been a volunteer:

"You really can't underestimate the importance of chemistry. A team has to have just the right balance of leadership and followership. And especially with physicians and medical professionals, it's not always a slam-dunk. It's not always a sure thing that we're going to get people who are willing to take direction from others."

Other comments focused on overall satisfaction with the trip. For example, a health system administrator who had been a volunteer offered this observation on success:

"Was the quality of care good? Was the client as well as the provider moved by the experience? The success is when they're able to serve but they also come away with a deeper appreciation for the people of the country."

And for others, success was measured largely by lack of disaster. A nurse who has organized trips to an area of rural Haiti that is difficult to reach noted that for her success means:

"When travel goes without a hitch and we don't have to worry about hurricanes."

A physician who is a regular volunteer offered: "If we've solved the problems that we were asked to solve without the worry of infection or injury or really truly causing harm to the patient or to the community, it's great."

Continuity is another important issue. For example, a health system attorney who has organized trips and supervised people who have gone on other missions responded regarding success: "Is it still continuing five, 10 years later? Does the relationship survive the departure of a CEO or of the key physician on our side, who wanted to do this?"

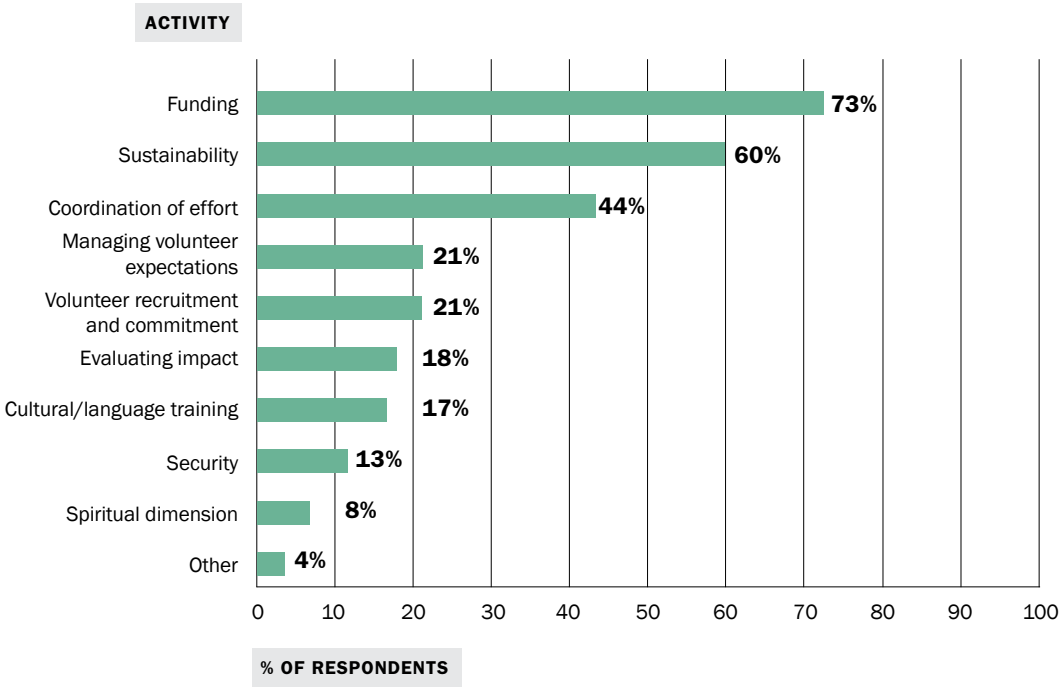
These responses are consistent with what we have seen earlier with regard to recruitment, preparation, and evaluation: organizers' major focus is, perhaps necessarily, on the team's ability to work well together, to accomplish specific tasks, to avoid harm to volunteers and patients, and to have a good experience. Yet they also consider it important to establish good and ongoing relationships.

WHAT ARE THE GREATEST CHALLENGES?

Organizers, volunteers and supervisors were all asked what they considered to be the greatest challenges to creating effective medical mission trips. The most frequent choices were "funding" (73 percent), "sustainability" (60 percent) and "coordination of effort" (44 percent).

The section that follows addresses "funding" and "sustainability" in greater depth. The challenge related to "coordination of effort" is addressed above regarding partnerships with host communities.

WHAT DO YOU THINK ARE THE GREATEST CHALLENGES TO CREATING EFFECTIVE VOLUNTEER MISSION TRIPS? (TOP 3 CHOICES ALLOWED) (N=352)



Section II

PHASE II RESEARCH

IDENTITY OF PHASE II SURVEY PARTICIPANTS

A 52-question online survey was distributed by CHA and CHA members to hospitals and clinics who received short-term medical mission trips. Out of 82 survey responses, 49 responses from 14 countries were included in the survey population. Those not included were:

» Respondents from the U.S. that confirmed they did NOT receive mission trips.

» Incomplete surveys from U.S. respondents.

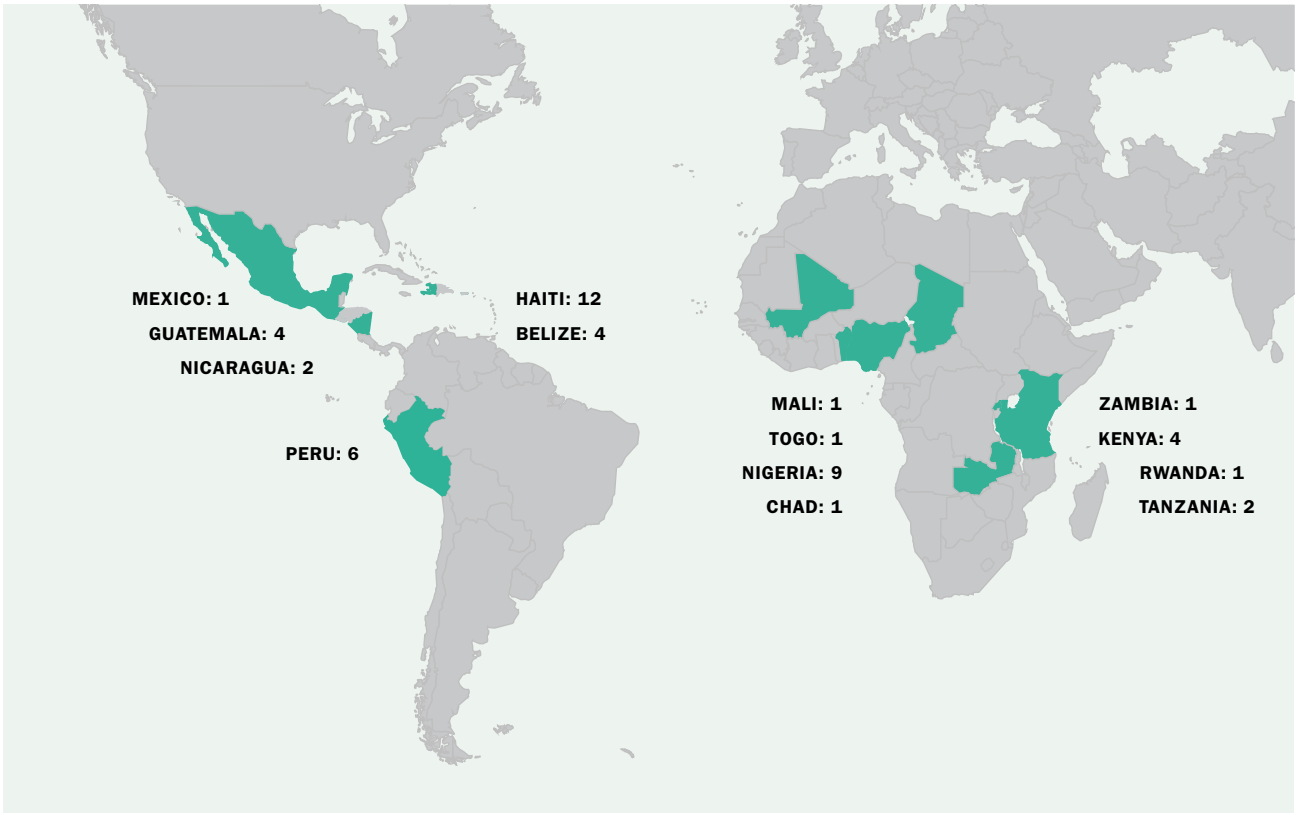
» Respondents from the U.S. that did not respond to the question if they did/did not receive mission trips.

» Respondents that reported that it had been over five years since they received their last mission trip.

» International respondents that did not complete the survey beyond background questions.

» Incomplete duplicates of completed surveys.

COUNTRIES OF SURVEY PARTICIPANTS

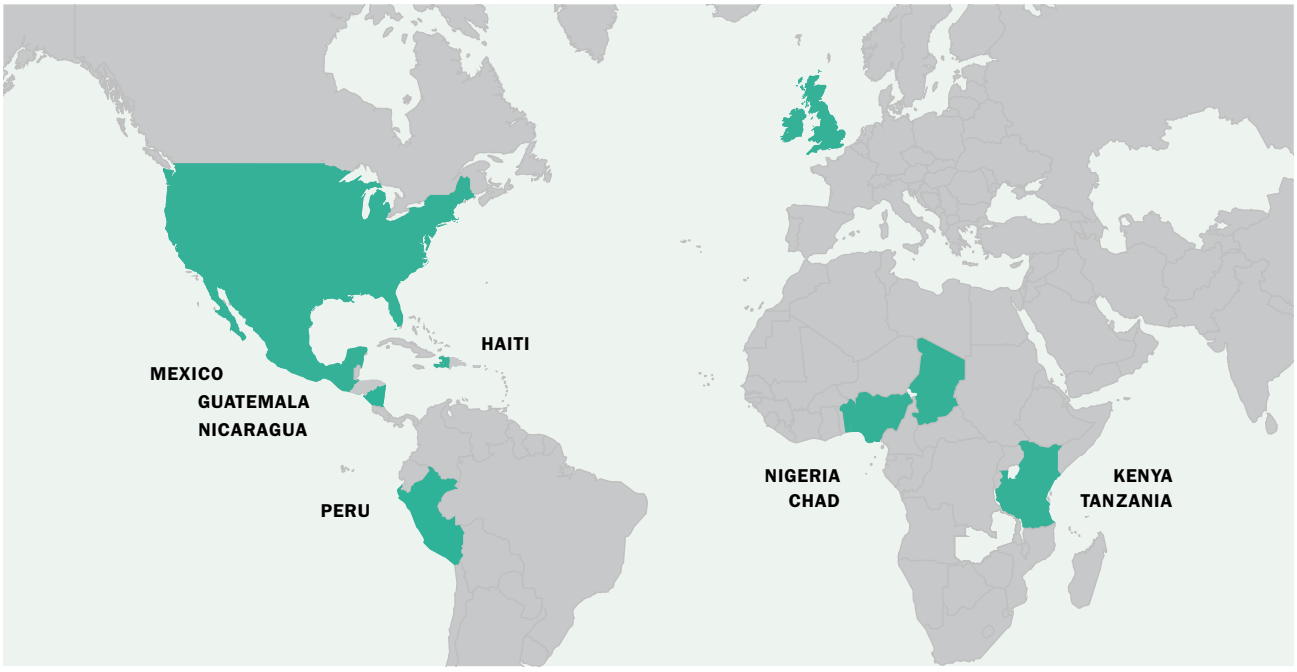


Survey participants played a variety of roles within their organizations as is reflected in the totals in the following table. Nearly 75 percent of survey respondents served in leadership positions, while over 40 percent were responsible for coordinating with medical mission trips from visiting organizations and an additional 26 percent were responsible for providing care to patients.

JOB RESPONSIBILITIES OF SURVEY RESPONDENTS	PERCENT OF RESPONDENTS
Serving in a leadership position (e.g., Chief of Staff, Hospital Director)	73.5%
Providing medical care to patients (e.g., doctors or nurses)	26.5%
Coordinating medical mission trips with visiting organizations	40.8%
Hiring clinical and non-clinical workforce	24.5%
Training clinical and non-clinical workforce	28.6%
Maintaining hospital technological capabilities	14.3%
Managing hospital budget, accounting and financial donations	20.4%
Managing inventory and procurement of supplies	18.4%
Maintaining patient medical records	10.2%
Managing data collection and reporting	20.4%
Providing administrative support	40.8%
Serving as a liaison to the community for public health campaign/education	18.4%
Serving as a liaison to government ministries and medical governing organizations	38.8%
Other	12.2%

The survey was followed by in-depth interviews with 25 individuals from 11 countries. Interviewees included 20 persons who had completed the survey or were affiliates of respondents, and an additional five interviewees were global health and medical mission subject matter experts from the U.S. and the U.K.

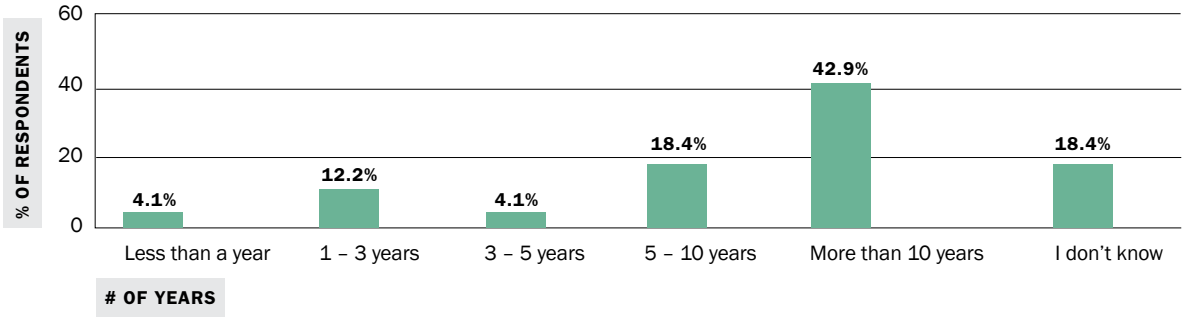
COUNTRIES OF PHASE II IN-DEPTH INTERVIEW PARTICIPANTS



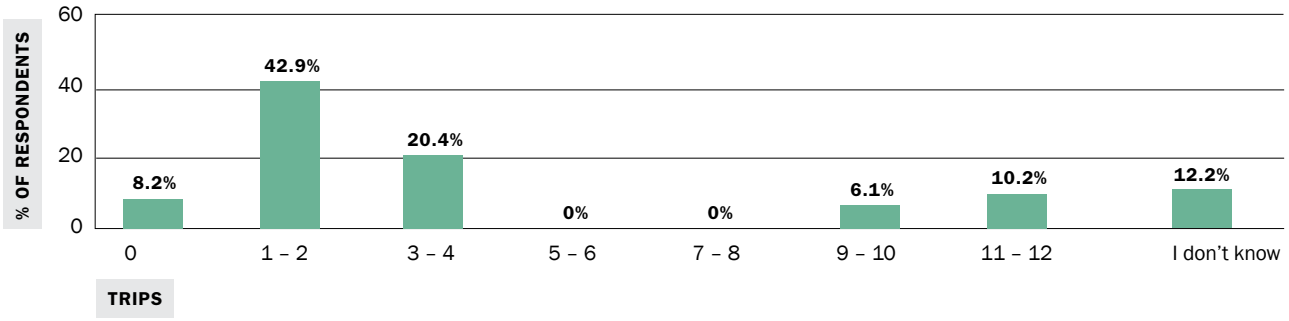
HOW OFTEN DO THEY HOST MEDICAL MISSIONS?

Over 60 percent of the organizations represented have been receiving medical mission trips for more than five years. The survey respondents also indicated a consistent flow of short-term medical missions. When combined, the organizations in this survey indicated they host more than 130 medical missions in a typical year.

FOR HOW MANY YEARS HAS YOUR ORGANIZATION BEEN RECEIVING MEDICAL MISSION TRIPS?



TYPICALLY, HOW MANY MISSION TRIPS DO YOU RECEIVE PER YEAR?

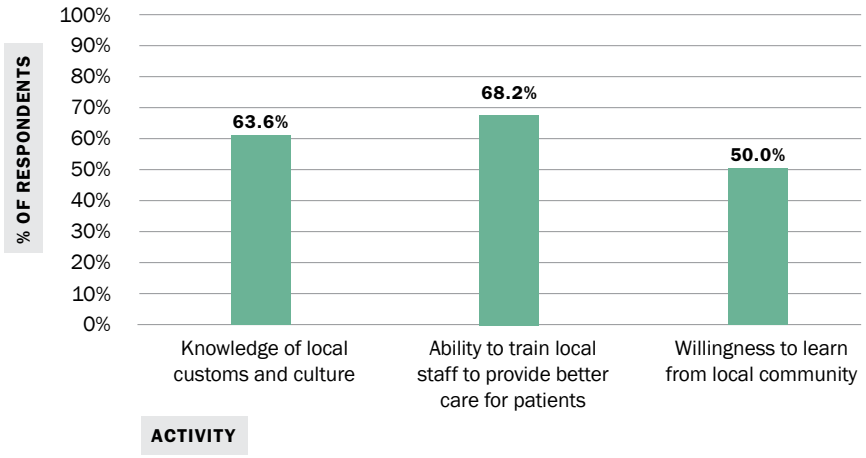


WHEN DID THE MOST RECENT MEDICAL MISSION TRIP TAKE PLACE AT YOUR ORGANIZATION?	
ANSWER OPTIONS	**RESPONSE PERCENT**
In the past 1 year	63.3%
Within the last 2 years	10.2%
Within the last 3 - 5 years	6.1%
More than 5 years ago	0.0%
I don't know	20.4%

PREPARATION OF VOLUNTEERS

Ability to train local staff to provide improved care for patients (68.2 percent), knowledge of local customs and culture (64 percent) and willingness to learn from the local community (50 percent), were among volunteer qualities that needed the most improvement.

TOP 3 VOLUNTEER QUALITIES THAT NEED THE MOST IMPROVEMENT



WHAT ARE THE MOST IMPORTANT QUALITIES OF VOLUNTEERS? [SELECT TOP THREE]	
ANSWER OPTIONS	**RESPONSE PERCENT**
Speak the local language	27.3%
Knowledge of local customs and culture	18.2%
Ability to train local staff to provide better care for patients	43.2%
Willingness to learn from local community	47.7%
Ability to work well with a team	65.9%
Willingness to work hard	36.4%
Technical skills	45.5%
Organizational skills	11.4%
Other	4.5%

Said a country director for a non-governmental organization (NGO) in Haiti, "It's challenging when new volunteers come in because sometimes people want to do something particular. For example, one volunteer had some statistics on breastfeeding and was passionate about the topic. It only eventually turned out to be somewhat useful."

Another comment shared by a director of outreach from a health organization on the African continent was, "To make a real impact, volunteers must be very good listeners. They must understand the local hospital's issues and give ideas to help manage their challenges in a better way."

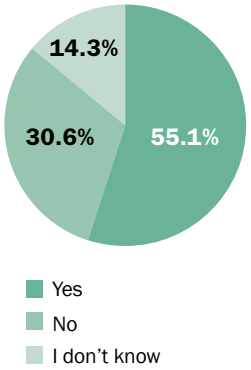
IDEAL LENGTH OF A TRIP

Only one out of eight respondents believed that one week or less was the ideal amount of time. Over 75 percent of respondents believed that the ideal amount of time volunteers should spend is more than one week. Thirty-eight percent believed the ideal amount of time was between eight days and two weeks.

While 55 percent of respondents indicated that some type of needs assessment was conducted to help prioritize the goals for the trip, responses indicated that nearly 45 percent of respondents did not participate in nor were unaware of a needs assessment occurring.

FROM YOUR PERSPECTIVE, WHAT IS THE IDEAL AMOUNT OF TIME THAT VOLUNTEERS SHOULD SPEND ON A MEDICAL MISSION TRIP?	
ANSWER OPTIONS	**RESPONSE PERCENT**
1 week or less	12.2%
8 days – 2 weeks	38.8%
2 – 4 weeks	10.2%
1 – 2 months	14.3%
More than 2 months	12.2%
I don't know	4.1%
Other	8.2%

IS A NEEDS ASSESSMENT COMPLETED PRIOR TO THE MEDICAL MISSION TRIP?

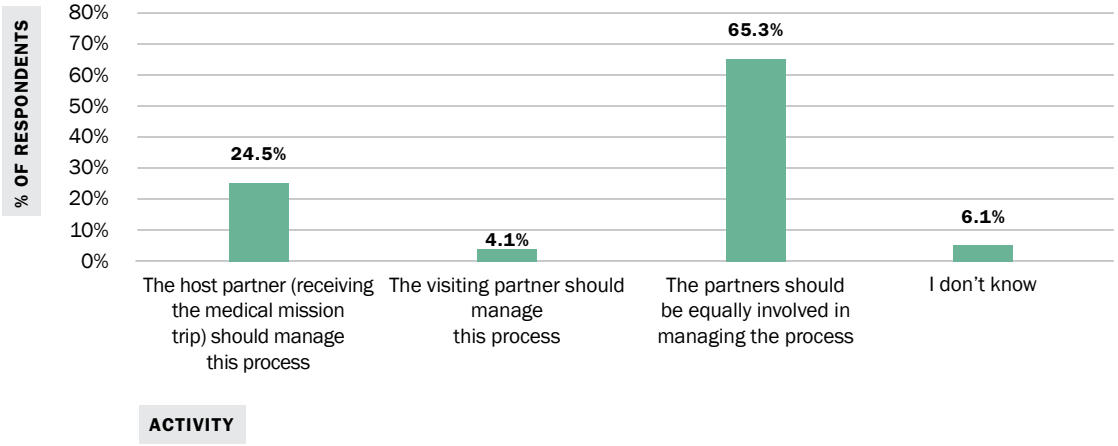


In interviews, respondents explained their experiences with volunteers and ideal lengths of time. "One week or less is a 'recipe for trouble,'" said a chief medical officer from a university teaching hospital on the African continent. "Patients don't show up on time, autoclave won't work, the whole trip is a waste. If two-plus weeks, we get concerns on the care of the team itself, and have security isssues. Thinking through feeding, and maintaining beyond two weeks is difficult. There's too much to maintain at the same tempo."

A Haitian foundation leader said, "Eight days to two weeks is the best. There is an upward trend: they arrive on a Saturday or Sunday, take a few days to acclimate/hit their stride, and this gives staff time to get to know them better. If a trip is more than two weeks it seems to be too long a time to be away for a physician; it takes away from their practice. In the years that I have been working fulltime in Haiti, no one has done more than two weeks."

When needs assessments are completed, 90 percent of host organizations indicated they should either manage or co-manage the process of conducting the needs assessment. Only four percent believe the visiting partners should manage this process.

IN YOUR OPINION, WHICH ORGANIZATION SHOULD CONDUCT THE NEEDS ASSESSMENT?



The survey demonstrates that currently, almost 35 percent of respondents either did not participate in or were unaware of a needs assessment occurring for their partnership. Said a hospital director in Guatemala, "If you truly put the interest of the people first, everything else comes from that. Do not serve yourself."

IF A NEEDS ASSESSMENT IS COMPLETED BEFORE THE MEDICAL MISSION TRIP, HOW OFTEN IS IT UPDATED THROUGHOUT THE PARTNERSHIP?	
ANSWER OPTIONS	**RESPONSE PERCENT**
Ongoing/periodic basis	49.0%
Needs assessment is only completed once at the beginning of the partnership	16.3%
Needs assessment was never completed	16.3%
I don't know	18.4%

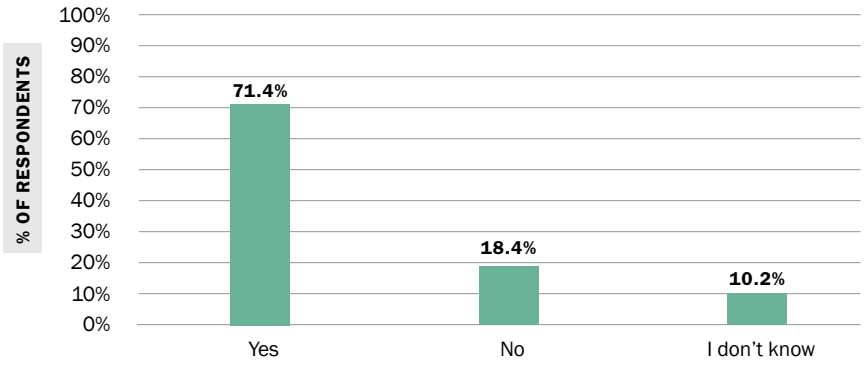
The survey indicated a significant gap in the current vs. ideal level of involvement of host organizations in defining the goals of the medical mission trip. Twenty-five percent reported that their organization has limited or no involvement in defining the goals and activities. Ninety-four percent believe that ideally, the host organization should be equally, primarily or 100 percent responsible for defining the goals and activities.

CURRENTLY, WHAT IS YOUR ORGANIZATION'S LEVEL OF INVOLVEMENT IN DEFINING THE GOALS AND ACTIVITIES OF THE MEDICAL MISSION TRIP?	
ANSWER OPTIONS	**RESPONSE PERCENT**
We have no involvement	4.2%
We have limited involvement	20.8%
We have equal involvement	27.1%
We are primarily responsible	29.2%
We are 100% responsible	8.3%
I don't know	10.4%

IN THE FUTURE, WHAT WOULD BE YOUR ORGANIZATION'S IDEAL LEVEL OF INVOLVEMENT RELATED TO DEFINING THE GOALS AND ACTIVITIES OF THE MEDICAL MISSION TRIP?		
Answer Options	RESPONSE PERCENT	RESPONSE COUNT
No involvement	0.0%	0
Limited involvement	0.0%	0
Equal involvement	54.2%	26
Primarily responsible	27.1%	13
100% responsible	12.5%	6
I don't know	6.3%	3
	ANSWERED QUESTION	48

When asked if it is a priority to sign a formal agreement (e.g., written agreement) with the visiting partner before any medical mission trips take place, 71 percent of respondents indicated that it was a priority.

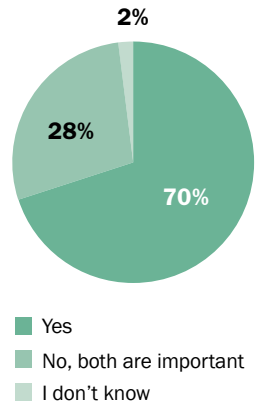
IS IT A PRIORITY TO SIGN A FORMAL AGREEMENT (E.G., WRITTEN AGREEMENT) WITH YOUR VISITING PARTNER BEFORE ANY MEDICAL MISSIONS TRIPS TAKE PLACE?



Nearly 49 percent of medical missions do not have quality control guidelines for supplies brought by volunteers.

DOES YOUR ORGANIZATION HAVE QUALITY CONTROL GUIDELINES FOR MEDICAL SUPPLIES BROUGHT BY INDIVIDUAL VOLUNTEERS FOR MEDICAL MISSION TRIPS?		
ANSWER OPTIONS	RESPONSE PERCENT	RESPONSE COUNT
Yes	44.7%	21
No	48.9%	23
I don't know	6.4%	3
	ANSWERED QUESTION	47

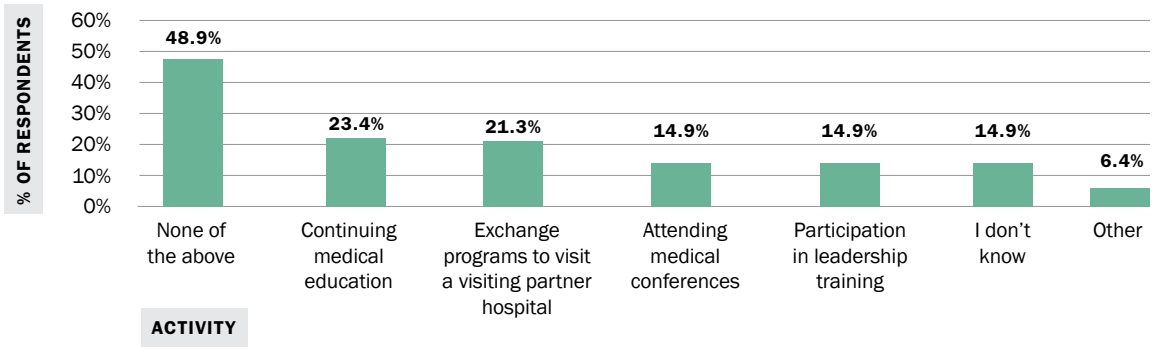
WOULD YOU LIKE YOUR VISITING PARTNER TO FOCUS MORE ON TRAINING FOR YOUR STAFF RATHER THAN DIRECTLY TREATING PATIENTS?



Evidence indicates capacity building is equal to or more important than clinical care, emphasizing the need for international partners to engage in capacity building efforts. Twenty-eight percent of international partners consider training the local staff to be more important than treating patients. While 70 percent indicated both are important.

Sixty-three percent of respondents were either unaware of (14.9 percent), or had no funding (48.9 percent) from visiting partners for educational opportunities for their staff. Of those that had received funding for educational opportunities, 23 percent had received funding for continuing medical education, and 21 percent had received funding to take part in an exchange program with a visiting partner hospital.

HAS YOUR VISITING PARTNER HELPED TO FUND EDUCATIONAL OPPORTUNITIES FOR YOUR STAFF?



There is a significant gap in training and shadowing opportunities during medical missions across the spectrum of clinical care. At most, fewer than 55 percent of medical mission trips include opportunities for shadowing and training for local physicians. Interviewees consistently voiced the need for opportunities for training and capacity building as equal to, if not more important, than service delivery.

FOR MEDICAL MISSION TRIPS, IN WHAT AREAS DO VISITING DOCTORS PROVIDE TRAININGS AND SHADOWING OPPORTUNITIES FOR LOCAL DOCTORS? [SELECT ALL THAT APPLY]:

ANSWER OPTIONS	RESPONSE PERCENT	RESPONSE COUNT
Direct primary care	–	–
(e.g., examination, diagnosis, treatment)	55.3%	15
Surgical care	55.3%	26
Specialty care	–	–
(e.g., ophthalmology, neurology, radiology)	53.2%	25
Patient screening (e.g., medical history)	31.9%	26
Medication/ prescriptions	27.7%	13
Follow-up care	23.4%	11
Other	14.9%	4
None of the above	8.5%	1
I don't know	2.1%	7

Said a project director in Guatemala, "We didn't just want to provide services. If we weren't doing anything for prevention and education, we would just keep seeing the same things over and over again." A woman religious who is a board member of a Haitian hospital said that "training and teaching local partners is as important, if not more important, than delivering care. Trips should be 50/50 health care service and teaching."

Respondents were asked about their partners' support in areas related to health care information. Fifty-eight percent of respondents indicated receipt of assistance in at least one or more of the areas. Collecting and managing patient data was the most prominent type of support received by 42.2 percent of respondents. An additional 31 percent received support in the development of tools for monitoring and evaluation, and 28.9 percent received assistance with compilation of key metrics for tracking performance. Forty-two percent had received no assistance or were unaware of such assistance.

Please note: as a result of being able to select several areas, the results in this table add up to more than 100 percent.

HAS YOUR VISITING PARTNER SUPPORTED YOU WITH ANY OF THE FOLLOWING REGARDING YOUR HEALTH CARE INFORMATION? [SELECT ALL THAT APPLY]	
ANSWER OPTIONS	**RESPONSE PERCENT**
Compilation of key metrics to track the performance of your health system (i.e., identifying benchmarks for patient care experiences, health outcomes)	28.9%
Public health surveillance system (i.e., tracking disease outbreaks)	11.1%
Collecting and managing patient data (i.e., patient medical records)	42.2%
Development of tools for monitoring and evaluation against identified metrics	31.1%
None of the above	31.1%
I don't know	11.1%
ANSWERED QUESTION	45

Metrics to track performance, 34.1 percent, and collecting and managing patient data, 29.5 percent, were most important areas related to health care information.

WHAT IS THE MOST IMPORTANT AREA TO YOUR ORGANIZATION RELATED TO HEALTH CARE INFORMATION? [SELECT ONE TOP AREA]	
ANSWER OPTIONS	**RESPONSE PERCENT**
Compilation of key metrics to track the performance of your health system (i.e., identifying benchmarks for patient care experiences, health outcomes)	34.1%
Public health surveillance system (i.e., tracking disease outbreaks)	11.4%
Collecting and managing patient data (i.e., patient medical records)	29.5%
Development of tools for monitoring and evaluation against identified metrics	11.4%
I don't know	13.6%

Forty-six percent of respondents had received no support in any of the specified areas related to health care workforce. Of those that had received support with their health care workforce, building or improving training programs for both clinical and non-clinical staff were most often referenced as having received support.

HAS YOUR VISITING PARTNER SUPPORTED YOU WITH ANY OF THE FOLLOWING REGARDING YOUR HEALTH CARE WORKFORCE? [SELECT ALL THAT APPLY]	
ANSWER OPTIONS	**RESPONSE PERCENT**
Ensuring the structure of your organization fits into the mission of your hospital	24.4%
Recruiting your staff	15.6%
Building or improving training programs for clinical staff	37.8%
Building or improving training programs for non-clinical staff	28.9%
Monitoring the performance of staff	13.3%
Staff planning (i.e., identify critical gaps in personnel and strategy to address)	15.6%
Clinical and non-clinical staff retention	11.1%
None of the above	37.8%
I don't know	8.9%

When asked what areas of health care workforce were most important, organizational structure and clinical staff training programs were most commonly chosen as areas of importance.

WHAT IS THE MOST IMPORTANT AREA TO YOUR ORGANIZATION RELATED TO HEALTH CARE WORKFORCE? [SELECT ONE TOP AREA]	
ANSWER OPTIONS	**RESPONSE PERCENT**
Ensuring the structure of your organization fits into the mission of your hospital	24.4%
Recruiting your staff	11.1%
Building or improving training programs for clinical staff	20.0%
Building or improving training programs for non-clinical staff	8.9%
Monitoring the performance of staff	4.4%
Staff planning (i.e., identify critical gaps in personnel and strategy to address)	13.3%
Clinical and non-clinical staff retention	4.4%
I don't know	13.3%

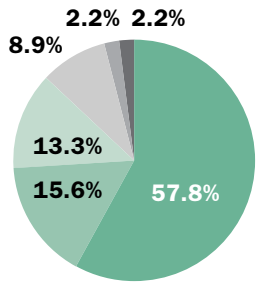
HAS YOUR VISITING PARTNER SUPPORTED YOU WITH ANY OF THE FOLLOWING REGARDING YOUR LEADERSHIP CAPABILITIES? [SELECT ALL THAT APPLY]	
ANSWER OPTIONS	**RESPONSE PERCENT**
Hospital leadership training	20.0%
Relationship management with non-medical organizations (i.e., local government ministries)	17.8%
Leadership transparency and accountability	26.7%
None of the above	51.1%
I don't know	11.1%

WHAT IS THE MOST IMPORTANT AREA TO YOUR ORGANIZATION RELATED TO LEADERSHIP CAPABILITIES? [SELECT ONE TOP AREA]	
ANSWER OPTIONS	**RESPONSE PERCENT**
Hospital leadership training	35.6%
Relationship management with non-medical organizations (i.e., local government ministries)	17.8%
Leadership transparency and accountability	33.3%
I don't know	13.3%

The survey suggested that nearly 55 percent of the organizations responding had received support with medical products, vaccines and technologies. Forty percent of those responding had received assistance with the procurement of supplies and equipment and nearly 27 percent had received support in inventory management.

HAS YOUR VISITING PARTNER SUPPORTED YOU WITH ANY OF THE FOLLOWING REGARDING YOUR MEDICAL PRODUCTS, VACCINES AND TECHNOLOGIES? [SELECT ALL THAT APPLY]	
ANSWER OPTIONS	**RESPONSE PERCENT**
Creation of guidelines to ensure quality of medical supplies	13.3%
Mechanisms to monitor the quality and safety of medical products and technologies	24.4%
Inventory management (e.g., tracking of medical supplies)	26.7%
Procurement of medical supplies and equipment (limit counterfeit and substandard products)	40.0%
Distribution of medical supplies and equipment	26.7%
None of the above	35.6%
I don't know	8.9%

WHAT IS THE MOST IMPORTANT AREA TO YOUR ORGANIZATION RELATED TO TREATING PATIENTS? [SELECT ONE TOP AREA]



- Supporting a health care model that itegrates prevention, treatement, and rehabilitation activities
- Building the capacity of hospital management across departments
- I don't know
- Building a referral system in your community, based on setting up a network of providers
- Monitoring patient safety
- Supporting decision-making on long-term investments in hospital infrastructure (e.g., buildings, plant and equipment, utilities)

When asked about most important areas related to medical products vaccines and technologies, the responses were evenly mixed among all categories. Inventory management was important to 22.7 percent of respondents.

WHAT IS THE MOST IMPORTANT AREA TO YOUR ORGANIZATION RELATED TO MEDICAL PRODUCTS, VACCINES AND TECHNOLOGIES? [SELECT ONE TOP AREA]	
ANSWER OPTIONS	**RESPONSE PERCENT**
Creation of guidelines to ensure quality of medical supplies	13.6%
Mechanisms to monitor the quality and safety of medical products and technologies	15.9%
Inventory management (e.g., tracking of medical supplies)	22.7%
Procurement of medical supplies and equipment (limit counterfeit and substandard products)	15.9%
Distribution of medical supplies and equipment	15.9%
I don't know	15.9%

When asked about what was most important for patient delivery, the respondents overwhelmingly, 57.8 percent, chose support for integration of prevention, treatment and rehabilitation activities.

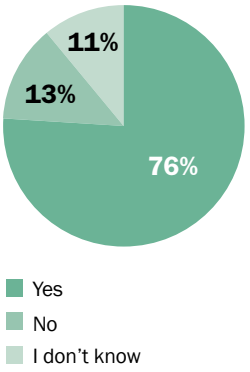
WHAT IS THE MOST IMPORTANT AREA TO YOUR ORGANIZATION RELATED TO TREATING PATIENTS? [SELECT ONE TOP AREA]	
ANSWER OPTIONS	**RESPONSE PERCENT**
Supporting a health care model that integrates prevention, treatment, and rehabilitation activities	57.8%
Building the capacity of hospital management across departments	15.6%
Monitoring patient safety	2.2%
Building a referral system in your community, based on setting up a network of providers	8.9%
Supporting decision-making on long-term investments in hospital infrastructure (e.g., buildings, plant and equipment, utilities)	2.2%
I don't know	13.3%

When asked about past support and the importance of finance capabilities, fundraising was overwhelmingly the most supported and the most important to the respondents.

HAS YOUR VISITING PARTNER SUPPORTED YOU WITH ANY OF THE FOLLOWING REGARDING YOUR FINANCE CAPABILITIES? [SELECT ALL THAT APPLY]	
ANSWER OPTIONS	**RESPONSE PERCENT**
Raising additional funds	48.9%
Reducing reliance on patient out-of pocket expenses and moving towards an insurance model of pre-payment	17.8%
Budgeting / financial planning	28.9%
Accounting	20.0%
Reporting on financial transparency and accountability	20.0%
None of the above	33.3%
I don't know	8.9%

WHAT IS THE MOST IMPORTANT AREA TO YOUR ORGANIZATION RELATED TO FINANCE CAPABILITIES? [SELECT ONE TOP AREA]	
ANSWER OPTIONS	**RESPONSE PERCENT**
Raising additional funds	46.7%
Reducing reliance on patient out-of pocket expenses and moving towards an insurance model of pre-payment	15.6%
Budgeting / financial planning	13.3%
Accounting	0.0%
Reporting on financial transparency and accountability	15.6%
I don't know	8.9%

IS THERE AN OPPORTUNITY FOR YOU TO PROVIDE FEEDBACK TO YOUR VISITING PARTNER AT THE END OF A MEDICAL MISSION TRIP?



Over 75 percent of survey respondents said that there is an opportunity to provide feedback to visiting organizations. However, while the ability to provide feedback is relatively high, interviewees identified misalignments between U.S.-based organizations and their international partners. They said that the fear of losing the partnership is a major obstacle to providing real feedback and that they perceive feedback is rarely incorporated into future planning efforts.

Advice offered by respondents included, "Overwhelmingly, people do not evaluate the impact of trips. And when they do, they survey the volunteers when they go home, or they are anecdotal evaluations, or reports of 'we saw x number of patients and provided x number of training programs," shared a global health instructor. One Haitian hospital executive said, "There should be an open feedback session after every medical mission trip. Feedback should be given from both the visiting and host staff and implemented during the next medical mission trip."

Interviewees identified misalignments between U.S.-based organizations and their international partners. They said that the fear of losing the partnership is a major obstacle to providing real feedback and that they perceive feedback is rarely incorporated into future planning efforts.

Notes

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FOR MORE INFORMATION

This report, as well as all of CHA's International Outreach resources, are available at **chausa.org/international.**

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