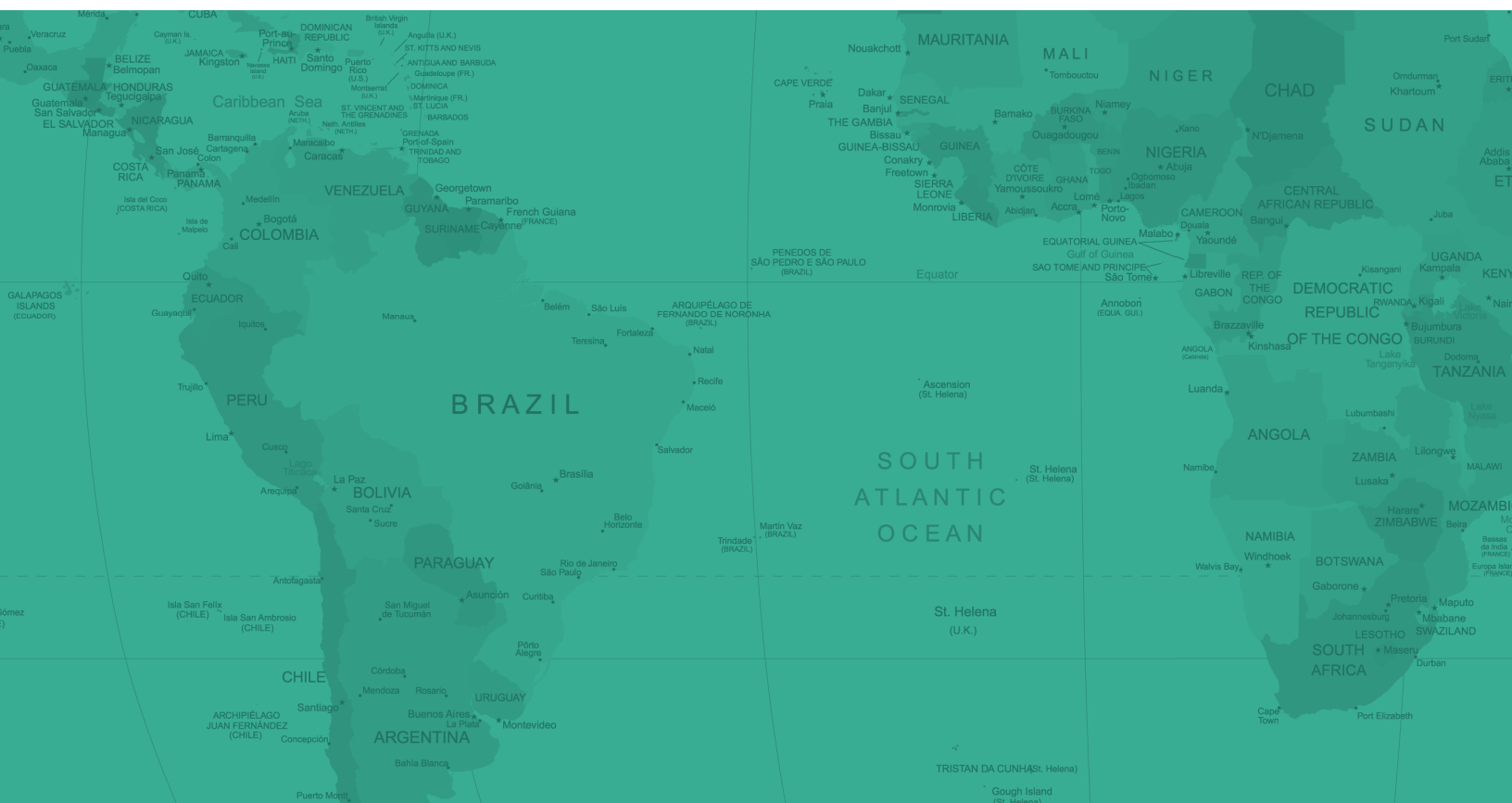




Short-Term Medical Mission Trips: *Phase I Research Findings*

PRACTICES & PERSPECTIVES OF U.S. PARTNERS | 2014



A Passionate Voice for Compassionate Care



Foreword

In recent years, the Catholic Health Association of the United States (CHA) has conducted research or compiled and shared guidance to increase the effectiveness and positive impact of CHA-member international, mission-based activities related to medical surplus donations and disaster response. Now, our activity is reaching into an area highly requested by CHA members and even other not-for-profits and Non-Governmental Organizations (NGOs): short-term medical mission trips.

CHA is frequently asked for best practices and/or orientation materials or other guidance that can be used by groups conducting short-term medical mission trips. Admittedly, there is information available, but not much specific to health care or that connects this work to Catholic social teaching and our commitments to human dignity, justice and equality.

To gain a greater understanding of what is actually being sponsored by Catholic health ministry, or that member associates are participating in, CHA launched a research study of short-term medical mission trips in 2014. The goal: to create a snapshot of current practices and to share recommendations for increasing the effectiveness of short-term medical mission trips.

This report provides the results of the first phase of this research project; phase II will include an assessment of impact in countries where these mission trips are happening. It also includes recommendations Catholic health care and others can use as guidance in conducting future short-term medical mission trips.

We hope this research and these recommendations help you in your international outreach activities.

The Research Team

This research and report by CHA was conducted and developed by Judith N. Lasker, Ph.D., Fr. Michael Rozier SJ, MPH, a Jesuit priest and Bruce Compton, CHA's senior director of International Outreach.

BRUCE COMPTON

Senior Director of International Outreach

CATHOLIC HEALTH ASSOCIATION

Bruce Compton is senior director of international outreach for the Catholic Health Association of the United States (CHA). He is based in the association's St. Louis office. Mr. Compton is responsible for assisting and supporting CHA-member organizations in their outreach activities in the developing world. His duties include facilitating collaboration among CHA-member organizations and others, seeking to enhance the impact of international ministries. Additionally, he is responsible for education regarding international outreach issues and encouraging CHA members' participation in various activities of international ministry.

Compton lived in Haiti from 2000 to 2002, and he continued to work in support of health missions in the developing world after he returned to the U.S. He did so in his capacity as founding president and chief executive of Springfield, Ill.-based Hospital Sisters Mission Outreach, a ministry organization bringing surplus medical supplies from Midwest hospitals to medical missions in the developing world.

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Dr. Judith N. Lasker is the N.E.H. Distinguished Professor in the Department of Sociology and Anthropology at Lehigh University in Bethlehem, Pa. She earned her bachelor of arts degree at Brandeis University and her master of arts and doctoral degrees at Harvard University. In 2014, she received the Centennial Medal from Harvard's Graduate School of Arts and Sciences for "contributions to society as they have emerged from one's graduate education at Harvard."

Dr. Lasker's major areas of interest are in the field of medical sociology, with particular emphasis on women's health issues (especially chronic illness and loss) and international health. Her publications on these and other topics have appeared in psychology, public health, medical and sociology journals. She is coauthor with Susan Borg of *When Pregnancy Fails; Families Coping with Miscarriage, Ectopic Pregnancy, Stillbirth, and Infant Death* (Bantam Books); and *In Search of Parenthood; Coping with Infertility and High-Tech Conception* (Temple U. Press); and with Ed Collom and Corinne Kyriacou of *Equal Time, Equal Value: Community Currencies and Time Banking in the US* (Ashgate Publishing).

Her current research examines short-term international service programs in public health and medical care and their impact on host communities. She has reported the results of this research at public health and sociology conferences and in a forthcoming book: *Giving Back? Short-Term International Volunteer Programs in Health*.

FR. MICHAEL ROZIER, SJ

Doctoral Student

Department of Health Management and Policy

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Fr. Michael Rozier is a Jesuit priest and doctoral student in the Department of Health Management and Policy at the University of Michigan. He is formerly a faculty member of the Saint Louis University (SLU) College for Public Health and Social Justice.

After receiving his master of public health degree at Johns Hopkins University, Fr. Rozier worked as an ethics fellow with the World Health Organization. He subsequently received a faculty appointment at SLU, where he taught courses in global health, health and justice, and public health ethics. He also was director of the undergraduate division of the college and oversaw service learning activities, including several trips abroad with students. His areas of research focus on goal-setting and resource allocation in low-income countries, the relationship of medical missions to the local health systems they serve and the ways public health ethics frames health challenges differently than medical ethics.

As part of his Jesuit training Rozier has lived and worked in Canada, Switzerland and throughout Latin America.

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Executive Summary

BACKGROUND

Over the past two decades, the number of short-term international mission trips for the provision of health services has dramatically increased and Catholic health care has participated in this growth. While these experiences provide an opportunity for Catholic health care to continue its mission of reaching out to those persons who are poor, sick and vulnerable, there are consistent concerns about their value and effectiveness. Considering the significant human and economic investment in health service trips, it is essential to gain a better understanding of these activities and to consider how they can provide the maximum benefit for all involved.

The Catholic Health Association conducted a research project in 2014 to identify leading practices in short-term medical mission trips which focused on the effectiveness of short-term medical missions to improve the health of host communities and provide positive formational experiences for volunteers.

METHOD

This study's initial goal was to gather as much data as possible on current and ideal practices. CHA distributed an online survey to Catholic hospitals and health systems to reach those who had participated in or had overseen a short-term medical mission, but it was open to anyone who chose to respond. With over 500 respondents, this is likely the largest existing dataset on short-term medical missions. The survey was followed by 18 in-depth interviews with a cross-section of the survey respondents.

FINDINGS

Survey participants collectively had been on a minimum of 949 trips over the past five years. The “most recent” trips that were reported on included approximately 2,300 volunteers traveling to 45 countries at an estimated cost of \$3.45 million. Organizers estimated that about one-fourth of this amount is spent in the host countries.

CHA member organizations sponsored about 40 percent of these trips. Many CHA member hospitals and health systems do not directly sponsor medical mission trips, although they may provide indirect support.

Overall, participants expressed great satisfaction with mission trips. They considered them to be extremely valuable for volunteers (91 percent), for Catholic health care (78 percent), and for host communities (75 percent). Responses to the question about value to host communities was the only one of the three which elicited strong reservations, e.g., medical missions are only valuable if designed well, and there are concerns about increasing dependency and causing harm.

The greatest challenges to creating effective medical mission trips were identified as funding, sustainability and coordination of effort. There were also a number of areas in which there were significant gaps between the characteristics of “actual” and “ideal” trips. They include:

SELECTION OF VOLUNTEERS

Most trips accept almost every person who applies. Organizers strongly preferred greater selectivity of volunteers. They expressed a desire to include only those who work well in teams and are willing to learn from the host community and reported their wish to exclude those who are non-compliant with the rules or who have physical or mental health issues.

LENGTH AND CONTENT OF ORIENTATION

When there is an orientation, it typically lasts one to two hours; participants ideally want orientation to last half a day. Preparation usually emphasizes information about flights, vaccinations and packing. Volunteers desire much more preparation in cultural competence, country history, language and specific skills needed for the trip. Volunteers also want to have preparation for the activities they will be engaged in and personal and group reflection about the trip.

LENGTH OF TRIP

One third of participants' trips lasted one week or less; most participants believe that trips should last longer.

ROLE OF PARTNER

The importance of having an effective and trusted partnership in the host community emerged from the study. The most frequent role of partners is assisting with logistics and services. Participants expressed a preference for partners to be more centrally involved in establishing goals.

EVALUATION

The major focus of evaluation, when it is done, is on the volunteers' experience and the logistics of the trip itself. There is hardly any systematic assessment of the impact of medical mission trips for host communities. Evidence of impact is primarily anecdotal.

The report concludes with recommendations in each of these areas and others that emerged from the study.

A FINAL NOTE

This investigation, by focusing on Americans involved in medical missions, does not allow us to document health benefits to poor communities who host medical missions — presumably the most important measure of their value. But it does give us important insights into current practices and perceptions of those in the U.S. who are engaged in short-term medical mission work. Given Catholic health care's global network and its shared sense of mission, it is uniquely positioned to be a leader in setting a standard for short-term international health volunteer efforts more broadly.

SECTION 1

Introduction

Over the past two decades, the number of short-term international trips for the provision of health services, as well as for personal and professional formation, has dramatically increased. Catholic health care has seen a significant increase in the number of these types of experiences. While such experiences provide an opportunity for Catholic health care to continue its mission of reaching out to the poor, sick and vulnerable, there are consistent concerns about the value and effectiveness of these trips.

Most volunteers and supporting organizations assume that the developing countries and their populations are benefiting from these trips. However, there is little evidence that this is the case aside from anecdotes, often very compelling ones, of lives saved and services appreciated. With Catholic health care providing significant human and economic investment in health service trips, it is essential to gain a better understanding of these activities and to consider if and how they can provide the maximum benefit for all involved.

THEOLOGICAL FOUNDATIONS

Catholic health care has a rich tradition of embodying the principles of Catholic social teaching through a continuation of the healing ministry of Jesus. These principles are used both to support and to critique short-term medical missions. Some people offer them as a clear response to the poor and marginalized in our global community. Others question whether these trips are the best use of limited resources. Some feel that the relationships that develop foster human dignity across national and economic lines. Others wonder whether subsidiarity might be better served by building local capacity and strengthening local systems. Let us consider some of these principles as they relate to short-term medical missions.

LIFE AND HUMAN DIGNITY: the moral vision for any society is rooted in its respect for life and human dignity. Our global interconnectedness demands that our vision for dignity includes brothers and sisters in our local communities and those as across the globe. If we have the material, human, and financial resources to provide health services to those without access, our tradition invites us to do so.

In an effort to support the Catholic health ministry, the Catholic Health Association began a project to identify leading practices for effective short-term medical mission trips to low-income countries. Sharing these practices aims to increase the impact and effectiveness of health teams in two areas: improving host communities' well-being and providing positive formational experiences for volunteers.

Some people question whether Catholic health care should be involved in short-term medical missions at all. There are a significant number of critiques demonstrating the damage these trips can do: undermining local health providers; leaving patients without follow-up to treatment; and promoting a savior-complex among participants. We certainly know that good will is not enough to ensure a positive role for health professionals in short-term trips. Nevertheless, despite the possibility of unintended negative consequences, there is a strong belief within the Catholic health care community that these trips hold tremendous promise for both host communities and volunteers.

OPTION FOR THE POOR AND VULNERABLE: the burden of disease falls disproportionately on the poor. This is true both locally and globally. Even as the gap between rich and poor continues to increase, targeted efforts to care for the poor and vulnerable show that we are motivated to care for those in need rather than only for those who have the resources to pay for services.

SOLIDARITY: the work of short-term medical missions must be more than technical delivery of care. It is also an opportunity to bring individuals in closer contact with their brothers and sisters. In doing so, all involved are invited to consider how we are a single human family, bound by our desire to be fully alive.

We might also consider short-term medical missions in light of other moral traditions in the Church, such as the promotion of virtue. Let us consider some central virtues as they relate to these projects.

CHARITY: as one of the theological virtues, charity is held in our tradition as the love of God and the love of neighbor.

It goes beyond the superficial notion of giving to another in need and is evidence of genuine relationship. When done well, short-term medical missions move beyond charitable donations of time and goods and evoke love of neighbor for those involved.

JUSTICE: as one of the cardinal virtues, justice enjoys a variety of definitions, including rendering to everyone what they are due. Short-term medical missions can give volunteers an experience of host communities enjoying the high-quality health care they are due and therefore help the volunteers imagine a more just world. Such imagination can only make the achievement of such a world more likely.

COMPASSION: literally meaning, “to suffer with,” compassion is a virtue with an obvious emotional component. Rather than sympathy, compassion places

one alongside the sufferer and is more likely to motivate one to alleviate the other’s suffering. Short-term medical missions have the potential to increase compassion if the volunteers are given the spiritual resources and time to reflect on the suffering they encounter.

Catholic social teaching and virtues are just two of the many lenses we can use to understand the theological foundations of short-term medical missions. Scripture, tradition, Church teaching and many other resources provide valuable insights for those interested in understanding the way these trips connect with the mission of Catholic health care.

“I think there needs to be this sense of mission that’s beyond the ego of individual organizations.”

FACULTY MEMBER OF A CATHOLIC UNIVERSITY
organizer, volunteer

STUDY METHODS

The goal of phase I of the research project was to gather as much data as possible on current practices in short-term medical missions so that the potential of these trips will more often be realized while minimizing their risks. To do so, this study included two parts.

Part one was an online survey made available through the Catholic Health Association. 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) this is likely the largest existing database on short-term medical missions.

Part two of the project included in-depth interviews with 18 individuals who had completed the survey and indicated their willingness to be contacted. These individuals represent a cross-section of the survey respondents in terms of both their positions at home institutions and their roles in mission trips. The interviews allowed us to gather additional information on the practices and perceptions of

short-term medical missions. The interviews focused on several areas that form the focus of this report: preparation and orientation of participants; relationship to in-country partners; evaluation of benefit of trip to the participants and the community; and characteristics of and barriers to successful trips.

This investigation, by focusing on Americans involved in medical missions, does not allow us to document health benefits to low income communities who host medical missions — the most important measure of their value. But it does give us important insights into current practices and perceptions of those in the U.S. who are engaged in short-term medical mission work.

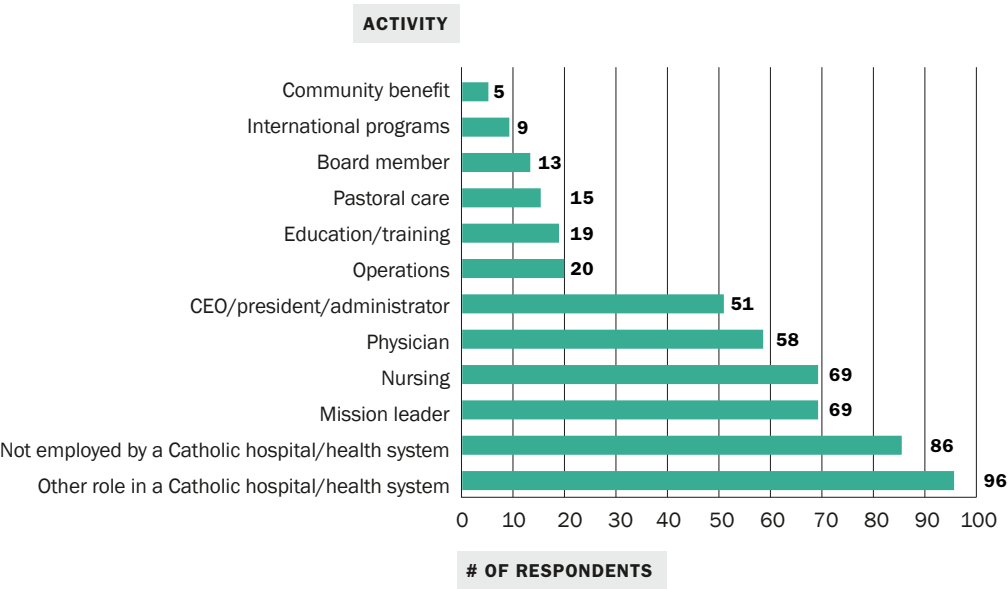
In our effort to focus on desirable practices, we asked survey participants a number of questions for which they reported both on the most recent trip they took and on an ideal trip. Many characteristics of preparation, partnership and evaluation would be similar in ideal and actual trips, but there were several areas in which responses were notably different.

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.

SECTION 2

The Current Landscape

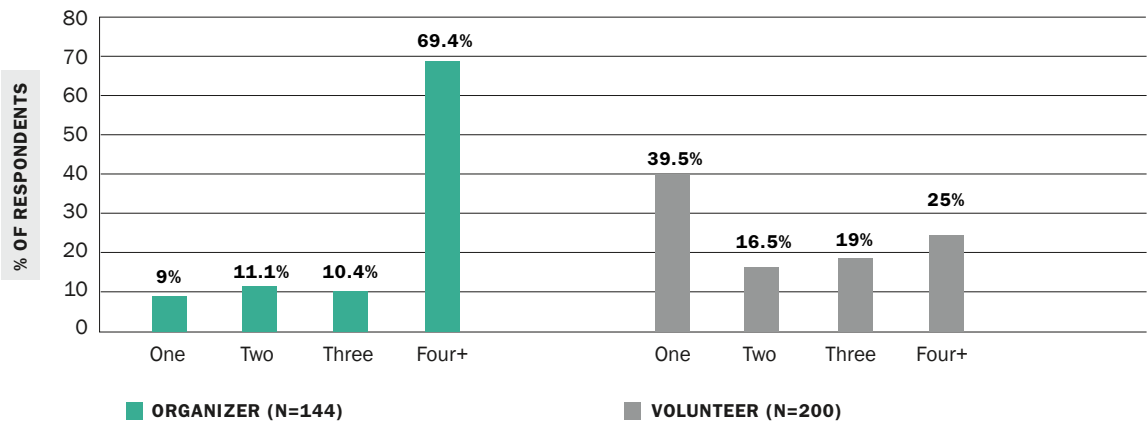
Here are some basic facts about trips as described by survey participants, including their size, cost and destination.

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

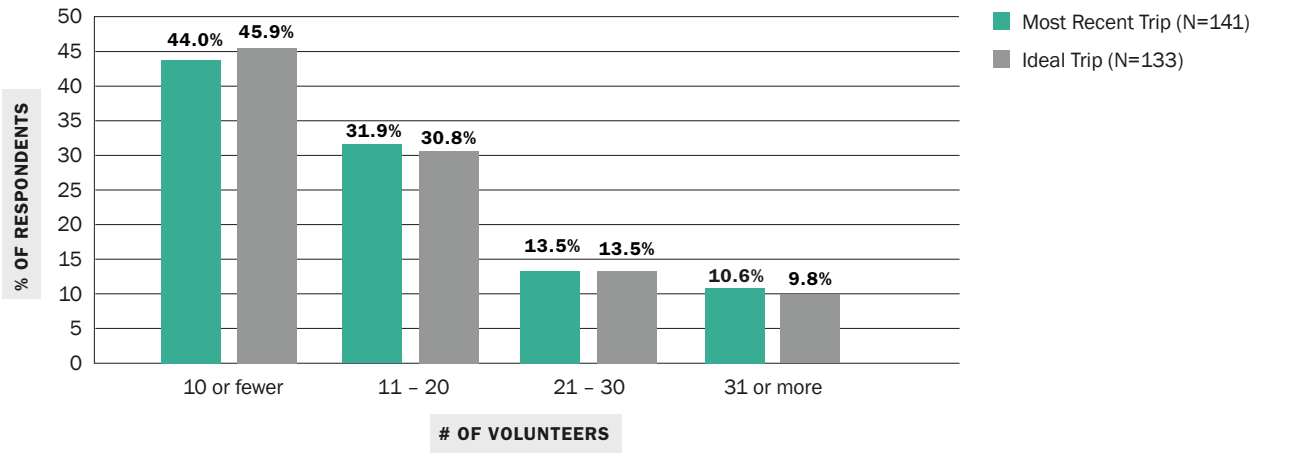


HOW BIG ARE THE TRIPS?

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?

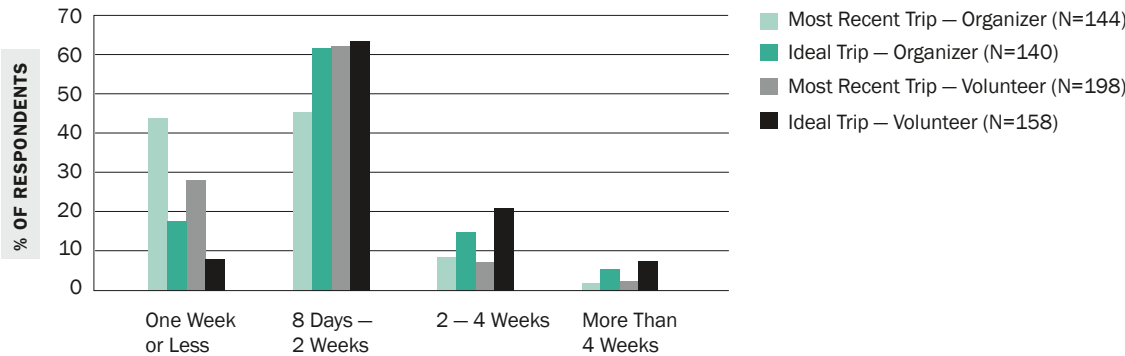


HOW LONG DO THEY STAY?

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.

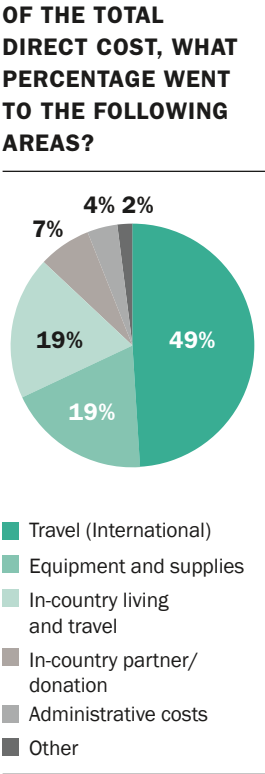
HOW LONG DID YOU STAY IN THE HOST COUNTRY? BASED ON YOUR EXPERIENCE, WHAT WOULD BE THE IDEAL LENGTH?



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.



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.

SECTION 3

The Value of Trips and Their Primary Goals

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.
- Personal and/or spiritual fulfillment/growth/transformation.
- 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).

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.

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:

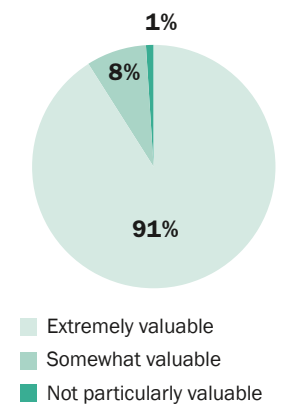
- Support, promote, and continue to go on (or wish to go on) more mission trips.
- Increased gratitude for what we have in the U.S. (resources, health care, etc.).
- Gained a new perspective in life which has led me to become or want to become a better person.
- Deeper commitment to service both abroad 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.

- 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.

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



“WHAT WE FIND IS when we go to do these short-term service trips, we’re not doing much to save, serve, change the communities; we’re doing much more to learn and to serve ourselves, to figure out how we connect to the rest of the world and some of the injustices, some of the social ills that happen because of policies that happen in our country or policies that our countries have that affect those countries.”

DIRECTOR OF INTERNATIONAL PROGRAMS

at a Catholic medical school who has been an organizer, volunteer, and supervisor reflecting on the value of medical mission work for the volunteers and for the students with whom she works

“THIS IS AN UNTAPPED RESOURCE for improving our employee satisfaction. ... there are so many regulations, and we’ve got to get this score, to this number. I think we as an industry so quickly lose sight that it boils down to one human taking care of another human. And these trips help to refuel that. I think that our employees would benefit from it and as a result our institutions would benefit from it if we encouraged it heavily.”

HOSPITAL ADMINISTRATOR

volunteer

“I THINK THAT when you have a surgeon and a scrub tech working side by side and spending a week together, when they go back to their post at their hospital and someone’s complaining about the surgeon or someone’s complaining about the scrub tech, they think about one another differently.”

DIRECTOR OF INTERNATIONAL PROGRAMS

for a Catholic health system

“WE REALLY SHOULD LOOK FOR THAT PERSON who’s early in their career, who may or may not have a missional heart. They may not be called to it; they may not be in a church or a parish that does this sort of thing. But wow, what power if, at their work, they could be encouraged and supported to some extent to go to Haiti and spend a week and a half. When they come back, they are going to be a far better and more loyal associate than if they hadn’t gone.”

PRESIDENT

of a foundation associated with a Catholic hospital; volunteer

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."

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?"

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"

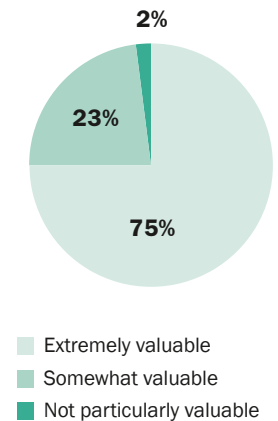
"Unless the foundation is built and developed to make the host systems self sustaining, mission trips are often just a Band-Aid to a much larger problem."

"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)



SECTION 4

Central Features of Mission Trips:

CURRENT AND LEADING PRACTICES

Many people experienced in medical missions believe that they can be extremely valuable to host communities, but only if a number of conditions are met. Their comments, as well as those from interviews, provide us with important recommendations for improving the effectiveness of medical missions for all people involved.

MEDICAL MISSION TRIPS ALMOST ALL SHARE SEVERAL KEY COMPONENTS:

1. Establishment of partnerships in the host country
2. Recruitment and selection of team members
3. Preparation of volunteers
4. Planning and carrying out of activities
5. Evaluation and debriefing following the trip

In this section we look at each component for both current and preferable practices.

ESTABLISHMENT OF PARTNERSHIPS IN THE HOST COUNTRY

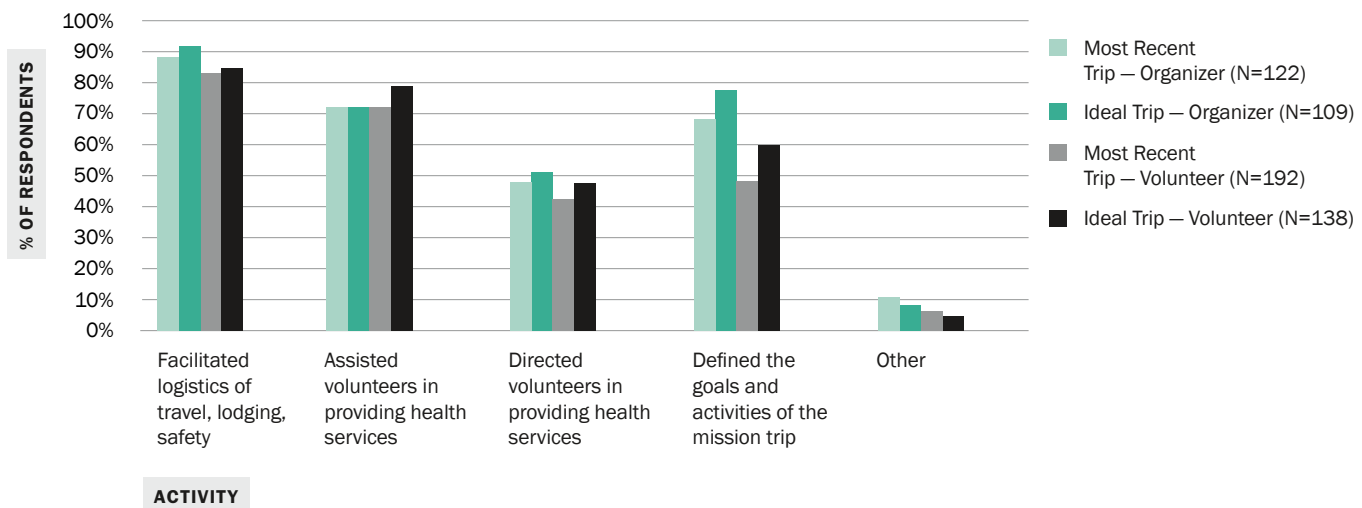
When asked to classify their primary partner, the majority of organizers indicated that it was either an NGO (non-governmental organization), a church or a hospital. Others referred to religious congregations (e.g., Sisters of Charity) or leaders based in the host country, or to multiple partners, as 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.

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.

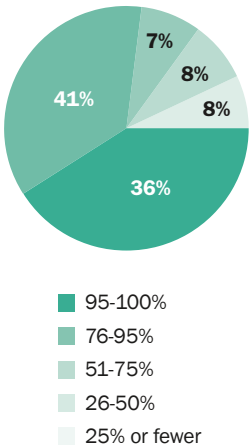
We asked organizers, “What specific skills or qualifications were most important when you recruited for the most recent mission trip?” They could select up to three items from a list of eleven possibilities. The most commonly chosen were, in order of preference: primary care training (56 percent), character 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:

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



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%

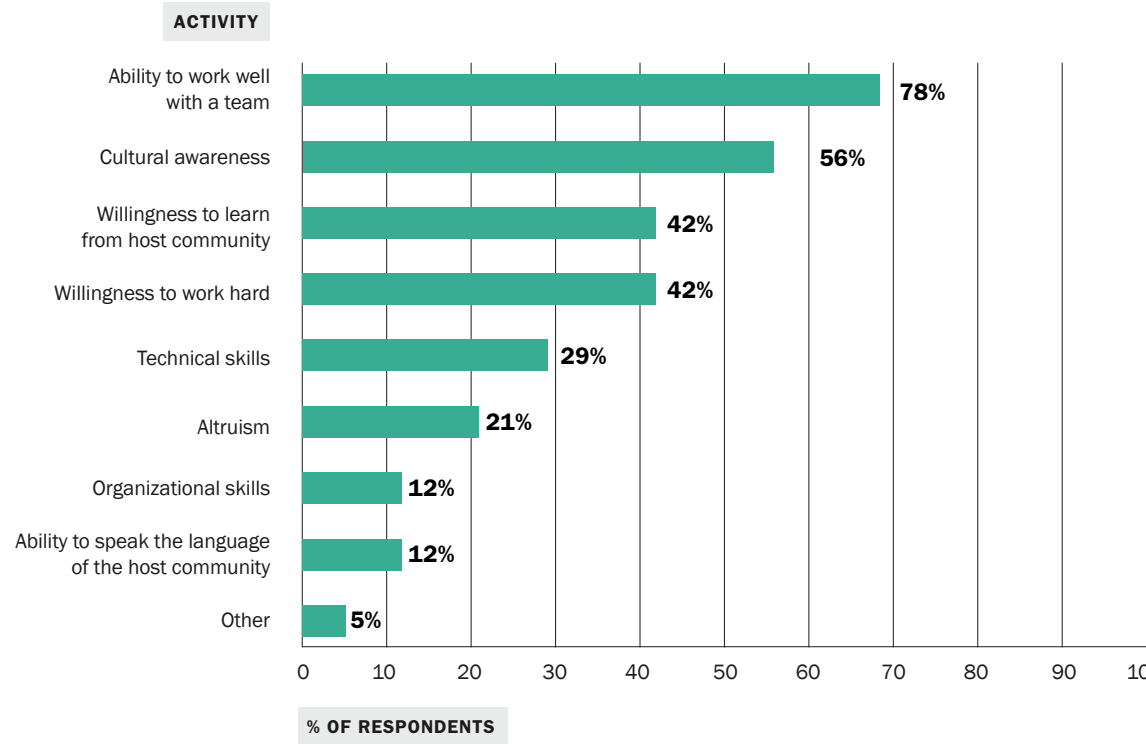
Some organizers we interviewed referred to occasional problems with team members. For example, one said,

“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)



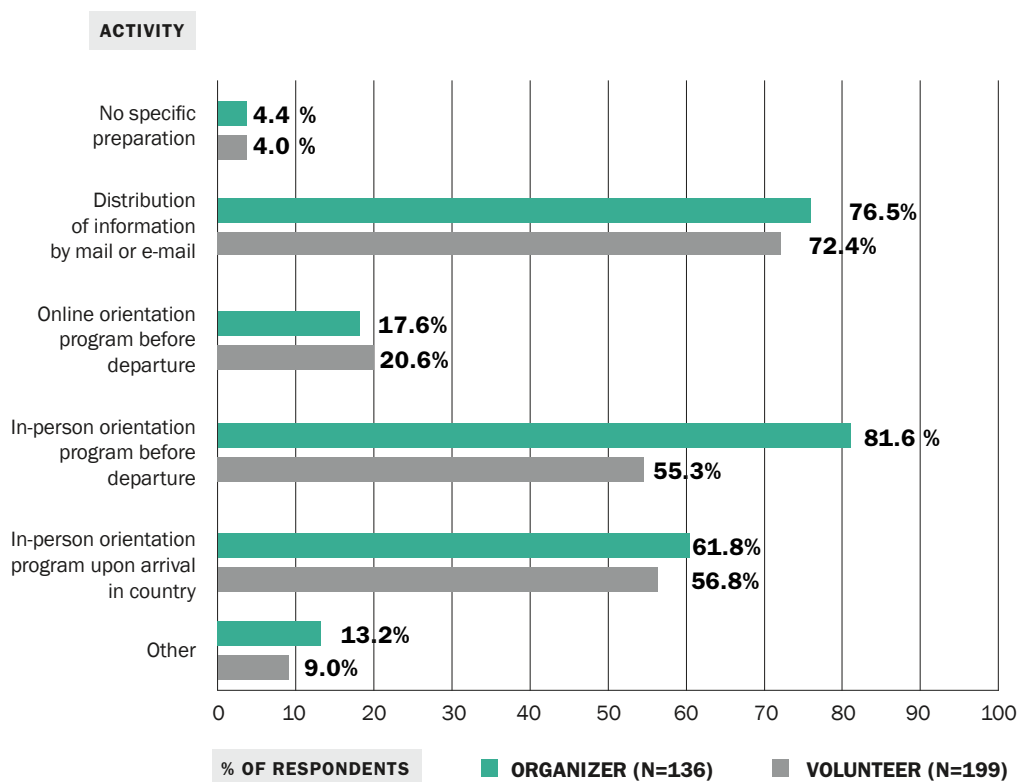
The most common response under “other” was flexibility.

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

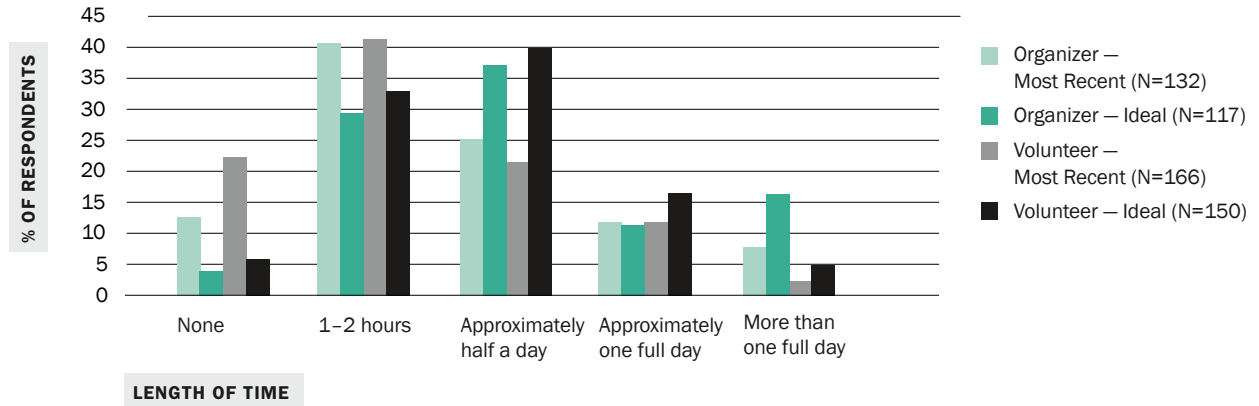
WHICH OF THE FOLLOWING KINDS OF PREPARATION DID YOU RECEIVE FROM THE SPONSORING ORGANIZATION IN ADVANCE?



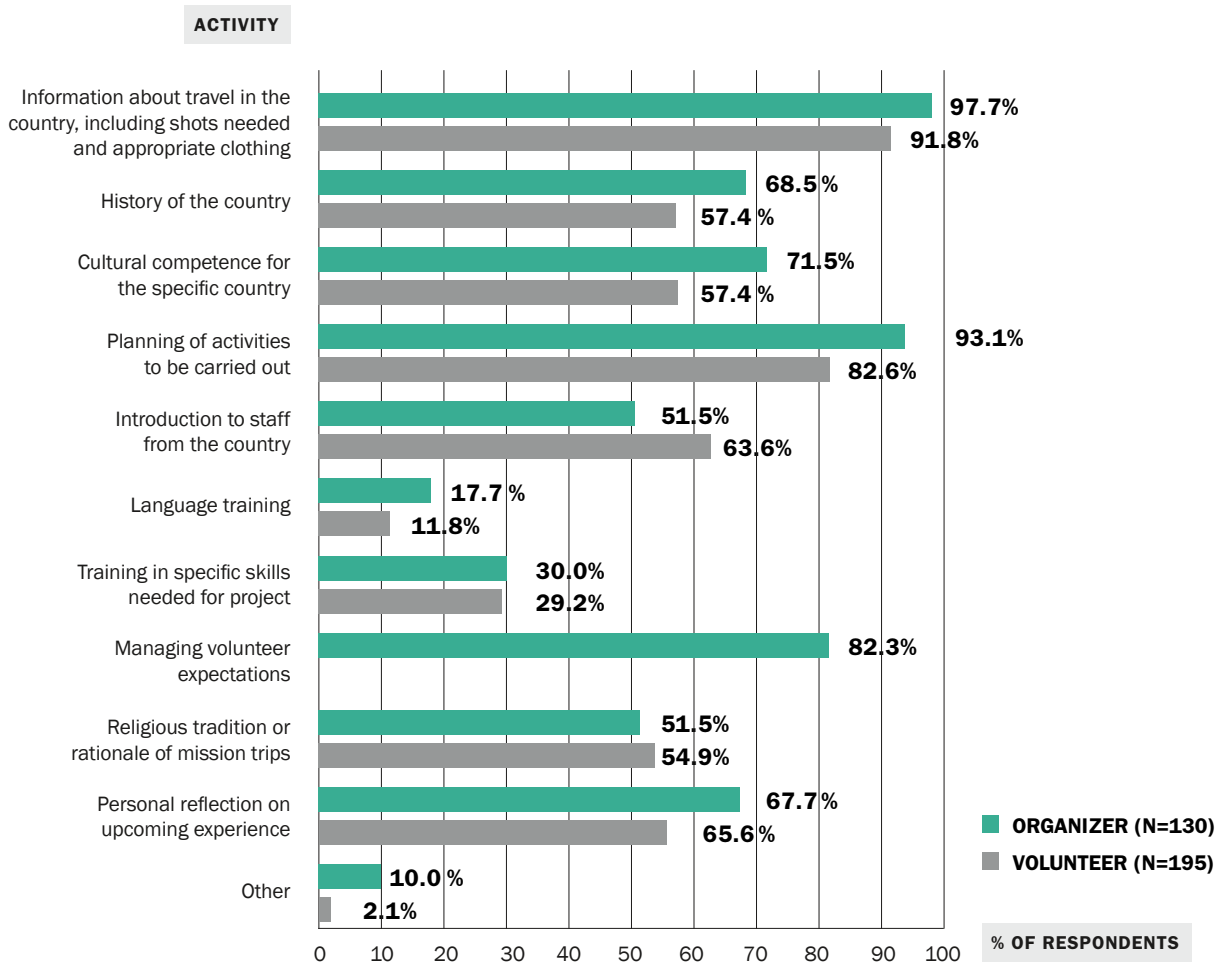
The challenge of having to “manage expectations” cited by almost one in four organizers, speaks to the issue of volunteer preparation, which is often brief. Eighty-two percent of organizers indicated that they had held an in-person orientation in advance of the trip, although only 55 percent of volunteers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

This 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.

AN EXAMPLE OF AN ORIENTATION

“We give them prep lists of things to do and I have them read Mountains Beyond Mountains, which is, of course, specific to Haiti as an orientation. We have a film that was created by the students on a previous trip to say this is the place; this is what it looks like. This is what you’re going to be doing. You want to see physically where you’re going to be living. You want to see the quality of the roads that you’re going to be traveling on for four and a half hours to get there. This isn’t a spa. You’re going to be working in an area that’s resource-poor.

We have an extensive volunteer information handout, which goes into everything from what they need to bring, to Creole phrases, to an orientation about what they’re likely to encounter once they’re there. There is a pre-trip phone call with a volunteer coordinator in which she talks to them about getting themselves oriented to what the trip will be, some of the dos and don’ts, but also being available to answer any questions. In going to Haiti with students, there are concerns about safety and illness, what about dengue fever and lots of different kinds of questions like that. The last thing that we did was there was a video, it was an orientation to what doing a mission trip is not, which is not about saving people, it’s not about helping people, it’s about serving and it’s about what you’re going to gain from that.

We have all of these volunteers going into the country and they want to hold Haitian babies and go home and say they had this feel-good experience, yet it doesn’t serve the people. They throw money around. It’s very disrespectful, but it’s an unconscious disrespect because there’s a lack of understanding about really thinking through what is the intention of this trip. What is the intention of this service?

We give the students assignments ahead of time. It’s not enough to show up on the day of the plane flying away. Having individuals responsible for understanding, say for instance, what’s the religion in Haiti, what is the history of Haiti, that person holds responsibility for teaching their peers about these things so that there’s a seriousness about this trip. ... I need to know what my work is. I don’t just get there and say okay, tell me what to do. So preparation beforehand is really important.

NURSING FACULTY MEMBER, CATHOLIC UNIVERSITY

organizer, volunteer

“The very best of the orientation was having people who had traveled before explain the realities of the mission to the new participants. Having the team meet, in person, if possible in advance just begins to create a whole different atmosphere than just having, for example, a phone conference or everybody gets a flyer or a handout. But having people who really have the perspective of an in-country person provide part of the orientation, that’s very helpful, too.”

ORGANIZER

ANOTHER EXAMPLE OF AN ORIENTATION

“The first immediate preparation is to address the fears and concerns of the volunteers. And so that means being really proactive about providing information about logistics and immunizations and the basic nuts and bolts of the trip. I think it’s important to affirm the participants and remind them from the beginning that they’re in safe hands.

And then it is really more about helping the team members gain a perspective, a sense that we’re not going in there to solve the hunger pains of the world, we’re not going in to solve all of the health concerns of the population that we’re going to find, but we’re there to encounter a community and listen and learn and be part of something that wouldn’t happen if it wasn’t for many people collaborating together. And then that changes the conversation, because otherwise it’s all about the poor people that we’re going in to save, and I think that that mentality is really dangerous.

We try to have the team leaders have a conversation with each participant in the group. We try to ensure that each participant is connected with a volunteer from a previous trip so that they have a dialogue partner who they can talk to about the trips.

And we ask everyone to do a bit of research. Then at the second meeting we ask everyone to share something they’ve learned about the country so that then it’s not the leaders talking to the participants, but there’s a little bit of the participants having ownership of some information and bringing that to the team meeting.

The third meeting, we’ve tried to have someone from our partner organization actually join the call and give a little bit of a presentation on how does all of this fit together. There’s always been a pretty good chunk of time in that conversation about logistics and questions. We have reflections at each of those meetings, and we’ve had people from other teams give a reflection about their service experience. We’ll have them share with one another about what they’re experiencing and what they’re thinking.

We haven’t done much around cultural competency and privilege. Part of the plan is doing a bit of identifying privilege and bringing that up at the second meeting.”

**DIRECTOR OF INTERNATIONAL PROGRAMS,
CATHOLIC HEALTH SYSTEM**

organizer, volunteer, supervisor

PLANNING AND CARRYING OUT ACTIVITIES

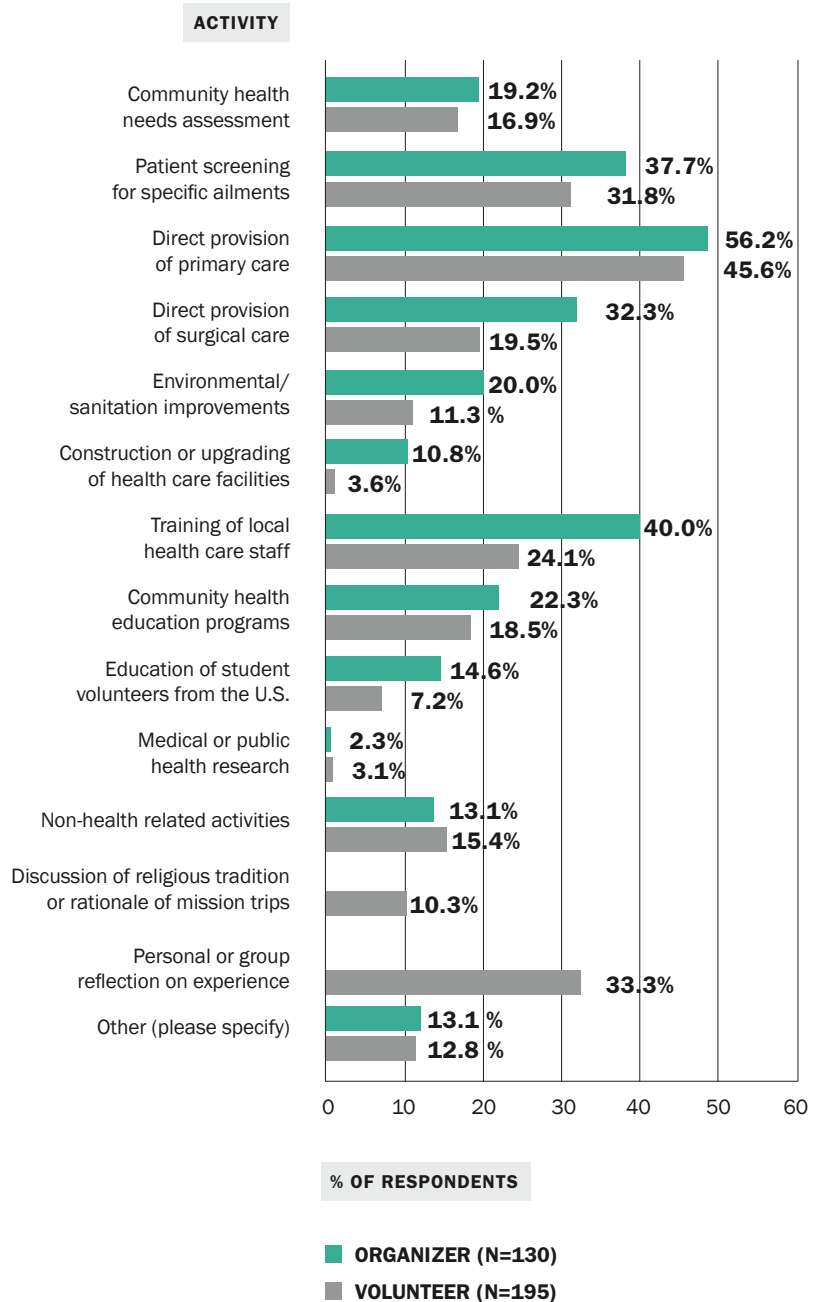
We asked both organizers and volunteers about the major activities they engaged in. There were some important differences in responses between the two groups.

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 evaluation 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).

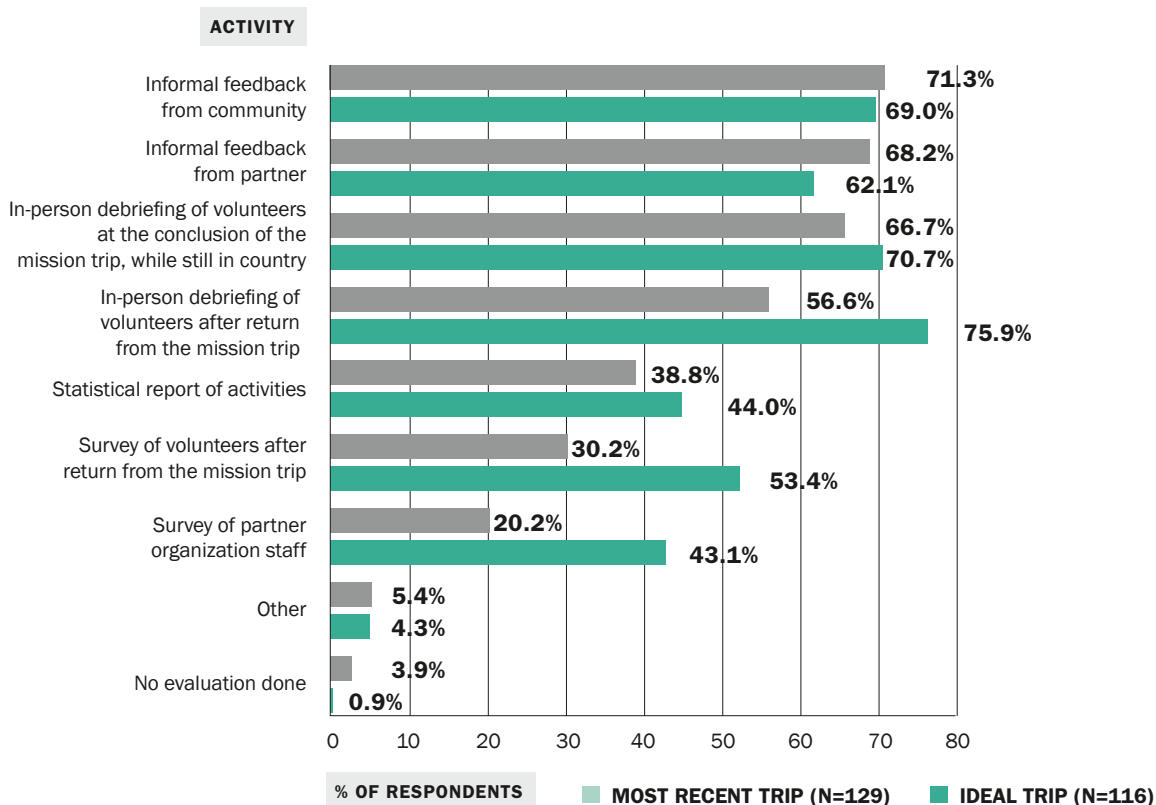
“WE HAVE OUR OWN DEFINITION OF SUCCESS.

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.”

HEALTH SYSTEM ADMINISTRATOR

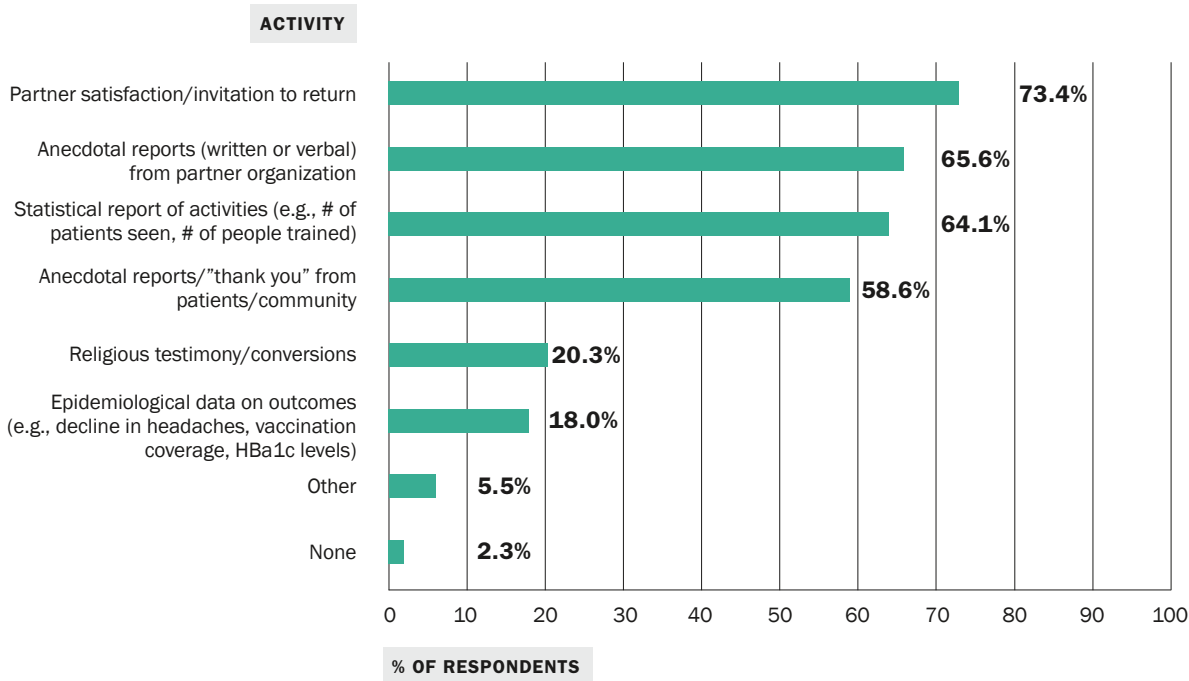
organizer, volunteer

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."

And 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.

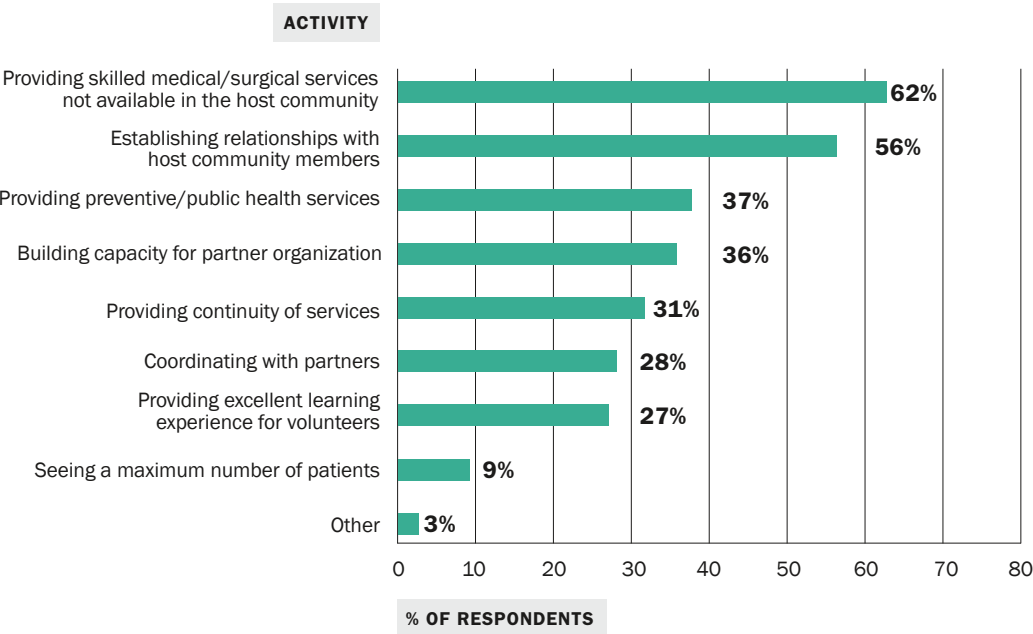
Many who are involved in medical missions are aware of this fundamental problem, but good assessment is difficult and expensive to carry out. It is an important challenge to sponsoring organizations and their in-country partners as they endeavor to make their efforts as useful as possible. Some are satisfied 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.

Successes and Challenges

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?”

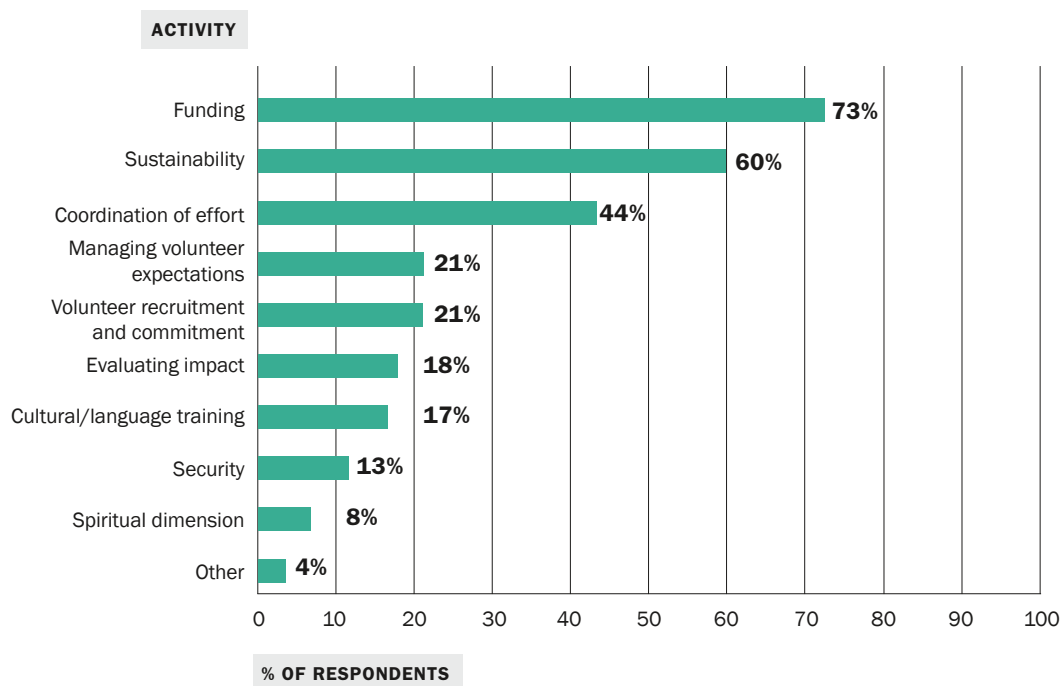
These responses are consistent with what we have seen earlier with regard to recruitment, preparation, and evaluation: organizers’ major focus is, perhaps necessarily, on the team’s ability to work well together, to accomplish specific tasks, to avoid harm to volunteers and patients, and to have a good 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)



FUNDING

The great concern about funding demonstrates the expense of mounting a medical mission, expense that is covered by volunteer fees, donations of money, and supplies by a variety

of organizations, and institutional support. The latter includes possible paid time off for employees.

SUSTAINABILITY

Sixty percent of survey participants considered sustainability to be a major challenge, and this requires further attention. An important finding is that only half of the organizers indicated that on their most recent trip volunteers contributed to activities that are continuously operating year-round. Another 26 percent participated in projects designed to be completed in just one visit. The remaining 24 percent worked on projects that depend on the arrival of volunteers at different times of the year. Unless these sporadic projects are folded into more permanent organizational activities (e.g., surgical teams working with local physicians at a hospital that sees patients year-round, or training of community health workers who work with local organizations on an ongoing basis), sustainability is definitely a problem.

A related concern is that specific destinations and partners are chosen primarily based on personal connections. When the people who initially forged the connections move to new jobs or a hospital's leadership changes, programs may also shift or disappear altogether.

Changes in leadership and personnel can pose difficulties on both sides. As a physician who has been a regular volunteer noted,

"The government [in the host country] changes every four years, and because these are government-run facilities, the administrators of the facilities change every four years. It takes two years, three years to really establish what you're going to do and then it kind of falls apart, so that, those are things that are frustrating for me."

The concerns about sustainability emerged quite clearly from interviews with people who have been organizers. As a nurse who had organized a number of trips said,

"You don't serve a population by going in with a bag of vitamins and then leaving at the end of the week; it has to be a sustainable program."

Several experienced organizers emphasized the necessity of spending a long time, even a few years, getting to know a community in order to understand the real needs and develop a trusting relationship that will make it possible to address those needs in an effective and mutual way.

A continuous relationship makes it possible to follow patients and increases the likelihood of consistent and good quality care. This most often involves working through local clinics and hospitals that have year-round staff and increasingly, electronic medical records. As the director of a medical mission organizer told us,

"As long as we can get Wi-Fi we can use [the EMR]. So the goal of that is to be able to actually pull up kids that have been seen before, know what was done in the past. If they were seen in our clinic, what did our pediatrician do so that particularly kids with chronic problems or complex problems don't get a different plan every time they come back to a brigade?"

The director of international programs at a Catholic university who has been an organizer and volunteer expressed the importance of working with an organization with continuous presence:

"The best kinds of partnership that we have are [where] we go in during our service visit and we join in with what they are already doing, and so these folks are on the ground, they are in the communities."

Experienced organizers often reflected on the importance of establishing continuous and mutual relationships in order to have the most impact. As one hospital staff member who had been both an organizer and a volunteer observed,

"Rather than having a clinic where we see 180 people a day and travel 8 hours to get to and from the little village at tremendous expense, it might have been better to have our out-of-country participation be more oriented towards training and advising and providing more critical resources to help develop ongoing public health resources. Figuring out ways to provide year-round care is less glamorous and heroic-looking, but [we should] budget

out funds to really provide needs throughout the year rather than coming for two weeks and doing a few clinics but then not having that ongoing monitoring.”

This same organizer reflected on how his program had evolved over time to become increasingly 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; for example, water quality and sanitation.”

BARRIERS TO PARTICIPATION

Survey participants who have not been on mission trips were asked if they might envision themselves becoming involved in one in the future. Of the 113 people who responded to this question, 54 percent indicated that they would be interested. When asked what, if anything, has prevented them from

going in the past, the most common explanations were competing priorities (42 percent), lack of time (35 percent), and lack of opportunity (29 percent). Just over one in four indicated a lack of money as a barrier, while one in five expressed uncertainty about their ability to make a difference.

SAFETY

A few people, in the survey and in interviews, referred to concerns about the safety of travel and work in some countries. In some cases, as indicated by one organizer, worries about safety may prevent groups from going at all:

“I believe that one of the requirements for doing this kind of work is that one’s willing to take those kinds of risks to a certain degree without being blatantly careless or stupid. But our mission trips eventually got hamstrung with the perception by our security people that it was not safe to even go to these locations.”

This was not a dominant concern; only 13 percent selected “security” as one of the top three challenges. Yet any trip has risks, particularly in a country where roads and transport are not well-developed, where there is potential for volunteers to contract communicable diseases, and where political instability and crime may be problems. Thus an organization must pay extra attention to the volunteers’ well-being and security.

SECTION 6

Recommendations for Practice

PARTNERSHIPS

(1) Identify partners who are reliable and respected advocates for their communities and have a continuous presence. A relationship of equality and mutual respect and cooperation takes time to nurture and formalize, but is essential to sustainability.

(2) Develop a Memorandum of Understanding (MOU) to define each partner's responsibilities, tasks and benefits. Review and update regularly.

(3) Identify several people within your organization who can be points of contact for host communities. The long-term success of trips may require someone other than the primary organizer, whose position within your organization can easily change. Partnership must be an institutional commitment rather than an individual one.

FUNDING EFFORTS

If the hospital or health system provides material or financial support, it should consider how to target its limited resources to fewer, well-run efforts rather than spreading resources across many projects with variable levels of success. This targeted support includes paid time off for employees, medication, supplies and staff time. The institution ought to ensure that the group facilitating the trip has similar goals as the institution itself regarding volunteer formation and host community health improvement.

ORIENTATION OF VOLUNTEERS

(1) Include topics in orientation of volunteers that may not seem immediately necessary but will prepare them for the experience, including historical and cultural information about the host country, unique cultural differences and an overview of the local health system.

(2) Include personal and group reflection on the role of volunteers that is designed to promote humility and realistic expectations. Prepare volunteers for the tasks they will be carrying out and for the importance of collaboration within their team and with host community staff.

(3) Require, insofar as possible, a real commitment to orientation activities. This will ideally be at least a half day of time, keeping in mind that it is not unrealistic for a group traveling for over one week to give four hours to prepare themselves for 168 hours of in-country activity.

(4) Ask repeat volunteers to go through the same orientation as everyone else, even if they express a feeling that it is not necessary for them. Their experiences and reflections benefit new volunteers. Their presence adds to the group cohesiveness that is beneficial when your group arrives in country. And they can always be challenged to consider ways in which this trip is not just a recapitulation of old trips, but is a unique experience that carries its own challenges and opportunities.

ACTIVITIES UNDERTAKEN

(1) Determine the activities of the mission trip through a collaborative process aimed at identifying community needs and volunteer ability. This may take more time that you anticipate and will likely require one or more trips to the host community by those skilled in community assessment before sending a larger group of volunteers.

(2) Since all activities should already be mutually agreed upon by volunteers and the host community, regularly confer with the hosts about how they perceive activities are going and the activities can be improved during your stay. They will often be reticent to offer direct criticism, so you should find ways for them to offer suggestions along the way.

(3) Consider which tasks volunteers are doing that can be carried out by the host community. Even though your volunteers may expect to take medical histories or run health education sessions, if possible, these activities can be done by local volunteers, thus building capacity during your short time in country.

(4) Give considerable thought as to how your activities might be causing unintended harm to the host community. Ensure that local health providers are seen as partners or leaders in your effort. Ask clinicians to consider complications that may arise from medications and procedures and create a plan of action with local providers. For example, potent medications given to a family with small children without childproof containers can be more harmful than no medication at all. Such unintended consequences are best understood through honest conversation with local health providers. In short-term medical missions, something can actually be worse than nothing.

EVALUATION

(1) A continuous presence (of your group or your association with a local organization) makes it more likely to be able to assess the impact of mission trips on communities. Develop metrics for effectiveness and track data after each trip. These should include population-level data and impact on the local health system. Anecdotes and informal feedback are insufficient to document effectiveness, and volunteers are not a good source for affirming the value of a trip.

(2) Consider the feedback from host communities when evaluating the trip, but do not count on “thank you” or requests to return as proof of your effectiveness. Very often there are benefits to host communities other than improving the community’s overall health: the relationships of solidarity built between hosts and volunteers, single medical interventions and ancillary income from your trip (donations to the organization, your group paying for lodging, etc.) to name a few. Therefore, positive feedback from communities is not always for the reasons organizers assume.

(3) The true value to volunteers should not be assumed and should be evaluated. Much like the evaluation of impact on host communities, this should be more than anecdotal. This is particularly challenging after volunteers return from the host country. Nevertheless, gathering feedback from volunteers on the formative elements of the trip is best done with some time between the experience itself and the evaluation.

IMPROVING SUSTAINABILITY

(1) Longer stays and more frequent returns to the same place make it possible for communities to know what to expect, develop relationships and have continuity of care, especially important with the rise of non-communicable diseases in most poor countries.

(2) Working with communities to identify and address underlying causes of ill health increases the chances of impact.

(3) Consider the ways in which your trip’s activities can be integrated into and improve the capacity of the continuous operation of the local health system. Doing so has the potential to strengthen the local health system and the local providers, making it more likely to achieve both short-term and long-term goals of the community.

THE IMPORTANCE OF LANGUAGE

(1) Given the power of language, it is important to describe mission work with appropriate terminology. If we describe the host community as “recipients” or “beneficiaries,” we inadvertently undermine the goal of a mutual partnership, reinforce stereotypes of superiority and inferiority, and make assumptions about whether people are truly benefiting. They are best described as “hosts” or “partners.”

(2) Although most groups characterize trips as “medical missions,” “surgical brigades” or something similar, there are instances where they are described as a “volunteer vacation” or “surgical safari.” The language used to describe the trip sets expectations for volunteers. The formative element for volunteers suggests the need for mission-oriented language as opposed to describing it as a vacation.

SELECTION AND RECRUITMENT OF VOLUNTEERS

(1) The recruitment of volunteers should only take place after the host community assessment has been completed. Then, the skills needed for the key activities can be identified and sought by trip organizers.

(2) Volunteers should be more carefully screened for adaptability to the medical mission trip experience; in particular, their ability to cooperate in a team and respect the host community members, and for skills needed by host communities. This may only be possible with greater screening procedures, such as interviews of volunteer applicants. Although technical skills are often necessary, they are only part of what makes a successful volunteer.

(3) Because trips are understood to be formative experiences for the volunteers as much as they are improving the health of host communities, organizers should be clear with volunteers about this reality and should look for volunteers who are open to being formed by the experience.

IMPORTANT QUESTIONS TO ASK ABOUT MEDICAL MISSIONS

If you are a hospital or health system administrator being asked to launch or support a medical mission, we recommend that you ask whether it is integrated into a larger strategic vision for the hospital or health system.

Regardless of whether you are organizing a trip, considering volunteering on one, or have a position of responsibility in Catholic health where you may be supervising or supporting others who go on missions, these recommendations lead us to suggest you ask some hard questions before proceeding with participation.

PARTNERSHIPS

Have we established a relationship with local leaders, including local medical staff, leaders and community members?

What kind of process have we used to determine shared goals? Have we taken the time to identify needs as defined by the host community and to establish trust?

RECRUITMENT AND SELECTION OF VOLUNTEERS

What kind of qualities and skills do we (organizers and partners) believe to be important in volunteers? Are these determined in collaboration with the host community once the goals have been mutually agreed upon? Are we doing enough to screen potential volunteers to be sure they bring what is needed?

How can we best engage those in the hospital/health system who can't travel to be involved in the formation of volunteers and the health of host communities?

ORIENTATION FOR VOLUNTEERS

Is there an effective pre-trip orientation, lasting half a day or more, that includes:

- Trip logistics and in-country activities, including why the activities volunteers will do have been chosen.
- History and culture of the host country, including an understanding of political and economic sources of poverty and need and cultural differences that may impact delivery of health services.
- Personal and group reflection on motivation and expectations.
- Learning of key phrases in local language.

IN-COUNTRY ACTIVITIES

Are there activities where volunteers can build capacity or transfer skills to local providers rather than performing tasks themselves? Again, are the volunteers trained in the skills needed and in the capacity to train others?

Might there be unintended negative consequences to the activities volunteers are engaging in? For example, are they bringing medications that will be available just once with no continuity of care? Will they be providing surgical interventions or chronic disease treatment without adequate follow-up? Will they be teaching lessons around health practices that are inappropriate for the setting?

EVALUATION

Is there an evaluation of the impact on the lives and professional work of the volunteers, both soon after the trip and over the course of time?

Is there an evaluation of the impact on the health of the host community? Do we have an understanding of success that is shared with the host community? Is the in-country partner involved in determining the best metrics for success and trained to collect the necessary data if they do not have those resources already?

Are decisions about future trips based on the results of evaluation?

SECTION 7

Conclusions

This report is intended to start a much broader conversation around short-term medical mission trips. Given Catholic health care's global network and its shared sense of mission, it is uniquely positioned to be a leader in setting a standard for international health volunteer efforts.

We are keenly aware that trips are very unique entities: staffing and skills of volunteers, types of in-country partners, disease burden of the host community and the mutual goals of organizations will all create a trip that cannot be specifically addressed in a report of this breadth. Therefore, the information presented here is not meant to be overly prescriptive. Nevertheless, we would be remiss if we ignored that there are practices we know to be deleterious to volunteers and the host community and others that improve the likelihood of a trip being effective.

Based on our experience, we believe that if done properly, everyone can benefit. One concern however, is that almost everyone (91 percent) who participated in the survey agreed that medical mission trips are extremely valuable to volunteers, but a lower percentage (75 percent) is convinced that they are extremely valuable to host communities. This discrepancy tells us several things.

First, we have better evidence that short-term medical missions benefit volunteers, although even this evidence is largely anecdotal. This occurs in post-trip debriefing of volunteers and continued conversations about the impact of trips on volunteers' lives. We do not have comparable evidence of the impact on host communities, which likely leads to more skepticism of their value.

Second, the trips may, in fact, be more valuable to volunteers than host communities. The assessment of value could be a very accurate assessment, which should lead us to consider how we promote and describe these trips. For understandable reasons, groups may be reluctant to frame them as volunteer formation instead of improving the health of host communities. Nevertheless, it would be worth reflecting on whether part of the consistent criticism of short-term medical missions might be rooted in people's perception that the trips lack honesty in their stated objectives.

The desire to identify leading 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 and we are not intentional in pursuing them, then we are doing ourselves and the host communities a great disservice. It may not be possible to prescribe what should always be done, but it is almost certainly possible to prescribe what should never be done.

The results presented herein are only the first phase of a larger research agenda. This report provides the perspective of those participating in short-term medical missions. Yet in order to gain a more complete picture, the perspective of in-country partners and communities who are served must be more fully understood. This is an even more under-researched area than the benefit to participants of short-term trips. And yet, it may be the most important area in order to answer how effective short-term medical mission trips truly are.

SECTION 8

Recommendations for Further Reading

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Notes

Notes

FOR MORE INFORMATION

This report, and the eight-page Executive Brief of this report, as well as all of CHA's International Outreach resources, are available at **chausa.org/international**.



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