

Reinventing Short-term Medical Missions to Latin America

Laura M Montgomery, Ph.D.
Professor of Anthropology
Department of Sociology-Anthropology
Westmont College
Santa Barbara, CA

Let us consider these realities. First, every country today in Latin America, except perhaps Cuba, has a segment of its population that lacks access to health care, sufficient income, and adequate living conditions to sustain good health. Second, hundreds of churches in the United States, Canada, and other wealthy countries have abundant resources and members who are physicians, dentists, nurses, and other health care workers, many of whom are willing to use their vacation times and their own funds to transport themselves, medical equipment, and medications to Latin America in order to provide free health care. Third, for many decades, health care has been a vital part of the mission of the Christian church. Fourth, traveling abroad and global communication are easier and cheaper than ever before. Fifth, every year short-term medical missions are an increasingly popular ministry for churches and para-church organizations. Given these realities, what could be problematic about the thousands of Christian, volunteer medical workers traveling to Latin America to provide health care to those in need?

It is critical to the Body of Christ that Christians cross cultural and national boundaries to share resources and life in Christ. Furthermore, the provision of health care has been an indispensable part of Christian mission, and service to the poor is at the heart of the work of the church. However, we have learned too much about inter-cultural missions and methods for improving health to ignore that fact that short-term medical missions, as currently constituted, are neither the most appropriate nor the most effective means of providing health care or improving health status, *regardless of the good intentions of those who plan, support, or participate in them*. In fact, they often reflect little understanding of the principles of health care that have proven to be effective as well as an immature theology of biblical servanthood. Sadly, short-term medical missions represent a step backwards from the knowledge and wisdom gained from decades of long-term missionary efforts and development work. These missions consume too many financial resources and too much expertise and time to produce results that are often insignificant or negative. The needs are too great. Short-term medical missions must be reinvented, and the encounter between those who go and those who receive must be mutually beneficial and collaborative, a theme that runs through many of the articles in this volume.

First, I will review some of the problems and challenges of short-term medical missions to Latin America in light of the principles of primary health care. Finally, I will offer some thoughts about the way in which these missions can be reinvented to more effectively improve the health status and access to health care of those they seek to serve as well as more clearly reflect a witness of biblical servanthood. My comments here are based both on my own observations and research projects as well as collaborations with others in three Latin American countries.

In 1978, the International Conference on Primary Health Care (PHC) held in the former Soviet Union and sponsored by organizations such as the World Health Organization (WHO) and UNICEF produced the Alma-Ata Declaration. This declaration holistically defined health as "...a state of complete physical, mental and social wellbeing, and not merely an absence of

disease or infirmity...” (Declaration of Alma-Ata, 1978). It defined primary health care (PHC) as:

...essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. [Declaration of Alma-Ata, 1978]

The emphasis of PHC is much broader than a curative model; it includes health education, provision of clean water and sanitation, and a focus on public health among other services. Furthermore, PHC is holistically integrated with other aspects of socio-economic development.

Twenty-five years after Alma-Ata, the Pan American Health Organization (PAHO) affirmed that PHC is a valid and effective strategy to improve health in the Americas (PAHO, 2003). Although PHC has been unequally and incompletely implemented in all parts of the region and social inequality has grown, PHC has achieved important gains in health:

Infant mortality has decreased by about one-third, all-cause mortality has declined in absolute terms by 25 percent; life expectancy has increased, on average, by six years; deaths from communicable diseases and diseases of the circulatory system have fallen by 25 percent; and deaths from perinatal conditions have decreased by 35 percent. [PAHO/WHO 2007: 17]

Nonetheless, PAHO also points out that health systems throughout the Americas face challenges such as urbanization, aging populations, HIV/AIDs, chronic disease, violence, disability, environmental degradation, and vulnerability to natural disasters. Furthermore, “...persistently overburdened health systems and widening inequalities threaten gains already made and endanger future progress towards better health and human development” (PAHO/WHO 2007: 17). In this context, PAHO has called for a renewal and a re-articulation of the values, principles, and elements of a PHC program in the Americas. Below are the characteristics of PHC most relevant to our present discussion. PHC:

- is oriented towards quality;
- is sustainable;
- involves individual and community participation;
- is integrated with other activities of human development;
- is culturally acceptable;
- includes referrals to more specialized care as necessary;
- includes services of health promotion and prevention, early diagnoses, and self-care;
- provides curative, rehabilitative, and palliative care;
- is focused on populations;
- provides appropriate and effective care. [PAHO/WHO 2007: 23-48]

Throughout the description of these characteristics, PAHO makes it very clear that PHC programs must be based on evidence and reflect best practices. A major advantage of PHC is that:

international evidence suggests that health systems based on a strong PHC orientation have better and more equitable health outcomes, are more efficient,

have lower health care costs, and can achieve higher user satisfaction than those whose health systems have only a weak PHC orientation. [PAHO/WHO 2007:14]

Since many short-term medical teams claim that some of their primary, if not exclusive, goals are to increase access to health care for the poor, to improve health status, and to “make a difference,” PHC should inform the planning, funding, and implementation of their efforts. Because of the proven benefits, the rationale for and effectiveness of short-term medical missions should be evaluated from the perspective of PHC.

Lack of information is a serious impediment to a thorough evaluation of short-term medical missions. While many teams claim that they help the poorest of the poor, save lives, or improve the health status of communities, they or their supporters typically do not gather the type of information that is necessary to validate their claims. Rather, these groups frequently present “evidence” that consists of the testimonials of participants, the number of patients seen, the surgeries done or teeth extracted, or the expressions of gratitude by patients. Yet, Kurt Ver Beek’s (2006) research on participants of short-term mission teams suggests that even claims of “life changing” impacts on their own lives are, at best, modest in the long term. All of this information is interesting and important, but it does not provide a valid assessment of the impact of these missions on health status or access to health care. Appropriate data would, at minimum, include descriptions of the common and most pressing health problems in the community, the circumstances that contribute to these problems, existing health services, and both short-term and long-term outcomes of the care provided. Unfortunately, some groups do not even collect or maintain records on the patients they see much less make them available for future teams or local providers for continuing care. At the very least, we should demand that these teams gather the appropriate data to verify their impacts and claims. This absence of data clearly does not meet the requirements of PHC.

I have been working with a student and two missionary physicians to gather this type of information about short-term medical missions (also referred to as medical brigades) in Mexico and the Dominican Republic respectively. The teams that we have studied largely focused on general medical and dental care. I have also observed a medical brigade to Mexico that provided ophthalmic care, principally removal of cataracts and one in Honduras that performed plastic surgeries, often cleft-palate repairs, and dental care. These teams of licensed physicians, dentists, and nurses as well as other helpers were completely equipped to provide care for a few days up to one or more weeks. They differed in their Spanish abilities, understanding of cultural differences, health promotion activities, training for local providers, and coordination with local services. While these groups represent only a tiny fraction of the hundreds of groups that travel to Latin America each year, promotional materials available on the internet and anecdotal evidence from similar teams suggest that they are representative. All of these short-term mission teams depended upon volunteer labor, represented a curative model of care, and used large quantities of financial resources to transport participants and equipment to the sites. Now, I would like to discuss some of the ways in which the characteristics of this type of medical mission conflict with the principles of PHC and how they can unknowingly undermine the health status or access to health services of a community although they might help individual patients.

The impact of the volunteer labor of all types of short-term missions on local economies is a major concern that remains largely unaddressed, especially in a region like Latin America where un- and under-employment are chronic problems. Presently, these problems affect professionals as much as low-skilled workers as social sector spending has been contracting in

the majority of Latin American countries during the last two decades. According to the World Health Organization, only five countries in Latin America have a critical shortage of health care workers including physicians, nurses and midwives (WHO 2006). Where no critical shortage exists, the problem is often a mal-distribution of providers, because they seek employment in large cities where facilities, salaries, and living conditions are better. Compounding this problem, many countries are facing a loss of health care workers through emigration, because salaries and opportunities in their own countries are limited. Given the growing demand for health care workers in the United States, many countries in Latin America are losing healthcare workers to the U.S. (PAHO/WHO 2006). Mullan (2005) reports that physicians from Argentina, Bolivia, Colombia, Costa Rica, the Dominican Republic, Mexico, Peru, and Panama emigrate mostly to the United States, the largest number from Mexico. The nursing shortage alone in the U.S. could absorb “90 percent of the total number of nurses in Latin America and the Caribbean” (PAHO/WHO 2006: 5). While this might seem an argument for the necessity of short-term medical missions, foreign volunteer workers are, at best, a temporary solution and, at worst, one source of the problem. As Apolos Landa, a Christian physician who has worked with the Luke Society in Latin America for many years, poignantly observes, “the millions of dollars that are laid out to send physicians from the U.S. to third world countries would cover the salaries of under-employed physicians in these countries—physicians who need work and already understand the culture and language of those they serve” (2006: 2; my translation). Moreover, health workers who must live from their salaries are unable to compete in the long-term with the free care offered by volunteers. In addition, local workers are unable to provide such a large volume of free or follow-up care to the large numbers of patients who the short term groups have treated, even though that has been the expectation of some visiting teams. Furthermore, some short-term teams are duplicating health services already locally available, though those services sometimes go unnoticed by the visitors (Priest, personal communication). Free medications or materials and volunteer labor to construct clinics pose the same problems. Frankly, the visitors would not be able to do the same in their own communities. Even in situations where volunteers construct clinics and send medical teams to work in them on a regular, though short-term basis, natural disasters, changing donor priorities, and political conflicts may easily make it impossible for those groups to return. Furthermore, with the exception, perhaps, of some types of highly specialized care, adequate health care services are those that are regularly available locally and are locally sustainable.

It is unclear as well that the short-term medical brigades provide services mostly to patients who have no or limited access to health care or who are unable to pay; in fact, the data we have collected suggest the contrary. All of the teams discussed here worked in established hospitals or clinics; teams are typically not working in a vacuum. Interview data from one case in Mexico found that the majority of patients had seen a physician within the last six months (Montgomery, Dohn, M. , Dohn, A., and Holshausen 2006). Landa has observed:

“almost none of those seeking a [medical] consultation have a health problem when the [medical] brigade arrives except those with chronic cases (tumors, deformities, and degenerative problems). So they see the [visiting medical team] anticipating a possible problem...or to stock up on medication or simply from curiosity. [2006:2; my translation]

In the Dominican Republic, Drs. Michael and Anita Dohn, have noted that some patients are seeking second opinions from the visitors, something which the visiting physicians do not always

recognize (Dohn, M. personal communication). At times a patient has suspended a critical treatment if the diagnosis or treatment is different from that prescribed by a local physician. When these teams work without an understanding of how the patients are approaching them, the volunteers can unwittingly generate distrust in local providers. In the example from Honduras, the Honduran physicians were concerned that some patients were waiting to seek care until the “better” physicians from the United States arrived. Landa (2006: 3; my translation) also notes that patients begin to question, “Why pay for local services and receive generic medications when the ‘gringos’ give me brand-names and charge nothing?”

Some teams attempt to provide some form of continuing education to local health care providers or to demonstrate new techniques and procedures. Again, the reality can diverge from the ideal. Given that health care in the United States greatly depends upon technology, it can be difficult to transfer to other places that lack the same resources. Furthermore, Landa (2006) questions the assumption that health problems can only be treated and resolved by physicians and technology. I observed with the ophthalmic team in Mexico that the new treatment the visiting ophthalmologist was describing required laser equipment too costly for the Mexican ophthalmologists or the public hospital where the lecture took place. Ironically the hospital, at that time, did not have sufficient funds to buy some basic medications, because the government had reduced its budget. Even in the United States, we are discovering that technology-driven health care is unsustainable. Again, one goal of PHC is that individuals and communities have access to local, economically sustainable care. As previously suggested, would not the communities where short-term medical teams work be better served if the funds they used would be used to pay the salaries of local workers, to subsidize care for those who are unable to pay, or to provide incentives for local practitioners to work in rural areas or underserved regions? Even a system where national physicians and other health care providers regularly rotated to these areas while continuing to live in larger cities would be preferable to intermittent care by foreign volunteers who do not speak the language or understand the culture.

The model of medical care these groups provide is curative rather than promotive, preventive, or rehabilitative for three principal reasons. First the educational focus of most physicians and nurses in the United States continues to be curative. Second, health promotion and preventive or rehabilitative care require time, something these teams do not have. Third, the volunteers frequently do not have the language abilities for this type of care or to establish an effective therapeutic relationship. The use of translators and interpreters is problematic and complicated not to mention inefficient. When some groups do attempt to provide health education, they often use translated materials from the United States or other wealthy countries that, many times, are inappropriate to the cultural context. Teams often do not recognize that poverty, more than a lack of knowledge or motivation, prevents patients from engaging in preventive behavior—even tooth brushes and tooth paste cost money. Many of the problems

treated by these short-term teams such as parasite infections, dehydration, diarrhea, and some respiratory infections result from the lack of clean and sufficient water, poor sanitation, and substandard living conditions. Frequently, one time curative care only merely delays illness and death instead of improving health in an on-going manner (Townsend cited in Montgomery, 1993). Patients with chronic conditions such as cardiac disease, hypertension, diabetes, and chronic pain often attend the clinics of short-term medical teams. The effective treatment of these diseases requires continual care, education, and supervision; again something these groups by their very design are unable to give. If for no other reason, the visitors must consult and collaborate with local providers when treating these individuals. Although surgeries and dental treatments are necessary, they do not prevent health problems from occurring or re-occurring. For example, low-cost prenatal supplements would largely eliminate problems such as cleft palates and greatly reduce the need for expensive surgical repair. PHC recognizes curative care as only one element of a health care system, and to be effective it must be well integrated and coordinated with other types of health care and other development activities that respond more fully to socio-economic, cultural, and environmental conditions.

The short duration of the medical brigades contributes to a series of problems that work against the principles and goals of PHC. For one, the volunteers are not present to take care of the side effects of medications that they have prescribed or complications of surgeries they have performed. Rarely, do they gather information to determine the number of either positive or negative effects that occur after they have left the site. Although experience with patients from the U.S. or Europe may demonstrate that a procedure or drug may have few negative outcomes, much care needs to be exercised when extrapolating from living conditions and resources that are very different from those where the short-term teams operate. In the Dominican Republic, our follow-up interviews with patients approximately one month after they were seen by two short-term teams found that six per cent (of a total of 167 patients we were able to follow) experienced negative side effects from the medications received from the teams. The problems included minor consequences such as an upset stomach and more serious ones such as an irregular heartbeat. Some of the patients then needed to seek care from local providers; the free care ended up costing these patients time and money. Though the rate of side effects in this case was not excessive, the volunteers were not there to deal with them. In one instance, a team dispensed a medication without instructions in the local language, a practice which is indefensible. Distributing drugs unfamiliar to local practitioners also makes it more difficult for them to treat the ensuing problems.

Volunteers who will spend little time in a community have little incentive to learn about the local culture, the people, and the health conditions to a depth necessary to provide effective health care. Given such a short time in the country and the biases of biomedical educations, all of the groups functioned with superficial knowledge of the effect of culture on the health

behaviors, beliefs, and explanations. Another finding from our work in the Dominican Republic was that 36% of the 167 patients interviewed one month after their visit with the teams reported that they shared the medications they received with at least one other person, including an infant. They shared all types of medications from aspirin to antibiotics. This pattern of sharing reflects cultural patterns of social relationships. Yet, the brigades were unaware of this behavior. While the effects of sharing medication are not always negative, the possibility of overdose or the development of resistant bacteria is very real and serious.

Lastly and more importantly, although the care provided by short-term medical brigades is free, it is not cost-free. The volunteers donate their time, but spend significant sums for travel, food, and lodging. Again, little information is available about the amount of money spent. Information from the internet about organizations that sponsor these missions indicates that the average cost for each participant ranges between \$1000-\$3000 U.S. dollars, depending upon the location and duration of the program. Using the smaller amount, the cost to send a group of ten to provide a week of free care would be \$10,000. Assuming that the group sees 250 patients during the week, a typical number, the cost of each visit is \$40. While this is less expensive than in the United States, it is more than twice the charge for a consult with a private physician in a private hospital in a large Mexican city. I recognize that this analysis is imprecise. Nonetheless, a cost-benefit analysis of short-term missions is sorely lacking. If a patient only needs a common analgesic for a sore throat or headache, again not uncommon problems seen by these medical teams, then they have spent a significant amount of money when a local physician, nurse, or other health worker could have provided the same at much lower cost. Another example from the Dominican Republic illustrates the importance of analyzing the costs of such programs: the money that one group spent on T-shirts for themselves would have funded a community first-aid station for one year (Dohn, M., personal communication.)

Another way in which short-term medical missions consume resources is when they divert the time and efforts of local services to organize their visits; a concern echoed by Landa (2006) and many others about short term missions in general. In Honduras, when the teams of surgeons treated large numbers of patients, the nurses and other hospital personnel had to take care of these patients on top of their normal workload. Enormous amounts of time and energy are frequently dedicated to planning for these groups. I know of no study of these impacts, though Landa (2006) reports one situation in Latin America where the director of a clinic for poor families spends three months every year coordinating and hosting medical brigades from the U.S. Local practitioners have also commented to me that this is the price they feel they must pay in order to receive the support of these groups. We must ask: what type of Christian servant hood is this?

The sending organizations and churches believe that the direct participation of their members will increase their ability to raise funds. Again, this may be more of an assumption

than a reality. Ver Beek's research (2006) suggests that increases in giving are often very modest and that sometimes donations decline. Even if donations increase, are the benefits received by the participants greater for themselves than for those they seek to serve? If in reality the improvements in health and access to health care they bring are small or negligible, regardless of the benefits to participants, is it worth continuing with this model? Perhaps circumstances and conditions exist where short-term medical missions are an appropriate model of health care, but first we need clear evidence to inform us about what these circumstances would be.

Many of the problems presented here would be avoided if short-term medical missions were more deeply grounded in a mature theology of servanthood that reflected the incarnation of Jesus Christ (Philippians 2). This does not mean that the motivations of these missions are insincere; to the contrary their participants truly desire to make a positive impact on health as well as spread the Gospel. But biblical servanthood is profoundly sacrificial, done in humility and with empathy, and clearly focused on the needs of those being served rather than of those doing the service. However, it is difficult for any type of short-term mission team to orient programs in this way when they know little about those they hope to serve; moreover, such an orientation would preclude a "short-term" approach. While some participants may feel they have given up their vacation time and money, lived in more humble or "primitive" conditions than they do back home, or endured gastro-intestinal ailments, in reality these are rather small sacrifices that most can make for a short period of time. The greater demand is to lay aside one's own preferences, superiority of "expertise," and even one's desire to be needed to meet, in this case, the health needs of others. As Miguel Ángel Palomino incisively comments, "Mission without renunciation is not mission, no matter if it is short-term or long-term" (Palomino, 2006: 5; my translation). It means taking the time to learn the language and the culture, to gather information, and to encourage and engage in open and frank dialogue and collaboration with local churches and health care providers. But if we believe that we, North Americans, or, at least, so many of us must be present in the clinic or the hospital to serve others, then we are not acting in the best interests of those we seek to serve. Yet a common rationale that members of short-term teams offer is that their home churches or other sponsors would otherwise not be interested or involved in supporting local efforts without their direct participation. However, this assumption seems to take a very secular view of humanity that assumes we can only act out of our own self-interest; we sell short the power of the Gospel. Whether we recognize it or not, the structure of short term missions itself socializes their participants into a particular model of mission and service. Is it impossible for churches to model, educate, and disciple Christians into an incarnational view of servanthood informed by all we have learned about effective cross-cultural missions and programs of development?

The purpose here has not been merely to critique short-term medical missions but to call those who plan, support, and participate in them to reorient their efforts towards building health care capacity in local communities that would improve health status and access to health care, better imitate the servanthood of our Lord Jesus Christ, and strengthen His body. Indeed, the church can be a very effective location for health education and promotion, because, as communities, they can support and reinforce habits of good health (McElmurray, Marks and Cianelli, 2002). An orientation towards PHC would allow us to reinvent our efforts through collaboration and coordination that gives attention to the short-term as well as the long-term needs and requires more holistic and integrated solutions. The challenge for Christians in the Americas is to act in solidarity in order to serve the health needs of the poor in a manner that reflects international norms of health care and a biblical model of service.

References

Dohn, Michael. 2004. Personal communication.

International Conference on Primary Health Care. 1978. Declaration of Alma-Ata. USSR, 6-12 September 1978. http://www.paho.org/English/dd/pin/alma-ata_declaration.htm. Accessed 24 July 2006.

Landa, Apolos. 2006. "Misiones médicas a corto plazo: Experiencia de San Lucas Intl. . Misiones de corto plazo: Experiencias y perspectivas Latinamericanas. Lima, Peru, 2-4 de agosto, 2006.

McElmurray, Beverly, J., Beth A. Marks, and Rosina Cianelli. 2002. Primary health care in the Americas: Conceptual framework, experiences, challenges and perspective. Organization and Management of Health Systems and Services. Washington, D.C.: Pan American Health Organization

Montgomery, Laura M. 1993. Short-Term medical missions: Enhancing or eroding health? *Missiology: An International Review* 21(3).

Montgomery, Laura, Michael Dohn, Anita Dohn, and Kirsten Holshausen. 2006. "Circulating medication, second opinions, and quality of life: An empirical assessment of short-term medical missions." Annual Meeting of the American Anthropological Association. November, San Jose, California.

Mullan, Fitzhugh, M.D. 2005. "The metrics of the physician brain drain." *New England Journal of Medicine* 353:1810-18 (October).

Palomino, Miguel Ángel. 2006. "Misiones de Corto Plazo": Reflexiones desde América Latina. *Misiones de Corto Plazo: Experiencias y perspectivas Latinamericanas*. Lima, Peru, 2-4 de agosto, 2006.

Pan American Health Organization. 2003. Primary health care in the Americas: Lessons learned over 25 years and future challenges. 132nd Session of the Executive Committee, CE 132/12 (English; Original in Spanish). <http://www.paho.org/English/GOV/CE/ce132-13-e.pdf>. Accessed 24 July 2006.

Pan American Health Organization/World Health Organization. 2006. Human resources for health: Critical challenges for the region of the Americas. CD47/10 (English. 47th Directing Council, 58th Session of the Regional Committee. <http://www.paho.org/English/DPM/SHD/HR/CD47-19-eng.pdf>. Accessed 24 July 2006.

Pan American Health Organization/World Health Organization. 2007. Renewing primary health care in the Americas. A position paper of the Pan American Health Organization/World Health Organization. <http://www.paho.org/English/AD/THS/primaryHealthCare.pdf>. Accessed 12 May 2007.

Priest, Robert. 2006. Personal communication.

Ver Beek, Kurt Alan. 2006. "The impact of short-term missions: A case study of house construction in Honduras after Hurricane Mitch." *Missiology* 34(4):477-95.

World Health Organization. 2006. Countries with a critical shortage of health service providers (doctors, nurses, and midwives). *Global Atlas of the Health Workforce*. <http://www.who.int/globalatlas/default.asp>. Accessed 24 July 2006.