

Short-Term Medical Mission Trips: Research and Recommendations

By BRUCE COMPTON

Short-term medical mission trips invest millions of dollars and thousands of volunteer hours to provide people in the developing world with health care. The trips score high in terms of good intentions — but not necessarily in return on investment. Despite years of increasing popularity, health service trips have lacked a standardized evaluation process to assess patient safety, quality control and mission impact.

Now, after two years of research and study, the Catholic Health Association has released 20 best-practice recommendations for U.S. organizations considering, conducting and evaluating short-term medical mission trips in low- and middle-income countries.

Published in booklet form, *Short-Term Medical Mission Trips: Recommendations for Practice* is based on analysis of two phases of research.

“Much needed, compassionate care has been provided, but history shows us that it takes more than short bursts of visiting clinicians and volunteers to change the health status of a community, to build capacity and create sustainable access,” said Sr. Carol Keehan, DC, CHA’s president and chief executive officer. “Our tradition calls us to deeper relationships — ones whereby a commu-

nity and its caregivers are asked what the needs are, what the local ability is to meet those needs and what partnership might be developed to bridge the two.”

THE RESEARCH

CHA collected extensive and candid feedback in two phases. Phase I, which surveyed organizations and individuals who travel to low- and middle-income countries, involved more than 500 volunteers and medical mission organizers. Phase II, which concentrated on in-country organizers and recipients of the services, collected data from 82 international respondents who represented 14 countries.¹

CHA’s recommendations also incorporated content from the World Health Organization’s document, *African Partnerships for Patient Safety*.

“CHA provides a model for the global dialogue on standard principles for the partnership-based approach related to the need for considerable changes in medical partnerships,” said Lopa Basu, DO, the U.S. liaison for WHO’s Service Delivery and Safety Department and a global health adviser at the Armstrong Institute for Patient Safety and Quality, part of Johns Hopkins Medicine in Baltimore.

The 20 recommendations are organized into

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eight categories, which form a process for evaluating the usefulness of short-term medical mission trips. Each category includes recommendations for practice, a set of questions for reflection and a decision point to help an organization determine whether or not it should move forward or reconsider committing to a trip or activity. The categories are:

1. Self-assessment: Before any medical mission activities take place, take time to assess your organization’s history, motives and available resources.

The director of an international partner’s health care projects said, “Sometimes they need to be honest and say, ‘Maybe we shouldn’t come.’ And the local partner needs to have the honesty to say, ‘Thank you for offering, but your skills don’t meet our needs.’ To get to this kind of relationship, there needs to be an ongoing connection, someone in the field who has a continuing connection with the partnering organization. Otherwise, the partnering organization does not have enough time to get to know the community.”

2. Needs assessment: Understand the actual needs as assessed by your potential international partner.

While both sets of respondents agreed that needs assessments are necessary, U.S. respon-

dents said in interviews that they were concerned it would be asking too much of an international partner to conduct them.

However, 93 percent of international respondents said a needs assessment is appropriate. Of them, 68 percent said they should manage the needs assessment themselves, and 25 percent said they should co-manage the needs assessment with their U.S. partner.

3. Gap/asset analysis: After you understand the international partner’s needs and priorities, map the assets and determine the gaps.

The short-term medical mission studies and previous research conducted by CHA on medical surplus donations indicated that inappropriate donations can be the result of U.S. partners identifying gaps without gathering or heeding the international partner’s input.

Charles Evans, a retired health care CEO and former chairman of the American College of Healthcare Executives, is chairman of MedShare International, headquartered in Decatur, Georgia. MedShare collects and distributes surplus medical supplies and equipment, shipping to medically underserved communities in the United States and abroad.

Evans said he is “struck by the number of well-intentioned people who donate equipment, yet pay so little attention to what will be required

to set up, maintain and use it successfully once a medical mission trip concludes.”

Too many equipment donations and short-term medical mission trips are arranged as one-time-only events rather than part of a continuing program, Evans added. “You can’t build capacity or relationships by making one trip,” he observed.

4. Planning and preparation: If the U.S. organization’s resources match the needs as assessed by the international partner, create a formal plan for the activity.

This category recommends the partners work together to create a joint memorandum of understanding and collaborate to set goals and objectives for the trip. More than 70 percent of the respondents to Phase I of the research said it was essential to formalize these agreements in writing.

5. Volunteer selection and orientation: Those involved need to be well-positioned to be of assistance.

Organizations should explore the attitudes and expectations of their volunteers from the outset, said James A. Rice, managing director of Integrated Healthcare Strategies, a Kansas City, Mo., consultancy.

“A lot of folks want to ‘do good’ but don’t realize that they may communicate an air of arrogance or are not open to learning from their experiences in a host country,” he said.

A participant in 34 short-term medical missions, Rice recently returned from a leave of absence to support the U.S. Agency for International Development and Management Sciences for Health to strengthen the governance of health systems in low-income countries in Asia, Africa and Latin America. He noted the significance of CHA’s research and recommendations, saying they needed to be put into practice to create change.

“The value and power of their utility will be seen in how well people involved in mission trip planning use the information as part of their team development,” he said.

6. Implementation: Put the plan into action.

The recommendations in this category emphasize collaboration and partnership. Basu, a veteran

of 10 short-term medical mission trips, emphasized that it’s essential to remain flexible and to honor cultural norms, including the host country’s work styles. For example, a training program focused on patient safety and team building takes one day when offered in the U.S., but it requires two days in Uganda.

“The participants’ sense of time is differently paced [in Uganda], including a greater degree of socialization and a larger number of breaks throughout the day,” Basu said. “It’s a more mindful and slow-paced approach.”

Basu also recalled an incident that occurred during an Ebola outbreak. The hosts made it clear it was too costly for them to allow electric lights to burn 24/7, yet U.S. personnel kept the electricity running anyway, creating a poor impression. However, she and her colleagues used the experience as an opportunity to work with world health leaders to develop more effective partnership models.

The recommendations highlight the need for high-quality standards that align with international and local laws. A retired executive of a health outreach program in an emerging country

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was adamant that mission-trip planners and participants need to be more sensitive to the local laws, norms and standards.

“It is rare that groups even register with the government. It is a law that all MDs and nurses are to send their current U.S. license to the local health department for approval before they arrive,” the executive said. “How many groups stop by the health department to ask for the local norms and standards before going to a location to see 1,500 people in a week? Very few. Why is that? Would a hospital in Chicago welcome a doctor from China without knowing if this was a licensed practitioner? Never! But folks do this here.”

7. Monitoring and evaluation: After putting in the time, effort and resources, it is important

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— ROD HOCHMAN, MD

to know if you are making a positive difference in the community you are serving.

Metrics must supplement narrative or anecdotal evidence. In Phase I research, 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 and they ended up back in the hospital? It’s the outcome issues that are the hardest to collect the data on.”

8. Lessons learned: Document what has happened, what has worked, what hasn’t worked, and change course based on what you now know.

In Phase I research, an organizer reflected on how his program had evolved over time to become more likely to improve health: “The first couple of years, we were spending time doing large clinics every day. And then, more and more, we started finding the health care workers, the volunteers, the midwives, the public health workers and setting up training events for them, or inviting them to join us in collaborative clinical experiences. And then finally, the last stage was that we were really trying to look at the country as a whole and look at the bigger, more sweeping issues.”

CHA’s recommendations resonate with health care community leaders who are most familiar with the challenges of short-term medical mission trips.

“Through its recommendations, CHA has created a template for how international medical mission work should be approached,” said Rod Hochman, MD, president and CEO of Providence St. Joseph Health, headquartered in Renton, Washington.

When Providence decided to focus its medical mission efforts on Guatemala three years ago, the

organization worked with its international health partners, Houston-based Faith in Practice and Medical Teams International, headquartered in Tigard, Oregon, to set goals and objectives. They were built on needs assessments created with plentiful input from the Guatemalans with whom Providence collaborates. (See story on page 23.)

“To our way of thinking, there are no short-term interventions. CHA’s *Recommendations for Practice* gently but firmly reinforces that way of thinking,” Hochman said.

Evans said CHA’s research has produced an “authoritative resource that is of great value to organizations that sponsor medical mission trips.” He has shared it with all of his affiliates and partner groups and pointed out that these are the kinds of issues the global health community has been discussing but has not acted upon.

“If the research and recommendations are widely shared and used, the impact will be felt around the world,” he said.

The Phase I and Phase II research results and related resources are available on CHA’s website at www.chausa.org/internationaloutreach/medical-mission-immersion-trips/short-term-medical-mission-trips---cha-research.

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NOTE

1. Phase I of the research project on short-term medical mission trips was conducted by the Rev. Michael Rozier, SJ, a doctoral student in the Department of Health Management and Policy at the University of Michigan in Ann Arbor; Judith N. Lasker, the N.E.H. distinguished professor of sociology in the Department of Sociology and Anthropology at Lehigh University, Bethlehem, Pennsylvania; and Bruce Compton. The study included an online survey and in-depth interviews. Phase II was conducted by Compton and Accenture Development Partnerships. It was underwritten in part by Ascension Global Mission. Phase II included an electronic survey followed by in-depth interviews.

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