SHORT-TERM MISSIONS NEED A FRAMEWORK

When considering this edition of *Health Progress* with its special focus on education, I remembered a fable from my childhood: *A young crab and his mother are spending the day on a beach's warm sand. The young crab begins to walk around, but can only walk sideways in either direction. The mother crab scolds him and tells him to point his toes in front of him and walk forward. The young crab explains that he would love to walk forward, but he doesn't know how to do it. He asks his mother to show him. The mother crab gets up and tries to walk forward, but she, too, can only walk sideways. She sheepishly apologizes and lies back down in the sand.*

BRUCE COMPTON

Doing, versus saying, is tough. For those of us who travel to low- and middle-income countries on behalf of U.S.-based organizations, how often do we enter a community and direct them to "walk forward" before we have seen if we, ourselves, can — or should — walk forward in that environment? Do we ever consider that walking sideways may be more appropriate for that place and culture? Did we take a teacher mentality or a student mentality with us when we boarded the plane?

In a meeting held prior to the 2017 Consortium of Universities for Global Health conference in Washington, D.C., I listened to some interesting perspectives on short-term activities, particularly as they relate to educational goals. The meeting spawned a coalition that envisions a future where all short-term international health activities are conducted ethically and make beneficial, sustainable contributions to global health.

The work of the group dovetails the Catholic Health Association's research in the area of short-term missions (see the "Thinking Globally" column in the July-August 2017 issue of *Health Progress*, www.chausa.org/publications/health-progress/article/july-august-2017/thinking-globally-the-future-of-medical-missions-is-partnership).

Overwhelmingly, we heard from those who travel on these trips that they don't get enough information ahead of the trip; conversely, we heard from in-country hosts that they often are not asked what it is that they need, or what their desired outcomes are. This was especially true in the case of education. Local hosts wanted the opportunity to be able to ask for specific training, rather than to have the volunteers assume what instruction they needed.

To share their insights and experiences with you, I asked several members of the coalition some questions. Their responses below can help shape a new idea of walking with their host partners — whether it be forward or sideways — to create a better vision for how short-term trips should take place.

The participants:

Henry Lin, MD, MBA, is executive director of The 53rd Week, a nonprofit think tank devoted to helping short-term volunteer programs overseas achieve optimum outcomes. He is a pediatric gastroenterologist at Children's Hospital of Philadelphia and assistant professor of clinical pediatrics in the University of Pennsylvania's Perelman School of Medicine, Philadelphia.

Jessica Evert, MD, is executive director of Child Family Health International, a nonprofit organization that provides global health education programs for students and institutions. She also is a clinical instructor in the Department of Family and Community Medicine at the University of California, San Francisco, where she helped develop the Global Health Clinical Scholars residency track.

Ruth McDermott-Levy, PhD, MPH, RN, is director of Villanova University's Center for Global and Public Health and associate professor in the College of Nursing, Villanova, Pennsylvania.

Shailey Prasad, MD, MPH, is executive director of the University of Minnesota's Center

for Global Health and Social Responsibility and associate professor in the Department of Family Medicine and Community Health, Minneapolis, Minnesota.

What is your experience participating in short-term trips with an educational component?

Ruth McDermott-Levy: In all of the travel education, nursing students receive preliminary education about the area to which they are going, including history, culture, politics, U.S. relations with the country, the health system and health practices.

I have traveled to Peru and Nicaragua with undergraduate nursing students to participate in week-long international immersion programs. Through local host country Catholic parishes, we have long-standing relationships with our host partners. Prior to the trip, we learn from the host partner what their needs are and how to develop health education programs for the local community health workers. Additionally, we make home visits to patients to do physical assessments and individual/family health education. The community health workers select the patient/families we visit and accompany us on the home visits.

In Nicaragua, we have partnered with a local school of nursing, and now the Nicaraguan nursing students work with the U.S. nursing students in presenting the health education to the community health workers.

I have also accompanied nursing students to Oman to learn about the Omani health system. In this situation, there was no "hands-on" nursing care; instead, the U.S. nursing students shadowed Omani nurses in clinical settings such as hospital wards, home care and primary care clinics.

Shailey Prasad: I have designed and supervised a few educational short-term trips ranging from undergraduate to medical resident level ones. I have been doing this for more than 10 years.

Jessica Evert: While I was a medical student, I participated in a program that took me from Ohio to Kenya. I was told I was there to "help." Our pre-departure training reinforced my underlying assumption that places in Africa were poor and needed outsiders to fix things.

One evening, I was asked if I wanted to do a procedure on a child that required sticking a needle around the spinal cord to help diagnose the child's ailment. I had never done this procedure, was not properly trained, nor was it necessary for me to do it, as a local doctor who was expert in this procedure sat next to me. I attempted the procedure and failed, putting the child through unnecessary pain and delaying the diagnosis.

Since then, I have committed myself to advocating for and being a part of providing global health experiences for students that are countercurrent to the "perfect storm" that I experienced. Through Child Family Health International (www.cfhi.org), I am able to work with partners in 10 countries to provide educational opportunities that are intentional in their ethical, pedagogical and philosophical approach, so other students won't be duped, as I was.

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— JESSICA EVERT, MD

Henry Lin: Most of my experience with short-term trips has included an educational component. We have partnered with various universities to build educational components into their international trips. For example, recently we partnered with McMaster University [in Ontario, Canada] to help develop their "alternative spring break" curriculum and served as a host site. Students have an academic requirement to learn about a specific topic in global health as it pertains to the community. To accomplish all of this requires close collaboration with our local partners.

Does intention matter in your experience? Does a desire to be of service trump a desire for appropriate outcomes? How should desire to be of service relate to appropriate outcomes, in your opinion?

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this is the stated goal, we feel that the intent is better corralled to satisfy the learning objectives. Learners benefit a lot from nonclinical trips in which they observe and learn about the health systems of the countries they go to.

RML: The short answer to whether intention matters is, no. As licensed health professionals, nurses must respond to patient, family and/or community needs with accurate, evidence-based care that is within the scope and standard of practice for professional nursing. In short-term global health experiences, we should respond to the needs of the community, not our needs, and develop health education programs that provide accurate and economically, socially and culturally appropriate information.

JE: I see the question about intention as a lack of alignment between "desire to serve" and "appropriate outcomes." If service is meant to improve global health and address health disparities, then there needs to be more authenticity about how to accomplish that. We cannot nurture young people's desires to serve by allowing them to do unsafe, unethical activities under the auspices of service. Allowing undergraduate students to deliver babies, take histories, do physicals, dispense medication and provide other clinical patient-care activities is unsafe, unethical and antithetical to the foundations of global health and human rights.

HL: I think that intention matters at the outset in terms of, "Are you being honest with yourself?" People search for global health opportunities for a variety of reasons that range from personal and professional growth to a genuine desire to help others. Regardless of intention, one should be thoughtful about the impact on the receiving community. In particular, volunteers should ask, "What is the goal of the sending organization for this effort?" and "What is the perception and seeming actuality of these efforts for the receiving community?"

If we held up a mirror to our own practices, what might we want to think about fixing, from your perspective?

RML: Health care providers are naturally "doers" and "fixers" — we have a hard time sitting still and observing. Yet we need to be comfortable keeping our hands off and learning from our international partners. They have practiced, treated and healed people with minimal resources, which demonstrates remarkable skill and creativity.

SP: We need to further emphasize the learning aspect of it. I would want the "learners' humility" to be the overriding premise of the experience.

JE: That thousands of students go abroad every year to "play doctor" in low- and middle-income countries goes against secular global health principles, as well as faith-based values. We all must look in the mirror and consider our spheres of influence: how we are complicit with the status quo or even actively allowing harm to masquerade as help. Real, sustainable gains in global health are not made overnight or by foreign trainees doing hands-on patient care in poor communities around the world. Students need to be oriented to a more authentic version of what global health is and what it is not.

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— HENRY LIN, MD

HL: I think that honesty is the key. It is nearly impossible to enter a situation and truly have "the" answer. It is hard to say what needs to be fixed, but two things stand out:

1. We should always begin by involving the in-country community in ways that empower them to speak up about their needs. We have to recognize the power differential between the visitor asking what is needed and the target community trying to ask for the "right" thing.

2. We need to have a formalized method for evaluating and reflecting on our stated objectives. That kind of framework will help improve our current services, regardless of intention.

What other questions should we be asking about short-term, educational-focused global health activities?

RML: If we are truly focused on the learning objectives of short-term global health nursing education and putting the host communities first, we should be asking:

1. Do our learning objectives address the global health experience in a way that supports the host community?

2. Are we working with students to understand that we are guests and that we need to respect the needs and resources of the communities we visit?

3. Are we supporting equitable partnerships and professional exchanges with host country partners?

SP: Are we following the cardinal principle of "First, do no harm" in all our activities? This includes harm to communities, health systems and local economies, as well as individuals.

JE: How can we create educational experiences that do not entail students doing hands-on patient care in global communities where they are not the best-equipped person to do so?

We need to know the opportunity costs and losses when poorly designed short-term activities are allowed to take place in global health, whether educational or service in nature.

HL: Who is the intended audience? What are the actual needs of the community? Are the services provided actually making a difference, truly needed, perceived positively and verifiably an ideal utilization of resources? Are the information and materials to teach trustworthy and evidence-based? What else already exists, i.e., can we leverage or utilize existing resources so as to not reinvent the wheel?

Does anyone have a story to share that provides good insight?

RML: My students and I accompanied a Nicaraguan nurse to a remote clinic in the mountains of Nicaragua. A man who had been bitten by his horse came to the clinic for care. The Nicaraguan nurse, the only provider present, skillfully cleaned the wound, discussed recent tetanus vaccine status, then reconstituted an antibiotic and drew up 3 cc of the antibiotic solution to be administered in the muscle in the upper arm. I commented to one of my U.S. nursing students that that was more solution than I was accustomed to giving in the upper arm muscle (typically the deltoid is 2 cc or less). The students asked, "Aren't you going to tell her?" My response was, "No, that was just an observation of difference in practice. I've never treated or been educated to treat a horse bite in a remote area." Later, my students and I talked about the incident and the importance of respecting our host's practice, recognizing the differences and learning from them.

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