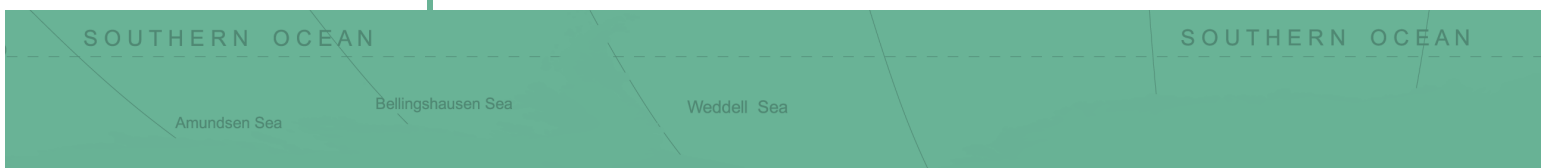




Short-Term Medical Mission Trips: *Recommendations for Practice | 2015*



A Passionate Voice for Compassionate Care



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

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Guiding Principles for Conducting International Health Activities

CHA and its members have named six Guiding Principles for Conducting International Health Activities. These principles bring to life the richness of Catholic social teaching and tradition. Based loosely on the “Oath for Compassionate Service” in the book *Toxic Charity* by Robert Lupton, and insights from a special workgroup CHA convened to examine current international health program practice in light of our ministry’s commitments, they are offered to help Catholic health care most appropriately conduct international programs. They include:



PRUDENCE

Don't just do it

Good judgment requires controlling our enthusiasm to do good so that we also do it well, even in times of emergency. Technical expertise is necessary but not sufficient for action. International activity requires many things, including assessment, planning and evaluation.



PATIENCE

Build capacity, not dependency

We should neither conduct activities that a local community can do for itself nor participate in one-way financial giving. The process of getting to know your partner — in order to build capacity — often takes longer than expected and requires patience.



AUTHENTICITY

Know thyself, know thy partner

There are many motivations for U.S. and international organizations to engage in international health activities. An invitation from a true partner who is part of the local community and its health system, knowledge and understanding of our respective motives and full transparency regarding our goals are all necessary if we are to do our best work.



EXCELLENCE

Best intentions do not equal best practices

Something is not always better than nothing. Low-resource settings do not permit lower standards. The high standards we follow in the U.S. — in delivering health care and developing partnerships — should not be set aside when working abroad. The laws of the country must be followed, the men and women providing services must be competent in their roles, and outcomes must be measured by quality, not simply quantity.



HONESTY

Trust is earned and learned

Meaningful partnership requires a high level of trust and multiple lines of communication. Both U.S. and international partners must recognize that the other likely perceives risks in being totally honest. Both must listen for things said and unsaid, which takes both time and practice.



HUMILITY

We all have something to learn

Partnerships marked by mutuality and respect build relationships where both the U.S. and international partners benefit and take away relevant lessons. True cultural competence is necessary for a two-way learning process in any development activity.

Learn more about the Guiding Principles at CHAUSA.ORG/GUIDINGPRINCIPLES

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

Introduction

Over the past two decades, the number of short-term international mission trips for the provision of health services has dramatically increased. Catholic health care has participated in this growth. According to researchers at Harvard Medical School, an estimated 6,000 medical missions are sent from the United States to low- or middle-income countries every year with an annual expenditure of at least \$250 million dollars.[†]

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.

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.

To date, CHA has conducted two phases of research on short-term medical mission trips — one from the perspective and practices of the U.S.-based partners, and the second, from the perspective and practices of those who receive these trips in low- and middle-income countries.

PHASE I BACKGROUND

Gaining the U.S. Perspective

In 2014, CHA completed a study of short-term medical mission trips to understand the goals, best practices and perceived impact of these trips from the perspective of volunteers and trip organizers. Conducted by Fr. Michael Rozier, SJ, doctoral student, Department of Health Management and Policy, University of Michigan; Judith N. Lasker, Ph.D., the N.E.H. distinguished professor of sociology in the Department of Sociology and Anthropology at Lehigh University; and Bruce Compton, CHA senior director of international outreach, it included two phases: an online survey and in-depth interviews. The survey targeted employees of Catholic hospitals and health systems who had participated in or had overseen a short-term

medical mission, but it was open to anyone who chose to respond. With the majority of over 500 respondents answering between 36 and 47 questions (volunteers and organizers, respectively) it was likely the largest database on short-term medical missions. The in-depth interviews were held with 18 individuals who had completed the survey and indicated their willingness to be contacted. These interviews provided additional information on the practices and perceptions of short-term medical missions.

PHASE II BACKGROUND

Gaining the International Perspective

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

The Recommendations for Practice in Section I of this document are based on the results of this two-part study. To see the full details from Phase I and Phase II — the charts and graphs conveying the survey responses — go to www.chausa.org/international. There, they are provided in a PDF report, *Short-Term Medical Mission Trips Survey Results*.

[†]<http://www.biomedcentral.com/1472-6963/8/121>

Summary of Findings

PHASE I

Survey participants collectively had been on a minimum of 949 trips over the past five years. The “most recent” trips reported on in the 2014 survey included approximately 2,300 volunteers traveling to 45 countries at an estimated cost of \$3.45 million. Organizers sponsored about 40 percent of the trips and estimated that about one-fourth of this \$3.45 million is spent in the host countries.

Overall, participants expressed great satisfaction with the mission trips they volunteered for or led. 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.

Overall findings included:

- » 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 greatest challenges to creating effective medical mission trips were identified as funding, sustainability and coordination of effort.

PHASE II

Survey respondents indicated a consistent flow of short-term medical missions. The trips reported on in the 2015 survey indicated that collectively, the respondents typically host more than 130 medical missions per year. Individually, respondents reported they receive anywhere from one to more than 11 missions teams per year at their location/organization. Over 60 percent of the organizations represented have been receiving medical mission trips for more than five years.

Survey participants played a variety of roles within their organizations. Nearly 75 percent of survey respondents served in leadership positions, over 40 percent were responsible for coordinating with medical mission trips from visiting organizations and 26 percent were responsible for providing care to patients.

Overall findings included:

- » Preparation and Selection of Volunteers — Similar to Phase I, respondents indicated the most important qualities of volunteers were willingness to work with a team and willingness to learn from the local community.
- » Volunteer Qualities — The qualities referenced as needing the most improvement included ability to train local staff for patient care, knowledge of local

customs/culture and willingness to learn from the local community.

- » Needs Assessment — Just over half of current missions conduct a needs assessment. Survey and interviews indicated that too often the needs are being identified by the U.S. partner. The importance of a needs assessment managed by the international partner or equally co-managed with the U.S. partner emerged from both the survey and interviews.
- » Development of Goals — The survey indicated a significant gap in the current vs. ideal level of involvement of host organizations in defining the goals of the medical mission trip. The international partners overwhelmingly indicated their desire to be more involved in the process of defining the goals and activities of missions.
- » Length of Trip — Similar to Phase I, only one eighth of the respondents believed that one week or less was the ideal amount of time for a medical mission.
- » Role of the U.S. Partner — Ninety eight percent of respondents indicated that capacity building is equal to or more important than clinical care. Interviewees consistently reiterated the need for training and capacity building.
- » In-kind Donations — The survey suggested that the majority of organizations had received support with medical products, vaccines and technologies. Unfortunately, over half of those responding either don't have or don't know about quality control guidelines for supplies being brought in by volunteers. This combination has often led to donations that are inconsistent with the greatest needs and are at times unusable.

Overall, the research tells two sides of the same story — a story where people are reaching out to their global neighbors. Whether the motivation is extending the mission of a health organization to low-income countries, personally reconnecting to a call to serve in health care, or alternatively, requesting health services and supplies from organizations with staff that are willing and able to provide them, boosting a local economy for a short period of time, accessing

education and mentoring, or for the many other reasons that exist, medical missions are happening often and need to be continually examined.

To see the data charts from Phase I and Phase II, go to www.chausa.org/international, where they are offered in a document.

ABOUT THIS GUIDE

This guide provides data, guidance and commentary. While not prescriptive in nature, the Recommendations for Practice and the accompanying questions for reflection should lead a process of assessing any current international activities as well as those that arise in future.

As you will see, there are distinct opportunities for CHA members associated with responsible international outreach to:

- » Strengthen the mission of Catholic health care globally.
- » Be a leader for the broader international development community and in the world of global health.
- » Build support from the CHA donor community.
- » Establish the cultural awareness and relevance to better serve patients at home.
- » Strengthen the capacity of international partners to deliver quality care to their communities.
- » Recruit the next generation of top talent.

We hope that in 10 years, if asked, U.S. participants and international partners would share stories different than ones shared in the 2014 and 2015 research projects. Stories where volunteers feel they were fully prepared for the entire experience well ahead of traveling abroad, and once there, that they were able to share their competencies and build up the people of the local community. We hope to hear from international partners that their staffs' skills and competencies were acknowledged, utilized and expanded and that the community's capacity was increased exponentially through partnering.

Section I

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

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

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

SELF ASSESSMENT

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

NEEDS ASSESSMENT

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



GAP ANALYSIS/ASSET ASSESSMENTS

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

PLANNING AND PREPARATION

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

VOLUNTEER SELECTION AND ORIENTATION

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

IMPLEMENTATION

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

MONITORING AND EVALUATION

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

LESSONS LEARNED

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



SELF ASSESSMENT

Before any medical mission activities take place, take time to assess your organization's history, motives and available resources.

RELATED RECOMMENDATIONS FOR PRACTICE:

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

QUESTIONS FOR REFLECTION:

- » What do we know about our organization's history related to international and charitable activities (sponsor, health system, hospital, employee, related organizations)?
- » How will past activity affect our ability to do medical missions?
- » What has motivated us to consider doing an international medical mission?
- » How do our motives keep the international partner community as the focal point?
- » What resources (financial, personnel, technology, other) have we budgeted?
- » How do we propose those resources will be executed?
- » How have we ensured that all stakeholders (sponsors, board, executive leadership, management, mission leaders, clinicians, employees, other) have been appropriately engaged and provided approvals where necessary?

DECISION POINT:

Based on available resources and levels of commitment, move forward to conduct a needs assessment or reconsider involvement in this project.

In Phase II, the director of an international partner's health care projects reflected on knowing yourself and knowing your partners: *"Sometimes they need to be honest and say 'maybe we shouldn't come.' And the local partner needs to have the honesty to say, 'thank you for offering, but your skills don't meet our needs.' To get to this kind of relationship, there needs to be an ongoing connection. Someone in the field who has a continuing connection with the partnering organization. Otherwise, the partnering organization does not have enough time to get to know the community."*



NEEDS ASSESSMENT

Once you have concluded the self-assessment and determined it is appropriate to move forward, consider where the request originates and understand the actual needs as assessed by your potential international partner.

RELATED RECOMMENDATIONS FOR PRACTICE:

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

QUESTIONS FOR REFLECTION:

- » Who invited us to take part in this activity and how did they find us?
- » Is the organization/individual that made the invitation a reliable and respected advocate for their community with a continuous presence in country?
- » Does this invitation make sense given our historical context?
- » Who assessed the international partner's needs? How?
- » How might we determine if the assessed needs are a symptom of a larger problem?
- » How are our stated motives and budgeted resources aligned to respond to the assessed needs?
- » What baseline data do we have from the needs assessment?
- » What additional data do we need in order to ensure we can measure future impact?

DECISION POINT:

Once you have confirmed the locally assessed needs, move forward to conduct an asset assessment or if the assessed needs do not match your organization's needs, reconsider involvement in the activity.

In Phase I of the research, a U.S.-based 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 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.”*



GAP ANALYSIS/ASSET ASSESSMENTS

After you understand the needs prioritized by the international partner, map the assets.

RELATED RECOMMENDATIONS FOR PRACTICE:

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

QUESTIONS FOR REFLECTION (U.S. AND INTERNATIONAL PARTNER):

- » What are the local resources available to fill the prioritized need?
- » Would financial support allow for the appropriate local community resources to be engaged?
- » If local resources are not currently available, who or what assets are in place where competency development or capacity building would fill the assessed need?
- » What local assets are available to assist with competency development or capacity building?
- » Will developing competency or increasing capacity be sustainable beyond our involvement?
- » What budgeted resources (financial, human, technological, other in-kind) do we have available to assist in developing local competency/capacity as it relates to the locally-prioritized needs?

DECISION POINT:

Based on understanding the local community needs and the available resources, move forward to plan for action or reconsider involvement.

In Phase II a director of outreach from an African health services project said it quite simply: *“To make a real impact, U.S. partners must be very good listeners. They must understand the local hospital and give ideas to help manage their challenges in a better way.”*



PLANNING AND PREPARATION

If your resources are a match for the assessed needs, move forward to plan for the activity.

RELATED RECOMMENDATIONS FOR PRACTICE:

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

QUESTIONS FOR REFLECTION:

- » Does the identified need require that we expend resources for ongoing travel and in-country expenses?
- » Can we fully or partially address the need via technology?
- » Does our MOU define each partner's responsibilities, tasks and benefits?
- » How are our specific goals and objectives sustainable for the local community?
- » What are the specific resources that will be needed to accomplish this mission?
- » How are the tasks divided among volunteer positions?
- » Does each volunteer/position have a plan of action that helps the mission achieve its defined goals and objectives?
- » How will this plan of action build capacity of the local community?

DECISION POINT:

After you have defined how you will move forward, the specific goals and the personnel needed, you must now determine a timeline for volunteer recruitment and orientation.



VOLUNTEER SELECTION AND ORIENTATION

Regardless of your decision regarding a virtual or in-person project, the people involved need to be well-positioned to be of assistance.

RELATED RECOMMENDATIONS FOR PRACTICE:

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

QUESTIONS FOR REFLECTION:

- » Is our volunteer selection process and orientation transparent and honest about objectives, conditions and limitations of the medical mission?
- » How have we incorporated historical and cultural information about the host country, unique cultural differences and an overview of the local health system?
- » What resources have been identified to increase the cultural competence of our volunteers?
- » How does the orientation provide unbiased, first-hand accounts of the conditions, expectations and needs of our international partner?
- » In what ways could our orientation program include a “train the trainer” component to allow for further dissemination of the lessons we share?
- » What techniques and best practices for training are included on topics requested by the international partner?
- » How might we connect our new volunteers to past volunteers?
- » In what ways should we incorporate international partner staff in the volunteer orientation?

DECISION POINT:

Make a final determination that you have the appropriate team members with the skills and information needed to meet the goal of the activity.

In Phase II of the research, the director of an international partner on the ground identified a specific challenge to volunteers who aren't appropriately prepared: *“It's challenging when new volunteers come in, because sometimes people want to do something particular. For example, one volunteer had some statistics on breastfeeding and was passionate about the topic. It only eventually turned out to be somewhat useful.”*



IMPLEMENTATION

Now that you have done the groundwork, it is time to put the plan into action.

RELATED RECOMMENDATIONS FOR PRACTICE:

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

QUESTIONS FOR REFLECTION:

- » How do our actions show that we value the knowledge of our international partner's staff?
- » What portions of the broader health care community (local, regional and national health ministries, community-based NGOs, other health care providers) need to be included in activities to carry out our mission?
- » How might our interventions hurt local health providers' business or the local economy?
- » Who else from the local community needs to be informed of the interventions we will be conducting? How will these messages be delivered and by whom?
- » How have we ensured that we are using appropriate resources that are available locally?
- » Will anything we are doing make the local community more dependent on continued support?

NO DECISION POINT.

In Phase II, a retired executive of a health outreach program in a low-income country was adamant that mission trip planners and participants need to be more sensitive to the local laws, norms and standards: *"It is rare that groups even register with the government. It is a law that all MDs and nurses are to send their current USA license to the local health department for approval before they arrive. How many groups stop by the health department to ask for the local norms and standards before going to a location to see 1,500 people in a week? Very few. Why is that? Would a hospital in Chicago welcome a doctor from China without knowing if this was a licensed practitioner? Never! But folks do this here."*



MONITORING AND EVALUATION

After putting in the time, effort and resources it is important to know if you are making a positive difference in the community you are serving.

RELATED RECOMMENDATIONS FOR PRACTICE:

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

QUESTIONS FOR REFLECTION:

- » What baseline information do we have that will allow us to use metrics to assess the impact?
- » How have we ensured that our impact measures relate to quality outcomes and not the quantity of activities?
- » What are we doing to track and share data based on each trip?
- » How are we working with our international partners to plan future trips based on increasing impact?
- » How are we being mindful that using anecdotes and informal feedback aren't sufficient evidence of impact?

DECISION POINT:

Use the information you have collected to assess the impact on the community served and determine if adjustments are needed and/or if future trips should be reconsidered.

In Phase I, a health system administrator who has served as both an organizer and a volunteer noted, *“We see 1,000 kids in a two-week mission. So what happened to those kids? Did they just go home, take their medicine like they're supposed to and now they're all better? Or did the medicine never get given, it got sold to somebody else, it only got half taken and they ended up back in the hospital? It's the outcome issues that are the hardest to collect the data on.”*



LESSONS LEARNED

Document what has happened, what has worked, what hasn't worked and change course based on what you now know.

RELATED RECOMMENDATIONS FOR PRACTICE:

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

QUESTIONS FOR REFLECTION:

- » When will we provide opportunity for two-way feedback regarding what worked well and what didn't?
- » How can we create a “safe place” for the sharing of honest feedback, especially given our cultural differences?
- » What media will we be using to share our experiences and outcomes? What if the outcomes aren't positive or if something goes wrong?
- » What steps will we take to incorporate feedback to improve future outcomes?

DECISION POINT:

Based on assessed impact and feedback collected, determine how, where and why you will communicate what you have learned.

In Phase I, an 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.”*

CONCLUSION

This report is offered as a means of helping Catholic health organizations consider short-term medical mission trips in low-income countries — whether sponsoring a trip or supporting associates who participate in them. As a ministry committed to providing help and hope to those most in need, it is natural to share our expertise, our time and our resources with partners in the developing world. However, how we do this must be carefully assessed to ensure that intents match outcomes.

Delivering high quality clinical practice and holistic capacity building that includes educational components is a significant step toward building strong international partnerships and strengthening health systems.

To access additional information online, as well as to review the Phase I and Phase II research results, go to www.chausa.org/international.

Section II

EXAMPLES FROM PHASE I AND PHASE II RESEARCH

PARTICIPATION PERSPECTIVES

A director of international programs at a Catholic medical school who has been an organizer, volunteer and supervisor, while reflecting on the value of medical mission work for the volunteers and for the students with whom she works, said: “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 to understand some of the injustices, some of the social ills that happen because of U.S. policies that affect other countries.”

A hospital administrator and volunteer, said: “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.”

A director of international programs for a Catholic health system, said: “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.”

A president of a foundation associated with a Catholic hospital who also volunteers, said: “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.”

ORIENTATION PERSPECTIVES

A nursing faculty member at a Catholic university who is also an organizer and volunteer, said: “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 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.”

A director of international programs, Catholic health system organizer, volunteer and supervisor, said: “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 asked 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 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.”

A U.S.-based organizer, said: “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.”

PLANNING COMMENTARY

A leader of a development network on the African continent described his experiences with successful examples of planning for medical missions: “All missions must have the objective of sustainability. Missions should have specific objectives to achieve, to teach basic skills, to make a difference. The scope of missions needs to be well-defined and narrow, no matter what type of activity — even if you do multiple missions. Be specific! Give yourself outcomes and indicators you want to achieve, then decide who you want to serve.”

He explained that there is often a disconnect that occurs between visiting volunteers and international partners. “It is challenging for someone in the Western world to go and operate in a low-resource environment; prior, basic experiences working in

similar environments is a must. Also, it is an issue when a cardiologist comes to help, but the needs are actually for cholera treatment. A baseline, situational assessment needs to be conducted — you need to prioritize the needs of your international partner.”

Finally, the leader emphasized the importance of connecting with those communities that U.S. organizations are trying to help. “People have gone through medical missions many times — most did not change anything. To get it right, talk to people who will tell you their experiences and some of their challenges in order to make your own missions effective. Missions must include very good listeners; understand local issues and give ideas to help manage issues in a more professional way.”

HIGHLY REGARDED CAPACITY BUILDING

A former country health foundation leader described a successful approach to conducting medical missions.

She said, “In our partnership with Avera, volunteers ask the local community what their needs are when they visit. Volunteers bring only one backpack and everything else has to be bought local and when they leave, most is donated.”

The leader appreciated her U.S. partner’s emphasis on capacity building. “The Avera approach is also successful because of its focus on providing capacity building efforts. When they visit, they conduct

trainings. Our medical workers needed training on breastfeeding so Avera brought lactation consultants. During other trips, they brought cloth pads for menstruation and taught the local women how to make the pads in a sustainable way.”

She also highlighted what she saw as differentiating Avera volunteers from others. “Successful qualities that Avera volunteers have include asking local leadership what they need; having cultural humility, and providing continuity over the course of many short-term medical mission trips.”

HIGHLY REGARDED EDUCATION PARTNERING

Said a leader from the Sangre de Cristo Health Care Project in Guatemala: “The Sangre de Cristo Health Care Project’s success lies within its holistic approach for delivering health services to the community. They believe that health care issues cannot be addressed in silo — that several factors contribute to the health of an individual and to truly improve the quality of health, a program has to address all facets. The program has a heavy emphasis on education that includes several trainings on personal hygiene,

reproductive health, food production and agriculture. Prevention is particularly important to cure the source of the issue, rather than treat its effects.

“We didn’t just want to provide services; if we weren’t doing anything about prevention/education, we would just keep seeing the same things over and over again. Health and the environment. If the environment is not going to be healthy, we’re not going to be healthy.”

Section III

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CHA RESOURCES

CHA has a compendium of resources highlighting international outreach programs and practices. You can access all of these resources online at CHAUSA.ORG/INTERNATIONAL.

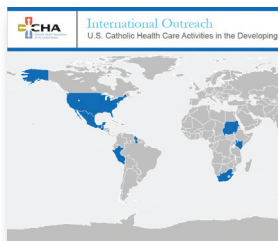
Here are a few we would like to highlight:



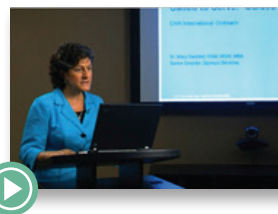
Disaster Response: Considerations for Catholic Health Care
Created with assistance from Catholic Relief Services and Catholic Charities USA, this booklet offers considerations for appropriately responding to domestic or international disasters.



The Case for International Outreach
This video makes the case for undertaking and expanding international outreach activities.



International Outreach Activities Map
Learn where U.S. Catholic health organizations are partnering in the developing world.



Called to Serve: Guided by Tradition
This video highlights the “call” to participate in the ministry of Catholic health care and, specifically, international outreach.



Video Scenarios
This online tool includes three scenarios and expert video responses for each. Ideal for group discussions and formation.



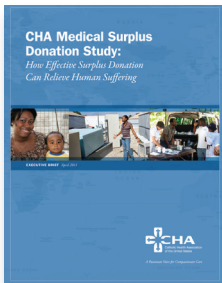
“The Heart Which Sees” — On Being Neighbor
This video explores the Biblical story of the Good Samaritan through a theological reflection that relates to today’s realities, particularly in international outreach.



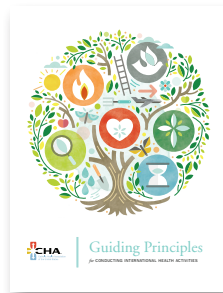
Medical Surplus Recovery, First Do No Harm
This video highlights the case for appropriate donations.



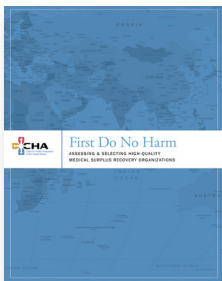
Responsible Redistribution of Medical Supplies & Equipment: Leading Practices for Hospitals & Health Systems
This resource shares high-impact leading practices every hospital and/or health system should adopt when starting or enhancing a medical surplus recovery program.



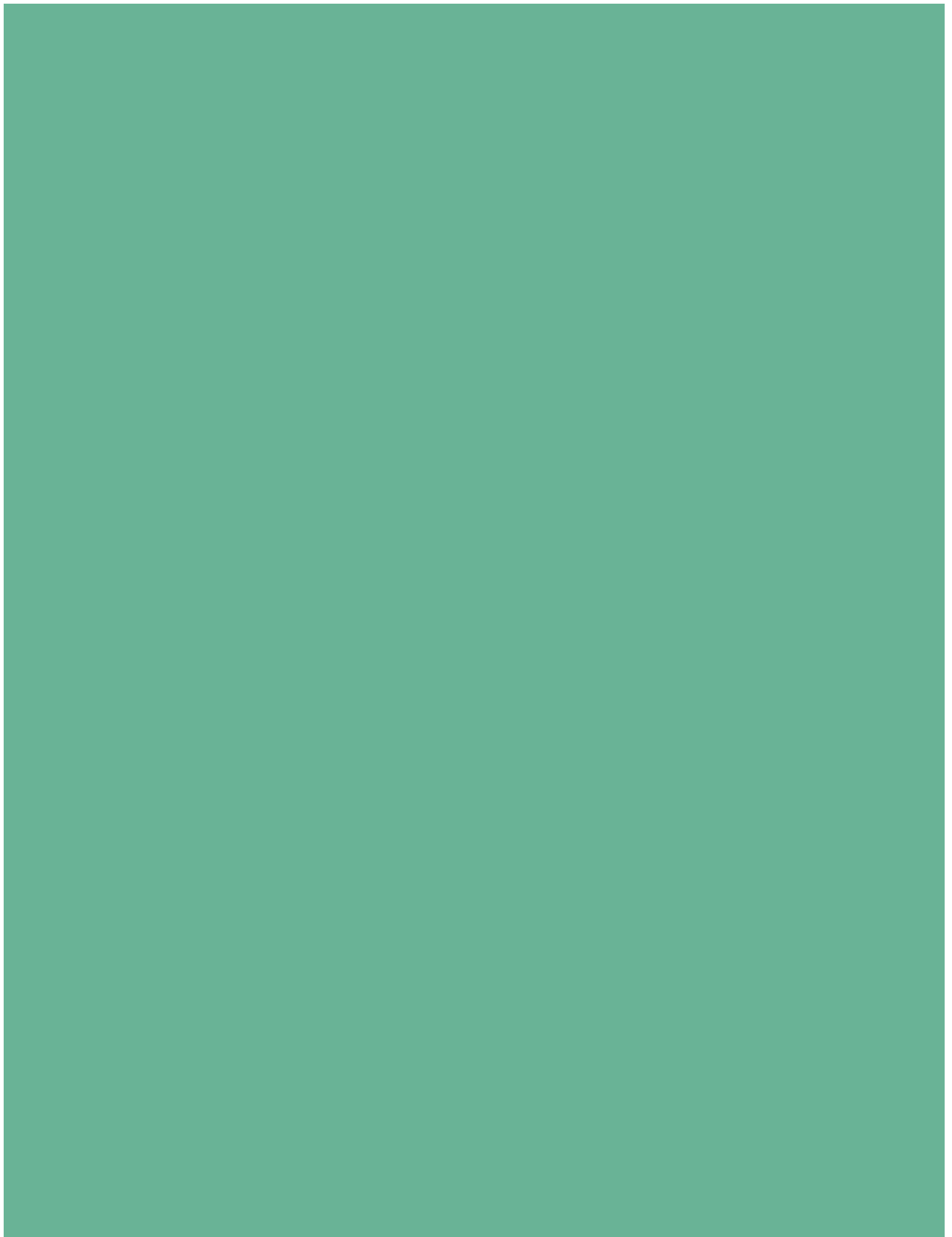
CHA Medical Surplus Donation Study: How Effective Surplus Donation Can Relieve Human Suffering
This 18-page report presents findings from a 2010 study of medical surplus donation.



Guiding Principles
CHA and its members have named six Guiding Principles for Conducting International Health Activities. This booklet offers those principles along with questions for consideration and a modern day parable to open up a robust dialogue on international programs.



First Do No Harm — Assessing & Selecting High Quality Medical Surplus Recovery Organizations
(Includes an electronic assessment dashboard tool)
This booklet is a guide for assessing the practices and effectiveness of Medical Surplus Recovery Organizations.



FOR MORE INFORMATION

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



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