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**SHORT-TERM MEDICAL MISSIONS: A TOOL FOR UNDERSTANDING  
DAMAGING PRACTICES, BEST PRACTICES, AND PROGRAM  
EVALUATION**

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## ABSTRACT

Short-term medical missions (STMMs), defined generally as short-length trips (ranging from 1 week to several months) where participants from one country travel to another country to provide medical or health-related care, have grown in popularity and number in recent years. As STMMs have grown, the global community has increasingly identified their damaging practices (which can result in reduced benefit to host communities or actively cause harm) and best practices (which can result in enhanced benefit to both participants and host communities). While best practice principles are becoming more common in the field and in the literature, many STMM programs continue to perpetrate problematic damaging practices. Thus, prospective STMM participants who want to contribute in a meaningful and beneficial way must understand damaging vs. best practice principles, as well as how to apply those principles in selecting a program. However, it remains difficult and overwhelming for prospective STMM participants to find information on damaging vs. best practices, and it is even more difficult to know how to apply that knowledge in evaluating which STMM programs are the most beneficial. This project reviews the literature and consults with field experts to create an accessible yet detailed tool for prospective STMM participants to more easily learn about these STMM practices and know how to apply that knowledge in evaluating prospective programs, including sections on mindsets, damaging practices, best practices, and strategies for program evaluation (including a 2-page program evaluation instrument).

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## INTRODUCTION

A ‘short-term medical mission’ (STMM) refers to a short-length trip or expedition (ranging from 1 week to several months) where participants from one country travel to a host community in another country to provide medical or health-related care (typically from a high-income country (HIC) to a low- or middle-income country (LMIC)). These expeditions are sponsored and organized by a variety of organizations, from for-profit companies to nonprofit organizations to religious groups. They have been growing in number and popularity over the last few decades (Lasker 2018), attracting both experienced healthcare professionals and participants with little health experience. Medical student participation in STMMs is especially growing, and medical schools often encourage students to participate (Martiniuk 2012; Wilson 2012).

STMMs and other short-term humanitarian expeditions are often viewed as beneficial experiences for both the participants and the host communities. Benefits to the host communities might include extra hands and energy, equipment and resources, learning and capacity building, health improvements, patient satisfaction, financial/employment benefits, social capital, etc. Benefits to participants can include the opportunity to learn about and experience new cultures, learn new skills and health strategies/information, travel, develop and practice community engagement values, build social capital, etc. (Lasker, 2016).

However, these mutual benefits are not assured—as STMMs have grown in popularity and in number, the global community has increasingly recognized common STMM practices that reduce benefits, or in some cases, cause harm (Dupuis, 2004; Green et al., 2009; Guttentag, 2009; Kraeker & Chandler, 2013; Lasker, 2016; Loiseau et al., 2016; Martiniuk et al., 2012; Roberts, 2006; Silberner, 2019; Wilson et al., 2012). As such, experts, researchers, and people working in the field of global health are increasingly criticizing STMMs and raising concerns about specific STMM practices. At the same time, many are identifying STMM best practices to solve these harmful practices and instead, maximize STMM programs' mutual benefit (Dupuis, 2004; Green et al., 2009; Kraeker & Chandler, 2013; Lasker et al., 2018; Loiseau et al., 2016; Martiniuk et al., 2012; Wilson et al., 2012).

The following sections briefly detail the major damaging practices and best practices currently agreed upon in the literature.

### Damaging Practices

Damaging practices are those that cause harm to a host community or diminish the benefit of a STMM project. There are seven overarching damaging practices reviewed in this section: avoiding partnership and mutuality, completing unsustainable projects, using unskilled and unethical labor, promoting dependency, propagating Western dominance and superiority, completing projects with a limited impact, and avoiding learning and critical reflection.

The first damaging practice is a lack of partnership and mutuality, which encompasses several problems. When a STMM does not create a partnership with the host community (or when it does, but does not consult with community members about needs and solutions), its project may not address local needs or desires, becoming unneeded, ineffective, duplicative, or even damaging (Dupuis, 2004; Kraeker & Chandler, 2013; Roberts, 2006). A lack of partnership with the host government and healthcare system can diminish project effectiveness and undermine capacity building (Martiniuk et al., 2012; Wilson et al., 2012). Additionally, if a STMM does create a partnership with the host community but does not cultivate a mutual or equitable partnership, they may prioritize foreign participants at the expense of the host community, be disrespectful towards hosts, create a false hierarchy of 'helpers' vs. 'receivers', and

de-emphasize mutual learning—all of which can hurt project effectiveness and reinforce systems of dominance (Green et al., 2009; Lough et al., 2012; Rosenburg, 2018). This also includes when participants exhibit a lack of cultural awareness, which can undermine mutual respect and jeopardize healthcare quality (Green et al., 2009; Kraeker & Chandler, 2013).

Another problematic STMM element is a lack of sustainability. STMM projects may be unsustainable if they provide no options for follow-up care after their participants have left or do not work alongside a long-term intervention that will create opportunities for healthcare outside of the STMM (Green et al., 2009; Lasker, 2016; Martiniuk et al., 2012). STMMs also often focus on immediate needs over root causes, which creates a short-term as opposed to long-term effect (Green et al., 2009). Additionally, participants may not continue community engagement work after a STMM, which can be another manifestation of short-term impact.

Under unskilled/unethical labor, STMMs may allow participants to perform medical procedures for which they are untrained, creating a major ethical problem (Dupuis, 2004; Guttentag, 2009; Lasker, 2016; Wilson et al., 2012). They may also bring unskilled participants, who can perform unnecessary work, perform work incorrectly, or take local jobs (Guttentag, 2009; Lasker, 2016). In addition, STMMs may provide poor-quality care, due to the factors listed above (e.g. short-term, lack of cultural awareness, unethical participant practice, etc) (Guttentag, 2009; Lough et al., 2011; Wolfberg, 2006).

STMMs may also promote dependency. This includes promoting the ideology that Western knowledge and methods are superior and should be relied on instead of host community practices (Guttentag, 2009). STMMs may also create dependency by not working to build host community capacity or by competing with local healthcare professionals, leaving host community members dependent on outside help for healthcare instead of bolstering the host infrastructure (Guttentag, 2009; Lasker, 2016; Lough et al., 2011).

In a similar vein, STMMs may propagate the harmful and false ideologies of Western superiority (the idea that Western knowledge/methods/people are superior) and white saviorism (where a white person 'rescues' a person of color from their own situation) (Windholz, 2017). STMMs may act as agents of neocolonialism, by bringing Western ideas to a host community while extracting benefits (e.g. travel, satisfaction) for Western participants (Lasker, 2016). Participants may reinforce their stereotypes about people from other countries, rationalize the poverty they see, and in extreme cases, may even abuse their power to directly harm host community members (Guttentag, 2009). STMMs and participants may also focus on the host community's needs over their strengths, while focusing on their home community's strengths over its needs, perpetrating the idea that their home community is 'better' (and enabling neglect of domestic problems).

When STMMs engage in any of the damaging practices above, their beneficial impact on the host community is strictly limited. Given a limited impact, STMMs may be inefficacious, as large amounts of money are spent on travel and accommodations (which may be more effective if invested directly into the project) (Lasker, 2016). STMMs may also conduct no evaluation of their projects' success, making it difficult to quantify impact and to improve (Lasker, 2016).

Finally, STMMs and participants may not emphasize learning and reflection on the issues above, as well as the systems of inequity and root causes of the problems they are trying to address (Palacios, 2010)—which makes it easier to commit damaging practices and to see STMMs as an acceptable solution for global healthcare problems, despite their short-term nature and other flaws.

## Best Practices

Fortunately, there are also widely-recognized best practices to counter the issues above. These include true partnership and mutuality, a focus on capacity-building, an emphasis on sustainability, a commitment to challenge Western superiority, and critical reflection.

Firstly, STMMs can cultivate equitable, mutual partnerships with the host community. This includes using community-driven needs assessments to define projects and solutions, emphasizing mutual respect and learning between participants and host community members, practicing cultural humility, demonstrating knowledge of the host language, and specifically defining participant roles (including never allowing untrained participants to practice medical procedures for which they are unlicensed) (Lasker, 2016; Lasker et al., 2018; Loiseau et al., 2016; Wilson et al., 2012). All of these things strengthen the partnership between the STMM and the host community, leading to better outcomes, more successful projects, and greater long-term impact.

STMMs can also focus on building host community capacity through a long-term presence, attention to root causes, effective knowledge-sharing, and working together with the local government and health care system (Lasker, 2016; Wilson et al., 2012). Capacity-building lessens issues of dependency, maximizes a project's benefits, and makes a project more long-lasting and sustainable.

In addition, sustainability is better achieved when STMMs bring participants on longer trips (the longer, the better) and when a STMM is one facet of a larger, long-term, on-the-ground program in the host community (Dupuis, 2004; Lasker, 2016; Lasker et al., 2018; Loiseau et al., 2016; Roberts, 2006; Wolfberg, 2006). This way, the short-term participants are but one element of a bigger program to improve healthcare in the area—which minimizes many of the detrimental impacts that come with a short-term intervention (i.e. dependency, lack of follow-up, etc). STMMs can also continuously collect data and evaluate their programs, working towards continual improvement and growth (Lasker, 2016; Wilson et al., 2012). STMMs and participants can learn about and work to address root causes and larger systemic causes, which has a greater long-term impact than immediate needs work. Participants can also continue their community engagement after a STMM, ensuring sustainability on the participant side as well as the host community side.

STMMs can challenge Western superiority and dominance, including white saviorism, through a myriad of positive practices such as equitable partnerships, building relationships, centering the host community in project narratives or photos, challenging assumptions, focusing on a community's strength, avoiding oversimplification, and confronting power dynamics, to name a few (Lasker et al., 2018; NoWhiteSaviors, n.d.; Windholz, 2017).

Finally, STMMs and their participants can reflect on issues surrounding STMMs (including all the above information), systemic influences and root causes, and their own personal impact as part of the project (Sutcliffe, 2010). Continual learning and reflection during all stages of a STMM can help to ensure that participants and programs behave in line with best practices and ethical principles. This also can help to contextualize STMMs in the larger global fight for equity.

## Project Goal

Unfortunately, prospective participants who are interested in participating in an ethical, beneficial STMM may find it difficult to find the foundational information on damaging practices vs. best practices because it is densely academic and inaccessible. Much of the STMM information that is accessible (e.g. articles, blogs) is vague or lacking breadth.

Additionally, a gap exists when it comes to understanding how to translate knowledge of damaging vs. best practices into evaluating a particular STMM program. With so many STMM programs available, it can be overwhelming and difficult to try to sort out which programs use best practices, especially as a prospective participant unfamiliar with the field.

This project aims to fill that gap by creating a tool that is accessible while still providing an in-depth overview of STMM practices as well as how to evaluate STMM programs to determine whether they are utilizing best practices. The tool will be specifically geared towards students or other medically-untrained prospective participants, because there is high interest in STMM participation in this demographic coupled with a high possibility of perpetuating damaging practices (e.g. through a lack of knowledge or practicing unethically).

## **METHODS**

The research conducted for this project was primarily exploratory. Literature reviews were conducted through database exploration and the snowball method of sifting through relevant bibliographies. Additionally, research included generic internet searches for non-academic sources of information, including blogs, articles, and service-abroad websites. The research also involved interviews with various professionals in the field of global health, including nonprofit staff and University of Utah faculty who are involved in STMM projects. Information from all these sources was combined and collated into categories to define main best practices vs damaging practices, as well as strategies for evaluation of programs. The information was then synthesized into a graphic tool encompassing the most essential points highlighted by the research, including examples, links to further reading, and an evaluation instrument.



## **RESULTS**

The project yielded a tool for prospective STMM participants, especially students, to use to learn about STMM quality and evaluation. The tool is divided into four sections: mindset, damaging practices, best practices, and program evaluation. Within each section, there is an executive summary, followed by longer, more detailed information on each practice or subset of information. Sections also include real-world examples, quotes, pop-out boxes on additional related subjects, and resource banks with links to other readings and content. The tool uses conversational language in order to remain accessible. Additionally, the final evaluation section includes an evaluation instrument that can act as a 'rubric' in evaluating program quality. The tool is included below in the Appendix.

## DISCUSSION

The purpose of this tool is to provide prospective STMM participants, especially students or other participants without medical skills, with a basic overview of STMM practices and principles. These principles are increasingly agreed upon in the field and in the literature, but as a first-time, prospective STMM participant, one 'doesn't know what they don't know'. This tool combines information from many sources to provide a broad, foundational overview for prospective participants to find context and a basic understanding of what they should be looking for in a STMM. In addition to combining information from many sources, the tool makes it accessible to a non-academic audience—much of the literature on STMMs is academic, overwhelming (e.g. requires reading several long, dense papers), and/or published by journals that require a subscription. Articles that are more easily accessible, such as newspapers or blogs, tend to only touch on one or a few STMM practices, and thus also necessitate broad research and reading to get an understanding of all the issues. If it is too difficult for prospective participants to learn about these issues, they may decide not to participate or may participate on a STMM that does not follow best practices. This tool addresses this issue, making it easier for prospective participants to find this information by presenting it an accessible way while still including a broad range of STMM practices to provide a solid informational foundation for newcomers.

Additionally, and perhaps most importantly, the tool includes ideas for concrete ways to assess the quality of any given STMM. Such evaluation tools are often overlooked—while there is a growing amount of information on damaging practices and best practices, it's difficult to find guidelines on how to determine whether a program uses best practices or not. Even when participants understand best practices, it can be difficult to know how to determine whether a program uses best practices or find a high-quality program, especially given the overwhelmingly large number of programs that exist and the ways in which program websites, marketing, and staff work to make their program look as high-quality as possible in order to attract participants and donors. Thus, the evaluation section of this tool, which provides specific strategies, places to look, and questions to ask, fills an important gap and enables prospective participants to translate their knowledge into beneficial action.

Summed up, this tool enables prospective participants to be more informed consumers when it comes to STMMs—better understanding the issues and how to apply that knowledge when looking at programs—so they are able to make a more informed decision about whether and how to participate in a STMM.

The tool can be used by any prospective STMM participant, in addition to anyone interested in learning more about STMM principles and evaluation (including past participants, donors, programs, etc). However, the primary barrier to the use and implementation of the tool is a lack of awareness, including not knowing the tool exists, an inability to find the tool, or a lack of understanding/desire to learn about the issues in the first place.

This tool is not all-encompassing and ought to be used only as a basic foundation for learning about STMMs and best practice principles. While it does provide a solid overview, it does not include all considerations and principles, it is not contextually tailored (as any implementation of practices must be), it is based on exploratory research in a field that is constantly changing and growing, and it is written from a U.S.-based perspective. Learning about and improving STMMs is a long-term process, where best practices continually change and grow as more is learned about program effectiveness. The tool should simply be used as a foundational starting point on a journey of learning about STMMs.

One particularly difficult and interesting area of this project is the continued debate over where the line between a good program and a bad program falls—from those who argue that

even organizations who use bad practices are still generating enough utility to be worth it (largely refuted at this point by the mounting evidence of the negative and harmful effects of damaging practices), to those who argue STMMs can be successful, but only if conducted specifically in accordance with best practices (the stance that this project takes), to those who argue that STMMs should not be conducted at all because they are too rife with problems (for example, many programs including well-known NGOs like Partners in Health and Doctors without Borders only use long-term, highly trained volunteers) (Lasker, 2016). This debate is pressing and passionate and must be continually navigated by the author and those who are involved with STMMs. This project is simply one phase in that journey of continual learning and growth—which includes the continual identification, refinement, and enforcement of best practice principles within STMMs (which are likely to continue for many years).

Future directions for this project could go in many directions, from studying information accessibility and breadth (e.g. defining problems of informational access among prospective participants or evaluating what prospective participants know before they embark on a STMM) to practices of program evaluation (e.g. studying how prospective participants evaluate and choose STMM programs), from awareness-building (e.g. investigating how to spread awareness of these issues among prospective participants) to improving the actual guidelines and information available to prospective participants (e.g. expanding on the tool set forth here). Additionally, there is of course much work to be done in continually identifying damaging vs. best practices; regulating, enforcing, and/or encouraging the use of best practices; and the overarching work of improving STMMs and development aid overall.

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## **APPENDIX**

The tool begins on the following page.



# SHORT-TERM MEDICAL MISSIONS: A TOOL FOR UNDERSTANDING DAMAGING PRACTICES, BEST PRACTICES, AND PROGRAM EVALUATION

## OVERVIEW

This document is a tool for students or others interested in learning about and/or participating in short-term medical missions (STMMs) abroad. The tool will include an overview of STMM damaging practices, best practices, and how to evaluate program quality based on those practices. Each section contains an executive summary followed by a more detailed look at each topic. This tool will enable you to gain a foundational understanding of the issues surrounding STMMs and make better-informed choices as to how you want to engage in this area. While it is primarily geared towards students or other untrained participants on short-term medical expeditions, many of the principles can also be applied to different skill levels, trip lengths, and focus areas.

- **If these concepts are new to you, you can begin with the mindset section and work through the document.**
- **If you already have a general idea of these concepts, you can read the executive summaries in each section (and find more details for anything you are unfamiliar with below).**
- **If you already understand these concepts very well, you might begin with the ‘evaluating programs’ section.**

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## INTRODUCTION

**Short-term medical mission:** a short-length trip (1 week to several months) where participants from one country travel to another country to provide medical or health-related care (often from a high income country (HIC) to a low or middle income country (LMIC))

If you are a student interested in participating on a STMM abroad, it can be overwhelming to know where to start. The field of STMMs is rife with damaging practices to the point that some people argue they shouldn't be conducted at all. On the other hand, there is growing recognition and emphasis on best practice principles that can make these trips successful. The desire to affect positive change is a wonderful thing, but it is not enough on its own—it must be channeled into a meaningful, beneficial, and ethical program.

That's where this tool comes in. This tool is meant to provide you with the basic information on damaging practices and best practices in STMMs, as well as strategies for finding organizations who are utilizing best practices. This information will enable you to become a more informed consumer—able to understand the debate around STMMs, evaluate program quality, and make the right decision for yourself in terms of how to engage in global volunteering. The content is geared towards students or others with little medical knowledge who are interested in health-related volunteering, but almost all of the principles can be broadly applied to other skill levels, focus areas, and trip lengths.

This tool is based on an exploration of current STMM literature and conversations with people in the field. It is not all-encompassing and should be used as a starting point on your journey of learning about STMMs. The learning is ongoing and debates continue about the merits of these trips. Additionally, this tool is written from a U.S.-based perspective. It is not meant

### STMM BENEFITS

While there is a lack of systematic evaluation of STMM benefits to host communities, benefits to host communities from quality STMMs can include extra hands and energy, equipment and resources, learning and capacity building, health improvements, patient satisfaction, financial/employment benefits, social capital, etc. Benefits to participants can include the opportunity to learn about and experience a new culture, learn new skills and health strategies/information, travel, develop and practice community engagement values, build social capital, etc. (Lasker, 2016)

to draw a defined line between 'bad' and 'good' organizations—these programs exist on a spectrum—but rather to provide you with some foundational information so you are better able to be an informed consumer and to make your own decisions about STMMs.

The tool is split into four sections: mindset, damaging practices, best practices, and evaluating programs. Each will begin with a brief executive summary of the section, followed by longer descriptions of each principle or idea within the section, some examples, quotes, and pop-out boxes that contain other ideas and resource links.

## DEFINITION OF TERMS

**Short-term Humanitarian Mission (STHM)** — a trip where participants from one country travel to another country to provide any sort of social development work (often from a high income country (HIC) to a low or middle income country (LMIC))

**Short-term experience in global health (STEGH)** — a similar short-term, health-related experience where participants travel to another country (often HIC to LMIC), but where the focus is primarily on participant education

**Participant** — a person who travels with a STMM to a host community (often called volunteers or foreign volunteers); this does not include locals from the host community who are participating. This would be you if you participated in a STMM!

**Host / Host Community** — the local community that receives STMM participants from abroad

**Local** — referring to the host community or a host community member

**Organization** — any group, usually a nonprofit, that sends or receives STMMs

**Program** — a large-scale, long-term intervention geared towards a specific outcome (could take the form of research, education, interventions, initiatives, etc)

**Project** — a smaller-scale initiative within a program

## MINDSET

### EXECUTIVE SUMMARY

Before diving in to detailed damaging practices vs. best practices, this section contains a general overview of initial topics for beginning the process of learning about STMMs. This overall mindset includes:

- **Motivation to Participate.** Primary motivations for participating should not be self-serving (e.g. to

travel, to build a resume) and altruistic motivations should be realistic (not to ‘save the world’) and acknowledge local agency (not to ‘rescue’ the locals).

- **Commitment.** Participants commit to finding an ethical program and acting ethically during a program.
- **Learning Mindset.** Participants are open-minded, ready to learn, and prepared to spend time doing research on ethical practices.
- **Partnership Mindset.** Participants are ready to work with people in a different community, as partners and equals (not as ‘helpers’ and ‘recipients’).
- **Impact-Driven Mindset.** Participants are committed to doing projects based on beneficial impacts, not assumptions (e.g. about what a community needs, or that projects are inherently beneficial).
- **Project Role.** Participants are realistic about the skills they bring and their impact.
- **Questions to Ask Yourself.** Includes your motivations; your readiness to learn, commit, and adopt positive mindsets; how you will continue your work and apply what you learn to your home community; and how you will talk about your experience.

## MOTIVATION TO PARTICIPATE

Motivations for participating in a STMM can vary widely. It’s important to figure out your own reasons for wanting to go. While the best programs will have mutual benefit for both hosts and participants, if a participant’s primary motivation for going is self-benefit over benefit to the host community (e.g. building a resume, having an adventure, travelling), it’s better to stay home or travel as a tourist instead.

Also keep in mind that you do not need to travel abroad to help people—there are problems in all of our communities that need addressing, so ask why you’re interested in going abroad to get involved. If you are not interested in getting engaged in justice work in your home community but want to do so abroad, you might be more interested in travel—go as a tourist! Think about whether you are just interested in working on problems abroad because they are ‘exotic’, because they seem simple or easy to solve, because there might be less penalty if you make a mistake, or because there might be freedom to practice medicine you’re not trained for—all of which are problematic motives.

Take a look at your altruistic motives as well. If you’re going because you want to save the world, know that a short-term trip won’t do it. Also think about how you view the local people—if you want to help because you

pity them or think they need ‘rescuing’, that mindset needs to change. What we really need is a desire to make change as a guest and equal partner, without pity or the idea of ‘rescuing’.

## COMMITMENT

Once you’ve examined your motives, you have to make the commitment to work with an ethical, quality program that uses best practices. There are many programs that use damaging practices, and STMM organizations are not regulated, so it’s on you to commit to and find an ethical program! Beyond the organization, this includes your personal commitment to act ethically before, during, and after a STMM.

## LEARNING MINDSET

The most important thing is to start this process with a learning mindset! Are you ready to take on the challenge of really learning about STMMs? This field is complex, difficult, and without black & white answers. To participate in an ethical STMM, you’ll need to do a lot of learning and research about how to do this work well—and about other relevant issues in the field of global health (e.g. development aid, systemic inequity, etc).

Be ready to learn, to listen, to be challenged, and to be humble at all stages of the process, and also to share your insight and perspectives. This is a long-term process that will continue throughout the rest of our lives. And as you work through this process, acknowledge mistakes and grow from them.

**QUOTE** “There are no black and white answers here – and if you need them, global health is not the field for you” (Two Dusty Travellers, n.d.).

## PARTNERSHIP MINDSET

A pervasive mindset in STMMs and society at large is that foreign participants arrive solely in the role of ‘helper’ or ‘rescuer’ of the people in the host community. There is more detail in sections below, but this mindset is both untrue and damaging. Instead, we need the mindset that we are all partners, we are all equals, and we are all learners working together. Mutuality is paramount. We also recognize that as foreign project participants, we are hosted by communities as guests.

## IMPACT-DRIVEN MINDSET

The value of volunteering abroad is often assumed; there is a common idea that ‘any help’ is beneficial. But this is not true, certain types of ‘help’ can be unnecessary, unwanted, or damaging (as will also be

detailed below). Leaving behind this mindset that all volunteering is beneficial will allow us to work on projects that are impact-driven, evaluation-based, and truly change outcomes in communities (while avoiding negative or unneeded projects).

## PROJECT ROLE

Start thinking about what skills you bring to the table and the value you can bring to a project. Also understand that you will have a limited impact as a STMM participant, because you will be there for such a short period of time. The real impact on the community comes from the host community itself; from the long-term, sustainable elements of the program; from what you do on a long-term basis in your own community; and from systems-level advocacy. This also means that participants should not be centered in the execution of the project or in the narratives and imagery used to describe the project (again, think equitable partnership).

When you think about a STMM, talk about it with others, or share photos, promote these positive mindsets and avoid perpetuating damaging mindsets (e.g. by focusing on the partnership instead of centering yourself, or by realistically assessing your contribution).

## QUESTIONS TO ASK YOURSELF

- Why are you interested in going?
- To have an adventure? To build your resume? To travel somewhere 'exotic'? To post and share about it? Would you go if you couldn't tell anyone that you were going or couldn't post about it?
- Do you pity the locals? Do you see them as needing to be rescued?
- Are you ready to commit to participating in an ethical way?
- Are you ready to learn and be open-minded?
- Are you ready to be challenged?
- What are you qualified to do?
- What skills and qualifications do you have? How might you add value to a project?
- How will you apply what you learn to your home community?
- Are you engaged in your home community as well? Do you recognize and want to address the problems that exist there?
- How will you continue your engagement work at home after you've returned?
- As mentioned, your impact on a STMM will be very limited. Would you continue learning and doing engagement work afterwards (locally or abroad)? Are you willing to commit to continually working towards justice?

## PARTICIPANT CHARACTERISTICS

There are surely dozens of attributes that make good STMM participants, but in general, the best participants are adaptable, hardworking, humble, and respectful. They have interpersonal skills and technical skills that can benefit a project. And they are good listeners, open to new ideas, and approach the project as a partnership. Poor participants, conversely, don't follow the rules, are disrespectful or bossy, don't communicate well, and are disrespectful of culture. (Lasker, 2016)

- How will you talk or post about a STMM?
- Will you communicate about a STMM (through words or photographs) using the above positive mindsets and the best practices detailed below (e.g. will you center yourself, or center the host community and the partnership)?

# DAMAGING PRACTICES

## EXECUTIVE SUMMARY

After addressing initial considerations and finding the right headspace, it's time to delve into damaging practices. While on the surface, STMMs may seem inherently beneficial, there is strong growing literature defining damaging STMM practices that reduce host community benefit and can harm the host community. (Benefit to the host community must be the top priority in a good STMM). This section, detailing those practices, will be very negative—but don't get discouraged or paralyzed! The goal is to give you information on what organizations should not be doing so that you can better analyze programs.

The following damaging practices will be covered:

### Lack of Partnership and Mutuality.

- **Not Addressing Local Needs/Desires.** Organizations might complete projects that are unwanted, unneeded, duplicative, ineffective, or damaging instead of what the host community wants or needs.
- **Prioritizing Foreign Participants.** Organizations might emphasize participant experiences at the expense of the benefit to the host community.
- **Avoiding the Local Healthcare System & Government.** Organizations might not work with the local healthcare system or government, which

diminishes project effectiveness and undermines capacity-building, among many other problems.

- **Lack of Mutuality.** Organizations and participants might form inequitable partnerships with hierarchy ('helpers' vs 'receivers'), show disrespect towards locals, and de-emphasize mutual learning and benefit.
- **Lack of Cultural Awareness.** Organizations and participants might participate with little knowledge of the host culture, undermining mutual respect and jeopardizing care.

#### **Unsustainable Programs.**

- **Short-Term.** STMMs might not provide options for follow-up care for their patients, and might not work with a long-term intervention that will create healthcare access for patients outside of the STMM.
- **Not Addressing Root Causes & Systems.** STMMs might focus only on immediate needs, without an awareness of or commitment to address underlying root/systemic causes—which will only have a short-term effect.
- **Lack of Participant Continuation.** Participants might let their community engagement end when they return home from their STMM.

#### **Unethical & Unskilled Labor.**

- **Unethical Labor.** Participants might unethically perform medical procedures they are untrained for.
- **Unskilled Labor.** Participants without specific skills and defined roles may do work that is unnecessary, complete work incorrectly, or take local jobs.
- **Poor Quality of Care.** By virtue of brevity, lack of cultural awareness, lack of specified skills, lack of follow-up, etc., STMMs might provide poor quality medical care.

#### **Promotion of Dependency.**

- **Knowledge & Superiority.** STMMs might promote ideology that Western knowledge, methods, and people are superior.
- **Labor & Infrastructure.** STMMs might not work with the local healthcare system to build capacity, leaving patients dependent on the STMM itself for care, and can also compete with local professionals and affect local healthcare investment.

#### **Propagation of Western Dominance & Superiority.**

- **Western Superiority & White Saviorism.** STMMs might (intentionally or unintentionally) propagate Western Superiority ideology (the idea that Western methods/knowledge are superior) and White Saviorism (the idea that a white person can 'rescue' people of color from their situation), both of which

are harmful and false.

- **Colonialism & Neocolonialism.** STMMs might be neocolonialist, by bringing Western ideas into communities while extracting benefits from them (e.g. travel, personal satisfaction, etc), and participants might be unaware of the complex legacy of colonialism and neocolonialism as root causes of the issues they're trying to address.
- **Reinforcing Stereotypes & Rationalizing Poverty.** Participants might reinforce their stereotypes about host community members through STMMs, or rationalize poverty in the community because the locals are strong or happy.
- **Neglecting Problems at Home.** STMMs and participants might assume only problems in the host community, and only strengths at home, neglecting both the host community's strengths and the important issues at home.
- **Abuse.** As an extreme, participants might abuse their power as foreigners to abuse or exploit host community members.

#### **Limited Impact.**

- **Fragmentation.** STMMs might not work with other organizations, local systems, and each other, creating a fragmented patchwork of care options.
- **Lack of Evaluation.** STMMs might not evaluate their programs and thus do not improve based on impact data.
- **Efficaciousness.** Spending lots of money on flights and accommodations, as well as flying in labor, is not always the most effective way to provide medical care.

**Lack of Learning and Critical Reflection.** Participants might not learn about or reflect upon the myriad issues above, making it easy to perpetrate these damaging practices and assume STMMs are the best solution to global health issues.

**QUOTE** "The field of global volunteerism is littered with the wreckage of the well-intentioned but poorly informed." (O'Neil, qtd in Lasker, 2016, p. 4)

#### **LACK OF PARTNERSHIP AND MUTUALITY**

Many organizations don't partner with a host community partner—almost half of organizers in one study didn't always have a local partner. This causes many problems. (Lasker, 2016)

#### **NOT ADDRESSING LOCAL NEEDS/DESIRES**

When there is no partnership with the host community, programs assume to understand community needs without consulting with the community members.

This can also occur even with a host community partnership, if the foreign organization does not adequately consult with the host community (e.g. a host community may still partner with an organization that does not share its priorities due to conflicting incentives like cultural hospitality norms, financial benefit, etc). This often leads to a fundamental gap between the services provided and the services that the community actually needs or wants—projects may be unwanted, unneeded, duplicative, ineffective, unsustainable, or even damaging. A few generic examples include when programs bring technology that doesn't function in the local setting, perform trainings where the information is not applicable or effective in the local context, provide a service already being provided by the local healthcare system (or even another NGO), provide medications that will run out quickly with no option for refills, perform a damaging intervention, or foster distrust in the local healthcare system. (Dupuis, 2004; Kraeker & Chandler, 2013; Roberts, 2006)

**EXAMPLE** Many STMMs bring equipment and technology to low income areas where there is not the electricity or technological capacity to use it. New, expensive machines get dropped off and sit unused in storage for years because there isn't the power, the training, or the technology to make them useful. (Dupuis, 2004)

**EXAMPLE** A local staff member in Namibia expressed the ineffectiveness of training, saying, "what they are teaching will be very much at odds either with what our guidelines were, which were not perfect, or what we physically would be capable of doing". Specifically, volunteers taught practices like spending 20-30 minutes with each patient, "which is clearly not feasible with over 4,000 patients" (Kraeker & Chandler, 2013, p. 485).

**EXAMPLE** Roberts (2006) observed medical teams in Guatemala bringing bags of vitamins to distribute and described three ways in which this practice could be damaging: a) a child could take all the vitamins at once and get sick, b) a child could feel better after taking the vitamins, so when they aren't feeling well again, the mother prioritizes vitamins over locally-prescribed medicine, or c) injection-related problems rising (as vitamins in Guatemala are injection-based). (Roberts, 2006)

## PRIORITIZING FOREIGN PARTICIPANTS

Some organizations prioritize the foreign trip participants' experiences over the impact on the host

community. This is not to say that there cannot be participant benefit—that's part of project mutuality—but it can't be at the expense of the community. Practices that prioritize participants include spending money disproportionately on the participant experience and accommodations (instead of the project impact), determining the value of a project based on the benefits to the participant instead of the benefits to the community, or picking projects based on what participants can do instead of what the community needs. Prioritizing participants can also result in undue burden on the local staff, participants performing duties they are not a good fit for, and inefficiency (e.g. slowing down a process so that a participant can be directly involved). All of these practices compromise the benefit to the community, and nonconsensually using a community primarily for the benefit of participants is exploitation. (Lough et al., 2011; Rosenberg, 2018)

**EXAMPLE** One nonprofit orphanage in Guatemala offers air-conditioned suites, a pool, and a zoo for the volunteers who visit from HICs, investing a huge amount of money in the comfort and experience of the volunteers that could be going to their programs. (Rosenberg, 2018)

**EXAMPLE** "One Guatemalan project coordinator of short-term medical volunteers expressed that he felt he was 'half project coordinator and half tour guide'" (Green et al., 2009, Burden on Host Organization/Community section). (This is not to say tourism is bad, as it can be a great way to contribute to the local economy and learn more about the culture, but it should not be the host organization's responsibility to facilitate a fun tourist experience for their volunteers at the expense of the project.)

**QUOTE** "There is something highly problematic about service that 'uses' encounters with tragedy and poverty as a means to any ends other than the alleviation of suffering, either directly or indirectly" (Kimelman-Block, 2010, qtd in Lasker, 2016, p. 216).

**QUOTE** "The positive impact on the community must be maximized, and never be relegated to a secondary role following student learning" (De Leon, 2012, para. 8).

## AVOIDING THE LOCAL HEALTHCARE SYSTEM & GOVERNMENT

Even when STMMs partner with a local nonprofit, many do not interact with the local healthcare system or government. Working outside of the local healthcare system can mean an STMM is breaking country

regulations, duplicating efforts (either by the local system or other STMM groups), ignoring local expertise and management strategies, minimizing effectiveness, and leaving no strategy or options for follow-up care. It can also foster resentment among local health professionals, undercut local jobs, and compete with local private practitioners who may be forced to leave the area. Additionally, when a STMM doesn't work with the local doctors, it can foster higher patient trust in foreign doctors, making patients less likely to have faith in their own local providers. (Green et al., 2009; Martiniuk et al., 2012; Wilson et al., 2012)

Many STMMs also avoid working with the local government—and do so without penalty, because countries often don't have the resources to enforce requirements for visiting medical professionals. Not following in-country governmental procedures is an ethical problem and demonstrates a clear power imbalance—consider how difficult it is for a foreign medical professional to be able to enter the U.S., or practice medicine here. Not involving the government can also cause governmental resentment, diminish project effectiveness, and lead organizations to focus on priorities that the government does not share (making them less sustainable). (Lasker et al., 2018; Wolfberg, 2006)

**EXAMPLE** A STMM might give a patient medication but no documented record, so at a follow-up appointment their local doctor must repeat the exam because they do not know what medication was provided. (Green et al., 2009)

### LACK OF MUTUALITY

Even if a partnership exists with the host community, there can be a lack of mutuality between foreign participants and hosts. Many people, including participants and STMM organizations, view STMMs with a strict hierarchy: the participants in the role of 'rescuer' and the host community in the role of 'needs rescuing'. When the relationship contains these undertones, where the parties are not equal partners, there is little mutual respect, learning, or benefit.

There is often a lack of respect for local knowledge and expertise, which is overshadowed by participant "expertise" even if participants are not trained or knowledgeable about the local context. Some participants are actively disrespectful, elitist, and condescending towards locals, and even when participants are not actively disrespectful, underlying assumptions that foreigners are more skilled than locals, programmatic structures where participants

are cast as helpers and the locals as receivers, and an emphasis on the foreigners' ideas all contribute to a culture that lacks respect. Additionally, there is often little emphasis placed on mutual learning and benefit, ignoring how much the participants can learn from the locals—about their culture, how their healthcare systems function, how they may work with limited resources, what their solutions are, etc. (Dupuis, 2004; Green et al., 2009; Sullivan, 2018)

This lack of mutuality is disrespectful, undermines the partnership, makes hosts feel as though they are not equal partners, propagates Western superiority, sours programmatic relationships, cuts participants off from the opportunity to learn from hosts, and overall diminishes program effectiveness.

**QUOTE** "Many volunteers come expecting to teach something new or improved and do not respect the fact that many ways of thinking and operating have served the people just fine for decades and even centuries. Are there more efficient ways of cutting the lawn than using machetes? Of course, but machetes get the job done just the same" (Frankel, qtd in Lasker, 2016, p. 122).

**QUOTE** "There is also an assumption among practitioners in global health that knowledge is created in the Global North to be received by those in the Global South. (Thus, students from HIC who visit LMIC are assumed by many to be "helping", while even within direct exchange programs, students from LMIC visiting HIC are assumed to be "learning")" (Lasker et al., 2018, Host Perspective section).

### LACK OF CULTURAL AWARENESS

Often participants arrive with little to no knowledge of the cultural norms, history, beliefs, environment, and language of the host community and country. This lack of understanding undercuts the mutual respect and learning that are integral to equitable partnerships. It can also jeopardize care—participants may ask inappropriate questions, cause offense, or provide culturally inappropriate care. Medically, this includes an absence of knowledge about the prevalent diseases in the area, the most widely-used management strategies, the local traditional medicine, and how the local healthcare system functions. This can lead to participants attempting care or training that does not function in the local context. (Kraeker et al., 2013)

Lack of cultural awareness also includes inadequate knowledge of the local language. Many participants

on STMMs have little or no understanding of the host community language. This impedes project efforts, causes problems through misunderstandings, and can make participants a burden rather than a benefit because host community members must spend their time translating. (Green et al., 2009)

**EXAMPLE** A foreign provider asks questions in a culturally inappropriate way and does not receive accurate or fully truthful answers because they've offended or confused the patient, compromising care. (Kraeker et al., 2013)

**EXAMPLE** As one local healthcare provider from Namibia said, "they were teaching how you must, bare minimum, physically examine and take a history from a patient....yeah the thing is we can't do that because most of us don't speak, for example, [the local dialect]" (Kraeker et al., 2013, p. 484).

## UNSUSTAINABLE PROGRAMS

### SHORT-TERM: NO FOLLOW UP AND NO LONG-TERM PLAN

STMMs are by nature short-term. This can cause problems including a lack of follow up for patients who are seen by STMMs (if the visiting team does not coordinate with local healthcare professionals to create a plan for local follow-up) and lack of a long-term intervention that will allow patients to access care without the STMM. For example, a lack of follow-up could occur when STMMs provide medications that the patient will not have access to after their supply from the STMM runs out, or perform surgeries and leave before patients can get help for any complications that arise. A lack of long-term intervention might enable a patient to see a primary care doctor just once, while the STMM is in town, instead of on a regular basis, or provide care for one group of patients but leave no options for future patients (or those who did not receive care). This does not mean that short-term or one-time care is not beneficial, but if it is not in partnership with a long-term program, its impact is brief and non-lasting. (Green et al., 2009; Lasker et al., 2018; Martiniuk et al., 2012; Roberts, 2006; Wolfberg, 2006)

**QUOTE** "The projects [volunteers] complete are not sustainable at all. They finish projects and feel a sense of accomplishment, but once they leave, the projects crumble to the ground...since they are here for a short amount of time, they do not completely understand the culture, people, or what the community needs" (Mitchell, qtd in Lasker, 2016, p. 147).

## SIMPLIFYING OTHERS' PROBLEMS

While participants likely understand the intense complexity of their domestic healthcare problems, they may travel on STMMs without recognizing the equal level of complexity of healthcare problems abroad. Viewing other people's problems as 'simple' rationalizes a short-term intervention as a solution, contributes to damaging practices (e.g. promoting an intervention that has unintended consequences), and allows us to avoid working on the complex problems in our own neighborhoods. Participants may try to address problems abroad instead of working on the problems at home because it's 'easier', further removed, and allows them to avoid accepting their own community's issues—this is not the reason to be going on a STMM. (Martin, 2016)

The practice of simplifying doesn't just apply to problems, but to people as well. Some organizations present people in host communities and their needs as simplified to attract participants, and some participants also define people in host communities only by their needs—both of which rob local people of their complexity and uniqueness. (Guttentag, 2009)

A couple of cool resources to check out: Adichie (2009)'s TED Talk on the 'Danger of a Single Story' and Martin (2016)'s quick article on simplifying others' problems.

**QU** Organizations may present local community members in "simple dualisms and essentialised concepts of "other" ' (p. 682). As examples of this imagery, Simpson cites quotations describing how Brazilians exhibit 'energy and joy', Paraguayans 'are unfailingly charming' and welcoming, and Bolivians are 'generally shy and gracious' (pp. 682–683)" (Simpson, 2004, qtd in Guttentag, 2009, p. 546).

**QUOTE** As local participants in Green's (2009) study put it, short-term work that is not coordinated with a long-term element is "the worst kind of care" (Green et al., 2009, Coordination section).

## NOT ADDRESSING ROOT CAUSES & SYSTEMS

STMMs often address the outcomes of problems (e.g. treating diseases) without addressing the root cause. The root causes of health problems are often incredibly complex and difficult to tackle—healthcare access, clean water, food security, poverty, education, etc—but if they are not addressed in conjunction



with the negative outcomes they cause, the problem can never be solved. Beyond the root causes of an issue in a particular community, these issues are also influenced by larger, underlying systemic problems like global inequity, dependency, power imbalances, etc. Again, this is not to say that addressing outcomes is not important, but without an awareness of and commitment to long-term work on root causes and systems, the health problems addressed by STMMs will continue to occur. (Green et al., 2009; Wolfberg, 2006)

**EXAMPLE** A STMM performs a deworming campaign but does not address the community's lack of clean water. This helps the people who receive direct treatment, but does not prevent anyone from contracting worms from the water supply in the future, and necessitates consistent deworming campaigns until the root cause is addressed. (Green et al., 2009)

**QUOTE** “[The] primary problem in Guatemala is a lack of public health infrastructure and lack of primary care coverage due to a lack of financial resources....[Short-term medical work] does not, and cannot, address these primary health issues of Guatemala. We already have many surgeons and other physicians who are well trained to take care of all problems common in our country. The lack of healthcare in rural areas is not due to a lack of physicians; it is due to a lack of resources to provide clinics, hospitals, and supplies to these areas” (Ministry of Health Official qtd in Green et al., 2009).

### LACK OF PARTICIPANT CONTINUATION

Beyond the program's lack of sustainability, there is a lack of sustainability on the participant side if the participant arrives home and does not continue with community engagement work. For some participants, their STMM experience does not inspire (or reinforce) a commitment to continue working towards positive change, to applying what they've learned to other communities (at home or abroad). When a STMM participant lets their engagement work stop when the trip ends, it's another way in which the STMM was short-term.

## UNETHICAL & UNSKILLED LABOR

### UNETHICAL LABOR

On STMMs, medical students or other untrained participants may perform medical procedures for which they are unlicensed and untrained. There are many contributors to this ethical problem. Some participants are excited about the chance to practice medical care

they couldn't do in the U.S., and some organizations tout that 'opportunity' as a benefit of their program. STMM patients may be used to train medical students in procedures they rarely see in their own country. But it is not always so outright—untrained participants are often simply assumed to be experts because of unequal power dynamics, and there is often a lack of participant supervision, both of which enable participants to practice unethically. Even those committed to acting ethically may feel pressured to perform procedures when faced with difficult situations where patients have no other options. An untrained person practicing medicine is unethical and unacceptable, in the U.S. and anywhere else. (Dupuis, 2004; Guttentag, 2009; Lasker, 2016; Wilson et al., 2012)

This can also extend to other trained healthcare professionals if they try to diagnose or treat diseases with which they have no experience or training. (Wilson et al., 2012)

**EXAMPLE** An undergrad student volunteered in a remote village in East Africa. She was there between visits of volunteer physicians and was effectively acting as the local physician—feeling pressure to help seriously ill patients while knowing that she was untrained and unqualified to do so. (Lasker, 2016)

**EXAMPLE** Renee Bach was a woman who at age 20, with no medical training, opened a center in Uganda (performing much of the medical care herself) that took in 940 severely malnourished children—105 of whom died. She is now being sued in Ugandan civil court. (Aizenman & Gharib, 2019)

**EXAMPLE** 'Fistula tourism' is an example of surgical tourism, where surgeons may travel to other countries with the motives of seeing interesting cases or improving their skills. (Martiniuk et al., 2012)

**QUOTE** “When I arrived in Uganda, there was no checking of my credentials—the colour of my skin and my nationality stood as my qualification” (Medical student, qtd in Lasker, 2016, p. 151).

### RELIGION

Another ethical issue is when STMMs use their mission to proselytize. While using religious beliefs as the motivation for helping is not problematic, it is exploitative and unethical to condition the receipt of medical care on religion in any way. (Lasker, 2016)

## REGULATION

There is no global regulation of STHMs, no official global checks or balances to protect against unethical practices. Countries may have their own specific rules and regulations for STHMs or STMMs (for example, doctors may be required to register with the country's government), but these regulations are not always enforced because of logistical difficulties, funding, conflicting priorities, etc. Barriers to implementing regulation include the difficulty of enforcement, the idea that volunteering is inherently beneficial, concern that regulation would deter participation, etc. (Lasker et al., 2018; Wolfberg, 2006)

## UNSKILLED LABOR

Organizations often bring unskilled participants, without defined roles, expectations, or limitations. These participants perform non-specialized tasks, some of which are unnecessary (e.g. if the local organization has no real job for a participant and is just trying to find something for them to do). Unskilled participants may also complete work ineffectively, incorrectly, or unethically if they are given jobs for which they are not trained or are unfamiliar with. As general laborers, they may also take the jobs of local people who could do the same work. And while some people might think teaching is a great way for unskilled participants to be involved, teaching itself requires specific knowledge and skills—especially when teaching about healthcare topics and in a new cultural setting. (Lasker, 2016; Lough & Tiessen, 2018; Guttentag, 2009)

**QUOTE** “Skilled practitioners--builders, engineers, surgeons--can perform a real service here. Generalists--well-meaning people with no specific skills who come out on short-term mission visits, those who “teach the children to wash their hands” but can only do it in English--are a drain on resources and often come away thinking that they have made a “real difference” when all they have done, in my opinion, is taken a lot of photos, had a “feel good” experience and stretched the resources of the mission here” (Rosenfeld qtd in Lasker, 2016, p. 148).

**QUOTE** “I heard about and observed many instances in which volunteers were doing work that could be much better performed by community members who spoke the language, knew the situation, and were not there for only a week or two” (Lasker, 2016, p. 204).

## POOR QUALITY OF CARE

Participants with little training, and even those who are highly trained but have limited cultural knowledge, are

unfamiliar with the environment, and stay for a short period of time, may provide poor quality care. Factors discussed above, like lack of cultural awareness, not involving the host community, lack of follow-up, and language barriers can all contribute to poor quality of care. Shortness of stay also contributes, especially when STMMs rush through visits to get a higher ‘body count’ (number of patients seen in one day). Some projects are completed inefficiently or poorly because participants want to be directly involved. Working with unfamiliar colleagues, under unfamiliar conditions (e.g. areas with fewer resources), and addressing extremely complex health issues (that may be new to visiting professionals) all contribute as well. Beyond labor, many STMMs also bring poor quality equipment, like medicines or supplies that are expired waste in the U.S. All of these factors can mean worse care for host communities, and justifying poor care ties back into the idea that ‘any help is beneficial’. (Dupuis, 2004; Green et al., 2009; Guttentag, 2009; Lough et al., 2011; Martiniuk et al., 2012; Wolfberg, 2006)

**EXAMPLE** “A study of anesthesia care provided by Operation Smile volunteers found that although the complication rate associated with facial-cleft surgery in the field was similar to rates in developed countries, the brevity of missions may contribute to avoidable illness and death” (Fisher, 2001, qtd in Wolfberg, 2006, para. 4).

**QUOTE** “Of likely concern is the quality and efficacy of the medical care provided by foreign doctors who can be unfamiliar with local health needs, local culture and the strengths and limitations of the healthcare system in which they must leave their patients for follow up care” (Martiniuk et al., 2012, Common critiques of medical missions section).

**QUOTE** “If the medications aren’t fit for human consumption in the US, why should they be fit for human consumption in a poor country?” (Green et al., 2009, Resource and Information Sharing section).

## PROMOTION OF DEPENDENCY

Many STMMs promote dependency on foreign mission trips and aid, instead of bolstering and developing local healthcare infrastructure. STMMs that have no plan for follow-up, partnership, or long-term impact leave no options for care outside of their mission, which can cause communities to become dependent on those STMMs for their healthcare, especially when there are few local resources. Additionally, if STMMs offer services at lower or no cost, community members may wait and rely on those services even when local

resources are available. (Green et al., 2009; Lasker, 2016; Wilson et al., 2012)

## KNOWLEDGE & SUPERIORITY

STMMs can promulgate a deference to outside knowledge, as they often arrive with the abovementioned mindset of ‘knowledge-holders’ serving ‘knowledge recipients’ and exist within the larger system of Western dominance and power imbalances. This is a different form of dependency on Western knowledge that can discourage local ideas and methods (discussed in more detail in the following section). (Guttentag, 2009)

Foreign services and resources are often perceived as superior. Patients may trust and prefer outside physicians over local physicians, because of things like racial bias, colonial roots, and power imbalances—especially if the foreigners are not working with the local medical professionals. If locals have more faith in foreign providers and services, they may not trust their local physician, or may wait for another STMM to receive care instead of going to their doctor. This undercuts the local system and promotes dependency on foreign providers and resources. (Green et al., 2009; Lasker, 2016; Loiseau et al., 2016)

**EXAMPLE** One Guatemalan surgeon in Green’s study said that Guatemalan patients “tend to put more faith in a blonde haired, blue eyed, white skinned foreign physician than their own Guatemalan physicians” (Green et al., 2009, Coordination section).

**EXAMPLE** In Loiseau’s study, foreign services and resources were perceived to be of better quality than local services. (Loiseau et al., 2016)

## LABOR & INFRASTRUCTURE

Overall, when STMMs do not partner with local organizations and work to build local capacity, they are conducting an intervention where patients are fully reliant on outsiders.

In terms of labor, STMMs can displace or compete with local healthcare professionals by providing free or discounted services, something that is exacerbated in areas where there is already health worker unemployment. Beyond medical professionals, untrained participants can replace locals who could be paid to do the same work. Local physicians may also leave the country’s public sector to find jobs with international NGOs, which strengthens the NGO’s presence and weakens the country’s local infrastructure. All of these promote dependency by undercutting the

local workforce, forcing patients to rely on foreign help rather than strong local infrastructure. (Guttentag, 2009; Laleman et al., 2007; Lasker, 2016; Lough et al., 2011)

It’s also possible that the presence of STMMs and foreign medical intervention can affect governmental decisions about investing in or improving local healthcare (e.g. there may be a lower incentive for the government to invest in healthcare in areas that receive lots of STMMs). (Green et al., 2009)

**EXAMPLE** After the 2010 earthquake in Haiti, hundreds of NGOs brought in free medical services—which were needed, but displaced many local Haitian physicians who had to leave or be hired by outside NGOs that often left a few months later. (Lasker, 2016)

**EXAMPLE** In Guatemala in 2009, the government considered the number of healthcare services in an area when deciding whether to invest in healthcare there. The temporary foreign health projects performed in an area skewed that number and discouraged investment in long-term, local health resources. (Green et al., 2009)

**QUOTE** “Hiring and (when needed) training members of host communities to carry out many of the important activities of a volunteer organization have much value. Yet financial constraints or the desire to involve more volunteers may limit this, to the detriment of the program and the morale of host community members” (Lasker, 2016, p. 203).

## PROPAGATION OF WESTERN DOMINANCE & SUPERIORITY

**QUOTE** “Power is at the heart of this, with the ability it gives richer countries and institutions to impose their ideas, intentionally or unintentionally” (Crisp, 2010).

## WESTERN SUPERIORITY & WHITE SAVIORISM

Western superiority (the idea that Western methods, knowledge, and culture are superior) is pervasive in many STMMs. Some organizations or participants may actively propagate Western superiority ideology (e.g. by promoting the ‘rescuer’ mindset or ignoring in-country methods). Most STMMs utilize and propagate Western knowledge, values, and methods as they do their work, so even when STMMs try to avoid this problem, unconscious superiority and power dynamics are often embedded in projects and participants unconsciously apply their values and ideas while working. (Crisp,

2010; Parfitt, qtd in Crisp, 2010)

Another similar ideology is white saviorism—when a white person or white culture enters a community of color (whether at home or abroad) and ‘rescues’ people of color. This ideology, too, assumes that white ways of doing things are better and that a white person is automatically helpful (instead of recognizing the agency and power of people of color). Again, some organizations and participants actively propagate white saviorism (e.g. by centering the white participants as saviors in the program narrative) and others try to fight it, though underlying racial biases are omnipresent and embedded in the work as well.

Both of these ideologies are about one group of people having more value than another, and tie in to everything that’s been discussed above—they fuel the ‘rescuing’ mindset, enable STMMs to avoid partnering with the host community, paint community problems as simple, elevate participants to ‘hero’ status, etc. Beyond what’s been discussed, the ideas that knowledge and best practices can only flow from the West/white culture to other countries, instead of the other way around, is paternalistic, condescending, and false. Though certainly many Western practices are very good and effective, the idea that Western methods are always the best is false; they are simply the dominant ways of doing things. Western methods may not function well domestically, let alone in a community abroad with different resources, culture, and government, where the

## RESOURCE BANK: WHITE SAVIORISM & COLONIALISM

Check out some of the following easy-access resources on white saviorism and colonialism.

- Cole (2012) coins and explains the term ‘white saviorism’ in a response to the Kony 2012 documentary.
- Karan (2019) discusses colonialism in global health in an article with NPR’s Goats & Soda.
- These instagram accounts address white saviorism and the ‘rescuer’ narrative: @BarbieSavior (satire), @NoWhiteSaviors, @HumanitariansofTinder (examples of unethical/exploitative photography).

Image (bottom): Barbie Savior [@barbiesavior]. 2017, November 7. Barbie Savior [Instagram photograph]. Retrieved from: [https://www.instagram.com/p/BcApnH\\_nwW-/](https://www.instagram.com/p/BcApnH_nwW-/)

application of Western methods can be harmful. Focus on Western methods means programs might ignore local ideas/methods, which undermines equitable partnerships, is disrespectful, and hurts program outcomes. It perpetuates power imbalances, colonialist practices, paternalism, and condescension. It also means that Western or white participants don’t take the opportunity to learn about non-Western or local ideas and practices, many of which could be applied at home to improve domestic health outcomes. Finally, it breaks



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barbiesavior Today I sacrificed my daily beauty regimen (using my Rodant in Heels™ product line) to visit the local “hospital” (if you can even call it that!) to love on and care for all of my sweet African angels. It provided me the perfect opportunity to snap some selfies with the less fortunate, even with poor lighting. One of the greatest lessons I’ve learned over the years is taking selfies in Africa is NOT for the faint of heart...it’s an art form. One I have perfected, along with my super toned thighs. There is a social media guide floating around for people who try to volunteer just like me, so I’m glad there is now something out there to help you all learn how to be more like me! #exceptnot #dontbeaB #readtheguide #staycaringandstayin



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NOVEMBER 27, 2017

## GIFT-GIVING

Gift-giving (e.g. handing out stuffed animals to children) is typically classified as a damaging practice because it can reinforce the power dynamic between foreign participants (including contribution to Western superiority issues and Western idealization), promote dependency (as a hand-out), and create equity issues (e.g. who gets a gift vs not). It also tends to be unsustainable and often does not address an identified need.

the world up into two sections, West vs. non-West, which is erroneously simplistic because the global landscape is so complex and multilateral.

**EXAMPLE** One country built a new state-of-the-art center for difficult disease cases to follow the Western standard, but this meant there was not funding for local prevention measures that would've been more effective at improving health outcomes. (Crisp, 2010)

**QUOTE** International development so often carries an implication “of people doing things for other people, of knowing better, and of there being somehow a clear distinction between developed and developing countries” (Crisp, 2010, p. 100).

## COLONIALISM & NEOCOLONIALISM

Neocolonialism is a form of colonialism where powerful countries use economic, political, cultural, and other pressures (including development aid or foreign assistance) to influence, control, and extract benefits from less-powerful countries. As participants on any STHM extract benefits from communities (such as personal satisfaction, professional development, adventure/travel, etc) and bring Western ideas into those communities (often with the assumption that those Western practices are the best way of doing things), STHMs can be colonialist and/or neocolonialist. (This is regardless of intention—colonists also thought they were doing good work by ‘civilizing’ new lands). It’s also important to be aware that the history of medical missions is rooted deeply in colonialism (e.g. a long-term medical mission would provide healthcare to try to obtain community compliance during colonization) and that colonialist ideology is still highly pervasive and dominant. (Lasker, 2016)

Beyond STHM-specific practices, neocolonialism and the legacy of colonialism are systemic causes of many of the humanitarian issues and dependency problems STHMs try to address. Thus, this also ties back into how STMMs address immediate needs but don’t look at

root causes or deeper systemic factors, like economic and political power imbalances. Again, this is not to say that work that provides for immediate needs is not important—it is—but it alone is not a sustainable solution, as the drivers of those needs will persist.

**EXAMPLE** Some people argue that any form of STHMs are neocolonialist, while others argue that STHMs can challenge this pattern with partnership, mutuality, and best practices. (Lasker, 2016)

**QUOTE** “Whether international/intercultural community work is just another form of colonialism (or assimilation!) is an important question to ask ourselves” (De Leon, 2012, para. 4).

**QUOTE** “It is maddening that the reductions in the social safety nets of poorer countries promoted by many of these same governments and by international financial institutions such as the World Bank and International Monetary Fund have created the very need to which those same actors have responded by promoting volunteer interventions” (Lasker, 2016, p. 11).

## DEVELOPMENT AID

STMMs are one small facet of the development aid sector, which is also wrapped up in damaging practices and power dynamics. Foreign aid often serves a country’s own interests, corporations, and politics. Aid is often linked to trade or other political/economic stipulations so that most of it ends back up in the donor country, or it may be given in the form of loans, which sink countries into debt and exacerbate power imbalances. Development aid and humanitarian assistance also typically reflect the ideologies of the more powerful countries who control them—again perpetuating Western superiority and Western ideas. Aid systems are also very complex, with lots of varying actors, requirements, and priorities for recipient countries to navigate, even as there are few mechanisms to hold donor countries accountable. (Lasker, 2016; Crisp, 2010)

**QU** “All of them [individual countries, international agencies, NGOs] gave aid on their own terms and all of them wanted it monitored against their own criteria. It is only a small step from here to telling people what to do” (Crisp, 2010, p. 82).

## REINFORCING STEREOTYPES & RATIONALIZING POVERTY

A common belief about STHMs in general is that they lead to better cross-cultural understanding in participants—but this has yet to be shown by empirical data. Short-term missions may instead reinforce stereotypes that participants hold about the local people. Participants may also think of the people they met as exceptions instead of dismantling their stereotypes. Even if participant perceptions about locals do change, participants may focus on themselves and how lucky they are instead of the inequality experienced by locals. (Guttentag, 2009; Rosenberg, 2018)

STHMs also have the potential to rationalize poverty and inequality. Participants may view locals as ‘poor-but-happy’, an idea that can be used to romanticize, rationalize, and even justify inequality because it seems those in poverty are happy or they don’t know better. (This instead of recognizing the strength and positivity of the locals as further reason to dismantle inequality). (Guttentag, 2009)

## NEGLECTING PROBLEMS AT HOME

Some STMMs and participants focus only on the problems in other countries, and only on the strengths in their home country, which is another dimension of a superiority mindset and neglects domestic problems. In reality, both domestic communities and communities abroad have flaws, needs, and strengths. Ignoring this complexity leads to all the same problems that come with superiority ideology (see above). And because STMMs focus on communities abroad, some people view them as neglecting equally-important domestic needs, especially given concerns around STMM effectiveness.

## ABUSE

Foreign participants, especially those who are white, are often conferred inherent trust (due to Western superiority and ‘any help is good help’ ideologies)—which sometimes opens the door to abuse and exploitation. Participants can take advantage of their privilege and abuse host community members, either through direct physical or sexual abuse or by practicing damaging or unlicensed care.

## LIMITED IMPACT

All of the abovementioned damaging practices lead to STMMs having a limited impact on the host community. Below are a few additional impact-related concerns.

**QUOTE** “I would say that at best it’s neutral. In other words, the cost at best is offset by what [volunteers] may contribute, but I wouldn’t want to say that they’re a real asset” (Nathanson, qtd in Lasker, 2016, p. 145).

## FRAGMENTATION

Multiple STMMs may travel to the same area without working together with each other and the community, resulting in fragmentation of care. STMMs also might only treat an isolated disease, work in an isolated geographical area, or perform an isolated intervention, all of which contribute to fragmented care. (Lasker, 2016)

**EXAMPLE** Of 177 NGOs in a district in Nepal, half were in the healthcare sector, and there was no coordination among them. (Citrin, qtd in Lasker, 2016)

## LACK OF EVALUATION

Many programs dedicate few or no resources to evaluation of their programs because evaluation is difficult, benefits are assumed, or there aren’t the resources to do so. But this means that programs have no idea whether their projects are having a real impact on the measures they’re trying to change—and they don’t actively try to improve based on that impact (or lack thereof). (Lasker, 2016)

**EXAMPLE** “The assumption of benefit is so strong that even for many people deeply committed to doing this work, the idea that there should be some kind of formal accounting seemed surprising” (Lasker, 2016, p. 184).

## EFFICACIOUSNESS

Given all of the concerns with STMMs and their limited impact, STMMs are not the most efficacious way to provide care—especially given how much money is spent to facilitate them. If the amount spent on airfare, lodging, etc for short-term participants (usually upwards of USD 2,000) was instead donated to be spent directly on local programming, the impact would be far greater. Flying in personnel is also not the most effective way to obtain the necessary labor. However, participant and organizational stakes in the current system mean that this money might not be spent in another way. (Lasker, 2016; Martiniuk et al., 2012)

**QUOTE** “What business did our team of 10 members...have spen[ding] approximately \$30,000 toward travel and hotel costs.... when the entire cost of building a new 30-bed wing for the hospital

in Ghana was \$60,000?” (Abdullah, 2008, qtd in Martiniuk et al., 2012, Common critiques of medical missions section).

**QUOTE** “It is very tempting to ask what else might have been accomplished had the money been sent directly to the host partner. Of course, the reality is that without the opportunity to travel and encounter new places, without the possibility of a hands-on experience of helping, and, for some, without the gratification of receiving others’ admiration, volunteers and donors would simply not spend their funds in this way. “Just send the money” is an unrealistic alternative” (Lasker, 2016, p. 210).

## LACK OF LEARNING & CRITICAL REFLECTION

Many programs do not include structured education or critical reflection around the damaging practices

and issues above. Participants often do not learn about the issues, self-reflect, or question their impact, which makes it easy to fall into the above damaging patterns, both organizationally (e.g. working with an organization that does not following best practices) and personally (e.g. propagating white saviorism or automatically assuming the benefits of their short stay). (Loiseau et al., 2016; Palacios, 2010)

**QUOTE** “Development is often marketed as “making a difference” wherein specific skills are not really required, but a desire to help is [16]. This thereby justifies the volunteer work done by unskilled individuals (mostly youth) within international settings as a development “solution” [16]. When international volunteers participate in these types of projects and fail to self-reflect or question the actual impact that their services and/or presence

## RESOURCE BANK: HOST PERSPECTIVES

**QU** “If the massive investment in short-term health programs is to be justified, it must be in terms of the value to the third and most important party in this picture—the host communities” (Lasker, 2016, p. 115).

There is a lack of research in the area of host community perceptions of STMMs (although there is lots of anecdotal evidence). While community member perceptions are very dependent on the particular program, there have been a small number of studies on host community perspectives in different settings—check some of them out below (keeping in mind the authors’ described limitations, such as how studies are primarily conducted by Western researchers, the inability to generalize qualitative studies, or the pressure to review STMMs positively).

- Laleman et al. (2007) interviewed 8 physicians in Sub-Saharan Africa about their perceptions of international health volunteers. DOI: <https://doi.org/10.1186/1478-4491-5-19>
- Green et al. (2009) interviewed 72 individuals involved in STMMs and/or the healthcare system in Guatemala (e.g. Guatemalan providers, foreign providers, etc) about their perception of short-term medical volunteer work. DOI: <https://doi.org/10.1186/1744-8603-5-4>
- Kraeker & Chandler (2013) interviewed 9 healthcare professionals in Namibia about their perceptions of foreign medical professionals who visited to either learn or teach. DOI: 10.1097/ACM.0b013e3182857b8a
- DeCamp (2014) interviewed 30 patients receiving care from an NGO in the Dominican Republic about their perceptions of the program. DOI: <http://dx.doi.org/10.1080/17441692.2014.893368>
- Kung et al. (2016) interviewed 35 physicians/project coordinators with a specific NGO in Bolivia and India about their perceptions of visiting medical student trainees. DOI: 10.1111/medu.13106
- Lasker (2016) interviewed 119 people involved with STMMs in several countries about their perspectives on STMMs. Book: Hoping to help: The promises and pitfalls of global health volunteering, Part III. The Host Communities
- Loiseau (2016) interviewed 33 host community staff members, host community members and volunteers in the Dominican Republic on their perceptions of international volunteerism. DOI: <https://doi.org/10.1155/2016/2569732>
- Nouvet (2016) interviewed 52 relevant stakeholders in Nicaragua about their perceptions of STMMs. DOI: <https://doi.org/10.1080/17441692.2016.1220610>
- Lasker et al. (2018) performed an overarching literature review of 27 studies on STMM best practices and guidelines, including a section on the specific insights from host perspective studies included in the review. DOI: 10.1186/s12992-018-0330-4

have on the community, these elementary notions of development are perpetuated” (Loiseau et al., 2016, p. 11).

**QUOTE** “If you don’t want to grapple with these issues, please do not volunteer abroad” (Two Dusty Travellers, n.d.).

# BEST PRACTICES

## EXECUTIVE SUMMARY

With growing understanding of all the problems detailed above, the literature and the field have started to try to define STMM best practices—what STMMs ought to be doing to be successful, mutual, and beneficial.

In general, best practices include avoiding the damaging practices discussed, but this section will go into more detail on what specific best practices look like. It’s unrealistic to expect a program to be perfect and use every single best practice, but good programs must utilize the main principles detailed below.

**True Partnership & Mutuality.** Participants, organizations, and host community members are equitable partners in a mutual relationship.

- **Community-Driven Needs Assessment.** Projects are informed by community needs assessments, driven and defined by the host community, to ensure they are necessary and effective.
- **Mutual Respect.** All partners show respect for each other.
- **Cultural Humility & Language.** Participants practice cultural humility (learning as much as they can about the culture, while recognizing its complexity), remain respectful and humble, and work to learn the language of the host community.
- **Defined Roles.** Participants have clearly-defined roles and limits that are necessary to the

project—and no participant performs any medical procedures for which they are unlicensed or which they would not be permitted to perform in their home country.

**Capacity Building.** Programs build host community capacity (avoiding dependency) through a long-term presence and attention to root causes.

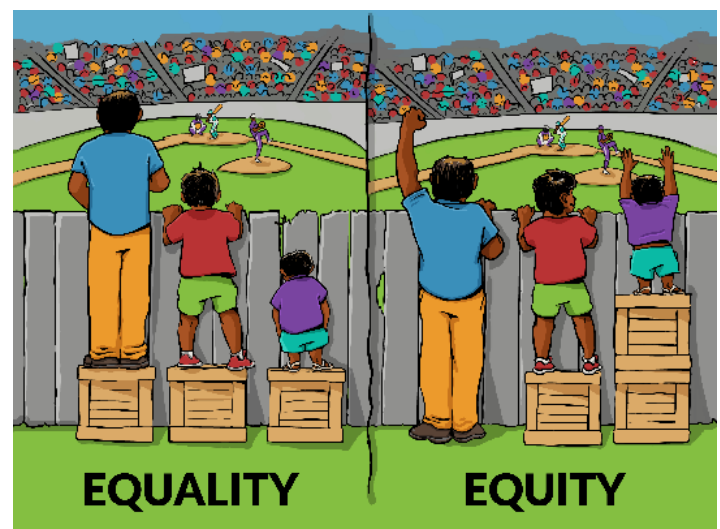
- **Knowledge Sharing.** Projects might share knowledge to strengthen the local system, while maintaining an emphasis on mutuality.
- **Working with Local Governments & Healthcare System.** Programs partner with the local system and government to build capacity and maximize effectiveness.

**Sustainability.**

- **Longer Trips.** STMMs are longer in duration—the longer, the better (1+ months at least).
- **Long-Term Program.** STMMs are a small portion of a larger, long-term, on-the-ground program.
- **Monitoring & Evaluation.** Programs collect data and evaluate their progress, continuously improving their practices.
- **Root Causes & Systems.** Programs and participants are aware of and working to address root causes as well as larger global systems of inequity.
- **Participant Continuation after Return.** Participants continue their community engagement after their STMM has concluded, either with the same host community or in their own communities.

**Challenging Western Superiority.** Programs and participants challenge Western superiority and white saviorism through a myriad of positive practices like equitable partnership, centering the host community, challenging assumptions, building relationships, etc.

**Learning & Critical Reflection.** Organizations and



## EQUITY VS. EQUALITY

Equality is when everyone receives the same resources and opportunities, while equity is when resources are distributed based on people’s specific circumstances.

Image: Interaction Institute for Social Change | Artist: Angus Maguire. (2016, January 13). Illustrating Equality VS Equity [image]. Retrieved from: <https://interactioninstitute.org/illustrating-equality-vs-equity/> and [madewithangus.com](http://madewithangus.com)



## HOST COMMUNITY'S VOICE

Additionally, working with one organization in the host community does not necessarily mean that organization is representative of the community's voice. Similarly, it's important to work with partners beyond the top level of leadership in the host community. In some cases, providing services or training to only certain members of a community may reinforce pre-existing power dynamics. (Guttentag, 2009; Lasker, 2016; Loiseau, 2016)

participants reflect on the issues, including larger root causes and systems, and the program's impact, engaging and learning as part of a continuous process before, during, and after a STMM.

**Other.** STMMs coordinate with other organizations, do not proselytize, maintain quality logistics, share their financial information, and ask participants to cover their expenses.

## TRUE PARTNERSHIP & MUTUALITY

The most important piece of a good program is a true partnership between the host community partners (organizations, leaders, nonprofits, medical systems, etc. within the host community) and the foreign organization(s) and participants. Not only does a partnership exist with the host community, but host partners and the foreign organization (including participants) are equitable partners and the relationship is mutual. Mutuality includes mutual stakes (i.e. partners are each heavily invested in the project), mutual learning, mutual respect, and mutual benefit (i.e. all parties are receiving benefits). (Loiseau et al., 2016)

Each partner brings different skills and plays a different role, but all are valued. Everyone enters the project with a learning mindset, excited to both share knowledge and learn from each other. Partners make decisions together and work together towards shared goals that benefit everyone. Partners build strong relationships and allow space for critical dialogue and growth. This addresses the problem of 'not involving the community', because host community members are partners and leaders in all aspects of the project, from needs assessments to final decision-making. Respect replaces superiority, the word 'partner' replaces labels like 'helper' vs. 'beneficiary', and mutual benefit (with specific emphasis on the host community benefit) replaces prioritization of participants. (Kraeker et al., 2013; Lasker, 2016; Lasker et al., 2018; Loiseau et al., 2016; Wilson et al., 2012)

**QUOTE** These partnerships require "deep reciprocity – that is, not just being of benefit to each other, but learning from one another. Such relationships are based on solidarity among equals and are conducted in ways that uphold dignity for all involved" (De Leon, 2012, para. 6).

**QUOTE** In a study of host community health professionals, participants emphasized the need for projects to be equal, cooperative, and mutually beneficial—where "we learn from them, they learn from us" (Kraeker et al., 2013).

## COMMUNITY-DRIVEN NEEDS ASSESSMENT

Great programs are community-driven, with needs and solutions defined by the host community members and host partners, who best understand their communities. These programs might perform needs assessments in the community to determine what community issues are the most important or pressing, to figure out what the program should address. One approach to needs assessments is the Community Based Participatory Research framework, where researchers and community members are fully integrated and involved in all stages of the research process, and findings lead to actionable projects. With defined areas of concern, programs can create specific goals, design projects, and decide how (and whether) short-term participants may help the program advance (including needed participant skills and roles). This includes collaborative brainstorming and research on what methods will be the most effective in addressing the defined community needs. The needs assessment process ensures that a project is necessary, desired, and effective. (Lasker, 2016; Lasker et al., 2018; Kraeker et al., 2013)

## MUTUAL RESPECT

Real partnerships are built on mutual respect—participants show respect for their hosts, and hosts

## MUTUALITY

Part of mutuality and the deconstruction of Western superiority ideology is a deep understanding, appreciation, and respect for the incredible community work happening worldwide. All over the world, people are creating and maintaining amazing new programs to improve health, and sharing of these ideas can be multilateral, mutual, and go in all directions. Challenge assumptions that Western methods are the best. Read up on the initiatives, programs, and organizations in the community or country you may be travelling to and think about how they could be applied to improve health at home.

show respect for them. Good participants recognize that they are guests in the host communities, respect local methods and leadership, and show gratitude and consideration towards their hosts. Each partner enters the project ready to learn, understand, respect, build relationships, and execute the project as well as possible. Hierarchy, superiority, condescension, paternalism, assumptions, and ignorance are absent from these partnerships. Great organizations facilitate this type of environment. (Wilson et al., 2012; Lasker et al., 2018)

**QUOTE** “Mutuality means that volunteers recognize and honor the gifts they are receiving and respect the givers, just as they hope the gifts they bring will be valued” (Lasker, 2016, p. 167).

**QUOTE** “How, for example, could a well-meaning American “help” a place like Uganda today? It begins, I believe, with some humility with regards to the people in those places. It begins with some respect for the agency of the people of Uganda in their own lives. A great deal of work had been done, and continues to be done, by Ugandans to improve their own country...” (Cole, 2012).

### CULTURAL HUMILITY & LANGUAGE

Cultural humility is when a foreigner shows deep respect for a new culture, learning as much as they can about it while recognizing that culture is rich, layered, and too complex to fully understand as an outsider. Great organizations create an environment of cultural humility. Before leaving, participants learn as much as they can about the local culture, history, environment, traditions, and the local health system (including how the system works, the main health problems, and the local strategies for solving them). While in the host community, they act and learn with cultural humility. (Bezruchka, 2000; Kraeker et al., 2013; Loiseau et al., 2016; Wilson et al., 2012)

Additionally, good organizations prioritize and facilitate knowledge of the local language, which makes participants more effective and reduces the burden on the host organization. Great participants know the language of the community they’re visiting, or at least study up on it beforehand to learn key phrases, especially when working with multiple or less well-known indigenous languages. This shows respect, a desire to learn, and an effort at making connections. Where participants do not know the local language, there are measures in place to provide translation—while ensuring that the need for translation does not cause undue burden on local staff. (Kraeker et al.,

2013; Lasker, 2016; Lough et al., 2011)

**QUOTE** In Loiseau’s study of STMM host community perspectives in the Dominican Republic, volunteers, hosts, and local community members identified the need for cultural sensitivity and understanding, saying “[the volunteers] need to know how the people live” and “they need to know what is going to be helpful” (Loiseau et al., 2016, Ideal Volunteer Skillset section).

**QUOTE** “Haiti is a Third World country and the United States is a well-known, developed country, so if we’re trying to do things the way you’re doing in the States, it will not fit here in Haiti. You can come with ideas. We are glad to hear what you think and from what you’re telling us, we will decide what can fit in our clinic. When the volunteers come, they need to know that we are all a team...We know what’s going on and when you come to help, we appreciate that, but please follow what we’re telling you to do which is very important. Because we know better how things go here” (Haitian physician, qtd in Lasker, 2016, p. 165).

### DEFINED ROLES & ETHICS

With a specific, community-driven program, participants will have clearly defined roles and limits, especially when untrained participants are involved in a program that provides direct patient care. In good programs, all participants have a necessary, predetermined, and specific role. These roles should be necessary for the project and avoid taking the job of a local worker, and each participant should know what will be expected of them! Participants with medical skills may be specifically requested (some organizations only recruit medically trained participants). Participants who are not medically trained may be able to assist in areas like technology, data collection, translation, logistics, communications, etc—or even simply be an extra pair of hands—as long as these roles are necessary, welcome, and requested.

Participants do NOT perform any medical tasks for which they are unlicensed or which they would not be permitted to perform in their home country. This includes licensed medical professionals who are untrained in other medical specialties. Medical professionals follow all in-country regulations, including registration and/or licensing requirements. Good organizations do not allow unqualified participants to practice, and have policies in place to prevent situations where participants have the opportunity or feel pressure to do so (e.g. leaving participants unsupervised). Good participants also

make a personal commitment to engage in ethical practices! (Lasker et al., 2018)

**QUOTE** “Volunteers can help. The word is help, not do. It is up to us to do but they can help...outsiders would always play a supplementary role. I don’t think that they’re makers of changing our health system” (Ghanaian hospital employee qtd in Lasker, 2016, p. 165).

## CAPACITY BUILDING

Great programs build local capacity. Each of their projects actively avoids creating dependency on external teams, organizations, and resources, and instead works to strengthen the local infrastructure and healthcare system. The goal is for the host community to be self-sustaining. This typically requires a long-term, on-the-ground presence in the community and a focus on prevention or root causes (both discussed in subsequent sections). It also includes knowledge sharing and partnerships with the local healthcare system and government, discussed below. (Lasker, 2016; Lasker et al., 2018)

## KNOWLEDGE SHARING

Knowledge sharing (or training/education) is a great tool for capacity building because it creates a long-term impact that strengthens local healthcare systems. This can include training local workers in any healthcare-related topic, exchange programs, and ‘training the trainers’ (training hosts how to train others in their community). (Green et al., 2009; Wilson et al., 2012)

To avoid the challenges that exist in this approach (e.g. training is not matched to the local context, promotes Western over indigenous practices, etc), good knowledge-sharing is requested by the hosts, relevant and appropriate for the setting, and based on culture, context, environment, resources, and other factors. Good knowledge-sharing is also open to adjustment or new ideas that will make it more effective in the local context. There must be a heightened emphasis on mutual learning in these cases, as participants may be more actively placed in the role of ‘teacher’ (e.g. the foreign participant shares how to do a procedure, while the local provider shares how they’ve addressed that problem with limited resources). Overall, any training should be welcome, culturally-sensitive, and given by participants who understand the local context and how to convey the information—teaching itself is difficult and complicated, and should be informed by its own best practices to be effective (as Lasker (2016) notes, “The idea of American students arriving in another country and almost immediately “teaching”

local residents about sex or any other topic, based on internet research, is appalling” p. 202). (Bezruchka, 2000; Lasker, 2016; Lough et al., 2011)

**QUOTE** “You really need to be training Haitians and not just sending people down back and forth, back and forth. You’re enriching the airlines, but you’re not really accomplishing much long term” (Reichert, qtd in Lasker, 2016, p. 145).

## WORKING WITH LOCAL GOVERNMENTS & HEALTHCARE SYSTEM

Great programs help bolster local healthcare infrastructure by working in partnership with the healthcare system. The healthcare system is one partner in the overarching equitable partnership. This builds patient trust in the local system, maximizes effectiveness, and reinforces local medicine, while avoiding duplication of care, job supplantation, or competition with local professionals. It also includes relying on locally-available equipment, medications, and strategies. (If any equipment or medications are donated, they are integrated into the system and the program works with the local supply chain or finds other local strategies for maintenance.) (Lasker et al., 2018; Roberts, 2006; Wilson et al., 2012)

Good programs also work with and through the local government. Working with the government demonstrates respect for in-country practices and an acknowledgement of foreign participants as guests; facilitates working with the government and public sector to strengthen the local health system, instead of competing with or discouraging government involvement; facilitates projects that address community-identified, or government-identified, priorities in healthcare; offers better resources and easier access; and contributes to the longevity/sustainability of a project. (Lasker, 2016)

**QUOTE** “We work with the Minister of Health very closely....What we did was, we kind of said, “What are your goals?” And then what we did was we filled in the holes around those goals. Everything we do we’re partnering with Dominicans, we’re not

## ENVIRONMENTAL SUSTAINABILITY

Sustainability can also include environmental sustainability. Programs might incorporate environmental practices like reducing waste, locally-sourcing materials, addressing environmental hazards, reducing carbon footprints, etc—which often go hand in hand with better health and development.

## OUTPUTS VS OUTCOMES

Outputs are the basic numbers of what a program produces (e.g. number of patients seen, number of participant hours contributed, number of surgeries completed, number of trainings given) while outcomes measure the change and effect of those outputs on specific goals and measures (e.g. decrease in mortality from a disease, change in knowledge or behavior from a training, etc). Outputs are necessary, but outcomes are what measure the real impact of a program.

overrunning them. If they don't need the services, we don't bring them in" (Organization Director, qtd in Lasker, 2016, p. 169-170).

## SUSTAINABILITY

### LONGER TRIPS

The literature agrees: longer trips are better than shorter trips. On a longer STMM, participants have time to adapt to the new situation and context, learn how to function in the project, really settle into their role, build relationships and find that mutual benefit, accomplish more, and have an overall greater impact. The best minimum length for shorter trips is around 1 month, though certain specialties may still be beneficial during a shorter term and there is debate over whether shorter trips are still beneficial (some organizations only accept long-term participants). But overall, the longer the trip, the better! (Dupuis, 2004; Lasker, 2016; Lasker et al., 2018; Loiseau et al., 2016; Roberts, 2006; Wolfberg, 2006)

**QUOTE** "Host staff members in my research are quite clear about the inferior value of very short-term volunteers" (Lasker, 2016, p. 207).

### LONG-TERM PROGRAM

Quality programs are committed to long-term work in the community. As discussed, a one-time STMM will not have a sustainable impact—so good STMMs are simply one small piece of a larger community project that is on-the-ground, continuous, and long-term. The participants are assisting on long-term projects that began before they arrived and will continue long after. The long-term program ensures follow-up and sustainable progress on the mission's goals, building the capacity of the local system so that the STMMs, and foreign involvement in general, will no longer be necessary. This also importantly ties in to mutuality and partnership—real relationship-building and the development of a true partnership takes time. (Lasker, 2016)

## SERVICE LEARNING

Service-learning, where students engage in community work as part of a course, deals with the same issues and can be an avenue through which students participate in STMMs. Mitchell (2008) defines beneficial, critical service learning as needing to incorporate these three elements:

- Social Change Perspective—reflecting on and analyzing systems, conditions, and structures that necessitate the 'service' work and recognizing that a community's needs do not imply deficits or blame
- Redistribution of Power—being conscious of power imbalances; challenging assumptions and recognizing inequality; and building equal, long-term partnerships where members of the community are fully integrated
- Developing Authentic Relationships—creating reciprocity and mutual learning where all have an equal voice; ongoing dialogue, exchange, and evaluation; and committing to the work, justice, and relationships beyond the end of the official 'service'

**QUOTE** "I think there are ways of making short-term volunteerism more effective by putting it into the context of long-term, locally planned, locally owned support" (Smith, qtd in Lasker, 2016, p. 209).

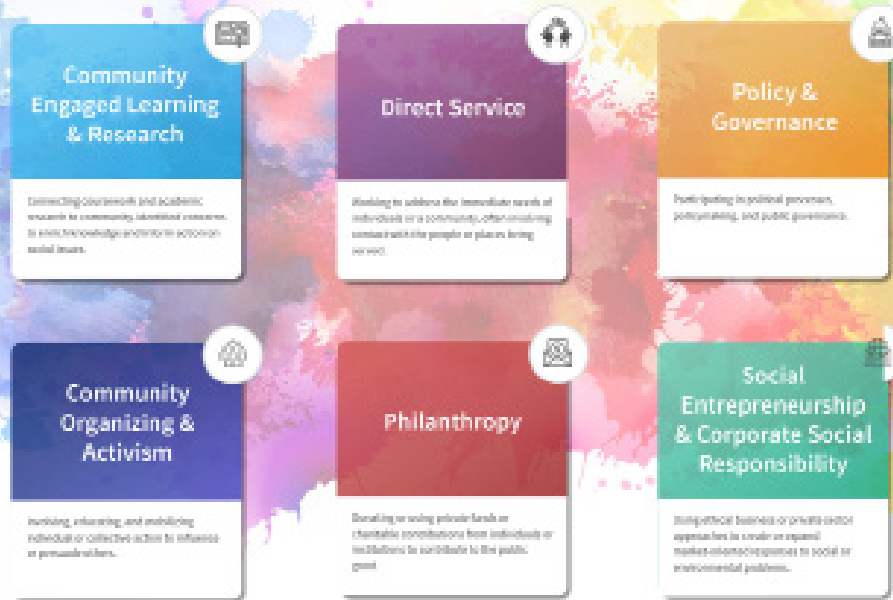
## MONITORING & EVALUATION

No program is or ever will be perfect, and thus evaluation and subsequent improvement are vital! Good programs challenge the assumption that development work is inherently beneficial. They collect hard data and evaluate their programs to determine whether they are meeting their goals and what needs to be improved. Program output data and anecdotal evidence are valid forms of evaluation, but it's also vital to analyze outcomes, which are better indicators of real, long-term change (and unfortunately, much more difficult to measure). Good organizations make the effort to do this type of evaluation—through a partnered, collaborative process between all parties involved. (Lasker et al., 2018; Wilson et al., 2012)

## ROOT CAUSES & SYSTEMS

Good long-term programs may also be addressing the root causes of the problem. Direct solutions to immediate needs are important, but addressing root causes like poverty, healthcare access, education, clean water, food security, etc. and looking towards prevention will make the real long-term impact! Additionally, beyond root causes of a problem

# PATHWAYS of Public Service & Civic Engagement



## PATHWAYS OF PUBLIC SERVICE & CIVIC ENGAGEMENT

One way to conceptualize the different ways to address social problems is through these 6 pathways developed by Stanford University's Haas Center (2019), designed to categorize the ways you can engage in your community. Different pathways focus more or less on immediate needs vs. root causes—STMMs typically fall under 'direct service'—but all pathways are necessary. (Haas Center for Public Service at Stanford University, 2019)

Image: Haas Center for Public Service at Stanford University. (2019, August 29). Pathways of Public Service and Civic Engagement [image]. Retrieved October 8, 2020 from <https://haas.stanford.edu/about/our-approach/pathways-public-service-and-civic-engagement>

in a particular community, good programs and participants are aware of underlying systemic causes of the problem, like the legacy of colonialism, neocolonialism, Western dominance and superiority, economic/political power imbalances, dependency, etc. Large-scale, long-term change also requires engaging with and challenging these bigger, global underlying factors. Of course, one program may not be able to do everything—direct/immediate service, prevention, addressing root causes, and addressing larger systems—but they should be aware of their place within this greater context and help facilitate participants' awareness of this as well.

Essentially, STMMs can be a starting point, a way to plug in and make a small impact on the scale of direct service, but there is also work to be done on the level of root causes and the level of larger systems, and individual and programmatic engagement across all those levels is necessary for progress. (Check out

Sutcliffe, 2010 for a brief look at how some of the theories of social change and systems might apply to STMMs).

**QUOTE** "Responding to individual human needs is important, but if the social policies that create these needs is not also understood and addressed, then the cycle of dependence remains" (p. 13)" (O'Grady, 2000, qtd in Mitchell, 2008, p. 53).

**QUOTE** "Participants must take the time to learn about the global, economic, cultural, social, historical, and political context in which they are themselves entangled (by virtue of their own positionality and heritage, that of their partners, and that of the issues being addressed)" (De Leon, 2012, para. 7).

**PARTICIPANT CONTINUATION AFTER RETURN**  
As discussed, STMMs are by nature short-term

## NEEDS-BASED VS. STRENGTHS-BASED

Needs-based programs focus their programs on what the community lacks and how to fill that gap, while strengths-based programs focus on a community's inherent strengths and how to enhance those strengths or use them to solve problems.

and limited-impact, and the real impact on host communities is the long-term work being done on the ground throughout the year. The other opportunity for long-term impact comes with what the participant does after returning home.

Was it a one-time thing? Or will the participant continue to support the host organization, and bring what they learned home to apply as they work to solve problems in their own communities? That is what the best participants do—they use what they've learned and continue to make change, in their own community or abroad, through any or all of the pathways of service. Good organizations also facilitate and encourage this continuity through preparation, learning, reflection, and follow-up with participants. (Keep in mind that continued work requires the same best practices principles!)

For some programs, the main priority is to turn participants into long-term advocates and leaders through their short-term programs. However, such a transformation requires facilitation and cannot be prioritized over the host community's needs. (Lasker, 2016)

## CHALLENGING WESTERN SUPERIORITY

Good programs and participants do not propagate "US-centered global monoculture" (Bezruchka, 2000, p. 78), western dominance/superiority, or white superiority/saviorism! Instead, they turn this narrative on its head—they challenge power imbalances between foreigners and hosts and ensure a true, equitable partnership where hosts are in positions of power and leadership; they create an atmosphere and culture of mutual respect and humility; they build solid, genuine relationships; and they challenge assumptions (e.g. that knowledge can only flow from the Western world outward, that STMMs are inherently beneficial, or that an unskilled foreign participant will automatically be of use in a project). (Lasker, 2018)

Other ways to challenge Western superiority include passing the mic (giving a platform to the people in the communities engaged in the work); de-centering the foreign participants, removing the concept of

heroism and instead highlighting the local leaders and projects; challenging stereotypes and sharing the dignity, strength, and awesomeness of host community members when sharing information about the program through words or photographs (though still avoiding tokenism); emphasizing a community's strengths instead of highlighting what they lack; recognizing and sharing the complexity of the issues being faced (not oversimplifying); collaborating on projects defined by the community, rather than those defined by outsiders; respecting the agency of host community members; listening; recognizing and confronting power dynamics and privilege; learning and reflecting on those power dynamics and larger systems/causes of inequity; and committing to continuous change! Additionally, challenging WS and other systemic problems (as discussed in the 'Root Causes & Systems' section above) can also include using political (voting, contacting political representation, political activism), financial (donations, where you spend your money), and social (who you interact with, how you create dialogue, challenging social pressures) influence. (NoWhiteSaviors, n.d.; Windholz, 2017)

## LEARNING & CRITICAL REFLECTION

It is vital to understand and reflect on all these issues. Part of critical reflection—before and after an STMM—is wrestling with its efficaciousness and impact. It's challenging your own internal assumptions. It's analyzing the program you're interested in to see whether it uses best practices or damaging practices. It's learning and thinking about other, better methods for development work. It's analyzing your motivations for going on a STMM and thinking about what other arenas you will work to affect change in after you return home. It's thinking about underlying root causes and systemic issues, and how those things can be addressed.

Great participants will engage with these issues (as you are now), educate themselves on these topics, and critically reflect on their impacts. Great programs will facilitate this process, with education and critical reflection before, during, and after a STMM.

## OTHER

Additional best practices include:

- Groups and organizations working in the same location coordinate with each other so there is no duplication of efforts. (Loiseau et al., 2016)
- Participants cover their own expenses so that they are an assistance, rather than a burden, to the host organization. (Green et al., 2009)
- Organizations and participants do NOT proselytize or condition the receipt of healthcare on religion.

(Lasker, 2016)

- Organizational logistics are high quality and efficient, including everything from participant travel plans to clinic structure to communication pathways.
- Organizations are transparent about their finances.

## CONCLUSION

You've now been armed with the knowledge of damaging and best practices in STMMs. Again, this is a basic overview, and this topic requires continual learning, reflection, and growth. It's clear that STMMs are not the ideal way to improve healthcare, but perhaps if they are conducted in accordance with the best practices above, they can be a valuable piece of that fight. This continues to be debated. It's difficult to define the 'line' between a bad program that should not be conducted and a good program that, while imperfect, brings enough value to be worth it. It's even more difficult to find where and how an unskilled volunteer can fit into that puzzle. But hopefully the above information allows you to reflect and wrestle with where that line might be.

**QUOTE** "If short-term occasional health services were the best way to get medical care, we'd be doing it in our own countries, and obviously we are not. We know that short-term trips are not the perfect way to provide healthcare services. But we also know that there is an incredible demand for healthcare services in poor areas, and an incredible supply of volunteers that want to support projects around the world. The trick, then, should be to improve the way in which these volunteers provide services, minimizing the negatives of short-term trips and maximizing the positives, while also supporting the capacity of local healthcare systems" (MacGregor qtd in Lasker, 2016, p. 16).

# PROGRAM EVALUATION

## EXECUTIVE SUMMARY

As demonstrated, it is a big responsibility to select a program if you are interested in participating on a STMM. It will require time and commitment to research quality programs. You will critically analyze programs to decide whether they align with best practices and with your values. And remember that no program is perfect, they exist on a spectrum—you'll have to weigh the positives and negatives of each program to make

your own informed choice.

The program evaluation process may seem overwhelming, but this section aims to make it less daunting by describing questions and strategies for analyzing programs. At the end of this section, there is also an evaluation instrument you can use to consolidate the process (or you can always create your own system for evaluation).

This section includes:

**Your Skills.** Define what skills you bring to the table so you can more easily find a good program fit.

**Questions to Ask.** Use this list of questions to evaluate programs during your research.

### Analyzing Language.

- **General Language.** Evaluate whether the organization talks about best practices and principles in depth.
- **Narratives of the Community.** Evaluate how the organization describes host community members (as partners vs. passive recipients).
- **Emphasis on Mutual Benefit.** Evaluate whether the organization uses language about mutual benefit (vs. overemphasizing the benefits to the participant).
- **Partnership vs. Rescuing.** Evaluate whether the organization implies participants rescue the host community members.
- **Complexity vs. Oversimplification.** Evaluate whether the organization simplifies the problems, the people, and the community.
- **Realism vs. Overselling.** Evaluate whether the organization exaggerates participants' impact.
- **Substance vs. Vagueness.** Evaluate whether the organization uses vague phrasing and language that is not backed up by substance.
- **Ethics.** Evaluate whether the language is ethical.

### Analyzing Imagery.

- **Narratives & Partnership.** Evaluate the narratives created by the organization's imagery (e.g. partnerships vs. 'rescuers').
- **Ethics.** Evaluate whether the organization's photos are ethical (consensual, portray dignity, and don't disclose personal information).

### Finding the Information.

- **Look at Websites.**
  - **Nonprofit.** Find whether the organization is a nonprofit.

- **About Us/Mission Statements.** Evaluate the organization's mission.
- **Staff.** Find whether the organization has host community members on staff and in leadership.
- **Program Explanation.** Evaluate how thoroughly they explain the program.
- **Participant Matching.** Find how participants are vetted or matched to STMMs.
- **Participant Materials.** Find the materials given to participants and evaluate what's included in them.
- **Evaluation/Impact Data.** Find whether the organization collects data and evaluates its impact.
- **Finances.** Find whether the organization is transparent about their finances.
- **Look at Articles & Reviews.** Find and evaluate reviews of the organization.
- **Look at Accreditations & Rankings.** Investigate whether the organization is ranked or accredited.
- **Ask the Organization.** Get in contact with organizational staff to ask questions and evaluate the language they use in describing their program.
- **Ask Previous Participants.** Get in contact with former participants, to ask questions and evaluate their language.
- **Ask the Experts.** Get in contact with field experts (e.g. university faculty, nonprofit staff) to ask questions.
- **Work Locally First.** Work with the organization locally to get a feel for it before committing to a STMM.

**Program Evaluation Instrument.** Use this instrument to help evaluate specific programs.

## YOUR SKILLS

Begin by defining your skills and experience—including non-medical skills. For example, do you have language skills? Could you act as an interpreter so the local staff doesn't have to use their time to translate? Do you have experience with community research? Fundraising, grant writing, photography, social media, etc? When you have a solid idea of what you bring to the table, you can find a role that is right for you—one where you can do something meaningful without overstepping your qualifications.

## QUESTIONS TO ASK

Overall, you want to find a program that utilizes the best practices above and avoids the damaging practices. These are the most crucial questions to ask:

- Is there a partnership between the host community and the organization/participants, and is it a

- partnership of equity, mutuality, and respect?
- Does the program use ethical practices? (This and the above question are likely the most important.)
- Is the program long-term (and how)?
- Does the program build local capacity (and how)?
- Does the program challenge dependency and Western superiority (and how)?
- What would your role in the project be, and is it defined, necessary, and welcome?
- Does the program encourage and facilitate learning and reflection (and how)?
- What is the program's documented impact?

Below are some other, more detailed questions to think about as you're researching, split up into each best practice area. This list is also not meant to overwhelm you (you do not need to ask every single question of every single organization), but the goal is to give you ideas and help you start brainstorming.

## MINDSET

- Does the organization have a learning mindset?
  - Do they emphasize both participant and community learning?
- Does it have a partnership mindset?
  - Is partnership the foundation of the program?
- Does it have an impact-driven mindset?
  - Does the organization set goals, pursue impact-driven projects, and evaluate its outcomes?

## TRUE PARTNERSHIP & RECIPROCITY

- Is there a true, equitable partnership?
- Is there mutual benefit, with no excess emphasis on the participant benefits?
- Are both partners involved in project determination, planning, execution, and longevity?
  - Who makes decisions?
  - Does the organization have locals on their staff and in leadership positions?
- How does the organization decide what needs to address—through a community-based needs assessment or CBPR?
- Does the organization emphasize the importance of cultural awareness/humility?
  - Do they provide education on the local culture, context, and language?
- Is the participant's role specifically defined?
  - Are participants allowed to perform medical procedures for which they are unlicensed or that would be impermissible in their home country?
  - What would your role be if you participated with this organization?
  - What specific gap can you help with, and is it



- really needed?
- Could a local be doing your job?

## CAPACITY BUILDING

- Is the work based around capacity building (or does it create dependency)?
- Will the work you do continue to have an impact after the short-term team leaves?
  - Is there a training/education element?
- What is the plan for longevity/sustainability?
- Does the organization work with the local healthcare system and the local government?
- Does the program negatively impact the local labor market?

## SUSTAINABILITY

- Are they realistic about the limited impact that short-term participants have?
- How long are the program trips? (Ideal is 1+ month(s))
- What long-term work is happening on the ground, beyond short-term interventions?
- What is the plan for sustainability?
- Does the organization work on addressing root causes?
- Do they provide evaluation/impact data, showing how their programs have tangibly improved things in the community?
- Do they support and encourage participants to stay engaged once they've returned home?

## CHALLENGING WESTERN SUPERIORITY

- Does the organization address and actively challenge dependency, Western superiority, and white saviorism (e.g. through practices mentioned above)?
  - Do they provide education and critical reflection opportunities on these topics?
- Is the partnership equitable?
- Do they emphasize reciprocal benefit and mutual learning?
- Do they promote respect for the community's agency and recognize that the community is the main driver of its own change?
- Are they promoting damaging, stereotypical, and superiority narratives or equitable, strengths-based, and partnership-based narratives?
  - Do they challenge the damaging narratives (e.g. by highlighting the local leaders, focusing on community strengths, and not oversimplifying the issues)?
- Do they address systemic change?
  - Even if the program focuses locally, do they discuss underlying systemic issues?

- What are their policies on ethical and appropriate participant behavior (e.g. photography)?

## CRITICAL REFLECTION

- What education does the organization provide to participants?
- Do they facilitate critical reflection on higher-level issues like development, dependency, poverty, neocolonialism, etc?

## OTHER / LOGISTICS

- Where does the organization receive funding from (i.e. are they for-profit, making money off these programs)?
- What is the breakdown of program costs (how much goes to the actual program)?
- Do they provide participant support and training (e.g. translation, a code of conduct, information on participant roles, preparation, etc)?
- Do they vet participants for their medical training and ensure unlicensed participants do not practice any medicine?
- What are the expectations for participants?
- Do they specialize in health-related programs? (If they conduct many different types of projects, they may not have specific expertise or strong connections for their health-related STHMs.) (Two Dusty Travellers n.d.)
- Do they proselytize?
- How do they address any language barriers?
  - Do they bring fluent participants or use translators, or will participants be working without translation (this is dangerous, especially medically)?
- Do they give gifts in a problematic way?

## ANALYZING LANGUAGE

The language an organization uses to talk about its work—in its marketing, on its website, and in person—is often a good indicator of quality. Below are a few strategies for analyzing this wording, but keep in mind that organizations can say the right thing without doing the right thing. Additionally, most language indicative of lower-quality programs will be subtle—for example, few organizations will outright say that participants 'save' local people, but it may be implied and discernible in other ways.

## GENERAL LANGUAGE

Overall, notice whether the organization talks about best practices and principles—true partnership, host partners as equals, mutual benefits and learning, respect, locals in leadership, capacity building, empowerment, sustainability, working themselves out

of a job, etc. Additionally, see whether they expand on these principles and describe how their organization uses them. For example, a lower quality program might use the buzzword ‘capacity building’, but a higher quality program might use that buzzword and also define it, explain why it’s important in avoiding dependency, and/or describe how their program actively builds capacity through every project.

### **NARRATIVES OF THE COMMUNITY**

Investigate what kind of narrative emerges about the people in the host communities—whether the host community members are portrayed as dignified and respected partners, or needy and unable to solve their own problems. Most organizations will not call locals ‘needy’ or ‘helpless’ outright, but you can usually tell whether an organization emphasizes the partnership and agency of locals or tries to characterize them as in need of foreign help. This does not mean that factually describing local challenges (e.g. describing extreme poverty) is bad; it’s more about whether locals are portrayed with dignity and respect. (Again, this may not be explicit, but as you look into different organizations you will slowly get a feel for it.)

### **EMPHASIS ON MUTUAL BENEFIT**

High-quality organizations use language around mutual benefit, and describe the positives for both the community and the participants. Lower-quality organizations may over-emphasize the benefits to the participant—focusing primarily on why it will be a great experience for you. It’s important for mutual benefit to describe the positives for the participant, but if the organization is spending several sentences or paragraphs on benefits to the participant and only one sentence/paragraph on benefit to the community, that may indicate a lack of mutuality.

### **PARTNERSHIP VS. RESCUING**

At the extreme end, some organizations use language that implies participants are rescuing local people. This, too, is usually not outright, but can be implied if language focuses only on the locals’ needs and oversells the impact of the short-term participant. Again, look instead for programs whose language focuses on the partnership with locals and their active role as the drivers of change in their own communities.

### **COMPLEXITY VS. OVERSIMPLIFICATION**

Higher-quality organizations use language that realistically addresses the complex, interwoven challenges of improving healthcare. This includes a recognition that long-term, on-the-ground capacity building is the most important piece of a program.

Lower-quality organizations might instead oversimplify the problem to validate a STHM as the best solution. As mentioned above, some organizations also simplify the local people—for example, ‘Paraguayans are charming and welcoming!’ (Simpson, 2004, qtd in Guttentag, 2009).

### **REALISM VS. OVERSELLING**

Also notice language that oversells a participant’s positive impact. For example, “you will have the opportunity to change the lives of the local people” or “you will be one of the community’s greatest assets!” Asserting that a short-term visit by an unskilled participant will be ‘life-changing’ for locals is usually not realistic.

### **SUBSTANCE VS. VAGUENESS**

Organizations may have positive language/wording that sounds great but is not backed up by the substance of a program. So investigate vague language! For example, “through this program you will make a huge difference in the lives of the local people!” Using the phrase ‘make a difference’ is not a bad thing, but do they describe what that difference will be, or is the actual impact defined? Be wary of vague phrases that have ill-defined substance beneath them.

### **ETHICS**

The language should also be consistent with ethical principles. For example, be wary of language like “you can get involved in hands-on medical procedures” if there does not seem to be a vetting/screening process for participants.

### **ANALYZING IMAGERY**

The images an organization uses in their marketing and on their website can also indicate their underlying commitment to best practices.

### **NARRATIVES & PARTNERSHIP**

Analyze the narratives that the organization’s photos and videos create. Good photos can include those that highlight local leaders, portray host community members as active partners, emphasize community strengths, and challenge stereotypes. Bad photos are those that perpetuate oversimplifications, contribute to stereotypes, over-highlight participants (making them seem more important), make it seem like participants are in charge or ‘rescuing’ locals, focus on community needs (discounting strengths), and portray host community members as passive recipients instead of partners. Also ask: Do photos include locals and local leadership? Are there photos of just host community members? Does the photo show people with dignity?

Or, on the negative side, does the photo seem to separate the participants and the locals into separate categories, 'us' vs 'them'? Does the photo seem intended to create feelings of pity? Is it about showing how 'great' the volunteer is?

## ETHICS

Good organizations will use photos consistent with ethical photography principles—showing people with dignity (i.e. not in compromising or private situations; exploitative photos of people living in difficult conditions are often called 'poverty porn'), avoiding photos that disclose patient health information, and obtaining consent to post someone's photo. True consent is especially salient for photos of children, who cannot give consent, or when power dynamics might make someone feel pressured to give consent. Ask whether it would be acceptable to take and post the same photo in the U.S.

There are some great resources on this with more specific examples—check out RadiAid's Radiator Awards and the instagram accounts @BarbieSavior and @HumanitariansofTinder for examples of poor vs. quality imagery.

## FINDING THE INFORMATION

### LOOK AT WEBSITES

The easiest way to begin research is on the internet. You can start with a simple google search, look for nonprofits in your area, and/or use nonprofit association websites, databases, and university/school programs as starting points. Looking through organizational websites is a great way to narrow down the programs you're interested in. However, keep in mind that answers to many of the questions above might not be available on a website. Plus, lots of websites 'look' perfect even when the organization is not; while great organizations may not spend lots of time on their websites! (Two Dusty Travellers, n.d.)

As you look through organizational websites, in addition to looking for the questions above and analyzing the language/imagery, below are some other website-specific questions to ask.

**Nonprofit.** First, is it a non-profit organization or a for-profit organization? For-profit organizations may be more likely to prioritize profit. Nonprofits are designated in the U.S. tax code as 501(c)3 organizations and donations to them are tax-deductible. Is this noted on their website?

**About Us/Mission Statements.** This section of the website can tell you a lot—what is their mission? Does it revolve around mutual partnerships and capacity-building? Or is it problematic in any of the ways detailed above? This is a really important place to analyze the language. Read through a whole bunch of organizations' mission statements, and you will start to get a feel for which ones are the highest quality.

**Staff.** Do they have host community members on staff? In leadership positions?

**Program Explanation.** How well do they explain the project on the website (or if it's not detailed on the website, is that information available if you request it)? As mentioned above, be wary of vague descriptions. Are they specific about how the project was selected, the participants' roles, the project goals, and the project impact? Additionally, notice how much time is spent on the participant side of the project (e.g. your experience, your benefits) vs. the community side of the project (e.g. the community partnership, the community benefits).

**Participant Matching.** Can you find how they match participants to trips? Are participants screened for positions (especially those that require medical qualifications)? Or do they offer options for non-qualified participants to do any type of procedure or care that should be done by a medical professional (including the teaching of healthcare topics with no experience in education)? Look at the roles that non-medical participants play—are they clearly defined, ethical, and necessary?

**Participant Materials.** Do they have their participant materials available online (e.g. guidelines, handbooks)? If so, look through them to check out and analyze what is included (e.g. philosophies, values, how the program works, education on damaging practices/behaviors vs best practices, etc). What training and reflection is required of participants?

**Evaluation/Impact Data.** Does the organization have specific, evidence-based goals for what their programs will achieve? Or are their goals vague and intangible? On the website, do they describe how they conduct evaluation and present hard data describing their impact? Also think about whether evidence is based in anecdotes, outputs, or outcomes (while keeping in mind that evaluation of outcomes is very difficult).

**Finances.** Finally, are they transparent about their finances on their website? Great organizations make all

their financial information available, including where the money from any participant fees will go.

### LOOK AT ARTICLES & REVIEWS

Large organizations may have been analyzed by journalists or reviewed by previous participants. If you can find independent articles about a program (not articles written or funded by the program itself), they can give you insight into ethical/unethical practices. Organizations may also post participant reviews, but keep in mind they are unlikely to post any negative reviews on their own, and some even incentivize people to post good reviews or create scam reviews. Try to find independent, non-biased sources of review.

### LOOK AT ACCREDITATIONS & RANKINGS

You can also check out the many websites that rate/rank nonprofits, accredit them, or act as watchdog agencies. For example, CharityNavigator (perhaps the most well-known charity-ranking website in the U.S.) creates ratings for organizations based on Accountability & Transparency and Financial Health. However, be sure to think about what raters and accreditors use to make their judgments. They may be leaving important things out (for example, accountability, transparency, and financial health are not the only things that make a good program).

### ASK THE ORGANIZATION

Once you've found a few promising organizations, get in contact with them! Call, email, or video chat with a staff member and ask your most important questions (e.g. the top five important questions listed above). Also get a feel for how they talk about the work they do (analyzing the language and message as you do on websites). Really, the most important thing here is the partnership—do their words and answers reflect true respect and equity? In describing the program, do they highlight the work of the partners?

Great organizations are honest, especially about the complexity and difficulty of development work. Another good idea is to ask about their mistakes or bad testimonials. Are they willing to admit their wrongdoings in the past and explain how they're trying to improve? Beyond this, are they aware of and willing to discuss damaging practices and how STMMs can be problematic (and what they are doing about it), or do they quickly shove those concerns under the rug?

Do they seem genuine? It can be difficult to tell whether people just know the right words to say or whether they really believe in using best practices. As you talk to different organizational staff, you will get

a better feel for analyzing the language they use. And that's also why this is just one piece of the research process.

### ASK PREVIOUS PARTICIPANTS

You can also ask the organization to put you in contact with previous participants (if they don't want to, that is a major red flag). Again, ask your most important questions, and in the same way you analyze how the organization talks about the work on its website and through its staff, see how the previous participants talk about their experience. This is a very good indicator of the program's quality. How do they talk about the host community members—as partners and leaders, or as people they helped? This will be indicative of how the organization frames the project and partnership.

Specific questions that can be helpful include asking what about the project was meaningful for them, and what was meaningful for the community. Ask what their role on the project was (was it ethical, defined, and necessary?). Also try asking the participant what they felt their impact was (are they realistic about it?) and what problems they saw with the trip (do they candidly address areas for improvement?). Keep in mind: An organization may be more likely to put you in contact with a participant who had a great experience than one who did not, so this too may not always be a fully accurate reflection of the program.

### ASK THE EXPERTS

You can also reach out to experts on this topic, in your home community and beyond. Talk to university faculty in global health, learning abroad offices, nonprofit staff, NGO leaders, etc. and ask about general concepts or specific programs. They also might have program recommendations for you, or be able to give you feedback on an organization you've found.

### WORK LOCALLY FIRST

You can also see if an organization has local or remote opportunities to get involved. This way, you can get involved in the organization before committing to a trip. Working with the organization in-person will give you a much better feel for its philosophy, its values, and its principles—and how all those things translate into its work. You can get a feel for the people involved, how they view the work, and whether they are committed to best practices (or not). It'll also give you a chance to ask questions in person.

### CONCLUSION

Hopefully this tool has helped you to learn more about these issues, have a better idea of STMM best

practices vs. major damaging practices to avoid, and become an overall better consumer when it comes to STMMs. Debates continue about the merits and specific damaging/best practices of STMMs. Navigating this topic and these issues is an ongoing journey—we are continually learning and working to improve ourselves and our communities (at home and abroad) in pursuit of a better world.

Be sure to check out the linked resources and search for your own resources as you continue your own learning journey to become a more informed STMM participant. Also see below for a more succinct evaluation tool to use when analyzing programs.

# PROGRAM EVALUATION INSTRUMENT

PROGRAM NAME: \_\_\_\_\_

## INITIAL VETTING

As you begin to research prospective programs, first investigate these initial questions to determine whether you want to look into the organization further.

Is there a partnership between the host community and the organization/participants, and is it a partnership of equity, mutuality, and respect?

Does the program use ethical practices? (This and the above question are likely the most important.)

Is the program long-term (and how)?

Does the program build local capacity (and how)?

Does the program challenge dependency and Western superiority (and how)?

What would your role in the project be, and is it defined, necessary, and welcome?

Does the program encourage and facilitate learning and reflection (and how)?

What is the program's documented impact?

## IN-DEPTH EVALUATION

If after first glance it seems like a solid organization, use this section to do some more in-depth evaluation. The rating scale uses 'U' for 'unacceptable', 'A' for 'acceptable', and 'E' for 'excellent'. There is no threshold number of 'excellent' ratings, this is just for you to keep track of what you're seeing during your evaluation. You are responsible for deciding what you think an organization's value is!

## MAIN QUESTIONS

**How would you rate the organization in regard to the following questions? Does the organization...**

Have a true partnership with the host community (mutuality, respect, equity)? **U A E**

Use community-driven needs assessments to define projects? **U A E**

Emphasize cultural humility? **U A E**

Specifically define participant roles? **U A E**

Prevent participants from performing medical procedures they are unlicensed in? **U A E**

Build capacity? **U A E**

Work with the local healthcare system and government? **U A E**

Avoid hurting the local labor market? **U A E**

Conduct STMMs that are longer-term? **U A E**

Work as part of a long-term, on-the-ground program? **U A E**

Have a plan for longevity / sustainability? **U A E**

Address root causes / systems? **U A E**

Document its impact? **U A E**

Challenge dependency and Western superiority? **U A E**

Promote positive narratives of the community? **U A E**

Define and use ethical practices and behaviors? **U A E**

Share its financial information? **U A E**

Address language barrier issues? **U A E**

Provide training and facilitate reflection on these issues? **U A E**

## YOUR ROLE

What would your role be in this project? What skills or value could you bring to this project?

Notes: \_\_\_\_\_

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## IMAGERY RATING

Narratives & Partnership **U - A - E**

Ethics **U - A - E**

Notes: \_\_\_\_\_

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## LANGAUGE RATING

General Language **U - A - E**

Narratives of the Community **U - A - E**

Emphasis on Mutual Benefit **U - A - E**

Partnership vs. Rescuing **U - A - E**

Complexity vs. Oversimplification **U - A - E**

Realism vs. Overselling **U - A - E**

Substance vs. Vagueness **U - A - E**

Ethics **U - A - E**

Notes: \_\_\_\_\_

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