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**An Exploration of the Role of Short Term Medical Missions
in Health Care Provision in Honduras**

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Abstract

Short term medical missions, or medical brigades are teams of expatriate health professionals and lay people, who travel to Latin America and other parts of the world for a week or two to provide health care to the poor. While the number and popularity of these teams appears to be increasing, to date there has been little literature or critical research addressing their role.

This thesis addresses the role of Short Term Medical Missions (STMMs), who they are, what they do and how they fit into health service provision in developing nations. In particular it outlines the services provided by STMMs, including clinical services, resource provision and preventative services, it discusses the motivation for using STMMs as service providers and it also begins to explore the impact they have on the populations and on local health care services in the areas they operate. This is done within the context of Honduras, a nation that has seen an influx of these teams in recent years, particularly since Hurricane Mitch in 1998. Honduras faces many challenges in health and health care and STMMs have been seen by some as a means of “filling gaps”. This study questions whether STMMs are indeed actually filling real gaps, and if they are, whether they most appropriate means of doing so, as there are many limitations to the ability of short term, outside volunteers to provide quality services.

While not directly measuring the impact of STMMs on the health status of the population, this study discusses the actual and potential impact of STMMs on local health services, and argues that there are potential long-term consequences to their use. These consequences include an increasing dependency on outside assistance that may be detrimental to the long-term development of National health services.

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Abbreviations

BNA	Basic Needs Approach
BP	Before Present
CESAMO	Health Centres with a Physician
CESAR	Rural Health Centres (without a Physician)
MEDRETE	Medical Readiness Training Exercise – short-term health clinic conducted by the United States military.
NGO	Non-Governmental Organisation
PAHO	Pan American Health Organisation
PHC	Primary Health Care
PRA	Participatory Rural Appraisal
SAP	Structural Adjustment Policy
STMM	Short Term Medical Mission
UN	United Nations
UNAH	Autonomous National University of Honduras
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
US/ USA	United States of America
USAID	United States Agency for International Development
WHO	World Health Organization

Chapter 1: Introduction

Short Term Medical Missions (STMMs) or “Medical Brigades” have become common phenomena in developing countries around the world, particularly in Latin America. They allow western health professionals, unable to devote years of their lives to volunteering, an opportunity to “give back” or “help out” by offering health care services to “needy” areas. The rising numbers of STMMs has led to increasing criticism of the teams and what they do, however despite this there is little literature and few studies on the topic. This thesis aims to fill this gap by examining the role of Short Term Medical Missions (STMMs), looking in particular at who they are, what they do and how they fit into health service provision in developing nations.

The topic of STMMs is one that has roots in my own personal experience of health care in developing countries, and in more recent studies of health and development. My desire to travel and more particularly to work in the third world and to help those less fortunate was behind my choice to study nursing. It took me a few years to realise this dream; but in 1997 I was finally able to spend some time working with an NGO doing medical, dental and optical work in rural Vanuatu. This experience was the beginning of a journey, as it was at this time that I began to have doubts about the role of short-term volunteers in health care. These doubts arose as I observed the team doctor treating patients who presented with a variety of aches and pains, infections and medical conditions. For example we gave arthritis sufferers a months worth of paracetamol, knowing that while it might help control back pain now, the patient would probably not be able to access more once that month's supply ran out. We gave children treatment for parasites or malaria, but knew they could easily be re-infected. A woman with breast cancer was given symptom relief, but we knew she would almost certainly die without long-term treatment. I realised very quickly that the work we were doing was only short term, and therefore limited. This realisation was confirmed nearly a year later when I received a letter from the doctor I had worked with in Vanuatu. He had returned to visit the small rural hospital where we had worked and reported that once again the pharmacy, which we had completely restocked, was completely empty, and the generator we had fixed was again broken. It was as if we had never been there at all.

Despite the doubts that had arisen from this experience, I was still keen to do what I could overseas. My travels with a medical NGO took me to the Philippines for six months, then on to Central America for a year. While I had the opportunity to see many people receive health care, including eye surgeries, dental care and health education, my doubts never left. In fact if anything they were strengthened.

In 2001, I returned to New Zealand to marry, having become engaged to a Honduran while working in Latin America. Soon afterwards I enrolled in as a post-graduate student in Development Studies in order to try and understand these experiences and perhaps find some answers, although it soon became clear that the studies actually raised more questions than they answered. For example: what is the role of westerners in health care in developing nations? How can the health needs of the poorest be most effectively met?

It was also during this time that I joined an internet-based forum called projecthonduras.com. This is a website and listserv forum, described as “an online portal for information on ways to help Honduras” (www.projecthonduras.com, 2005). While the “Honduras-Health” email list hosted by projecthonduras.com is primarily used as a tool for networking and co-ordination between health-focussed groups in Honduras, it has also been the forum for much discussion and debate on short-term medical missions. The issues raised by practitioners in Honduras, combined with issues from development studies and from my own experience led me to the topic of the role of short-term medical missions in Honduras for this thesis.

While the origin of the topic is largely personal, one of the main justifications for undertaking this study was the dearth of literature addressing the issue of STMMs. What literature exists tends to be limited to the reporting of particular missions and to information about the logistics of medical work in developing countries. To date, the research that does exist appears to be directed towards defining and evaluating STMMs (Smart et al., 2004; White, Crone, Wieland, & Kleefield, 2004) or presenting an alternative role for mission teams (Oken, Stoffel, & Stern, 2004). There is clearly a need for more critical studies that examine what the teams are actually doing, and their role in relation to existing health services.

What are Short-Term Medical Missions?

As the name “Short Term Medical Missions” suggests, these are programmes or projects of a short duration, usually between 1-4 weeks. They may be offered by medical, religious or other organisations. The teams consist largely of health professionals, offering health services, which may include ambulatory, or family medicine clinics, surgical, dental, ophthalmologic or other specialist services. These services are usually targeted at poor or rural populations, and are offered free or at a nominal charge.

The terms 'STMM' and 'brigade' are used interchangeably in this thesis. The term “short-term medical missions” is one used in other literature on the topic, and is used in the more theoretical and literature-based sections of this thesis. However team members usually call themselves either a “medical mission” or a “medical brigade”, and they are known in Spanish as “brigadas medicas” or medical brigades. Therefore the terms “mission” and “brigade” are used alongside “STMM” in the data analysis and discussion chapters.

The Location

STMMs work many parts of the world, and are increasingly common throughout Latin America. However because of the limited time frame and scope of this thesis it was necessary to focus on one country. I chose Honduras as the location for this study as it has seen an influx of these teams in recent years, particularly since Hurricane Mitch in 1998. This growth was something I had observed during my time working in Honduras, and is also evident from internet searches on medical missions (Smart et al., 2004). I was also aware of a growing network of NGOs and individuals in the country who were interested in the topic, both through the projecthonduras.com website and personal contacts in the country. Honduras was also a convenient choice logistically because of my marriage to a Honduran and previous experience working in the country. This greatly simplified issues such as accommodation and transport in the field, and research issues such as translation (the role of my husband in this research is discussed further in Chapter 2).

The Research Problem, Aim & Objectives

This study is concerned with the role of short-term medical missions (STMMs) in health care provision, in the context of health and development in Honduras. The relationship between health and development is complex. As will be discussed later in this thesis, health affects socioeconomic factors and is itself affected by them. It cannot be isolated from socioeconomic, institutional and political factors of the development process (Bryant, 1969: 96) With this in mind the role of STMMs is examined in this study within the Honduran development context, the social, economic and political realities of Honduras as well as its health care system.

Although STMMs are not usually considered as a formal part of the health care system in Honduras- or elsewhere, it appears that they are becoming an increasingly common means of providing health care in Honduras. This raises many issues both in regards to the appropriateness and quality of the services provided, as well as the overall impact the teams are having on local health services and on the health status of communities and individuals.

In order to adequately address these issues it is important to explore several related questions. These include what health related activities the teams are currently undertaking, where and why they are undertaking these activities, and the nature of the relationships between the teams, their patients and the Honduran health sector. While a full analysis of the impact of the teams on communities and the health system in Honduras is not possible within the boundaries of this study, it does explore some of the actual and potential consequences of using short-term teams as service providers.

The aim of this study is therefore to define what role the teams are taking in health care provision in Honduras- both intentional and unintentional, and to explore the part that teams, health professionals and community members feel that team should- or should not- play in the health system.

While there has been some limited research on STMMs, this has mainly been done from the perspective of the professional, the health care provider. Therefore one of the objectives of this study is to allow the voice of those directly affected by the teams- the communities they serve, their host organisations and the local health care providers to be

heard.

Another important objective is to provide a more complete picture of what the teams are doing in terms of the health care services they provide, and the types of interactions they have with communities. This involves examining the motivations of the team members, the skills and resources they bring to the communities they visit, and the behaviour of the team and patients during missions in order to build a broader overview of the work of the teams and to begin understanding the impact they have.

Because of the limitations of this study- in particular the short time frame and limited number of teams involved, this study is not a definitive representation of all STMMs, even those working in Honduras. It is designed to draw out some of the issues around the use of STMMs in health provision and perhaps stimulate some discussion on the role they should, or should not play.

Thesis outline

This thesis consists of eight chapters, including this introduction. Chapter 2 outlines the research design, including the selection of field sites, and data collection and analysis methods. As a health-focussed research project it is particularly important to address concerns about confidentiality, informed consent and the role of the researcher. Therefore this chapter also discusses these ethical considerations.

Chapter 3 introduces the concepts of health and development, defining the terms and presenting a brief history of the interplay between health care and development efforts. It discusses some of the literature related to intervention in Health & Development, and in particular examines the role of NGOs in health care provision. It finishes with an overview of STMMs, their popularity and some of the criticisms levelled at them.

Chapter 4 is a background chapter on Honduras. A brief overview of Honduran history, economics and politics is given, before examining in more detail the health status of Hondurans and the state of the Honduran health system. This chapter also looks at the role of NGOs in health in Honduras, and discusses the regulation of STMMs in Honduras, and the characteristics of this growing “industry”.

The next three chapters present the data and findings of this research. Chapter 5 presents the framework developed during data analysis, and discusses in detail the role STMMs are taking as health service providers in Honduras. In particular it looks at how teams gain access to the communities in which they work, and what they actually do once they are there. Chapter 6 examines the reasons why STMMs have become so popular as a form of health care provision in Honduras, from both from the teams' viewpoint and from that of the Hondurans. This is followed by a discussion in Chapter 7 of the benefits and limitations of using STMMs to meet health needs. Chapter 7 also outlines the potential consequences of such an approach, for the health status of Hondurans and for the Honduran health care system.

The conclusion (Chapter 8) provides an overview of the research findings and the implications for health care in Honduras. It also highlights some questions that arise from this thesis and that should be addressed in future research on the topic of Short Term Medical Missions.

Chapter 2: Methodology

This research was undertaken as a qualitative study, and while a research plan was drawn up prior to commencing fieldwork, as with many qualitative studies the plan became very flexible. This chapter commences with a discussion of the theory and approach that underpin the methodology before examining in detail the research plan, ethical and personal issues encountered and what actually happened in the field. It finishes with an explanation of the data analysis methods used and how these affected the results outlined in the remainder of the thesis.

Theory and Approach

This study uses a qualitative approach, which is appropriate for several reasons. Qualitative research involves the interpretation of social phenomena from the point of view of the meanings employed by the people being researched, the use of natural rather than artificial settings for data collection and the process of generating rather than testing data (Bryman & Burgess, 1999: x). Qualitative methods are also used to address research questions that require explanation of, or understanding of social phenomena and their contexts (Ritchie & Lewis, 2003: 5). This approach is therefore well suited to the investigation of topics about which little is previously known. It is therefore a relevant approach to a study of Short Term Medical Missions (STMMs), a phenomena which appears to be growing in popularity, but about which little is objectively known. It is also a phenomenon that can be best understood in context- in the locations in which the teams are working. Additionally, this study is primarily concerned with roles, relationships and organisations, elements of social life identified by Lofland and Lofland (1995 : 101-113) as being appropriate to qualitative field research.

Although qualitative methods are well suited to obtaining much of the information required, they do not provide broadly generalisable data. In order to address this, the qualitative research was supplemented with some quantitative methods, including quantitative questions included in questionnaires and analysis of existing quantitative data. Although there is much debate in the literature about whether the two approaches can, or should be combined, there is value in using both in social research where the purpose is to gain a

greater understanding of the nature or origins of an issue but where there are questions that may require measurement of some kind (Ritchie & Lewis, 2003: 38).

Research Design- and what actually happened

Ethical Considerations

Ethical issues need to be considered in all research projects and this project was no exception. Particular ethical issues that arose in the course of this research were issues of confidentiality and anonymity, informed consent and the position or role of the researcher in the field.

Confidentiality

The assurance and maintenance of confidentiality in research serves both ethical and practical functions, granting the participant control over personal information and protecting them from unwarranted revelations (Olsen, 2003: 131). It involves two elements- protecting the privacy of participants, and holding in confidence what they share (Rossman & Rallis, 2003: 74).

There were two major confidentiality issues in this research- the anonymity of participants, and confidentiality of patient information.

The anonymity of participants was an issue, particularly for team members as the research involved small teams of non-Hondurans working in specific locations in Honduras. Although the exact identities may not be unknown to outsiders, it is possible that those involved will be able to identify participants from individual teams, and therefore full anonymity could not be guaranteed. This was explained to participants at the time consent was obtained (see below), and the following clause was included on all team questionnaires (Appendix 2):

“Please note that all effort will be taken to ensure complete confidentiality and anonymity, your name will not be used in the thesis or any publication. However in the context of a small team or particular location full anonymity may be difficult to guarantee.”

The other issue of concern was the confidentiality of patients. The fieldwork included periods of observation in health clinics, which would give me access to individual patient's medical information. As the use of individual medical data was not required for the purposes of this study the following clause was included in the information sheet (Appendix 1):

“This project will not involve the collection of information specific to any individual and their health care.”

Where medical data was included in field notes or referred to in interviews and questionnaires, all identifying features were removed prior to analysis. Discussion of particular cases and conditions within the thesis are therefore completely anonymous.

Informed Consent

Informed consent is the process by which voluntary participation in a research project is ensured. It involves informing the potential participant of the nature of the research and obtaining his or her verbal or written consent to participate (McKinney, 2001: 476).

However informed consent is problematic in qualitative research, as participants cannot always be fully informed at the very beginning because of the tentative and exploratory nature of most qualitative studies. Holloway and Wheeler suggest that in this case, informed consent is not a “once and forever permission” but an ongoing process of informed participation (1996: 43).

Prior to commencing fieldwork for this study it was necessary to obtain consent from participating teams. I sent information sheets to all organisation directors and team leaders as part of gaining access to the field (see Appendix 1), and thereby obtained initial written consent via email. This was not a final consent as individual consent had to be obtained from each team member. This was verbally requested and received in the field, at the time of data collection. This initially consisted of an explanation of the study and an opportunity to ask questions. Provided there was no changes to the path of the research, permission was requested simply at each stage of data collection using phrases such as “Do you mind if I sit and watch what you are doing here” or “Can I ask a couple of questions about what you are doing”. In this way participants knew I was collecting data

and had an opportunity to decline. Verbal permission was most appropriate because of the ongoing nature of data collection and the prohibitive logistics involved in obtaining written consents from all team members during the short time they were in the field.

Verbal consent was also obtained from patients, both for the reasons outlined above and because of concerns that patients may be suspicious about signing a formal document. It was also more culturally appropriate to request consent verbally. As Olsen (2003 : 129) states, “although many research situations exist where written and documented informed consent, as understood in parts of the West, may be the most appropriate means... it is ethnocentric to assume that a procedure so closely tied to a particular way of thinking is acceptable to people from all other traditions.”

I conducted a number of interviews with local health professionals and individuals involved in health care in Honduras. Where interviews were planned in advance I sent a copy of the information sheet prior to the interview date. Unplanned and informal interviews also occurred, in which case an explanation of the study was given prior to the interview commencing. As most interviews were one-off and there was no anticipated follow-up the consent itself was verbally obtained. Finally, a short explanation of the study and the rights of the participants was included in all questionnaires used, and completion of the questionnaire was considered implicit consent for the inclusion of that information in the study.

Positionality or Role of the Researcher

Researcher positionality or role was a key ethical issue in this research. As de Laine (2000 : 17) notes, ethical dilemmas in fieldwork usually have less to do with formal procedure such as informed consent and more to do with overlapping roles, relationships and the interests, expectations, allegiances and loyalties of the parties concerned. This is a particularly important issue for health professionals involved in qualitative research, and has been extensively addressed in the nursing research literature. This may be because of a perceived conflict of interest, in particular the research commitment versus a nurse's dedication to patient care.

The primary focus of nursing ethics is to safeguard the interest and well-being of patients, and this can lead to a conflict of interest when a nurse undertakes research (Holloway &

Wheeler, 1996: 40). In a professional role the person is recognised as a patient or client, but in a research role the same individual may be seen as an informant, or participant, and these roles cannot always be reconciled (Holloway & Wheeler, 1996 : 47). Additionally, the nurse usually has the clinical skills and experience to know what may occur when something is not dealt with immediately. This leads to the desire to intervene in a situation, which is a major ethical problem for nurses in research (Chentiz & Swanson, 1986 : 55,68). As Holloway (1996 : 47) states- 'health professionals cannot close their eyes to distress and pain because their professional training guides them towards being carers and advocates for their clients'.

A final problem particular to health professionals in research is conflicting role expectations- participants do not always comprehend the research role of the health professionals and often see them primarily as carers (Holloway & Wheeler, 1996: 43). This is especially true for research in developing nations. For example nurse researchers in Honduras following Hurricane Mitch found that study participants who had seen them working in clinics in a nursing capacity had difficulty understanding their research role and their inability to offer services (Crigger, Holcomb, & Weiss, 2001: 465).

The dual perspective may not always be a negative. It is possible to take advantage of interaction in the field- for example intervention or participation in some situations may open up new ways of thinking and provide new data (Chentiz & Swanson, 1986 : 56). Chenitz and Swanson suggest that unless the health of a participant is threatened, it can be appropriate to carry out interventions at the conclusion of the interview (68-69). This has been tried by nurses in health research with success. Millen (2004 personal communication), a non-nurse researcher studying HIV/Aids in Africa, had a nurse as a translator. The translator was not introduced as a nurse until the end of the interview, at which point the participant was asked if they had any questions that they would like answered. In this way Millen and the nurse were able to reciprocate, as well as avoid potential issues with bias and coercion.

Nursing research interventions such as offers of service or knowledge can also become important sources of data. Questions asked by participants, or assistance required may provide insights not seen in formal data collection methods. The key is in the researcher's awareness that they are intervening, noting why they intervened and the outcomes of that intervention (Chentiz & Swanson, 1986: 56-57).

The questions of role and positionality in research arose early in the fieldwork planning process- there was a clear decision to be made in regards to the disclosure of my nursing background, and from there the particular role I would take during the duration of the field research. In practise I found that once in the field the issue of positionality or identity was both more and less complex than I had thought. It was more complex because different roles and identities were needed at different times and places, however it was less of an issue than I had anticipated as it became quickly apparent what role I should take and when.

Even before I left it was clear that in order to gain access to at least one of the teams my nursing skills would be useful. Once I arrived in the field my role within the team and relationship with the team hosts became quite clear. All the teams had met in the USA and travelled together to Honduras. We met them at the brigade location, having arrived a few days earlier. This allowed me and my husband (who was accompanying me) to meet and talk with the host organisation prior to the team's arrival, and made it clear to both the hosts and the team that we were researchers. This did not preclude the teams from "adopting" us during the course of the week, which indeed they did- including us in team activities in the evenings and so on, however the roles remained distinct.

During the second team I was offered the opportunity to "take a station" and see patients in a clinical role. This offer raised some of the ethical issues discussed above in regards to role conflict and expectations but I decided to take this opportunity, mainly as a form of reciprocation- some of the team had gone to a second location for the day and the remainder were very busy and needing assistance. As noted above, Chenitz and Swanson (1986: 56-57) have suggested interventions such as offers of service or knowledge can actually become important sources of data, and this was my experience. Firstly, patient behaviour and responses to clinical questions provided some rich information that complimented the formal interviewing of patients. Secondly the experience of "doing" clinics gave me insight into the way in which teams behave and their responses to the Honduran context. I therefore continued to participate, at varying levels, throughout the remainder of the field research, as appropriate and when invited by the team.

The issue of whether or not to disclose my nursing background to patients was also relatively easily resolved once in the field. Although my biggest concern was whether or

not disclosure would influence the responses obtained from patients it soon became clear that as a white woman, in town at the same time as the team, it was simply not possible to distance myself and establish a separate role as researcher. In the eyes of the patients I was part of the team and the community's behaviour around me was congruent with that belief. My original plan was to undertake interviews and focus group discussions after the team had left, and in this way distance myself from the team. However in the field this was often impractical due to time and transport constraints, and did not solve the problem of bias as patients continued to associate me with the team (discussed further later in this chapter).

Selection of Field Sites

Using an internet- based search Smart (2004: 34-35), identified a total of 71 organisations actively involved in providing short-term medical missions to Honduras, including 21 large international NGO's and 50 smaller organisations. These NGO's include religious and non-religious organisations, and military, professional and academic groups. They also cover a wide range of focus and activity, from tertiary-level specialist and surgical services to children's health clinics and "primary health care" provision.

Honduras receives significant numbers of these teams each year- an internet search based on the organisations listed by Smart and on information from ProjectHonduras.com identified 20 teams that would be in the country during the fieldwork dates (November 2004 - February 2005).

Because of the number of teams and the wide range of types of team and activities it was important to decide on a focus for this research.

The first decision was to limit the research to teams undertaking general medical clinics- often called ambulatory or family medicine clinics. This was because surgical or specialist medical clinics usually operate from within hospitals and large medical centres in the cities. They are also providing services that may only be available on a very limited basis- or not at all. Therefore their role is already much more defined than that of a team working at a community level offering general services. However many teams combine surgical or specialist clinics at a local hospital with general clinics in surrounding villages,

and many combine medical work with dental and optical clinics. These teams were included for consideration, with the focus of the fieldwork to be on the role of the medical clinics.

Another issue that required some consideration was religion, or faith based teams. A significant number of short-term medical teams to Honduras are Christian - of the 71 organisations identified by Smart, 34 were "faith-based" (Smart et al., 2004: 35-36). A number of smaller NGOs integrate short term medical missions with proselytising/ evangelism, and that evangelising may be seen as the first role of the team- and in fact the sole purpose of medical work for some may be to seek converts (29-30). Because of the large proportion of teams from religious backgrounds it was important to include them in order to gain an accurate picture of the situation, but some boundaries were made. As the research focus is health care provision, the teams chosen were self-identified as having medicine/ health care as the primary focus rather than evangelism or religious works.

Another group identified as conducting medical clinics is military teams. In particular, the United States military conducts health clinics, called MEDRETEs (Medical Readiness Training Exercises), in Honduras, whose main functions are as training exercises for the army medical services (Yoder & Wassum, 2002). Because their main aim is training, and because of anticipated difficulties in obtaining clearance to conduct research, these teams were excluded.

Once surgical or specialist teams, and overtly religious and military groups were excluded there were 15 teams left which would be appropriate for this research. As there was only going to be enough fieldwork time to visit three or four teams onsite a sampling method was clearly necessary. Because of the limited time it was important to identify what Patton (2002 p230) describes as "information rich" cases. A purposeful sampling method was therefore chosen for this study.

While there was no guarantee of gaining entry into all teams, a modified form of criterion sampling was used to make the first choice of teams to approach. Criterion sampling involves reviewing all cases to meet some predetermined criteria of importance (Patton, 2002: 238). The aim was to have a sample of 2-4 teams, which included at least one professional or academic group, at least one religious and one non-religious group, and to

have both local and international NGOs represented. From this a prioritised, or “short list” was generated. The short list comprised of three teams that fit the sample specifications above.

The three short-listed teams were contacted two months before fieldwork was to begin. They were contacted by email, addressed to the director of the organisation. Two responded with invitations to join them in Honduras. A third team, a professional group scheduled for December 2004- the beginning of the fieldwork phase- replied that their team was probably not the best one to use in the research. Unfortunately, December is a very quiet month for teams in Honduras and I was only able to identify one other- a Church team. Although my plan had been to exclude overtly evangelical teams, I had few options and decided to contact them. I soon realised that this was actually fortunate as this particular team provided insights into the religious nature of STMMs and into the role of non-NGO teams that I would otherwise have missed.

Data Collection

A number of writers emphasize the need for flexibility in research design in qualitative research. The research design is a continuing process involving constant review, allowing for the element of the unknown that is always a part of social research, and for the exploration of unanticipated issues as they emerge (Ritchie & Lewis, 2003: 47). This was certainly the case with this research. A basic plan for data collection was drawn up during preparation for fieldwork, but the plan was of necessity flexible and was subject to much change in the field due to situations encountered in the field and new issues and ideas that emerged as a result of those issues.

Research tools planned and/or used in the course of the study included questionnaires, structured and informal interviews, and participant observation. Data was also collected from other sources- in particular from websites, team documentation and reports and personal accounts of mission experiences.

Interviews

Interviews, in particular in-depth interviews, are a major feature of qualitative research.

The plan for this research was to interview 2-3 members of each team, the team leader and hosts or representatives of the host organisation, local health professionals and a small sample of patients from each community visited- about 8-10 interviews per team.

Unstructured formal interviews were planned, but because of my lack of experience and the limited time I had to collect data a comprehensive interview guide was created. The key topics to be covered in interviews were relationships between the team and the sponsors/hosts and local health professionals, role perceptions, team actions and the perceived impact of the mission. Background questions were included about the team itself, and the mission location.

Once in the field, it became obvious that time was a major constraint on my ability to do in depth interviews, in particular with team members. The teams were only in the country for seven or eight days, working most days from 8am until 6 or 7pm, and often only taking a short break for lunch. I had hoped to conduct interviews in the evenings, but teams were usually very tired at the end of the day and retired to their rooms soon after the evening meal. This meant I needed to be a little more creative in obtaining data. For example, I was able to ask many of my questions during short informal interviews, conducted while travelling too and from clinics, and during coffee and meal breaks. After the first team had completed work for the week, I had an opportunity to conduct a group interview which enabled me to follow up questions unanswered during the week. This was not possible with the second two teams. By the end of the second mission I did not feel I had collected sufficient data and again looked for another method. I decided the most practical method of obtaining the information was via a questionnaire, and following discussion with the team leader decided to email the questionnaire to all team members after their return home. I used the same questionnaire with the third and final group, who preferred to complete it prior to departure and so I printed and distributed the questionnaire on site. Having administered the questionnaire to two teams, and still lacking some data from the first I decided to email the questionnaire to members of the first team, although by that stage two months had elapsed since that mission.

The questions in the questionnaire were taken largely from the interview checklist planned prior to the commencement of fieldwork, and were therefore mostly open-ended. The answers were analysed along with interview transcripts as qualitative data.

The response rate to this questionnaire was good- 26 responses were received from 39- a response rate of 64%. The best rate of response was obtained from the team who was given hard copies to complete before departure- 11 from 12 were received.

Interviews with patients were constrained by the problems related to my association with the team, and my status as an outsider or “gringo”. This issue was partially addressed with the use of my husband as a research assistant (see the discussion of “Personal Considerations” below), although it is clear that some bias may remain in the patient data collected.

Patient interviews were also constrained by time limitations. This was addressed with the use of short questionnaire interviews carried out at the clinics (see Appendix 3). Although only a limited number of these were completed the answers were remarkably consistent across all missions and locations, and the data from these was used in qualitative analysis.

In depth interviews were carried out in between missions with local health professionals, mission hosts, and other individuals involved in health care in Honduras. These interviews were largely unstructured- I introduced the study and topic asked a few open-ended questions attempting to elicit the views and perspective of the interviewee. This approach was quite successful, particularly as a means of obtaining data about the experiences of those individuals with medical missions.

Focus groups were planned with team members and with patient groups, however these proved to be difficult to implement in the field. One group interview was done with team members from the first team, but there was insufficient time and space to hold them with the second two teams, and information was instead obtained through individual questionnaires and informal discussions (as discussed above).

I also planned to use Participatory Rural Appraisal (PRA) techniques with focus groups with patients. As noted it became clear early in the research that focus groups, and therefore PRA with patients would be impossible due to time and transport constraints. The plan had been to approach patients after the team had left but I found that the patients often did not live near the clinic, or the clinic location was far from the location we were staying. Travel to meet patients and arrange focus groups would have taken more

time than we had to complete the research at each location. In the end, information from patients was collected in the form of questionnaire interviews conducted at the clinic location, and to a limited degree, in patient homes after the team had left.

The inability to undertake group interviews and complete the PRA exercises planned obviously had implications for my research and the amount and quality of data collected. It also meant I was unable to involve the community to the degree I had hoped, and any benefit to the community from discussion of STMMs and health in their area was lost. This was disappointing, although the nature of the interviews conducted tended to indicate that most people did not want to critique or question the teams, perhaps fearing the loss of those benefits the team brought.

Other Questionnaires

Conference Questionnaire- In October 2004 projecthonduras.com organised the “Conference on Honduras 2004”, a conference focused on education, healthcare, and community building in Honduras, which aimed to present and exchange information on grassroots volunteer projects to help the people of Honduras. It brought together more than 300 individuals representing over 100 non-governmental organisations (NGOs), agencies, companies, churches, foundations, medical brigades, and universities. This was a great opportunity to both collect data and to introduce myself and my research to the NGO community in Honduras.

Unfortunately due to the timing of the event I was unable to attend, but instead was able to send a questionnaire which was distributed and collected by a contact in Honduras (see Appendix 4). This self-administered questionnaire was directed at organisations rather than individuals as the idea was to collect background information about who does medical missions, what they are doing and where. I also hoped that this questionnaire would generate some interest in the research. Specifically the information sought from the questionnaire included questions aimed at identifying who is involved in STMMs in Honduras, what they are doing, where and why. Some open-ended questions were included to elicit opinions and ideas regarding the work of the teams, and why (or why not) the organisations use STMMs in Honduras.

A self-administered questionnaire was considered appropriate in the context. The respondents were mostly professionals and highly literate, I was confident of a reasonable high response rate given the context of the conference and none of the questions required a face-to-face interview (Bernard, 2002: 250). Unfortunately my initial positiveness about the return rate was unfounded and only four of approximately 50 were returned. This was obviously insufficient for analysis and generalisation. In an effort to improve the return rate I posted the questionnaire on the projecthonduras.com email list, which resulted in a further seven returned questionnaires. There are an estimated 42 humanitarian organisations and seven academic organisations involved in STMMs listed on the projecthonduras.com website. This made a combined response rate of 11 (four from the conference and seven from the website) out of a possible 49-50 organisations, or 22%. This was clearly insufficient for statistical analysis however I included answers to the open ended questions as data for qualitative analysis.

Later in the research process I was able to access a spreadsheet had been posted on the ProjectHonduras website, which listed all short-term missions to Honduras in 2004 known to the author Marco Caceres, their focus (medical, dental, surgical, construction or evangelical) and the location of the mission. Data from this spreadsheet helped answer some of the questions I had designed the questionnaire to cover, and I used it extensively as background information for this thesis.

During the design of this research I was in contact with Ben White, a researcher from Harvard University who was in the process of creating an evaluation matrix for short-term medical missions. Following an initial phase involving literature reviews and research at six sites in Latin America, White had developed a matrix for evaluating and comparing the success of STMMs in relation to six factors- cost, efficiency, preparedness, education and sustainability. Data collection for this matrix was in the form of anonymous survey-worksheets for mission leaders, participants and hosts, which were to be filled in via a form posted on the internet (White et al., 2004). These questionnaires were ready for testing at the time my fieldwork began. I offered to facilitate the completion of the questionnaires with the teams I was to participate with, in return gaining the use of the questionnaires and data collected for my this research.

In the end I did not use the Harvard questionnaires during fieldwork, mainly because of time constraints- the questionnaires were relatively long and involved and most

participants did not have the time. Additionally, on reviewing the questionnaires while in the field, I realised that many of the questions were either not relevant to my research, or were inappropriate to the team participating in my research. However some relevant questions from the Harvard questionnaires were integrated into the questionnaires for this study, and the issues were communicated back to White via email. White's work is also acknowledged elsewhere in this thesis.

Participant Observation

Observation is fundamental to qualitative research (Rossman & Rallis, 2003: 194). In qualitative studies it is particularly important, with the focus being on the interactional level of behaviour, as it is in the verbal and non-verbal behaviours that the symbolic meaning of an event is communicated (Chentiz & Swanson, 1986: 6). Observation was therefore a major component of data collection in this study.

The role of the researcher is of particular relevance in observation techniques, and is closely tied to the researcher's role discussed above. Based on the decisions made about role for this research, I initially decided to take what Gold (1958) terms a "participant as observer role". However within qualitative research there is room for a great deal of variation within that role (Patton, 2002: 265). As previously discussed, that flexibility was vital in this research as my role changed several times, both between and within teams, providing a much richer and fuller picture of the teams and their work.

Observation, with varying degrees of participation, was carried out in all three team locations, and on most days that the teams held clinics. I tried to observe all areas of the clinic at some point in the week- patient intake and waiting areas, medical, dental and optical clinics and the pharmacy area. In some areas and at some times this observation consisted primarily of sitting and watching the team and patients and their interactions. At other times more I engaged in more active participation, which varied from assisting with simple tasks such as packing medications to undertaking full nursing assessments.

Observation proved to be a particularly important tool in this research project, both because of the difficulty in obtaining interviews, and because the information received in interviews was often subject to bias and was often not full and complete. In particular,

patient interviews were limited by their desire to continue receiving free medical care. Observational data filled the gaps, and provided insights into the topic that were very important. As Polgar notes (1995: 149), an advantage of observational data collection is that the researcher is in a position to see and hear how people actually act, rather than their possibly biased reports and justifications. This proved true in the course of this research, where people's behaviour and informal comments were often more illuminating than information provided in formal interviews.

Literature as Data

While there is limited published professional literature addressing the issues related to STMMs the literature review provided many other sources of information on the topic, including mission reports, newspaper and magazine articles, websites and personal diaries and journals. Strauss and Corbin (1990: 55) call this 'non-technical' literature and note that, although not usually used as sources of data in quantitative studies, these sources play an essential role in qualitative studies, supplementing data received from interviews and observations. This is the case in this research where data collected from websites, newspapers and magazines and personal correspondence provided much background information for the study. Additionally, each team that participated in the fieldwork produced team reports or journals, which supplemented the field notes, and interview transcripts were therefore included in the data analysis.

As previously noted, the ProjectHonduras.com website also provided much valuable information, including a spreadsheet detailing all known STMMs to Honduras in 2004.

Personal Considerations

During the course of this research was fortunate to have my husband, a Honduran national, travelling with me. Prior to commencing fieldwork I envisaged his help would be invaluable as a guide, research assistant and translator. This was certainly the case, however. it soon became clear there were other advantages to having him there. As Scheyvens and Nowak (2003: 109-110) state, the presence of family members can provide entrée into parts of the community the researcher may not otherwise be able to access. They also note that partners may become a second set of ears to hear things

that the researcher may not understand or may be restricted from hearing. This was certainly the case during fieldwork for this study. While undertaking data collection with the first team I realised that my husband was obtaining good information in informal conversation with locals, which I was having difficulty eliciting myself. After some discussion we decided that he would try interviewing patients on his own. I discussed with him the questions I wanted to ask the patients, and developed a basic questionnaire to guide the interviews (see Appendix 3). This worked well and he continued with the interviewing throughout the remainder of the fieldwork. This approach proved very successful, as although patients associated him with the team, as a local and not a “gringo” he was able to obtain much richer data than I could alone.

The process of data collection for this study was also affected by other personal circumstances. In particular, a few weeks prior to commencing fieldwork for this study I found out I was pregnant. I decided, after much discussion with my family, doctor and supervisors, to go ahead with the fieldwork, most of which was carried out during the third and fourth months of the pregnancy.

My pregnancy had both positive and negative implications for data collection. Fatigue and nausea were obviously limiting factors, particularly during data collection with the first team. While able to sit and observe the team at work, and to carry out interviews during the day, I was often unable to spend full days at the clinic, or to do much data collection in the evening. This had implications for the data collection- limiting the breadth and depth of the data collected at that time. This was counter balanced by an unforeseen advantage. Although I had initially planned to keep the pregnancy quiet it was hard to hide the fatigue and nausea during my time with the first team, and my growing “bump” during the later teams. However instead of the negative reaction I feared (from health professionals concerned about having a pregnant woman around while working in remote locations), my pregnancy became a humanising factor and an asset to the research. Scheyvens and Nowak (2003: 112) note that taking children into the field “humanises (the researcher) to the community”. While my child was not yet born at the time of the research, this was my experience as well. Being open about the pregnancy resulted in research participants being more open and trusting with me, and the social interaction it generated greatly aided data collection. While increased personal involvement with research participants can lead to “contamination” of research data, as de Laine (2000:

108) argues, a degree of contamination is acceptable to qualitative researchers as an inevitable outcome of intrusion into the lives of people, and full knowledge of this “asserts the value of social interaction to the production of data”.

Finally, my pregnancy also affected my perspective on the data. I was more aware of particular issues and circumstances- in particular women's health and sexuality issues, and was able to explore these issues, which I may well have missed had I not have been pregnant.

Data Analysis

During the beginning phases of this research I contemplated and initially rejected the idea of using a grounded theory approach. I was concerned that I did not have the expertise or time to justify the use of this approach and decided on a simple thematic analysis of the data. However as I started planning for data collection and reading about collection and analysis I found myself steering back towards grounded theory. In hindsight the thematic analysis I had planned was in some respects a somewhat simplified form of grounded theory.

Grounded theory is a set of techniques, developed by sociologists Glaser and Strauss in the 1960's, which is used to identify categories and concepts that emerge from text and to link these into theories (Bernard, 2002: 462-463). The aim is to generate theory that is grounded in the data (Robson, 2002: 493). Because of the focus on theory generation rather than testing theory, grounded theory is most useful in areas where little research has yet been done, in particular in preliminary, exploratory and descriptive studies (Chentiz & Swanson, 1986: 7). Grounded theory is also particularly useful in applied areas of research, where the theoretical approach to be used is not clear or non-existent (Robson, 2002: 192).

Grounded theory has developed from the implications of the symbolic interactionist view of human behaviour. Symbolic interaction is akin to phenomenology; both are concerned with the experiential aspects of human behaviour, how people define events or reality and how they act in relation to those beliefs (Chentiz & Swanson, 1986: 4-5). According to Blumer (quoted in Chentiz & Swanson, 1986: 5) symbolic interaction rests on three premises- that human beings act towards things on the basis of the meanings those

things have for them, that the meaning of such things is derived from or arises out of social interaction and that these meanings are handled in, or modified through an interpretive process. This makes grounded theory an appropriate methodology for exploring the role of STMMs, particularly as the goal of this research is to explore how people define Short Term Medical Missions and their behaviour in relation to them.

Strict grounded theory design requires time and the ability to move back and forward from the field (data collection) and base (data analysis) (Robson, 2002: 193). In particular grounded theory calls for constant comparative analysis- the process of collecting data, analysing it, then returning the field to collect further data, until saturation is achieved (Chentiz & Swanson, 1986: 8). Unfortunately, full saturation was not possible in this research, because of the limited time available for fieldwork and the nature of the phenomena under study, and because the decision to use grounded theory came late in the research planning process. However some data analysis was commenced in the field, and the use of three different field locations provided a source of comparison as the data was collected.

The heart of grounded theory is identifying themes in texts and coding them for the presence or absence of these themes (Bernard, 2002: 463). On completion of the fieldwork, grounded theory techniques therefore provided a structured means of coding, sorting and analysing the data in this study. This process started with reading through the texts- field notes, interview transcripts, questionnaires and other qualitative data collected and highlighting key phrases and concepts. These phrases were coded and sorted into categories. As these categories emerged they were compared with categories from other data, looking for links and relationships. These linkages were then worked into the theory that forms the basis of this thesis.

Clearly, this study is not a full grounded theory study as a result of short time frame for completion of fieldwork and the lack of researcher expertise with the techniques. However the data analysis and the results presented in this thesis were strongly influenced by the ideas of comparative analysis and emergence put forward in grounded theory.

Conclusion

Data collection for this research was constrained by several issues including questionnaire

return rates, language, time and location. Personal circumstances and ethical dilemmas such as the role taken by the researcher also influenced the research. However with changes made to the research plan in the field and creative use of the resources available a rich pool of data was eventually collected.

In addition, because of the nature of the phenomenon studied and constraints on data collection most of the data collected was of a qualitative nature although the research had been planned as a qualitative study supplemented with quantitative methods. Some quantitative data was obtained from other sources, primarily from data already collected by ProjectHonduras.com, and this was used to add depth and some broad generalisability to the study.

The qualitative nature of the data collected during fieldwork for this study was ideally suited to a grounded theory – type analysis. While again there were constraints and the resultant thesis is not a full grounded theory study, the result presented in the next three chapters are strongly influenced by grounded theory and associated ideas.

Chapter 3: Health, Development & STMMs

Before examining the specific role of Short Term Medical Missions (STMMs) in health care in Honduras, it is important to place them in the larger context in which they operate, in particular in the fields of health and development. As health and development are both controversial terms, this chapter will first examine the concepts and theory regarding health and development and how they inter-relate. It will then discuss current trends in intervention in health care in developing countries and in particular the role of Non-Governmental Organisations (NGOs). Finally, it will focus more specifically on STMMs and the place they may have in health and development.

Health and Development

The terms 'health' and 'development', both seemingly simple, are in fact elusive and difficult to define concisely. The meaning of both terms varies widely depending on the context in which they are used, and on who is using them. Therefore it is important at this point to briefly discuss the meaning of the terms as they are used in this thesis.

Development is a particularly difficult concept, and it has come to be a very controversial one. In common usage, the word describes a process by which the potential of an object or organism is released, until it reached its completed form. It implies a favourable change, a step from simple to complex, inferior to superior, worse to better (Esteva, 1999: 8,10). During the twentieth century the word development came to be applied to the economic and political changes of communities and of nations, and it is now used in multiple ways- to identify a desired state of being, a historical process and even, as a verb, to describe what agencies and governments are doing (Thomas & Allen, 2000: 24-41). To be developed is to have attained a desirable state of being, and although the vision of a desirable society varies considerably, that state has come to be equated with industrialised or western society. However while the term development is considered a positive one for many, for two thirds of the world it is a reminder of what they are not, that is, that they remain in an "undesirable, undignified position"- being underdeveloped (Esteva, 1999: 10). Development in this case is considered to be the means of escaping underdevelopment, either through immanent development- part of a natural process, or

through intentional practice (Cowen & Shenton, 1995).

The concept of health is also much debated. Health is often perceived as being the absence of physical disease, and indeed the 'medical model' of health care tends to emphasise this (Phillips & Verhasselt, 1994: 3). However the Constitution of the World Health Organization (WHO) defines health as a state of “complete physical, mental and social well-being and not merely the absence of disease or infirmity”, and states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition (World Health Organization, 2004). This definition is now well accepted by the international community; although it implies far more complex interactions between humans and their environments than a simple medical model of health (Phillips & Verhasselt, 1994: 3). If health is more than the absence of illness, the implication is that the attainment of health requires more than just the treatment and eradication of disease.

The health of populations and individuals is inextricably bound up with development and the resulting changes to people's living environments. It is now well accepted that the least healthy societies are also the poorest economically (Wermuth, 2003: 141). Numerous studies, including studies by the World Bank, have shown strong links between poor health and social and economic deprivation. The Bank's 1975 Health Sector Report argues that a large percentage of disease in the Less Developed Countries derives from socio-economic conditions in those countries, and that it is the poverty of these nations that is at the root of their health problems. Poverty impacts on health in many ways, including poor housing, environmental sanitation and water supply, unemployment, low educational achievement and poor access to health services (Phillips & Verhasselt, 1994 p202).

Bodley (1999: 133-134) highlights three ways in which the development process affects health. He argues that not only does successful development make populations vulnerable to the diseases of “advanced” peoples, such as heart disease and diabetes; the process of development disturbs existing environmental balances and may therefore increase some bacterial and parasitic diseases. He also notes that when development is unattainable, poverty-related illnesses may actually increase in association with the crowded conditions of urban slums and the breakdown in small-scale socioeconomic systems.

The relationship between health and development is not one way. The development process itself is affected by the health of the population and poor health has long been accepted as a limiting factor for development. Poor individual health lowers work capacity and productivity, and at a population level poor health can restrict the growth of economies (Phillips & Verhasselt, 1994: 3-4). The relationship between health and development is a complex, two-way relationship. Health cannot be considered in isolation from other elements in the development process (Bryant, 1969: 96). As a result both the WHO and the World Bank now subscribe to the notion that improvement in health status of communities will not occur without simultaneous progress in political and economic development (Akukwe, 1999: 110).

However in practice there have been a number of paradigm shifts in the health and development debate and in health care practise in the developing world, which have followed the dominant economic models of the time. Historically biomedicine played a central role in capitalist imperialism, in efforts to maintain control of exploited populations. Disease was considered a major obstacle to European expansion in Africa, Asia and the Americas, and medical care for the colonisers was provided by the military and by physicians employed by the trading companies (Baer, Singer, & Susser, 2003: 330; Parfitt, 1998: 4). Although Christian medical missionaries soon introduced allopathic medicine into many of the indigenous populations, their main focus was on preaching and evangelising and the medical care given was simple (Baer et al., 2003: 330; Parfitt, 1998: 4). Only the indigenous ruling class was given access to similar services to the colonisers. As Parfitt (1998: 4) states, this policy served a political as well as humanitarian role as it promoted an elitism, which reinforced the development of a class system and helped reduce any threat to colonial power.

The introduction of Western medicine was met with strong resistance in many areas (Baer et al., 2003: 332), however following World War II, when many colonised states began gaining independence, modernisation soon became the preferred development model for many post-colonial states. As a result the new national health care services in developing nations followed those of the West, which were curative, urban-based and highly technological. Modernisation theory holds that economic growth would “trickle down” to the poorest. In the late 60s and 70s it became clear that this was not happening and development theorists began to question the use of economic growth, represented by

gross national product (GNP), as a measure of development. In particular, Seers (1969) argued that it was more pertinent to look at unemployment, inequality and poverty than GNP as a measure of development, and suggested that policies for economic growth should be accompanied by the redistribution of wealth. From these arguments came the Basic Needs Approach (BNA), which was first initiated by the International Labour Organisation (ILO) at the Employment Conference in 1976. Under BNA, development was redefined as a broad-based and people oriented process, and as a result development practice shifted to programs designed to create a minimum level of welfare for the weakest groups in society (Elliot, 2002).

The late 1960s also saw the emergence of dependency theory, which viewed underdevelopment not as a phase before economic growth occurs but as a condition created by Western capitalism. For example, Navarro (1982) argued that the highly skewed distribution of human health resources in Latin America was due to the economic and cultural dependency of Latin American countries, and that an egalitarian society- such as Cuba's- was needed to ensure the equitable distribution of health resources. This school of thought had a very strong impact on the health field, and the WHO and the United Nations Children's Fund (UNICEF) openly expressed enthusiasm for this strategy of development. In particular, they incorporated many aspects of the Cuban and Chinese health models into a new model of health- which they called Primary Health Care (PHC) (Asthana, 1994: 50-51). The Declaration of Alma Ata, signed at the UNICEF conference in Alma Ata in 1978 formed the foundation of the Primary Health movement. It states that "economic and social development... is of basic importance to the fullest attainment of health for all" (World Health Organization, 2000).

Unfortunately the initiative was under-resourced and suffered from competing viewpoints from the beginning (Koivusalo & Ollila, 1996). In 1979 Walsh and Warren (cited in Koivusalo & Ollila, 1996: 116) introduced the selective model of primary health care, arguing that the original comprehensive model was unattainable because of the cost and personnel required. The selective approach aimed to prevent or treat the few diseases that caused the greatest morbidity and mortality in developing countries, and those for which there was an efficient and cost effect means of control. The selective approach quickly gained substantial international support, and the World Bank, USAID and UNICEF actively promoted it among others (Koivusalo & Ollila, 1996: 117-118).

Since the late 1970s health and development policies have diverged. While the architects of PHC were calling for a redistribution of power and resources, developing nations were beginning to implement market-oriented policies prescribed by international financial institutions. Known as economic adjustment or structural adjustment policies (SAPs), they were imposed on indebted nations as conditions for further financial assistance (Asthana, 1994: 51). While some countries experienced improvements following implementation of these policies, many suffered as they jeopardised wider social objectives, in particular poverty reduction programmes, through budget cuts in health, education and nutrition (Phillips & Verhasselt, 1994: 202).

One of the most controversial issues in adjustment policies was their impact on health care expenditure. While the cost of health care continued to rise and as international health problems multiplied in magnitude, severity and complexity during the 1990s, evidence suggests that there was a marked decline in health expenditure in nations that underwent SAPs (Asthana, 1994; Hassouna, 1994). Along with expenditure cuts, the health system of many developing countries underwent a period of health reform, shifting towards a market-based allocation of health care, and systems that emphasise efficiency over equity. In developing countries, health care reforms have focused on making better use of existing resources and increasing the share of non-governmental agencies. This has meant a re-orientation of Health Ministries, the introduction of user charges for health care, privatisation of some health services and enabling of private medical care, decentralisation, introducing funding mechanisms for health insurance and different ways of contracting publicly provided services (Kutzin, 1995). In many cases structural adjustment loans from the World Bank were actually conditional on public sector reforms including health care reform (Koivusalo & Ollila, 1996: 147). Additionally, the financial contributions of many donor states has remained constant or even declined (Gellert, 1998: 19). As a result, in many places, access to government health services has been significantly reduced and has become increasingly dependent on one's ability to pay (Asthana, 1994; Hassouna, 1994).

Intervention in Health & Development

Decreasing access to government health services combined with increasing inequity in health has led to a rise in external intervention in health care in many parts of the world.

Two major actors- the United Nations (UN) family and NGOs undertake much of this intervention. This section will examine the role these organisations, and in particular the rise in the number of NGOs and their contribution to health and development.

Those in the UN family that have a role in health care include agencies such as the World Health Organisation (WHO) and the Children's Fund (UNICEF), the Bretton Woods Institutions, in particular the World Bank, and regional bodies such as the Pan American Health Organisation (PAHO). While the policies and practises of each organisation may vary considerably, the UN embodies powerful and near universal ideals which are underpinned by the UN charter and the Universal Declaration of Human Rights (Whitman, 2002). The role of the UN and it's agencies is not easily defined but it's impact on health in the developing world is undeniable. Through a combination of norm-setting (through publications such as the UNDP Human Development Report), data gathering and monitoring, the UN and its agencies have been instrumental in substantial advances in many areas of health and development (Whitman, 2002: 467). It also provides a focal point for new thinking, through the UN summits. Finally, the UN also has a more practical role, leading many of the disease eradication and health improvement programmes throughout the world, it's most notable success being the eradication of smallpox in the 1970's (Whitman, 2002: 466-467). The UN has the ability to address problems that no one country can solve by themselves, and advocates point to a record of achievement in humanitarian relief, challenging poverty and human rights abuses and placing environmental and gender issues on the world's agenda (Tharoor, 2005). Despite this the UN has been subject to much criticism, related to it's perceived failures in achieving it's goals, the imbalance of power inherent in the structure of the organisation and the increasing influence of transnational corporations (Millen, Lyon, & Irwin, 2000; Ransom, 2005).

Another important actor in health in developing nations is the NGO community. The term "NGO" was first used by the UN in 1949 and was initially applied to a wide variety of organisations, previously known as public associations, voluntary associations, social welfare organisations, charities and missions (Fernando & Heston, 1997: 10). Despite the increasing popularity of these "non-governmental organisations" there is a distinct lack of consistency in the application of the term NGO. This is compounded by the fact that three major terms are sometimes used interchangeably in the literature: NGO, private

voluntary organisation (PVO) and non-profit organisation (NPO) (Vakil, 1997: 2058). NGOs, along with churches, trade unions, special interest associations and the media, are classified as part of civil society, which is defined as the public space between individual citizens and the state, in which their activities occur collectively and in an organised form (Atack, 1999: 855). Vakil (1997: 2060) more specifically defines NGOs as self-governing, private, not-for-profit organisations that are geared to improving the quality of life of disadvantaged people. Although many would argue that this is not absolute, for the purposes of consistency this study uses this definition.

While the concept of non-governmental organisations is relatively new, the idea of humanistic service is not. It is considered by some to be an “elemental obligation of the family, tribe or clan” (Smillie, 1995: 23), and it is a fundamental tenant of most major religions. For example, Judaism presents itself as a religion with a humanitarian perspective based on the theological concepts of creation, revelation and redemption, and in Islam the Qur’an instructs Muslims to support charitable works as part of their religious life, and it is one of the “Five Pillars” of Islam (Smart et al., 2004: 28-29). In the West, Christianity has provided the roots for much humanistic service. In medieval Europe the church became the “dispenser of benevolence and charity”, founding schools, hospitals and universities. In the nineteenth century the church was joined by a proliferation of charitable societies and reform movements, whose pressure was one of the factors that gradually lead to governments taking greater responsibility for welfare (Smillie, 1995: 24). However most of these movements and organisations were primarily concerned with domestic issues. In the international arena the church who again led the way, establishing missionary organisations in many parts of the globe (Green & Matthias, 1997: 17; Vakil, 1997: 20). Some of the earliest NGOs were health-focused, many of them extensions on Christian missionary activity dating from the nineteenth century. In Africa, NGOs in the form of churches and missionary societies were the main providers of health care, and mission hospitals have continued to provide health services in many nations (Koivusalo & Ollila, 1996: 105). But while there is a long history of non-profit, non-State actors in health care in developing countries (Green, 1992: 78), it took the “moral shock” of two world wars to create a more general western consciousness about international responsibility, which lead to the beginnings of international institutions, foreign aid and many NGOs (Sogge, 1996 : 4; Van Rooy, 2001 : 21).

Over the past few decades the number of NGOs working in international aid and development has grown dramatically- Keane (2003: 5) estimated there are around 50,000 NGOs operating internationally. This growth is to a large degree the result of disillusionment with government, combined with a reluctance to hand over all activities to profit seeking enterprises (Streeten, 1997: 194). In the developing world this disillusionment with governments has been attributed to SAPs. As governments retreated from the provision of social services, NGOs found their role increased. In what became known as “gap filling”, they rapidly became a convenient, non-State method of delivering services to the poor, (Desai, 2002; Whaites, 2002: 8). NGOs have been enthusiastically promoted by both international development agencies such as the World Bank as well as critics of top-down development (Fisher, 1997: 441-442). In particular, NGOs are considered to have particular expertise with sectors and approaches that are relevant to basic human needs and helping the poorest- education, health care agriculture, rural development and community development (Smith, 1989: 398).

The private sector and NGOs now contribute a large proportion of health services in many parts of the world. However the profit motive of the private sector puts prices beyond the reach of the poorest (Hassouna, 1994). NGOs have therefore become critical sources of health care in developing countries and for vulnerable population groups (Akukwe, 1999: 107).

There is a profound sense of optimism reflected in the literature regarding the role of NGOs in the health sector, along with a strong belief in health as a human right. The non-profit sector is believed to have inclusiveness, social justice and equity at its core of its values, and to always work for universal access to health care (Daulaire, 2002: 426; Naidoo, 2002: 411). Akukwe (1999: 109) states that opinion is nearly unanimous on the desirability of NGOs in the current world fiscal environment where many nations cannot afford to provide even basic health services. In fact some of the major donors, including the World Bank and USAID now advise health ministries to contract with NGOs for the delivery of basic health services to the poor (Smith-Nonini, 2000: 359). Many national governments have come to rely on NGOs to provide services for their citizens, particularly those that are poor, marginalised or inaccessible geographically (Akukwe, 1999: 109; Gellert, 1998: 21).

There continues to be much debate over the role NGOs should take in development and

in health, and there have been many attempts to describe the particular roles and functions of NGOs. One of the major contributors to this debate is Korten (1990), who classified NGOs into four generations- relief and welfare, community development, sustainable systems development and people movements. Korten's first generation NGO strategy of relief and welfare involves the direct involvement of the NGO in the delivery of goods and services (often food, shelter or health care), usually to meet an immediate shortage or need- the NGO is a "doer". However relief and welfare assistance offer only temporary alleviation of the problems of underdevelopment, and are therefore not considered by Korten as a form of development assistance. In contrast, second generation or community development strategies are considered developmental as the focus of these strategies is on building community reliance on a small scale or project level. Organisations move from the first to second generation as they become aware of the limitations of relief efforts and the need for a more developmental approach. Frustration with the limits of second generation strategies leads to longer-term input into sustainable systems development at a regional or national level- which is generation three. At this level the NGO becomes a catalyst. The final level or people movement has the NGO as an activist or educator involved with national or global networks of people and organisations.

Another perspective on the role of NGOs is offered by Smillie (1995), who argues that Korten's typology is weakened by its focus on volunteerism as a basis for NGOs when most are not significantly volunteer based. He offers an alternative typology which, while still presented as an evolutionary process, is based on the pace of development and predominating ideology of the organisation rather than what the organisation does.

Smillie's first stage is community-based voluntarism. This corresponds loosely with Korten's first generation NGOs and involves religious and community based welfare activities and personal voluntary service. Smillie states that this stage is characterised by a "high degree of direct personal involvement and responsibility for the delivery of humanistic service". The second stage is institutionalisation, which grows out of greater need and greater numbers of people, and which leads to the formation of associations, which may complement services no longer being provided by the government. Although a volunteer ethic remains at this level it no longer predominates. The next stage, professionalisation is reached as demand for services leads to federation and

profesionalisation of associations, often also to government funding or replacement by Government agencies. The final stage is the welfare state, which Smillie terms the “ultimate in humanistic delivery systems”. At this stage charities and voluntary organisations theoretically cease to exist.

Lindenberg and Bryant (2001) present another framework that outlines a three step development continuum designed to help relate what is happening in a broader environment to families and their needs. During an emergency, relief efforts are paramount, involving the provision of resources such as food, shelter and medicine. Following relief is rehabilitation, involving the protection of assets and income, stimulated by reconstruction activities that may involve food and cash for work. Finally, in development phases, programs are to promote new income and assets are pursued.

While Korten's generations are evolutionary in nature- NGOs move through the generations as they mature- Smillie argues that the stages are neither “immutable nor is one necessarily superior to another” (Smillie, 1995: 35). NGOs may move forwards and backwards through the stages, or they may reflect more than one stage at any given time. Lindenberg and Bryant (2001) also state that their continuum is not meant to imply systematic movement from relief to development, but that the process may be more cyclical.

Although Korten presents an evolutionary process in his typology, he also argues that there has not yet been a substantial shift from first to second and third generation strategies and that much of what may be called second generation is more accurately described as relief and welfare. According to Korten these types of strategies do not result in empowerment or self-reliance, but they often create a long-term dependence on the NGO and the services it provides. In addition, he states that such humanitarian assistance does nothing to remove causes of the global crisis, and that in time the capacity to render assistance will be overwhelmed by growing demand (Korten, 1990: 141, 143).

Korten is not alone in making these criticisms. Fowler and Bierkart (1996) for example outline a number of semi-independent studies into the claims made by private aid agencies, and found that none gave them unequivocal support. In fact they found that agencies, through omission and careful phrasing, were not presenting a fair picture of

their performance. While there was some success at project level, they could take little credit for any progress in sustainable development, poverty alleviation and democratisation. They argue that the size and institutional position of most agencies does not give them sufficient leverage on the larger forces and systems which keep people poor, and governmental connections preclude challenging the self-interest of Northern countries that stand in the way of change (1996: 130-132). Sogge (1996: 145) describes NGOs as the “soup ladles of benevolence”, arguing that the role of aid agencies has effectively become that of a purveyor of supply and demand- the “North” is supplied with images and information about poverty in the “South”, eliciting a market demand for donations which is channelled to the South as a remedy for poverty and crisis.

NGOs have also been criticised on the basis that aid is often delivered without reference to the culture and political preferences of the society it is directed to, and that they may actually be a new guise of the “civilising mission”, which served as a humanitarian facade for the institution of colonial order in the nineteenth century (Koivusalo & Ollila, 1996: 105). Aid as imperialism is also identified by Mburu (1989) in a list of the short-comings of NGOs, other shortcomings he notes are the religious or quasi-religious background of many NGOs (even in non-religious contexts), unclear policies, uncertain resource bases, and mistrust.

Mburu (1989) also notes the use of expatriate personnel as a problem associated with NGOs. This is an important debate, as Chowdhury asked in an article in the Bangladesh Times in 1977:

“Who are these experts that come from thousands of miles away with the perfect plan for a village they have never seen, and a culture they have never lived?”

Sanders (1985: 218) argues that while foreign 'experts' may have the best of intentions, they face constraints of culture, language and training which make it difficult to work with the poor, and they do little to challenge the social order which produces ill health or to improve the health of the people.

These issues apply not only to the larger NGOs and their projects in developing countries, but also to STMMs. As self-governing, private, not-for-profit groups who are focused on

improving the quality of life of disadvantaged people they can be defined as NGOs, albeit small and often temporary ones. The following sections defines more clearly the phenomenon of STMMs and how the concerns raised in discussions of the role of NGOs can be applied to STMMs.

Short Term Medical Missions

STMMs fit the category of “volunteer tourism” or “voluntourism”, a form of alternative tourism, “tourism... where profit motives are secondary to a more altruistic desire to travel in order to assist communities” (Wearing, 2001: 12). It has its roots in volunteerism, which implies that individuals offer their services to change some aspect of society for the better (Callanan & Thomas, 2005). Volunteer tourism is a form of tourism that is growing, Callanan and Thomas (2005) argue that it has in fact become a “mass niche” and increasingly competitive market.

One factor which may help explain the growth of volunteer tourism is new and more rapid communication technology, in particular the rise of the internet. Individuals in the developed world now have access to far more information about the developing world through the media, written publications and the internet. The internet has also made it possible for potential volunteers “to ‘shop around’ looking for an organisation that suits their outlook and philosophy” (Smart et al., 2004: 5).

As a phenomenon in health care in the developing world, the popularity of volunteer tourism and STMMs has also coincided with the increasing availability and falling costs of air travel. An individual can now fly from any major developed city and within a few hours be in the developing world. This makes it possible to take a one or two week ‘vacation’ in an ‘exotic’ location. It also makes it possible for health professionals to spend their vacation time working in those locations. As Chambers (1983: 21) notes-

*“And northern academics too
are seasonal in their global view
For they are found in third world nations
mainly during long vacations.”*

Chambers (1983) discusses volunteer tourism in a development context, terming it “rural

development tourism". In rural development tourism, foreign or urban-based visitors (including government officials, health professionals, journalists, NGO staff and researchers) spend one or more days in a poor, rural community for varying purposes. Chambers highlights several problems with this phenomenon. Because of time and other constraints, development tourists are likely to not see the poorest, they are likely to miss other 'invisible dimensions' such as international influences, social relations and changes over time and their perceptions of the community are likely to be biased. In particular he highlights six biases that impede outsider's contact with the realities of rural poverty. These include a spacial (urban, tarmac and roadside) bias towards urban areas and areas served by major roads; a bias towards areas with existing projects; a person bias (towards the elite, males, services users and those active and present); a dry season bias and diplomatic and professional biases.

Despite this criticism STMMs have become increasingly popular over the past few decades and many NGOs- particularly smaller groups- appear to use STMMs as a major part of their strategy for intervention in health care. For example, Medical Ministry International (an organisation that sends STMMs to Latin America) has the following Mission Statement on their website (www.medicaldentalmision.com):

"MMI (Medical Missions International) is committed to meet the need for medical care among the world's poor with lasting solutions through excellence in medicine, patient care, and health education. We do this by:

- Mobilizing volunteers on short-term medical missions*
- Establishing and equipping permanent medical centers"*

Walsh (2004: 26) argues that mission participants receive invaluable learning experiences working in clinics with limited resources, learning to be flexible and innovative in their care. In addition, experiencing health care in third-world countries is believed to enhance communication skills and mutual respect for other cultures, giving the participant a deeper appreciation for global health and health disparities among nations. Crutcher (1995: 342) argues that since awareness of a problem is the first step toward the solution, a humanitarian mission "can be viewed as a mechanism for exposing people who can effect change to the realities of the developing world, which it is hoped will foster their participation in longer-term solutions".

Another important factor in the popularity of medical missions is religion. As discussed above, religious organisations have long played a part in the provision of health care services to developing nations. One anonymous author (1998) notes- "Medicine and mission have gone together in the mind of the Christian public for at least 100 years". Many religious organisations have found that providing first-hand experience of work in developing nations is one way of increasing their constituents support and interest in their mission activities (Montgomery, 2000).

The popularity of STMMs is reflected in the large volume of non-technical literature available on the internet, in professional journals, newspapers and other periodicals. There are many personal accounts, journals and news articles about teams and individuals who have participated, or will be participating in a STMM. There are also an increasing number of articles written offering advice, for example- "Advice for aspiring volunteer physicians" (Mitka, 1999), "Practical tips for medical volunteers" (Kightlinger, 2003) and "Are you ready for nursing in a developing country?" (Allen, 1999). STMMs are perceived by many as providing a valuable service to the developing communities. Through the teams, communities can access health care that may not otherwise be available to them (Murray, 1999; Walsh, 2004: 26).

While STMMs have become increasingly popular there is little critical literature on volunteer tourism or on STMMs themselves. Despite this some generalisations can be made from the literature regarding NGOs as with a few exceptions (such as the military "MEDRETE" program), STMMs are non-governmental and non-profit in nature and indeed many of the sponsoring organisations, which may be medical, religious or other organisations, are recognised NGOs.

As direct providers of a service to populations with a perceived or actual need, STMMs can be theorised as being what Korten (1990) describes as a first generation relief strategy. These strategies involve individual volunteers, with a high degree of direct personal involvement and responsibility for the delivery of the service, and so fit Smillie's (1995) stage one- community volunteerism. STMMs could be seen as having a role to play in development, at a first level, as a relief mechanism in emergency situations or where other forms of assistance are unavailable.

If Korten's arguments are correct, then the long term use of STMMs may create a long-

term dependence on the NGO and the STMMs. As noted above, he argues that relief strategies do nothing to remove the causes of the crisis and in time the capacity to render assistance may be overwhelmed by growing demand (Korten, 1990: 141, 143). This implies that STMMs may actually create further problems for the communities they seek to serve, that rather than encouraging empowerment or self-reliance they may reinforce dependency. It also implies that the long-term use of STMMs as health care providers may lead to growing demands for this type of health care, demands that STMMs may not be able to meet. Montgomery (2000) also notes these issues, arguing that while STMMs provide temporary but sporadic access to health care, overall, they do not improve long-term access and they may, in fact undermine existing services. This is an important issue for organisations using STMMs as a means of providing health care, and is one that is explored further in this thesis.

Despite the controversy these concerns regarding the specific use of STMMs as relief and development mechanisms do not appear to have been fully addressed in the literature. There is in fact very little actual research on STMMs, and what exists is mostly directed towards defining and evaluating the missions. Additionally, almost all literature on the topic is drawn from the perspective of the expatriate, with scant attention paid to the perspective of local health care providers and communities.

One researcher who has addressed the issue of STMMs is Smart (2004), who used an internet-based approach to find and categorise those organisations conducting short-term medical missions to Honduras for his Masters-level thesis. He examined their mission preparation, the needs assessment and evaluation methods used by missions, mission reporting, cultural aspects and costs. While Smart's research goes some way towards defining the issue he does not address the perspective of, or the impact on the local health care providers or communities. He identifies the importance of co-ordination with local professionals and national Health Ministries (2004: 68) however there is no development of this idea in the thesis. Smart concludes that despite their increasing presence in the developing world the cost, efficacy and long-term benefits of STMMs have not been objectively quantified, and it remains unclear whether they provide a cost effective and sustainable means of improving health care services in a target community.

Another relevant project is the STMM Matrix, a longitudinal study of the most effective factors for use in the evaluation and improvement of STMMs. The aim of this study is to

provide a means by which individual STMMs might objectively evaluate their program and its consequences so that a higher standard of care might be reached (White et al., 2004). At the time of writing, this project was in 'phase IV'- involving data collection, validity testing and eventually, statistical analysis of the results. While no results are yet available from the STMM Matrix project, another study has highlighted an alternative role for STMMs. Oken, Stoffel and Stern (2004) propose that STMMs could be used in health surveillance. This proposal comes from their experience with volunteer medical teams which had "been tremendously enriching, similar to sentiments expressed by other medical volunteers" (Oken et al., 2004: 207), however they had become concerned that STMMs did not have a long-term impact on the communities they visited. Their study, carried out in Honduras, demonstrated that in addition to the usual clinical care a visiting volunteer group could collect quality growth data that may assist in nutritional surveillance, identify predictors of poor growth and provide information useful for local public health initiatives. They conclude that by limiting visits to a geographically localised region, and by becoming integrated into local public health and rural development systems, STMMs can make a more lasting impact.

While there is little research on the topic, there have been ongoing arguments over the role and effects of STMMs, often played out in the editorial and commentary sections of medical journals and much of it related to the arguments about the role of expatriates in health care in developing nations that is discussed above. Bishop and Litch (2000: 1017) call it "inappropriate arrogance" to assume that anything a western doctor has to offer in the developing world is "progress", pointing out that Western doctors visiting for a short time may have little knowledge of local illness presentation, cultural elements or language, they may offer inappropriate treatment in an effort to "do something", that follow up is not usually possible and that doctors who practice in this way may be in legally difficult ground.

Mission participants are perceived as being both naive and ethnocentric, assuming that approaches suitable in one setting are appropriate in another, and they tend to explain behaviour and circumstances in terms of personal qualities of individuals rather than in terms of larger cultural patterns and structural issues (Montgomery, 2000). Additionally, most Western health professionals are used to working in a technologically advanced environment. In order to make the biggest possible difference they may espouse this type

of care to a population without the resources to sustain this level of health care, and in the process cultivate a dependent relationship with that community (Walsh, 2004: 24). Sanders (1985: 149) goes so far as to argue that the use of technologically advanced equipment and medication may cause expatriate health workers to unwittingly become agents of “medical big business”.

STMMs are also criticised on the basis that team members need to see tangible results—they want to see, quite literally, that they made a difference; otherwise, they are reluctant to volunteer time and money (Montgomery, 2000).

There is now an acknowledgment that STMMs are short-term, quick-fix solutions rather than a longer term, preventive approach, and that such “episodic, individual visits” can only offer minimal improvement to the health of a population (Oken et al., 2004: 208). Montgomery (2000) notes that if short-term missions devoted more of their budgets to supporting preventive measures, over time, the need for the services they provide would be reduced or even eliminated. Additionally, it is argued that the millions of dollars spent to send Western physicians to third-world countries could pay thousands of underemployed doctors in those countries—doctors who already understand the culture and language of the area, and who can offer long term and ongoing care (Van Engan, 2000).

Finally, medical missions have been criticised on the basis that while most of the reasons westerners engage in international work sound humanitarian they are, in actuality, self-serving. For example, Bezruchka (2000) argues that medical tourism from the U.S., even if humanitarian in intent, is a part of the bigger picture of U.S. Involvement in other nations, an involvement that tends to serve its own political and economic interests. This self-serving motivation is also criticised on personal and religious levels. While some advocates for short-term missions often justify them in terms of the inspiration or the awareness they provide for participants Montgomery (2000) questions whether this is a model for service which is “essentially is oriented to the needs of the server rather than to the served...”

Conclusion

It is clear that while STMMs have become very popular in recent years, they are an under-researched and very controversial form of intervention in health care. The health literature

does not appear to address the potential uses and drawbacks of STMMs in health care provision, and although there is much discussion in the literature regarding the role of NGOs and the use of relief strategies in a development context, this has not been applied to the particular issue of STMMs. However much can be implied from the discussion of the role of NGOs in a relief context, and the issues resulting from their long-term use. Application of the ideas related to NGOs to STMMs raises some very important questions, including issues of the dependency, the appropriateness of using STMMs in health, the role of aid and relief mechanisms and the use of expatriate personnel.

The dearth of literature on the topic of short-term medical missions, the probable western orientation of what literature is available, and the issues regarding the long term effects of STMMs on communities and on health care services are very real concerns given the increasing popularity and prevalence of these missions. It is important both for the communities served and for the organisations sending teams to know what STMMs are doing and what effect they are having. This study has been designed to address some of these issues with a particular focus on the Honduran context, which will be discussed in the next chapter.

Chapter 4: Honduras and Honduran Health Care

Honduras, known to locals as the “heart of America” and to many outsiders as the original “banana republic”, is the destination of many Short Term Medical Missions (STMMs) and is the geographical location of this study. It is therefore important to consider the geography, history, politics and economics and social situation of the country and how these factors have led to or influenced the health care system and the growth of STMMs in Honduras. This chapter provides this background information, before examining in more detail the health of Hondurans and the nature of the Honduran health care system.

General Background

History & Geography

Honduras is located in the middle of the isthmus of Central America. It is the second largest Central American republic, and is bordered to the Southeast by Nicaragua and to the West by El Salvador and Guatemala (see Fig. 4.1 below) (Library of Congress, 1993). Honduras lies within the tropics, but due to the terrain the climate varies across the country. It has a tropical wet climate and high temperatures in the north; a tropical wet and dry climate, high temperatures and a distinct dry season in the South and cooler temperatures in the interior highlands (Library of Congress, 1993). The population of Honduras is small, just 6.5 million in a land area of 112 492 square kilometres (Instituto Nacional de Estadística, 2005a), however despite the small population cultivable land is under pressure because of the mountainous nature of the country (Rowlands, 1997: 29).

Since the sixteenth century, the history of Honduras has been one of political and economic domination by outside superpowers- first Spain and then the United States. Prior to the Spanish arrival some of what is modern Honduras was part of the Mayan civilisation which emerged about 500BP in the highlands of Guatemala (Skidmore & Smith, 1997: 322). Various agricultural societies including the Pipil; the Ulva and Paya, the Sumu, and the Lenca populated the remainder of the country. The arrival of the Spanish in the 1520s led to the decimation of these ethnic groups through disease, mistreatment and the exportation of large numbers to the Caribbean Islands as slaves. A

major uprising against the Spanish in 1537, led by Lempira, was unsuccessful, although Lempira became a hero in Honduras, and his name lives on in the Honduran currency- the Lempira (Library of Congress, 1993).

FIG 4.1 MAP OF HONDURAS



On September 15 1821, Honduras, along with all the Central American provinces declared their independence from Spain (Library of Congress, 1993). This move to independence was peaceful, and as a result the colonial social order survived almost intact across Central America (Skidmore & Smith, 1997: 325). Following independence, the fruit industry gained power and the trade, dominated by U.S. fruit companies, grew rapidly. In particular three fruit companies- Standard Fruit, the Cuyamel Fruit Company and the United Fruit Company were able to obtain concessions from the government, to buy up lands, and to establish a virtual enclave community on the North Coast (Library of Congress, 1993).

During the early 20th century, Honduras was governed by a series of *caudillos*¹, including President Carias. Carias was a general in the Honduran army and one of the founders of the Honduran National Party, and he held the presidency from 1932-1949. Although essentially a dictatorship, Carias time in office was a period of relative peace and order.

¹ *Caudillo*- a military leader who holds a powerful, usually political position (Caudillo, 2005).

The country's fiscal situation, education and the road network all improved, and the army was modernised. Despite this democratic institutions withered, opposition and labour movements were suppressed and national interests were at times sacrificed to benefit Carías interests or those of his friends and relatives (Library of Congress, 1993). Following Carías rule, the military assumed a greater role in Honduran politics, launching several coups and a prolonged period of military rule. However military rule in Honduras did not take on quite the repressive characteristics that it had done in other parts of Latin America, being achieved mainly through negotiation and co-optation (Rowlands, 1997: 31).

In 1981 the country ostensibly returned to democracy, although the military continued to dominate, as economic and military aid poured into Honduras during the Nicaraguan war (Rowlands, 1997: 30). The US transformed Honduras into a launching pad- a 'land-based aircraft carrier' for Contra attacks against Nicaragua, and a base for intelligence and other operations in El Salvador and Nicaragua (Schulz & Sundloff Schulz, 1994; Skidmore & Smith, 1997). As Schultz (1994: 54) notes, in keeping with their political culture and history, in the face of danger Honduras had found a foreign protector, a '*patrón*', and opened themselves up even further to North American economic, political, military and cultural penetration.

Politics and Economics

Politics in Honduras has also long been influenced by what Skidmore (1997: 345) terms the 'triangular alliance' of power in Honduras- the landowners, the military and foreign investors (mainly the fruit companies). Following the Nicaraguan elections in 1989 the Contra insurgency slowly came to a close (Library of Congress, 1993). Peaceful elections were also held in Honduras and throughout the 1990's and into the twenty-first century civilian government has survived- at least in name (Skidmore & Smith, 1997: 347). Honduras is now considered a multi-party democracy; however Honduran politics is dominated by two main parties, the Liberal and National Parties, both of which are right of centre (Rowlands, 1997: 32). The parties are also both described as patron-client networks, more interested in amassing political patronage² than in offering effective

² Patronage can be described as a system where someone in a powerful position (the Patron) offers handouts in return for support (Patronage, 2005).

programs, and with emphasis on competition and power, rather than national problem-solving (Library of Congress, 1993). Political corruption is a continuing problem and elections remain dominated by “*caudillismo*” as the incoming party redistributes government jobs among its own supporters (Rowlands, 1997: 32).

At the end of the twentieth century Honduras remained one of the poorest nations in the region and dependent on US aid and fruit exports, hence the title “Banana Republic”. The country has made some attempts at agricultural diversification- other exports include palm oil, coffee, cotton, sugar, other fruits and seafood (Rowlands, 1997: 29-33), however the lack of resources and arable land, and a small domestic market continue to impede economic progress in Honduras. The large fruit companies have historically also dominated the manufacturing sector, although the development of free-trade zones has led to a significant increase in export manufacturing- mostly in clothing assembly for the US market (Rowlands, 1997: 30).

External debt continues to be a significant burden on the economy. In 1990 the government introduced structural adjustment policies which succeeded in curbing inflation, but had a negative effect on the poorest, partly because of the removal of subsidies on basic items (Rowlands, 1997: 33). There have also been tax increases, job losses, a rise in the cost of public services and cuts in public services, all of which impact on the poorest (Rowlands, 1997: 36). Despite this during the last two decades of the twentieth century Honduras made some progress in economic and social development.

This progress suffered another major setback with the arrival of Hurricane Mitch in October 1998. At the time Mitch was the fourth-largest storm to be recorded in the history of the Atlantic basin, unleashing torrents of rain (600mm in just five days) and causing flooding across 11 of the country's 18 departments. National losses associated with the hurricane are estimated at almost US\$3800 million, equivalent to 70% of the countries GDP (PAHO, 2002). One study found that in many regions one of every two households incurred medical, housing, or other costs due to Mitch, one in three suffered from a loss in crops, one in five lost assets and one in 10 lost wages or business income (Morris et al., 2002). The also found that the relief offered amounted to less than one-tenth of the losses incurred by households.

The Hondurans

The population of Honduras is 90% Mestizo (mixed race), with the remaining 10% made up of indigenous groups, and the Garifuna (Afro-Caribbeans) (PAHO, 2002; Rowlands, 1997: 29). Although the class structure in Honduras is similar to that in other Latin American countries, there is markedly less conflict between the classes than there is in Honduras's immediate neighbours, a situation that probably has its origins in the country's colonial and early republican history (Library of Congress, 1993).

Honduras has a small, but powerful, elite, because of the isolation and lack of exploitable resources, and the absence of a coffee industry this elite has been defined more by their control of the province's political system rather than by their accumulation of wealth (Library of Congress, 1993). The middle class in Honduras is a small but growing sector, primarily defined by economic factors, education and occupation. However the slow growth of industry in Honduras and the lack of employment opportunities has limited the growth of the middle class and most Hondurans remain poor (Library of Congress, 1993). The Honduran National Institute of Statistics (2003b) states that nationally about 64.5% of the population is "poor" (defined as households whose income is less than the cost of their basic needs- food, housing, clothing, education and health). The system of patronage also remains strong particularly in rural areas, where there is pressure on the poor to work for their patron to the neglect of their own, usually marginal, land (Loker, 2004).

Housing

For those that can afford it, comfortable housing is widely available in Honduras; but living conditions are dismal for much of the poor population. In rural areas, many poor families still live in one- or two-room thatch roofed huts (*bahareques*) built of adobe or sugarcane stalks and mud with dirt floors (Library of Congress, 1993). Urban areas are not a lot better, as new migrants crowd into the barrios. Most of these barrio residents live in rows (*cuarterías*) of connected rooms, which are usually constructed of wood, with dirt floors and are often windowless (Library of Congress, 1993).

The Family & Gender Issues

The fundamental social unit in Honduras is the family. Social identity and assistance comes through kinship networks, and family loyalty is an ingrained and largely unquestioned value. The trust, assistance and solidarity owed by kin acts as a protection against political and social upheaval (Library of Congress, 1993). The family is also the basic economic unit, based on a sexual division of labour. Men are responsible for work in the fields, women are the primary caregivers for children, prepare food, take care of small animals and perform household chores (Loker, 2004).

The social and cultural ethos of Honduras is heavily dominated by *machismo*³- (Rowlands, 1997: 34). On paper women have a strong position in Honduras, protected by the UN Charter abolishing discrimination against women, by national Family and Labour codes and by various legislation. In reality the situation of women is much bleaker. Women are primarily responsible for the welfare of their family, and often endure the violence associated with *machismo*. As Rowlands (1997 p34) states - "to be a woman in Honduras, as in most of Latin America, is to be the 'wife-mother-maintainer of the home'".

Religion

Most Hondurans are Roman Catholic; however Protestant denominations are growing quickly (Rowlands, 1997: 31). The Catholic Church in Honduras has traditionally been poorer and less influential than in the rest of Central America (Brett & Brett, 1988: 107), but despite this, to this day the Roman Catholic Church remains a powerful influence in Honduran society and politics. As in many parts of the world, the Honduran Roman Catholic Church has been a force pressing for social change and reform although its role has varied and, in many instances, has been contradictory throughout the years (Library of Congress, 1993).

Protestant, especially evangelical, churches have undergone a tremendous growth in membership since the 1980s. The Pentecostal churches in particular have become very popular, with upward of 75 percent of evangelical churches being Pentecostal (Hoksbergen & Madrid, 1997). These churches tend to emphasise the salvation of souls

³ *Machismo*- an exaggerated sense of masculinity that stresses physical courage and virility, and often implies the domination of women, and aggressiveness (Machismo, 2005).

over any sort of social vision (Hoksbergen & Madrid, 1997), although many do work in the social arena, sponsoring social service programs in many communities.

Education

The right to a free primary education for every child between the ages of seven and fourteen is enshrined in the Honduran constitution; however statistical information shows that the state of the public education system remains poor. Figures cited by UNICEF suggest that Honduras suffers from widespread illiteracy (about 25% percent of the total population). Even when children have access they usually do not complete their schooling. Only 58% percent of children enrolled in public schools reach Grade 5, and only 33 percent go on to secondary school (UNICEF).

Health & Health Care in Honduras

The Health of Hondurans

World Bank data indicates that health outcomes in Honduras have improved significantly over the last couple of decades despite high levels of poverty (World Bank, 2001: 46). For example, in the 1960s Honduras had an infant mortality rate (IMR) 50% worse than the Latin American average, however it reduced infant mortality at a faster pace than most of its neighbours, reaching the average for Latin America by 1995 (World Bank, 1998). Overall the health status of Hondurans remains poor, as reflected in the life expectancy at birth of just 67.2, the fifth lowest in the Americas (World Health Organization, 2005).

Although the data on mortality rate in Honduras is not considered particularly reliable (PAHO, 2002: 351) the National Institute of Statistics provides some statistics on mortality rates for 2000-2002, which show a mortality rate of 3.2 deaths per 1000 population (2003a). They report the five leading causes of death during that time to be heart disease (17%), cancers (12.2%), homicide (10%), diseases of the digestive system (6.8%) and cerebro vascular disease (6.6%). According to the World Health Organization (WHO) Honduras has the sixth highest mortality rate in the Americas for children under 5 years- 43 per 1000 (World Health Organization, 2005). The leading causes of death in this age group (excluding neonatal causes) are pneumonia, diarrhoea and gastroenteritis, other

illnesses of the digestive system and malnutrition (Instituto Nacional de Estadística, 2003a). Infant mortality is also high, with more than half attributable to neonatal mortality. The main causes of neonatal mortality are respiratory distress and bacterial sepsis (PAHO, 2002). Maternal mortality is also an issue in Honduras, with a mortality rate of 108 per 100 000 live births, nearly half of which occurred at home (PAHO, 2002)⁴.

Health in Honduras is affected by geography. Being located in a tropical region, the population is at risk from 'tropical diseases'- vector-borne illnesses such as Malaria, Dengue and Chagas 'disease, as well as infectious diseases such as Typhoid and Cholera. In Honduras, Malaria is considered endemic and although the exact number of cases that occur each year is unknown, the highest number of cases is in the Northern coastal area (PAHO, 2002).

Geographically, the country is also vulnerable to natural disasters. In just the last seven years the country has been struck by two major disasters- Hurricane Mitch, and a severe drought in 2000 affecting much of the Southern region of the country (PAHO, 2002). These disasters are associated with outbreaks of disease with the potential to cause epidemics, and with the worsening of poverty and the problems that causes.

Most of the major health issues faced by Honduras are largely related to poverty. Poverty is considered one of the major determinants of health in developing nations, and a major contributor to the high maternal and child mortality rates in Honduras. Specifically, poverty impacts health through poor housing, sanitation and water supply, uncontrolled vector occurrence, unemployment, low educational achievement and poor access to health services (Kloos, 1994). In Honduras 17% of households do not have access to potable water and 19% are without access to sanitation services (Instituto Nacional de Estadísticas, 2002). This, combined with poor food productivity and low incomes leads to a very low standard of living, particularly in the countryside where illness and poor diets are endemic. This is reflected in the health statistics. As noted above, malnutrition is a leading cause of childhood mortality in Honduras. A recent study in one rural area of Honduras found 10 per cent of children were moderately underweight and 3.3 per cent severely underweight, while 13.7 per cent were moderately stunted and 6.4 per cent were severely stunted (Oken et al., 2004). In part the problems with malnutrition in Honduras are linked to the typical diet of the rural population, which consists of corn (the primary

⁴ Compare this with a maternal mortality rate in New Zealand of 15 per 100000 (UNICEF, 2005).

staple food of most Honduras) made into tortillas, beans (the main source of protein), cassava, plantains, rice, and coffee, with only occasional supplements of meat or fish—most rural Hondurans do not eat meat frequently, and green vegetables are also not eaten frequently (Library of Congress, 1993). But these dietary deficiencies are worsened by poverty— children seen in villages with clean water and higher levels of development tend to have higher body mass index— and weight-for-age (Oken et al., 2004).

Malnutrition is linked not only to diet and food shortages but also to medical causes such as infection and parasite infestation. Diarrhoea is endemic in the population, with 200 000 reported cases annually between 1996-2000, 85% of them in children and adolescents under 15 years old (PAHO, 2002).

HIV/Aids is also a growing problem in Honduras, which has 60% of the cases of Aids reported in Central America. The transmission of HIV in Central America is largely heterosexual (83% of cases), and the epidemic is concentrated in high-risk populations— men who have sex with men, commercial sex workers, prisoners and the Garifunas (Afro-Caribbean descendants) (PAHO, 2002). An estimated 10.4% of commercial sex workers in Honduras are infected with HIV (World Bank Global HIV/AIDS Program, 2003).

Another major health issue in Honduras is injury and death as a result of accidents and violence. Together homicides, accidents, suicides and other forms of violence cause 22% of deaths, making accidents and violence the leading cause of death in Honduras (Instituto Nacional de Estadísticas, 2003a). The problems with violence have been linked to the *machismo* tradition (Rowlands, 1997: 45), and indeed the INE reports that 91.5% of homicide deaths (2000-2002) were male. Family violence is also an issue, with women being the primary victims. The Family Counselling Program deals with physical, emotional and sexual abuse cases in Honduras, and reports that 88% of the victims were female (PAHO, 2002).

Many of these health issues are also related to a lack of knowledge about the causes of ill health. It has been argued that most of the affected population does not relate its health problems to their real causes, such as malnutrition and environmental hazards. Instead, because these problems have always existed for the affected population, they tend to be accepted as normal. (Library of Congress, 1993)

The Health System

“The human being is the supreme end of society and of the State.

Everyone has the obligation to respect and protect the person.

The dignity of the human being is inviolable.”

(Article 59, Constitution of Honduras, quoted in Ramos Soto, 1989: 348)

The written Constitution of Honduras forms the basis of the entire politico-legal structure. Republican in form, it includes a declaration of individual and societal rights and guarantees, including those regarding family, children, work, social security, health, education, and culture and housing (Ramos Soto, 1989: 331). It offers a broad view of the concept of health which is not only somatic or limited to the curative-preventative level but which also encompasses fundamental aspects of mental health, individual and societal well-being (Ramos Soto, 1989: 348). Under the Constitution the State has four key responsibilities- as a regulator of health policies, as the health sector coordinator, as a supplier of health services and in education and research through the National University of Honduras.

Health policy is expressed in a national plan, designed to guide the activities of the Ministry of Public Health and Social Welfare. This plan gives priority to the neediest groups, and includes supervision of the private practice of medicine in order to ensure compliance with all rules ensuring health protection (Ramos Soto, 1989: 337-338). The State, through the national plan, is the coordinator of the health sector, however there has been some effort to ensure participation in health planning at the community level.

The State is also a supplier of health services. One of the functions of the Honduran President as general administrator of the State is “to adopt measures for the promotion, prevention, recovery and rehabilitation of the population (Article 245, Constitution of Honduras, quoted in Ramos Soto, 1989: 338-339). This has given rise to complex institutional structure, which is discussed later in this section. Finally education and research services in the health sector are also the responsibility of the State, in this case led by the Autonomous National University of Honduras (UNAH) which not only trains the nations health professionals (doctors, nurses, dentists, microbiologists, pharmacists etc), but has taken the initiative in scientific research addressing national problems including

mental health, environmental sanitation and hunger and malnutrition (Ramos Soto, 1989: 341).

Under the national plan, high priority is given to morbidity and mortality from designated diseases (Diarrhoeal diseases, vaccine-preventable diseases, malaria, dengue, acute respiratory diseases, malnutrition etc), to promoting and fostering the health of mothers, and towards activities in marginal urban and rural areas (Ramos Soto, 1989: 338).

The health sector itself consists of two sub sectors, the public and the private, however health care provision in Honduras remains largely public. In the public system, services provided by the Ministry of Public Health reach approximately 60% of the population. Approximately 10-12% of the population are served by the Honduran Social Security Institute and smaller proportions of the population are covered by the Armed Forces Health System; the National Social Welfare Agency; and the Department of Occupational Medicine, Hygiene, and Safety within the Ministry of Labour. The private sector, comprised of about 303 registered clinics and hospitals is estimated to serve about 10% of the population (PAHO, 2002).

To manage and administrate health services the Ministry of Public Health has divided the country into nine regions and 42 health areas that administer health services, and carry out health promotion, curative and health protection activities (these areas do not mirror the administrative-political divisions of the country). These health services are divided into six levels of care:

Level 1: Consists of non-remunerated, duly trained community volunteers including traditional midwives, health guardians who provide first aid, health representatives who work in the area of sanitation and organisation and volunteers in the Program for Vector Control (Malaria).

Level 2: Rural Health Centres (CESAR) which are under the direction of trained hospital assistants who offer curative and preventative health services. These are commonly called "*Centros de Salud*".

Level 3: Health Centres with a Physician (CESAMO), a health service under the direction of a physician, aided by a hospital assistant, nurse and in some places a multi-disciplinary team, providing preventive and curative services, and possibly also diagnostic services.

Level 4: Area Hospitals providing health services through outpatient consultation, emergency treatment and hospitalisation for care in four basic specialties- medicine, surgery, obstetrics-gynaecology and paediatrics. These hospitals have some basic support services such as X-ray, laboratory and operating theatres.

Level 5: Regional Hospitals that provide care in the four basic specialties and also other specialties, and provide auxiliary diagnostic services.

Level 6: National hospitals and highly specialised medical care complexes and provides specialised medical and physical care, basic and specialised diagnostic services and also education and research services. (Ramos Soto, 1989 : 339-341)

These systems are linked by a referral system, and patients are expected to follow this hierarchy, but the system is weak, suffering from low referral rates, low rates of reply to referral letters, an inadequate health information system and poor staff understanding of the system (Ohara, Melendez, Uehara, & Ohi, 1998).

In addition to the public health system the Honduran Social Security Institute (IHSS) operates a network of 28 hospitals and 20 clinics and 4 emergency clinics in the main cities only. However the Ministry of Public Health remains the main supplier of ambulatory services to the poor, while the IHSS and private providers tend to concentrate their attentions on the higher income brackets (World Bank, 2001: 49).

Despite a strong constitutional protection of health, the regulatory framework for health in Honduras is considered to be weak (World Bank, 2002: 4) and the health system has been heavily criticised for being functionally unsound and unable to deliver comprehensive protection to individuals or communities (Ramos Soto, 1989: 339). The health system is plagued by problems associated with unreliable technology, poor communication inhospitable terrain, and poor coordination of tasks (Swanson, 2000: 32). There is no mechanism in place for either the certification or the accreditation of health care facilities and providers, and the institutional capacity to implement and enforce regulations is almost nonexistent (World Bank, 2002: 4). In addition underdevelopment and permanent institutional crisis have eroded any continuity in organic health policy (Ramos Soto, 1989: 348).

The problems faced by the Honduran health care system were only exacerbated by the damage caused by Hurricane Mitch in 1998, which destroyed the system both physically and socially (Swanson, 2000: 33). For several months after the disaster all attention was focussed on emergency and temporary treatment aimed at preventing further loss of life. International aid, including bilateral aid and assistance from agencies including the UN agencies and major financial institutions such as the World Bank increased significantly following the hurricane (Smart, 2004: 20). While there is no record of the role and expenditure of small NGO's evidence from this research suggests that the number of these and the amount of assistance given rose dramatically after Mitch and continues to rise. The large amount of aid and assistance given has not been without impact on the Honduran health care system. Swanson (2000: 33) argues that the resulting reliance on international support has made it difficult for Honduras to gain the autonomy and skills to operate its own public health system.

In order to address the issues faced by the Honduran health system the Ministry of Public Health has undertaken significant health sector reform over the past decade in access to health services was made a focal point. In particular policy guidelines developed after Hurricane Mitch called for immediate action to rebuild the health system to meet the basic needs of Hondurans and for progressive changes (organisational, administrative and operational) to ensure access to health services with a higher level of equity, efficiency and quality (PAHO, 2002). However despite the destruction of the health system by the hurricane being seen as an opportunity to fix the system, the problems have not yet been resolved. In 2002 the World Bank noted that the system remained fragmented, with poor coordination between the public, private and social security sub-sectors, resulting in critical inefficiencies and bottlenecks (World Bank, 2002: 4). Research suggests that some of the reforms, such as decentralisation and the introduction of user fees may actually have increased inequities in the health system (Fiedler & Suazo, 2002).

The problems in the health system are reflected in a study of patients' perceptions of health services in Honduras (Leon, 2003). This study found that the poorest sector of the population has the most difficult access to services and receives the lowest quality of care. For rural Hondurans, emergency transportation may mean long hours on horseback for an ill or injured person- particularly among the indigenous population, where the sick may have to be carried in hammocks for long distances with the aid of neighbours recruited

along the way. The study also found that Hondurans favoured rural hospitals and clinics over urban hospitals, both because of their physical and social proximity, and because while offering diverse and specialised services. Urban public hospitals were perceived as providing low-quality and non-dignifying attention, especially to users of lower social status. The poor stated they felt excluded from the system, discriminated against and treated in a non-dignified manner. Hardships such as overcrowding or loss of vital information are considered common within the health system. These results are reflected in the data for this study, see discussion in Chapt. 7.

Health care in Honduras is largely bio-medically focused. Training provided at rural medical clinics for village level health volunteers, promoter and midwives is focused solely on modern western medicine, despite a long tradition of traditional health practises. A recent study of traditional midwives in Honduras found that they had a wealth of information on plant medicines used to promote maternal–infant health, but that much of the plant knowledge held by midwives had been largely ignored, and much has been lost. The researchers attributed this, at least in part, to the fact that in many communities midwives' knowledge is not highly respected. Although staff at the health centres maintained did not actually prohibit the use of plant medicine, but almost all of the midwives interviewed in the course of the study stated that they felt that they were no longer permitted to use them (Ticktin & Dalle, 2005). Despite this traditional health practices continue to be an important source of health care in rural and urban areas alike (Leon, 2003).

NGOs and STMMs in Honduras

While the beginnings of NGOs in Latin America has been traced to Catholic Church charities during the Great Depression, North American NGOs first appeared in Latin America in the 1950s (Eversole, 2003). Since then the number, size and type of NGOs has grown rapidly. This growth has been driven by increased international NGO aid during the political crises and violent conflicts of the 1980s, by economic adjustment programs which accentuated the gap between the affluent minority and the poor, and by massive international disaster relief programs (Sollis, 1995). In particular, in the aftermath of Hurricane Mitch NGOs of all types joined the relief effort. The flow of technical and financial assistance from external agencies for health in Honduras increased considerably

following Mitch (PAHO, 2002), encouraged by a government which openly prioritised infrastructural projects for agribusiness and industry and allocated 'human development' to local government, NGOs and the international community (Boyer, 1999). This prioritisation was not new, in Honduras NGO poverty-related spending frequently outstrips government poverty efforts. In 1989 for example, NGO poverty spending was estimated at \$US50 million, twice the annual budget of the social investment fund, the governments main poverty safety net (Sollis, 1995).

It is interesting to note that while the NGO community in Honduras grew significantly following Mitch not all offers of help were unreservedly accepted. Following the disaster one European Organisation planned to send a donation of medication along with a delegation of doctors to manage it's distribution. The offer was declined by Honduran officials was that the positive impact of foreign doctors is severely limited by their lack of familiarity with common tropical ailments and the local medical system, and that the level of support they would need (translators, nurses, guides, tourist-style accommodation and food) would outweigh any positive contribution they could make (Swanson, 2000: 34).

However the NGO community continues to grow, and the identity and nature of the sector is still being forged (Landim, 1987). Initially, most NGOs in Latin America developed in close relation with religious organisations, in particular the Catholic Church (Landim, 1987). Recent years have seen the arrival of U.S. Pentecostal Church agencies and their NGOs (Sollis, 1995). Another important group within Latin American NGOs is members of traditional left organisations, who may lack other outlets for their activities because of their political commitment or because of crises in their past activities. These groups and individuals often find that they can continue working for social transformation through the NGOs (Landim, 1987). As a result many working in NGOs have a traditional Christian left background (Landim, 1987). To counter these organisations, political elites in Latin America have organised their own NGOs, often directly linked to government and business interests (Sollis, 1995). The result is a numerous, but divided and heterogeneous NGO community (Sollis, 1995). There are advocates "for the right, the left, the poor and the environment... others are efficiently providing public services... Some NGOs are close to grassroots, and others are close to political elites." (Meyer, 1999: 46)

Within Latin America the 'welfare approach' (*assistencialismo*) was a prominent feature of the early NGOs, particularly those linked with the Catholic Church (Landim, 1987). While

the welfare approach was eventually dropped in favour of 'participation', the work of most NGOs in Latin America continues to be 'direct intervention', placing emphasis on activities aimed at meeting the needs of or improving conditions for their target population (Landim, 1987). This is evident in the health care sector where STMMs are one form of active intervention undertaken by NGOs.

STMMs are provided by a variety of organisations in Honduras. Smart (2004) identified three types of organisations involved in providing STMMs. The first was the large international organisations- organisations that are active in multiple countries, with significant administrative back up, and that may also have a professionally trained staff. Smart identifies 21 of these organisations, including the UN, Red Cross, Medicin San Frontiers and Peace Corps who do not organise missions but "are involved with such activities" (2004: 36). According to Smart, 15 of these large organisations provide medical missions as a core activity, although most are involved in many aspects of health care, not solely medical missions.

Smart found 50 smaller USA-based organisations involved in providing STMMs. Organisations were classified as small NGOs if they were active in only one or two countries had a small administrative component and a reliance on volunteers. Of the 50 organisations, 41 had medical missions as a core activity. Of these, 22 were exclusively medical, 19 provided general "health care" and nine provided services in addition to health care.

The third group offering STMMs in Honduras is what Smart terms "mom and pop" operations (Smart et al., 2004: 35). These consist of a group of volunteers originating in a specific locality within the USA that recruit volunteers and elicit donations by word of mouth, and do not tend to involve themselves in the wider volunteer community in Honduras. Smart states that there appear to be many such groups operating, but that the extent of their activities is almost impossible to ascertain (Smart et al., 2004: 35).

In addition to the expatriate groups identified by Smart, medical brigades are also provided by the American military and by Honduran political parties, particularly at election time; however a discussion of these is beyond the scope of this research.

The Ministry of Health has the job of coordinating the work of all external agencies in

health in Honduras, including medical brigades. These brigades are actually encouraged by the Ministry as a means of reaching more remote areas where they have poor coverage of national health services:

“...medical brigades that come and provide free services and medication, (are) very important for the poorest people that live far away from the main communities. Therefore the ministry of health welcomes any medical brigade that wants to come and help in Honduras, and will let them know where the most needy areas are located.” (Official at the Secretaria de Salud, January 2005)

In 2001 the Ministry published the “Manual of Norms and Procedures in the matter of Cooperation in Health”. This manual provides guidelines for health projects, donations, medical brigades and the actions of NGOs in health both in emergencies and under normal circumstances. Chapter 4, entitled “For medical brigades in normal situations” states that it is the role of the Ministry of Health to supervise national and foreign medical brigades in order to ensure that the activities they undertake are in accordance with the laws, policies, priorities and needs of Honduras (2001: 45). Significantly, the guidelines are designed to ensure that medical brigades work in areas, and with population groups that the Ministry has defined as priorities.

Brigades are required to contact the Ministry of Health, in writing, one month before their planned arrival. The Ministry then must establish if the health services on offer are within the framework of policies, needs and priorities established by the Ministry of Health. Medication and other donations must also be notified to the Ministry, who will verify if they fill their general criteria, technical specifications, or specific requirements. If the brigade is accepted they must then contact the Colleges of Medicine and Nursing in order to have their professional qualifications verified in order to practise in Honduras. The guidelines contain a flow chart of this process that is translated and reproduced in Appendix 5.

Social Tourism and STMMs in Honduras

The rapid rise in the number of STMMs in Honduras has led to a growing market in volunteer tourism. Many in the NGO sector have adopted the term “social tourism”, which

Marco Caceres, of projecthonduras.com defines this way-

"...individuals who travel to Honduras to help out in some way can be defined as "social tourists". They go to Honduras for a limited period of time, and then they go back home to their families and their jobs." (2002)

Social Tourism is becoming an increasingly significant part of the tourism sector in Honduras. While it is not possible to obtain the exact numbers of social tourists arriving in Honduras, Caceres estimates that the "social tourism" segment accounts for about one-quarter of the revenue generated by the overall tourism market in Honduras (2004). The popularity of Honduras as a destination for social tourists is reinforced in a study of volunteer projects in the tourism context, which ranked 153 destinations offering projects of programs for volunteer tourists. In this study, Honduras was ranked as having the 5th highest number of projects (Callanan & Thomas, 2005). During fieldwork long-term expatriates commented on more than one occasion that medical brigades constituted an industry. These comments were reinforced by observation. While travelling around Honduras we encountered many groups of westerners, in airports, hotels, restaurants and tourist sites, many of whom were medical teams. Caceres estimates that on any given flight to or from the country as much as one quarter of the passengers belong to medical brigades, church missions, university student teams, or some other type of group involved in social service activities (2005b). As a result of the volume of social tourists arriving, there is clearly now a growing infrastructure in Honduras aimed at providing for their needs. Evidence of this can also be found in the advertising material of many hotels and tourist-oriented businesses, which offer services directed towards medical brigades and other social tourists. There are tour operators that specialise in arranging group travel- for example the company "Tourist Options" states that they arrange travel only for groups of two or more and offer "special group rates (for) student groups, wholesalers and missionary/medical brigades." (Alfatravelguide.com, 2005). Some in the NGO sector itself have begun promoting the idea. In particular, Projecthonduras.com has started a "Social Tourism Program", which is "designed to develop a close working relationship with Honduras' tourism industry and provide support and recognition to individuals travelling to/within Honduras to perform volunteer work to help the Honduran people." Through the program, its website and the projecthonduras.com annual conference, participating businesses such as hotels, tour operators and restaurants offer discounts to individuals

and groups involved in volunteer work in Honduras.

Characteristics of STMMs in Honduras

While it is clear that while STMMs are used by many NGOs, and are encouraged by the Ministry of Health as a means of providing health care, no official records are kept of the STMMs and the exact numbers and characteristics of the teams is unknown. In an internet based search for his 2004 thesis Smart (Smart et al., 2004) identified 71 organisations actively providing STMMs to Honduras, although he states that anecdotal evidence suggests that the number of organisations involved may actually be higher. Some data is also available from the website projecthonduras.com where a significant number of organisations voluntarily submit information regarding their missions. This information is collated into the "Missions to Honduras" spreadsheet, which lists 80 missions for the year 2004 (Caceres, 2005a). Of these 80 missions 59 (or 72%) were medically oriented. This included teams that identified themselves as medical, surgical, ear care, eye care, dental care, facial reconstruction, orthopaedic care or urology.

Over two-thirds of the missions listed on projecthonduras.com (40 of 58) were recruited, or sponsored by an NGO. There are 19 organisations represented in the list of medical missions from 2004. Based on a review of their websites, most of these are small and focused primarily on health care in Honduras, with many using medical missions as the primary, or only, means of providing health services. This is somewhat lower than the 71 organisations identified by Smart (2004) as being actively involved in providing STMMs to Honduras, although only 56 (15 large International NGO's and 41 smaller USA-based organisations) of those 71 identified themselves as having STMMs as a core activity.

Most of these teams originate in the USA. Of 58 medical missions listed as visiting Honduras in 2004, all 58 were from the USA- 100%, although evidence from the fieldwork for this thesis indicates that a small number of teams do come from Europe. The predominance of North American teams is probably attributable to the proximity of Central America to the USA- a flight from Texas to Honduras takes only 3 hours and usually costs under \$US600.

A significant proportion of both the medical teams and the sponsoring or coordinating

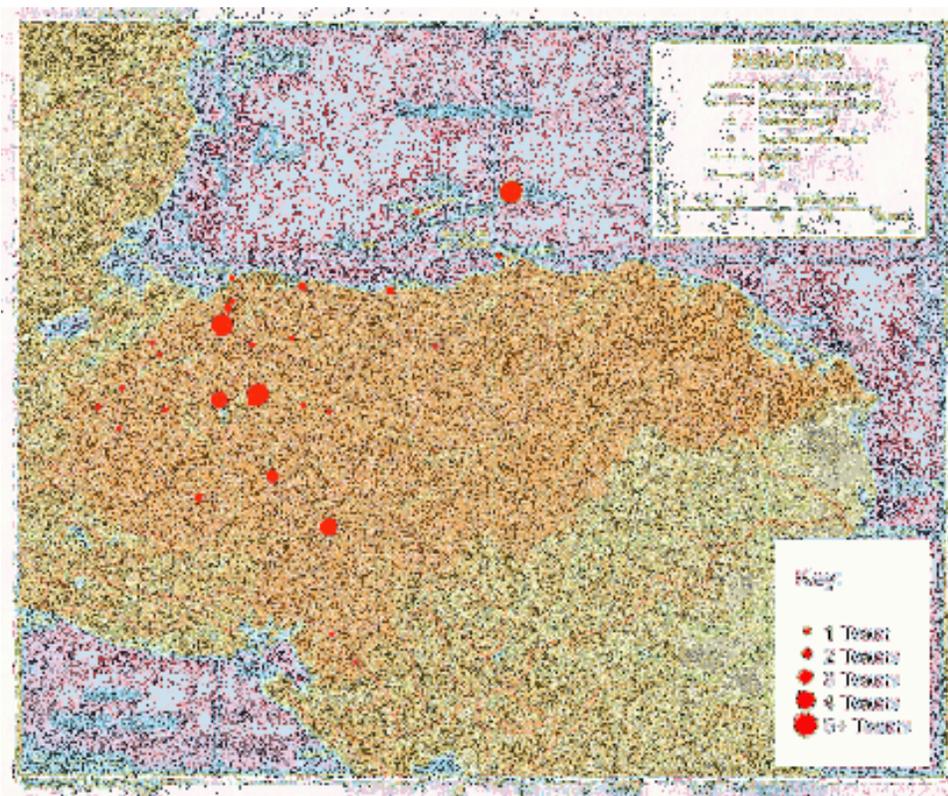
organisations are religiously oriented. Of the 59 “medical” teams listed on ProjectHonduras.com 36 (62%) were religious, 16 (28%) were non-religious and 5 (9%) were unknown. Of the 71 organisations represented in Smart's research (2004) 34 (48%) were identified as openly faith based or affiliated with a faith (all Christian). Of the three groups participating in this research, two were religious and one was not. While the degree of religiosity varies from group to group (from strongly evangelical to merely religiously affiliated) it is clear that religion plays a very important role in STMMs.

Team size is also variable. While no data is available on the projecthonduras.com website on team size and composition, the three teams participating in the research varied in size from 10-21 members. Evidence from interviews indicates that this is quite average, although team sizes can reach up to about 60 members. Teams usually consist of both health professionals- usually doctors, nurses, dentists and optometrists, translators and lay members. Lay members may be involved solely in auxiliary tasks (for example crowd control or sorting medication and supplies), they may be trained to do basic medical tasks (such as fitting glasses, dispensing worm medication or taking blood pressures) or they may be involved in non-medical activities such as evangelism and prayer or construction projects.

Mapping the locations of the missions completed during 2004 listed on the ProjectHonduras.com website (see Fig. 4.2) and comparing it with a poverty distribution map from the Honduran Institute of Statistics (Fig 4.3) highlights a significant issue for STMMs in Honduras. It is clear that most teams went to the northeastern area of Honduras, in particular to the Departments of Cortes, Yoro, Comayagua and Atlantida. Most of the team locations were within a few hours drive of the international airport in San Pedro Sula and many major tourist spots, and almost all were within a few hours drive of major roads. Few, if any teams went to the more remote and poorer Departments of Gracias A Dios, Choluteca, Valle, Lempira and Intibuca. This may in part be because significant number of teams that went to the went to major cities- San Pedro Sula, Tegucigalpa, Choluteca and La Ceiba- were surgical teams, who need, or prefer to work in major hospitals. However it is clear a significant number of general medical teams also stay in or near the major cities.

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Fig. 4.2 STMMS to Honduras in 2004



*Based on data provided by projecthonduras.com (Caceres, 2005a)

FIG. 4.3 MAP OF POVERTY IN HONDURAS USING THE LACK OF BASIC NECESSITIES METHODOLOGY



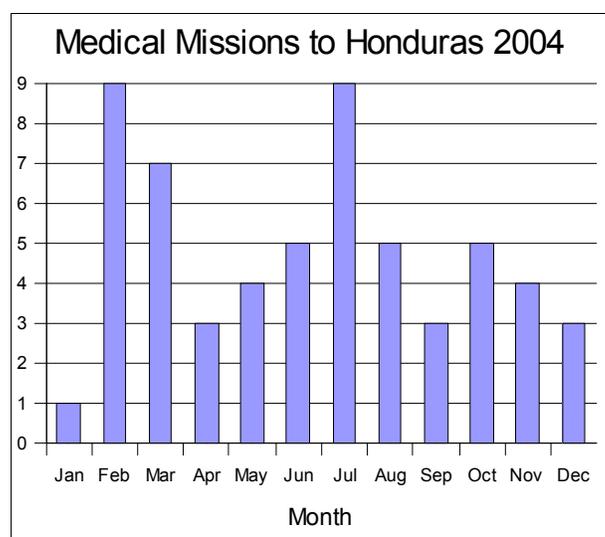
*Map from the Instituto Nacional de Estadísticas, Honduras (2005b)

The concentration of medical teams around urban areas and along major highways is a clear example of what Chambers (1983) terms “spatial bias”, or “tarmac bias”, the tendency of outsiders to follow networks of roads when visiting rural developing countries, due to hazards of poor roads, the comfort of the visitors, the location of accommodation and shortages of time and fuel (Chambers, 1983: 13). One of the hazards of this bias towards more easily accessible areas is that attention is directed towards the 'less poor' in those areas, and away from the poorer, as the regional distribution of the poorest often shows a concentration in remoter areas (Chambers, 1983: 13).

In addition to the potential neglect of the neediest, the concentration of medical teams in more developed areas also indicates that the teams are not coordinating with each other, or with the Ministry of Health. Although the guidelines clearly state that teams should be directed to the most needy areas, the evidence suggests that this is not happening

In his discussion of the biases that impede outsiders' contact with rural poverty, Chambers (1983: 21) also notes that outside visitors to tropical regions tend to avoid the wet seasons when travel is more difficult. This tendency is reflected in the timing of STMMs. ProjectHonduras.com lists an average of 5 missions per month for 2004 (Caceres, 2005a), with two peaks (see graph, Fig 4.4 below).

FIG. 4.4 GRAPH OF MEDICAL MISSIONS TO HONDURAS IN 2004, BY MONTH.



*Based on data provided by projecthonduras.com (Caceres, 2005a)

The first peak is between February and March, which corresponds with the dry season in Honduras. This is significant as the wet season is usually the time when malnutrition, morbidity and mortality all rise. Chambers (1983: 14) terms this the “hungry season and the sick season”- a time when the poor are more likely to be in need of medical assistance, and least likely to be able to afford it. The second peak is in July- corresponding to summer vacation in the USA, where most of the teams originate- another bias noted by Chambers.

The duration of medical missions is also an issue. Although specific data on the duration of STMMs is not available on projecthonduras.com, observational and interview data from the fieldwork for this study indicates that most teams spend just 1-2 weeks in the country- hence the term “Short Term” Medical Missions. The three teams involved in this research spent 6, 8 and 9 days in the country respectively. This means that the teams only see a 'snapshot' of the community, a moment in time. Seasonal trends, and cyclical and periodical events may never be seen (Chambers, 1994), and the health issues related to those trends and events are therefore not addressed.

Conclusion

The history of Honduras, its current political and social situation, and the state of the public health system have created a situation where STMMs are now becoming increasingly popular in Honduras. These teams involve a broad spectrum of individuals, working with a variety of organisations; however the particular role of STMMs in relation to the Honduran public health system has never been examined. In addition evidence suggests that STMMs are not well coordinated and that there may be serious issues with spatial and seasonal bias. The remainder of this thesis will examine these issues and others in relation to the services provided by STMMs in health care, and the impact they have on Honduran health services and the health of Hondurans.

Chapter 5: STMMs as Service Providers

Honduras sees many different medical teams each year. They come with a variety of motives and are involved in a wide range of activities, both health and non-health related. However during the course of this research it became clear that the main role of Short Term Medical Missions (STMMs) in Honduras is remarkably consistent and can be summarised under the heading of Service Provision. They are in Honduras as health service providers. The goal of most teams is to provide what health services they can during their stay, and indeed this is the expectation of the Hondurans (patients, local providers and officials).

There are both causative factors for, and consequences of, using STMMs as health service providers. These causative or motivational factors and the benefits, limitations and consequences will be examined in the following chapters. The remainder of this chapter will describe and discuss the role of STMMs in health service provision. In particular it will examine how STMMs gain access to the communities in which they work, and what services they provide.

Access to the Community

Before any brigade can begin work in Honduras, access to a community (or communities) must be arranged. This access requires the input of both the team and their hosts, although the amount of power exercised by each party varies considerably between different organisations and teams.

Gaining access requires two steps- initial contact, usually including an offer or invitation and then negotiation of the brigade details. The way in which initial contact between the hosts and team is made varies, sometimes it is made directly, and at other times may be through an intermediary individual or organisation. It may consist of an invitation or request for help from the host organisation or community or an interested group may make contact in order to offer their services to a particular organisation or community. These differing means of gaining access were well illustrated by the three teams involved in this research.

The first team gained access through church contacts. Church members who had been on previous evangelical and construction missions to Honduras had noted the medical needs of many in Honduras and encouraged the church to send a medical team. The team was formed and efforts were made to select a location for the team to work. They contacted a representative of their church denomination in Honduras, who then approached a church they felt would benefit from a medical mission.

The local pastor described it this way:

“Sometimes the ... church requests (a team) and other times there is direct contact from the team to the local church asking if the church could host them for the brigade they are planning to have in that location. For example this group that just left contacted us and asked if we would like them to come and have clinics... and we said yes because we wanted the team to come...”
(Honduran Pastor)

A nun who works and lives long-term in the community invited the second team. The initial invitation was to a NGO director she had met at a conference, and was for a doctor to work in a hospital she was building:

“ I wrote a letter to (the team leader/ NGO director) and said I needed ... a doctor ... and I gave her a picture of the emergency hospital... and I said I would be very very grateful if she would come. I thought she was the only one that was going to come... I never thought it was going to be a whole brigade but then later on I got an email saying would I be able to take them if there would be a Brigade and I answered back and I said yes, I would be glad to have 12 (people). Then I had another email from her saying what about 24? We cannot work 12 in one place and 12 in another one so I said ... yes...”
(Team host)

In this case the NGO sends teams on a regular basis to various areas in Honduras and usually works with established contacts in these areas, however the team involved in this research was visiting this particular town for the first time.

The final group has a long-standing arrangement with a government-owned company to provide services in a particular geographical area affected by the company's activities.

The NGO recruits and sends the teams, and the company decides which communities the team will visit, and also provides accommodation and transport for the team.

It appears from these three cases that while the team may be invited or requested, the initial contact and negotiation is usually done through an intermediary- an NGO, community or church group. This can be useful in linking STMMs offering particular services with communities that need these services, but can be disempowering for the local host and community, particularly where they have little input into where the team will be working and what they will be doing- as one host stated:

“The teams contact someone in (the city), who unfortunately does not know the situation (here) and they plan the brigades without providing time and space for input from local pastors and medical people.”

While the guidelines from the *Secretaria de Salud* (Ministry of Health) (2001) state that *Secretaria* has responsibility for the supervision and coordination of national and foreign medical brigades, evidence suggests that in practise they have little input into the planning of medical brigades. This may be in part because many groups do not contact the *Secretaria* when making plans. As an official from the *Secretaria* stated:

“Most of the groups are very organised and plan ahead with plenty of time, they get their qualifications checked by the school of medicine and this way they obtain this way permission to operate in the country for a short time. However they are teams that are not so well prepared and don't even request permission... I do not know if is because they are ignorant of the structure in place or just have a different agenda in mind and the medical brigade is just a way of achieving that agenda.”

The differing agendas of the brigades and the local hosts are important and are discussed later in this thesis. However it does appear that the *Secretaria*, wanting to make things easier for brigades, allows teams to work where they choose and does not enforce the guidelines for medical brigades (discussed in Chapter 4).

“(The Secretaria de Salud) does inform the teams of locations where there is a high need for medical services or for medication. However the teams themselves decide where they go and some choose to work with more easy

accessible communities instead of communities that are isolated and poor like the communities that surround (this town). Not many teams come this way and neither do Honduran doctors like to come this far away. Indigenous groups in these surroundings are like forgotten (people) because they don't have accessible health care.” (Doctor, Sec. De Salud)

Similarly it appears that local health professionals are not regularly consulted about brigade plans. In one fieldwork location, the staff from the local *centro de salud* (A CESAR or rural health centre) found out that the team was in town from a patient on the day the team started work, despite the fact that the brigade had been planned for weeks. In another location, the local nurse was told about the team ahead of time by visiting government officials, but had no input into the planning process. Most of the health professionals contacted in the course of this research were not happy about this, expressing the desire to be more involved and to have input into the decision making process, as the following highlights:

“We would like to see (the teams) come back... but they should coordinate (and work) in partnership with us the local and regional providers, who are aware of where the need is, in order to make the most effective use of the resources they are bringing to the country... It is important to remember that teams should work in partnership with the local health providers (instead of) competing with them or not acknowledging that they are the people responsible in the area of health, but helping each other for the good of the people of the community.” (Doctor, Sec. De Salud)

Finally, communities themselves have little input into the planning of brigades. During fieldwork only one group obtained any input from the community, and this was instigated by the host who consulted with a local women's group to help identify the communities most in need of health services. Communities usually are only informed by word of mouth, public notices and radio advertisements organised by the hosts in the days leading up to the team's arrival. While community members and patients did not identify this as an issue, for the most part they were very happy to have the team in their community, it illustrates the paternalistic nature of medical brigades. Western medicine has a history of creating this kind of paternalistic relationship. Parfitt (1998: 4) terms it the “vertical approach”, where medicine is “given away” to the local community, with no thought to

giving the community any say into what was provided or as to what contribution they might be able to make. While Parfitt uses this idea in a historical context, it is clear that this is still an issue in the context of medical missions.

The data from the research shows clearly that the choice of brigade locations and access to communities is largely controlled by the hosts (religious leaders, NGOs and in some instances, private interests) and the teams themselves. Input from the Secretaria de Salud, local health professionals and the community is limited, a situation that raises significant issues related to power and paternalism. The question of who decides where a team goes, and what it does while it is there is perhaps a reflection of the short term and “outsider” nature of medical brigades.

Services provided by STMMs

“The services we provided were de-worming, eye exams, medical screening for health problems and provision of antacids, cough and cold medicines, ear, eye and nose care, high blood pressure medication, skin and anti-fungal (creams), anti-bacterial salves and ointments, and with doctor consultation, antibiotics as needed. These services would be very difficult for the people to obtain if the brigade had not gone and provided these services.” (Team Member)

“(We) gave medicines to the sick, made referrals for requiring surgery and helped educate on issues of good health.” (Team Member)

As health service providers, STMMs are involved in a variety of activities. These activities can be divided into three main areas- clinical services, resource provision and preventative services. These categories are based on fieldwork with general medical/ family medicine clinics, therefore they may not be fully generalisable to specialist or surgical brigades.

Clinical Services

Most team members participating in this research identified their main activity during the mission as seeing patients:

“A number of children were given respiratory treatments who, without it, may have experienced a more serious illness. Without some of the medicines we had available and distributed, both children and adults may have had to suffer longer to rid themselves of an illness. Two cases of acute dehydration needed IV fluids.”(Team Member)

“We treated many medical needs, dewormed people in the village, gave Vit. A to children, gave eye glasses to many.” (Team Member)

Clinical services include assessment, treatment and referral activities. These are activities that involve the team in providing direct health services to individuals- consultation and assessment (provided by a doctor, nurse, optician or dentist), treatment on site, provision of prescriptions and referral to other health services. Observational data from the research suggests that most team members were involved in direct service provision during most of the mission, and that the patient consultation within the clinic setting is a key part of the modus operandi of the team. This service is usually provided in the form of temporary clinics. The teams participating in this research set up clinics in church halls, existing NGO clinics and in schoolrooms. However there are some teams- including most surgical teams- that work from national and NGO hospitals.

As noted above, once a team has made the arrangements to come to Honduras and the clinic location is confirmed the community is informed of the dates and location of the clinic through church and social networks, notices in public locations and radio broadcasts. This is generally the responsibility of the hosts. On the designated day, patients usually arrived at the clinic location before the team. “Crowd Management” (a term used by many team members and hosts) was almost always handled by the hosts, who designated the area where patients waited, provided seating if necessary, and prevented people from wandering into clinic areas. In two of the three teams patient registration was also handled by the hosts, who provided each patient with an assessment form (usually created by the



FIG. 5.1: PATIENT CONSULTATION 1
Example of a patient consultation area. Patients are seen in family groups, with the aid of a translator.



FIG. 5.2: PATIENT CONSULTATION 2
Another team, another patient consultation. Note the window behind with people watching and listening outside (the window had no glass).



FIG. 5.3: PATIENT CONSULTATION 3
The researcher undertakes patient consultations as part of participant observation. Again, note the open window.

team) and filled in details such as name, age and presenting complaint. This created some issues, which will be discussed later in the thesis. In all three missions, patients were called in to see the doctor or nurse by family group. Patients were usually called in to the clinic area by a local volunteer or host, in the order given at registration.

All three teams used a system of “stations”, where doctors and/or nurses doing patient consultations each had a designated space (usually spread out around a large room) with a chair for themselves, one for the translator (if necessary), 3-4 chairs for patients and a desk or bench for supplies and writing (see Figs. 5.1 & 5.2). All three teams also had a “pharmacy” set up, usually separate from the consulting areas where medication was unpacked and dispensed.

Consultations lasted between 5-45 minutes, depending on the size of the family and the presenting complaints. They usually consisted of a brief introduction, with each family member then being assessed individually. The assessment may have included-

- a review of presenting complaints listed on the assessment form
- brief history and discussion of symptoms
- a physical exam which may include one or more of the following:
 - BP, heart rate
 - temperature
 - visual inspection (ear, eye, wound)
 - auscultation (listening for sounds made by internal organs, usually using a stethoscope)
 - palpation (using touch to examine internal organs)

Following the assessment the team member discussed possible diagnoses and treatment with the patient- usually through a translator. Treatment was given for any conditions requiring immediate attention, depending on the available resources. Treatments observed during fieldwork were simple, and included the administration of IV fluids, nebulisers, the dressing of wounds and ear syringing. In some cases these treatments were given at the station, in others they were administered by a nurse in a separate area. Where further treatment was necessary, and available, the patient was referred on to a local health provider- this is discussed further below.

The consultation was usually completed with the provision of a prescription. Two of the teams required the patient to visit the 'pharmacy' to collect medication, the third provided medication at the station. Vitamins, parasite medication and Paracetamol were routinely given at the station, and in some cases team members gave other "giveaways" (soap, shampoo, clothing, shoes, sweets/ candy etc) either at the station or after the consultation.

It is clear both from observation during brigade clinics that most patients presented to the medical clinics with minor complaints, which are easily addressed by the team. For example, during one full day of participant observation, doing patient assessments with one of the teams, I saw 28 patients. The complaints these patients presented with, and their frequency, are listed in the table below (Fig. 5.4). Most patients presented with more than one complaint- the range was between one and five complaints (all complaints are listed here therefore the number of patients adds up to more than 28, however the percentage figure is calculated based on the 28 patients meaning the total is above 100).

FIG. 5.4: STMM PRESENTING COMPLAINTS

Complaint	No. of Patients	% of Patients
Headache	10	36%
Skin Conditions	9	32%
Cough/ Cold	7	25%
Urinary Tract Infection	5	18%
Parasites	5	18%
Abdominal Pain	4	14%
Heartburn	3	11%
Constipation	3	11%
Ear Complaint	3	11%
Arthritis	3	11%
Throat Complaint	2	7%
Hypertension	2	7%
Vaginal Infection	2	7%
Back Pain	2	7%
Pain- other	2	7%
Other	7	25%

From observations, this list of complaints appears fairly typical of the conditions seen by

medical mission teams. Because most conditions seen at the clinics were minor, and diagnostic and treatment tools were limited, most treatment was also simple, consisting largely of simple medications, dressings and education.

The limitations in diagnosis tools and treatment options meant that more complex cases usually had to be referred. Referral is an important part of clinical services, particularly in the context of STMMs who are usually not able to do follow up on patients seen in the clinic. Cases referred from the teams participating in the research included suspected cancers, goitre, congenital anomalies requiring surgical intervention, suspected HIV infection and cardiac conditions.

The exact way in which referrals were managed varied between teams and was usually consistent with the amount of contact and knowledge team members had of local health care providers (both governmental and non-governmental). At the most basic level, referrals consisted of the patient simply being told to see their own doctor. Two of the teams participating in the research managed referrals through host organisations (NGOs). In both cases the host organisation took responsibility ensuring the patient was able to get to the hospital and get the treatment necessary, but did not directly provide those services. Two teams liaised directly with health professionals from the local *Centro de Salud*, but only after the doctor and nurses had arrived at the team clinic and introduced themselves.

Resource Provision

“Even if it was only parasite medicine, Tums and vitamins we gave them then it was more than if we had not come.” (Team Member)

Resource provision is significant part of the service STMMs provide to Honduras. It includes the dispensing of medication to individual patients, the donation of medication and medical equipment to clinics and other local health providers, and non-medical “giveaways” to individuals and communities (including clothing, shoes, hygiene products and baby supplies). Providing resources, in particular medication, was considered by team members to be just one part of the service they provided to the communities they worked in, but was identified by Hondurans (hosts, local health providers, government

officials and patients) as being one of the major reasons why teams were welcomed. This is discussed further in Chapter 6.

All three teams participating in the research provided their own medications and medical supplies, bringing significant amounts with them from the USA. One of the responsibilities of team members before a mission is often to source the medications, usually by soliciting donations from pharmaceutical companies.

“Much of the medications were provided to the team free by different companies, enabling us to provide a larger quantity of treatment.” (Team Member)

Each team set up a “pharmacy” near the clinic stations to provide individual patient prescriptions (see Figs. 5.5 & 5.6). As noted above, two of the teams had patients go to the pharmacy to collect their medications after the consultation. The third team had the doctors and nurses liaise directly with a team member in the pharmacy and the medication was brought to the patient at the station. Because the teams had limited supplies and diagnostic equipment most medications given were simple- cough and cold remedies, simple analgesics, antibiotics and skin creams and lotions.

Teams also provided medication and supplies to local clinics and health providers. One of the three teams donated leftover medications to the local Centro de Salud at the completion of the mission. Another worked with an organisation that had a storage facility in Honduras where medications and supplies were kept for the next team, or for the organisations use in the course of their long-term projects in Honduras.

Despite welcoming the teams and the medications they bring, some local health providers (Hondurans and expatriates) raised concerns about the practise of teams bringing medication from the USA. One local doctor was doubtful about the need for them to bring medication, stating that “most of these medications can be bought at the local pharmacy.” Another believed that American doctors were more comfortable with “third or fourth generation drugs” but not with the more simple medications that are available in Honduras. It is a concern raised by health professionals in other parts of the developing world. On arriving at a refugee clinic in Africa, Bulstrode (1993: 1611) found that “the drugs we had brought with us were mostly irrelevant and far more expensive than those

which could be bought locally". This is a valid concern, as medicines bought by teams are often samples of expensive new drugs, which may be familiar to the American doctors but may not be available in Honduras and certainly are not accessible to most of the people seen at mission clinics. Honduran doctors following up on patients following the visit of an STMM may find them taking medication whose dosage and side effects they are unfamiliar with, raising significant patient safety issues. There may also conceivably be issues with interactions with other local medications the patient may be taking, and continued access to the medication for long term treatment.

Another issue raised was labelling. While the three brigades observed during fieldwork were conscientious in ensuring medications were correctly labelled, many involved in brigades over longer time periods told stories of poor or mislabelled medications. Labelling concerns include medications labelled in English, or using North American drug names instead of those known locally, and confusing or conflicting instructions. In one particularly worrying example, an American doctor working long term in Honduras told the story of a medical brigade he had been assisting. The team had run out of one particular medication as a result of particularly high demand, but had large amounts of vitamins. They approached the doctor with the idea of relabelling the bags of vitamins as the medication they had run out of and dispensing it- perhaps hoping for a placebo effect. While in this case the team did not go ahead with the plan, the story does raise significant issues about medication practises. As the doctor commented, it is unlikely this idea would have even been contemplated in a health facility in the United States.

These problems were also identified by case studies done by some NGO medical brigades. The average patient on these brigades received two or three different kinds of medication, and many mothers coming to the clinic had two to four ill children and therefore received up to fifteen medications. Because of the high levels of illiteracy in the community all communication was oral and medications were largely unlabelled. As a result, during house calls later, doctors discovered that much of the medication was not getting to the patients. In order to improve this cartoon pictures were used to identify the medications, and instructions were frequently given to an adolescent child whose literacy was usually much higher than the parents (Swanson, 2000: 35). The use of pictures on medication labels for identification and instructions was successfully used by one team during fieldwork for this research, and a translator who worked with this team and another

was observed showing members of the other team the labels and suggesting their use.

Finally, and perhaps most controversially, in addition to large quantities of medication and medical supplies many STMMs bring other “giveaways”- hygiene products such as toothbrushes, soap and shampoo; clothing and shoes, and toys for children being some of the more common donations. The amount of giveaways varied significantly from team to team, but all three teams participating in this research brought hygiene products- soap, shampoo and toothbrushes. Two teams bought additional items. One team bought “shoeboxes”- gifts for families consisting of shoebox-sized plastic containers filled with hygiene products, small toys (skip rope, crayons, soft toys), and confectionary. Another had large duffel bags filled with used clothing, shoes, toys, baby gear (nappies, blankets, clothing), and hygiene products.

The methods of distributing the giveaways also varied from group to group. Some items (usually smaller items such as the hygiene products) were given at the medical 'station' by the doctor or nurse. The duffel bag items were distributed from a separate desk in the clinic room, with patients lining up after their consultation to be given what they 'needed'. The shoeboxes were not distributed by the team at all but handed over to the mission host to distribute after the team had left.

As part of participant observation during the fieldwork, I had the opportunity to experience firsthand the practice of 'giveaways', and found that there is significant external and internal pressure to give, as this note from my field journal suggests:

“I chose to do as the team did, giving vitamins, Tylenol and worm medication to patients, as well as small gifts of soap or shampoo. In some ways I felt pressured to do this, there was an expectation from the patients that they would receive something and it was the practise of the team members (to give things). However I also felt an internal pressure, wanting to help these people who have so little with what I had, pills and giveaways.”



FIG. 5.5: THE PHARMACY

Drugs and medical supplies bought from the U.S. by one medical team.



FIG. 5.6: MEDICATIONS & GIVEAWAYS

Another team's supply area. On the front table is medical and supplies ready for dispensing, and at the back right are boxes awaiting unpacking. Back right are "shoebox" giveaways.



FIG. 5.7: A BIG EVENT

Members of a rural community queue, waiting to be seen by medical brigade volunteers.

In all locations during the fieldwork, patients and their families were observed approaching team members to request various items- usually what they had seen others receiving. Money was rarely requested, with most requests being for toothbrushes, extra medication such as vitamins or analgesics and toys for children.

Health Promotion

“Another important service is education pertaining to very basic hygiene, such as informing people of the need to boil the water before drinking it to kill parasites, washing hands and feet, using shoes or sandals regularly, recommending latrines for better hygiene, cooking outside the house to avoid smoke inhalation from kitchen fires, drinking lots of water (sterilised) on a regular basis to avoid dehydration.” (Team member)

“I hope that we made some impact on the patients. Perhaps through education, and in turn, hopefully they teach their families, for example, better hygiene.” (Team member)

The third activity STMMs are involved in Honduras is health promotion. Health promotion activities include health education, the provision of resources to promote health and the training of local health providers. This was noted by some (mostly by those who had worked long term or made repeated visits to Honduras) as being the most effective service teams could offer.

“(Teams should be) educating as many as possible about basic hygiene with the hopes of preventing diseases.” (Team member)

One NGO director, after 10 years in Honduras, noted that despite the fact that her organisation had stopped bringing STMMs for various reasons, she believed the teams had had some impact on health in Honduras, particularly when they focussed on prevention. In particular she stated she had seen a decrease in the numbers of dental caries in villages where dental teams have worked, and that there is a more awareness in the villages of the need for preventative measures (even if they are not always practised).

Although health promotion was also identified by many team members as one of the most

important contribution they could make to health in Honduras, from my observations very little time and energy was spent on these activities. This was acknowledged by some team members:

“The biggest long term impact can come in educating the people; (but) with the sheer numbers of patients, I’m sure how much time was available for education.” (Team member)

Two different approaches to health education were apparent during the missions. The first involved a team member (or one case, the local nurse who was assisting the team) holding a teaching session with a group of patients, on a particular topic such as dental hygiene or preventing parasite infestation. This was usually done in the waiting area while patients were waiting for consultations. While one team held teaching sessions each morning prior to commencing consultations, most education was done when team members had the time and motivation and there appeared to be little structure to the sessions.

The second type of health education observed was individual patient teaching undertaken by team members during patient consultations. This was usually brief and tailored to the individual needs of the patient, for example exercise and dietary advice, and information specific to patient's medical conditions.

Teams also provided some resources specifically for health promotion. These included some of the “giveaway” items- toothbrushes and other hygiene products in particular. One team gave shoes to all those who came with bare feet, as a means of preventing parasite infestation-

“(The teams provided) big assist (sic) in family medicine services and also in prevention. Putting shoes on bare feet is a great way to deter worms in the system.” (Team member)

Another team provided fluoride tablets to a local school, providing the teacher with enough tablets to treat every student for three years.

“In our concern to prevent dental disease, we established a Fluoride program for the schools in (this) area. We left 30,000 tabs of Fluoride and instructed

the local health provider on how to administer these tabs to the children in the first 3 grades of school, for the next 3 years. This preventive program will impact the dental health of these students by preventing dental decay.” (Team member)

In addition to patient teaching and the provision of resources for health promotion, some teams are involved in the education of local health professionals as a means of promoting health in the communities visited. This was identified by many team members as an important part of the service they provided:

“Providing care, education!!, Educating local caregivers, especially if local caregivers are self-taught” (Team Member, commenting on what STMMs should be doing in Honduras).

“(We) provided dental education to all dental patients while a local healthcare provider was present (and) demonstrated how to do appropriate self-breast exams to... (the team hosts) and the local doctor.” (Team Member)

Although the education of local health care professionals was recognised by many of the team members as being important, I did not observe this being done very often. This may be because of time limitations, because the teams did not often work with local health providers, and perhaps also because most had limited knowledge of who the local providers were.

Although many of the team members and others identified health promotion activities as being very important, the practise of the teams, as observed during fieldwork, indicates that the priority of the teams is the provision of direct clinical services- assessment, treatment and referral. With limited time and resources, teams prioritised individual patient needs:

“Due to the number of patients, we could only take care of... in many cases.. the (patients)worst problems.” (Team Member)

The priority given to direct clinical services over health promotion is reflective of a strongly bio-medical approach to health. This is consistent with Smart's (2004: 13) finding that “the majority of US based volunteer NGO's that operate Medical Missions in Honduras, follow

the model of curing rather than preventing illness". This may be a result of the very nature of STMMs. While most brigade members appear to be aware of some of the larger issues affecting health in Honduras, they do not have the time, knowledge or resources to address them.

Even when teams do focus on health promotion strategies, there is debate over whether short-term groups, which by definition do not have long-term relationships with local peoples or adequate, in-depth knowledge of local conditions, should be the ones providing preventative health care. As Montgomery (2000: 3) has pointed out "this ignores the reality that poor individuals often have neither the resources nor the living conditions in which to implement that knowledge, and many of the problems would take care of themselves if general standards of living and income improved". She argues that if treatment or preventive information is being provided with no acknowledgment of local health beliefs and practices, their efficacy is questionable. As an American doctor living in Honduras noted:

"The groups grossly UNDERestimate the magnitude of the problem, or they would not think that they could do anything in 1 or 2 weeks." (His emphasis)

Conclusion

This chapter has shown that most providers of, and participants in STMMs see their role as providing health services in Honduras. While sometimes invited into communities to provide these services they usually access communities through intermediaries, which raises many questions in relation to power and paternalism.

Once the teams have arrived they provide mostly clinical services- direct health services to individuals including assessment, treatment and referral activities, and resources- medication, equipment and other giveaways. Many also attempt to complement these with preventative services including patient education, although this isn't always a priority. However it is clear that the nature and value of the services provided is also questionable. The particular limitations and benefits of using STMMs as health care providers will be the focus of Chapter 7, which will also highlight the actual and potential consequences of this approach to health care. Before these issues are addressed it is important to discuss the reasons why this particular approach has become so popular in Honduras- what may be

the causative or motivational factors that have led to STMMs being used as health service providers. The next chapter will address these factors from both the team and the Honduran perspectives.

Chapter 6: Motivations

On the surface, the popularity of Short Term Medical Missions (STMMs) in Honduras is a mystery. From the evidence it is clear they are increasingly being used as health service providers in Honduras. Despite some effort at regulation there appears to be an open door to NGOs, religious and other groups willing to offer health services in Honduras- and no shortage of groups and individuals willing to go. But why would large numbers of Western health professionals give up vacation time and pay significant amounts of money to work in Honduras? Why are the teams so enthusiastically welcomed by the Honduran Government and public alike? The answers to these questions provide vital links in seeking to understand the role STMMs have in Honduran health care.

This chapter will therefore examine some of the reasons why STMMs have become so popular in Honduras. This is done from both from the teams' viewpoint and from that of the Hondurans, as there are some important differences between what the teams think they are there to do, and why the Hondurans continue to welcome them. These beliefs affect the nature of the services provided, and gives an insight into why the role of STMMs as health service providers has developed as it has.

The Team

While Hondurans have particular reasons for encouraging and welcoming the teams that come which will be discussed later in this chapter, a significant causal factor is the motivation of the individuals and groups that do go to Honduras. The phenomenon of STMMs simply would not exist if individuals from North America and other developed nations were not willing to travel to Honduras- often at considerable personal cost, in order to offer their services.

Motivation for working in another culture

The motivations of these individuals and groups are as diverse as the teams themselves, but it is possible to categorise these motivations into broad groupings. In an example of this, Parfitt's (1998) study of expatriate nurses working in developing countries in primary

health care identifies two major reasons why nurses travelled to work in another culture: “work as an opportunity for travel, sun and fun”, and “work as doing something”. “Doing something” included “helping the suffering”, “following a call” and “a worthwhile job”. These categories were reflected in the data for this study, which showed that the desire to travel and the motivation to help the poor were both major reasons why people join STMMs. However in this research religious motivations (“following a call”) appeared to be a particularly strong motivation and is therefore considered here as a category in it's own right.

Helping

“Helping the poor” is the most commonly expressed motive for participating in a STMM. In fact the word “help” was chosen to describe this motivation, as it was the term team members themselves used most often when asked to explain why they went to Honduras, for example:

“A desire to help others in need.”

“To help people.”

The online Oxford English Dictionary (2005) defines help as “to provide (a person, etc.) with what is serviceable to his efforts or his needs”... “to aid, assist, to supply or relieve the wants or necessities of; to succour” and “to afford aid or assistance; to benefit, do good to”. “Helping” is usually perceived as a positive act, an unconditional, compassionate response. It is a form of altruism, “...devotion to the welfare of others, regard for others, as a principle of action; opposed to egoism or selfishness” (Oxford University Press, 2005).

Leininger (1978) states that 'humanism', the ability of 'man' to express empathy, love and benevolence towards other 'men' is one of the major characteristics separating 'man' from the animal kingdom. 'Humanism' or the altruistic desire to help is a strong motivating factor, particularly for health professionals. One NGO director in Honduras commented that the people who participate in STMMs tend to be the type of people who were service oriented rather than materially oriented- people who “went into medicine to give or help... not those after flash cars or material processions”. This is consistent with Parfitt's study

(1998: 115,172) which noted that nurses generally have a “strong social conscience”, and in choosing to work overseas they were driven by a concern for people and a wish to make a contribution towards improving the quality of life for people in disadvantaged communities, often at considerable personal cost. Others have suggested that in order to even be considered as a volunteer, altruism must be the central motive, that the volunteer’s motive is a primarily selfless one (Bussell & Forbes, 2002: 248-249).

The idea of help as purely altruistic has been strongly critiqued by others, including Gronemeyer (1999), who argues that the idea of help has become institutionalised and professionalised, that it has become a form of colonialism- a colonialism that 'gives' rather than 'takes', in the expectation of a return. While this analysis is based on the 'help' offered in the larger context of development aid, it is worth considering the nature of the help offered by STMMs and the implications of that help for the communities and individuals served. For example the very idea of help is strongly tied to the perception of need. Many team members were motivated to help based on their perception of the needs of Hondurans, as the following statements illustrate:

“(I came to Honduras) to help those that have no or little access to medical facilities.”

“(I was) overwhelmed by the numbers of people without any medical care.”

This awareness was raised through previous visits, the media and the advocacy work of individuals and NGOs.

STMMs often offer help in response to a request from a particular community or group within Honduras. Gronemeyer states that in this case the sufferer remains the “master of his or her need” (1999: 65). Help therefore “allow(s) the sufferer to reapproach normality”, it is “an act of restoration” (Gronemeyer, 1999: 65). However while there is often a 'cry for help' from Hondurans (see discussion of Honduran motivations later this chapter) team members are frequently motivated to help when they compared the resources they had at home with what was available in Honduras:

“We have received so much that we feel compelled to help those less fortunate...”

“(I have a) deep desire to be of service to the underserved and to share the abundance I have been blessed with.”

“(I came because of) a desire to 'give something back'. As a medical professional, I am fortunate to have a good career and lead a good life. I wanted to help those who have less.”

Gronemeyer (1999: 66) argues that help becomes a source of shame when one becomes needy on account of another's diagnosis- including offering help as the result of comparison with a foreign normality. If the giver decides when the receiver is needy, help is no longer help in need but help in overcoming a deficit. The needy person loses control, he is no longer the “master of his neediness” and a relationship of superiority and inferiority is created (Gronemeyer, 1999: 65-66). This raises serious issues for STMMs, for it can be argued that in defining the needs of Hondurans by comparison with the USA, and acting on that basis, the team members may be reinforcing an unequal and paternalistic relationship. As one commentator has asked, “Are we ethnocentrically treating the people of the third-world as tragic objects to be rescued--or as equals to walk with and learn from?” (Van Engan, 2000).

The other concern with this type of motivation is that it involves an underlying assumption that if the team did not come these people would not get help:

“I'm motivated to do this because I believe that it can make a difference to people who have needs which are not easily met.”

This is a common assumption, which raises issues regarding the actual availability of health care in Honduras, and the level of local knowledge team members have on which they base their offer to help. These issues will be explored later in this chapter and the next.

Religion

Another major motivation in the formation of STMMs is religion. Religious involvement and religious beliefs have been shown to be associated with a greater likelihood to volunteer (Bussell & Forbes, 2002: 249-250). As was highlighted in Chapter 4

approximately half of all medical mission teams coming to Honduras have a religious motivation. The degree to which religion was a motivating factor, and to which it influenced the activities of the team varies considerably but some clear trends were apparent in the fieldwork and in the literature.

For many team members participation in a medical mission was simply about responding to “God's will”, as the following comments from team members indicate:

“God told me (to come)”

“I believe God wanted me to be there.”

Parfitt (1998: 115) calls this “following a call”, where individuals feel compelled to help others is based on a religious commitment. However there is a broad spectrum of religious motivation apparent between groups professing Christian motivation. At one end of the spectrum are teams that arrive in Honduras with a strong evangelical purpose, their primary mission being to proselytise. For teams like this the medical work is secondary, and may take a back seat to religious activities such as prayer, church meetings and evangelism. At the other end are teams for whom medical service is an expression of their faith, but who clearly separate medical from religious activities.

One of the teams participating in this research was overtly evangelical. They defined their mission by their religious beliefs- as *“Christian, (an) evangelical outreach opportunity”*. One team member went as far as to state that the medical team was there solely as 'bait'- the real reason for the teams visit to Honduras was to evangelise. The actions of the team reflected this, for example patients were asked to go to a “prayer” station after seeing the doctor and before picking up their medication. At the prayer station, a team member talked to patients about God, before inviting them to convert, and praying for them.

This particular approach probably arises from the premise that the first role of the church is the evangelistic mission (Stewart, 1999). Many fundamentalist Christian believe that a Christian's sole task is to “bring the gospel to a dying world... (and therefore) the command to evangelise is all that matters” (Reinhart Bonnke, quoted in Gifford, 2000: 38). Another author notes "To heal the body does not enhance a human's standing before God on the day of judgement. We need to be concerned for the whole person but to treat

disease and not to tackle sin is not Christian work” (Anonymous, 1998: 1). Within evangelical circles these ideas are controversial, and there is much debate over the use of medical missions as an evangelism tool. The idea that medical missions are a solely a tool for evangelism is not universal among Christians, and in many medical missions the evangelical motivation is often combined with an altruistic one, as in the aim of one of the teams in this research:

“To help other people and spread the word of our Lord Jesus Christ.”

While for some volunteering for a medical brigade may give the individual the opportunity to pass on core values and beliefs, for others it is an opportunity simply to express these values (Bussell & Forbes, 2002 : 249-250). In this situation participation in a medical mission is more about Christian responsibility than about evangelism. For example one team member described her purpose for coming as:

“...living the gospel of Jesus by helping the poor.”

In this case, medical work is less of a way into preaching or “bait for the Gospel”, it is an end in itself - “compassionate caring as a good thing (and) an expression of the Spirit of the Master” (Anonymous, 1998: 1).

While the religious motivation is strong, it clearly is not shared by all, and in fact is a deterrent to some. One of the teams involved in the research was non-religious, and several team members commented that they had chosen this organisation because of its non-religious nature-

“I was looking for a non-religious group, (which) eliminated the majority of medical brigades.”

“(This organisation's) missions are all to Honduras and I like their philosophy. To provide medical care without any references to religion.”

“In the hotel, prior to leaving for (the brigade location), we met a group that had finished a mission. Their emphasis appeared to be more on missionary work than medical care. Though they may be well intentioned, I don't believe providing medical care should come with conditions, i.e., being “saved”,

converting, etc.”

Some individuals had even stronger responses to the role of religion in STMMs.

“(Teams should not) push religion- it's not our purpose.”

“Don't connect the medical care you give with any preaching or religious reward!!!”

One NGO director in Honduras went as far as to state that her organisation did not work with overtly evangelical groups as “they force people to lie” (by converting in order to receive medical treatment), and as a result “the team themselves ends up lying when they report back to the church the number of 'conversions”.

Personal

While most team members had an altruistic or religious motivation for participating in an STMM, many also had very personal reasons for doing so. In particular, one of the most common reasons given was that of personal fulfilment. Team members report that being part of a medical mission has a positive impact on their lives-

“(Coming on a medical mission) makes me feel good”

“I thoroughly enjoyed that trip. It changed me in ways that I believe make me a better person.”

“The people in Honduras are amazing, they have nothing but still they are the most generous people I have met... I need to come here to become humble and to appreciate the haven I am in”.

This sense of personal fulfilment is widely reflected in the non-technical literature, much of which is born out of individuals' experiences of STMMs. For example in an article entitled “How to feel really good after a vacation”, Kane (1998) argues that doctors who volunteer to work in remote or relatively underdeveloped areas find satisfaction from simply being able to help the poor and make a difference in their lives.

Some participants acknowledged that they probably received more from participating in the mission than the recipients' did:

"We feel the medical brigade receives more blessings than we can possibly give."

"I think I got as much out of it as the patients. A true win, win experience."

One STMM participant, writing in an online report, summed it up this way- "we're probably getting more out of it than (the patients) are... what's a couple of pills for a lifelong lesson?" (Egan, 2003). This is consistent with Wearing's (2001) assertion that the volunteer tourism experience offers the individual an opportunity to develop themselves. Cnaan and Goldberg-Glen also demonstrate that, in addition to an altruistic motive, volunteers also tend to act on egoistic motives (1991). Therefore while volunteer tourism may be defined by an emphasis on altruism, it is clear those self-developmental experiences and the "intrinsic rewards of contributing" (Callanan & Thomas, 2005: 184) also play major roles in motivating volunteers for STMMs.

Significantly, Van Engan (2000) argues that while participants may call those experiences "life changing", often that "life changing" experience is based on an emotional response to a situation they do not really understand, often returning home "simply counting the blessings they have of being North Americans having gained little insight into the causes of poverty and what can be done to alleviate them" Van Engan, 2000: 2}.

More tangibly, self-developmental motivations also include the improvement of professional skills and experience. This particularly evident among health professionals who may join medical brigades as a means of challenging or enhancing their skills-

"(I came to Honduras as a) challenge to medical skills"

"(The medical mission) ranks up there as one of the most rewarding experiences I have ever had as a nurse. I enjoy my profession and I have always wanted to use my skills outside my country and this gave me the opportunity to do so. "

Again, this motivation is reflected in the literature, for example "...when you're there, there

are no [health maintenance organisations]. It's just you and the patient and your diagnostic abilities... finally, you're able to fulfil that dream you had as a medical student trying to help people" (Adams, 2002). There has even been some research on the benefits of doctors' experiences in a third world countries, which concluded that these sorts of opportunities are beneficial, because they both expose the doctor to advanced pathologies they may not see in Western practise, and because they force individuals to become more resourceful and task efficient (Jacobs, Young, & Mittal, 2002).

While the major reasons for individual's participation in medical missions were altruism, religious or some form of personal or professional fulfilment, many come for more individual reasons. Several mission participants stated they joined the mission at the invitation of a friend or family member or as a means of enriching relationships, while others were interested in travel opportunities:

"(My friend) comes and was so enthusiastic I felt I wanted to try it."

"(I) wanted to get to know my mom (also participating in the mission) better and closer"

"...to see new places (and a) change of environment"

"This was the most valuable time I have ever spent... The people are so receptive & the children are so lovable. It was a wonderful experience to see how other cultures live, the many needs in these areas & I am so thankful for the blessings I received personally by being able to spend time in Honduras. It has been a life changing experience that I will grateful for forever."

Most mission participants however had multiple reasons for going to Honduras, and in particular saw STMMs as a mean of combining service to others (for altruistic or religious reasons) with personal desires:

"(I came on a medical mission to) help others less fortunate and to gain new perspectives on life"

"(I come to Honduras) because of the poverty, the lack of basic healthcare, and the great contacts made over the years"

While personal reasons are undoubtedly important motivating factors in STMMs, as noted in Chapter 3 some commentators do not believe they are helpful. For example Montgomery (2000) questions whether it appropriate to have a model for service which is essentially oriented to the needs of the server rather than to the served. The issue is quite controversial, with one American doctor working long term in Honduras (who had assisted multiple medical teams in the past) stating that-

“...the (short term) groups are SELF centred. They are seeking a humanitarian and spiritual experience for THEMSELVES.” (emphasis his)

He argues that most groups come for their own purposes and are not particularly interested in Hondurans. While this may seem extreme, it is relevant to note that one team, when asked in a group interview about their reasons for undertaking a medical mission never once mentioned Hondurans, nor health care. The answers given were entirely oriented towards spiritual reasons.

The Hondurans

While the teams may be motivated to come, they would be unable to work in Honduras without the assistance and cooperation of Hondurans, both at national and local levels. The motivation for this assistance and cooperation- and for the large numbers of patients that line up to be seen by brigades (see Fig 5.7)- is related to a combination of the high levels of need and the poor condition of local health services. Politics and religion also play a part in motivating Hondurans, particularly for brigade hosts and volunteers.

Health Needs

It is clear from the preceding discussion that many groups and individuals are motivated to come to Honduras because of the health needs they have heard about or seen. It is also clear from the discussion in Chapter 4 that this need is real. Hondurans- particularly poor Hondurans- suffer from high mortality and morbidity rates. Illness and death from preventable and treatable diseases is high, especially among children

While the three participating teams saw few acutely unwell patients the long-term effects of chronic illness was apparent. Patients presented with complications of uncontrolled

diabetes, untreated infections and advanced cancers. Teams also saw the effects of poverty on the health of patients including malnutrition, parasite infestations and general ill health.

Team hosts and patients all identified poor health as a reason why they needed STMMs. For example, one mission host noted that in their area many people suffer from diarrhoea and vomiting, and that shortly before the team arrived three children suffering from gastrointestinal illness had died as there was no one available to treat them. Teams are perceived as being an answer to the considerable health needs of the country and are therefore welcomed:

“(Medical brigades are necessary) ...firstly because of the profound need that we have in health in this area, especially the situation of those people that live in the marginalized places, the extremely poor...”

In addition to the problems related to poverty, Hondurans are particularly susceptible to health problems linked with natural disasters. This was illustrated following Hurricane Mitch in 1998, which killed 5657 people and injured 12272, and directly contributed to a rise in cases of dengue, cholera and gastrointestinal infections (PAHO, 2002: 353). Because of significant damage to the public health system and the inability of local health centres to cope, outside medical assistance was an important part of the relief effort following the hurricane. It is therefore possible that the continued rise in the number of medical missions operating in Honduras since Hurricane Mitch has reinforced the belief amongst Hondurans that STMMs are desirable as providers of health care.

However while in general the health status of Hondurans is not good, and there is evidence from the fieldwork to support this, the data from the three teams that participated in fieldwork for this study does not fully support the claims that the teams are necessary simply because of the ill health of Hondurans, or that they are in fact doing anything to improve the health status of Hondurans. Indeed as noted in the previous chapter, most ailments treated by STMMs are minor, and most teams do not have the resources to address major health problems they may come across, many of which may require full diagnostic and treatment services, often at a tertiary (large hospital) level. It is possible that the poor health of Hondurans may in fact be directly linked to the lack of these services in poor and rural areas, and if that is the case then the use of outside medical

teams to meet those needs can only be fully understood in light of the condition of local health services. It may be that STMMs are welcomed, even invited, to Honduras as not necessarily because Hondurans are sick, but because they are perceived as a means of meeting health needs not currently met by other health services in Honduras. This is discussed in the following section.

Poor Local Health Services

Patients, mission hosts and local health professionals highlighted a variety of reasons why local health services were unable to meet the health needs of the population. These issues, including availability and resourcing of health services, affordability of health care and issues with the quality of care given locally, were given as reasons why STMMs were important more often than the health care needs themselves.

As discussed in Chapter 4, the major provider of health care services in Honduras is the *Secretaria de Salud*, which has a well-established network of hospitals and clinics across the country. Most small towns are served by at least a “*centro de salud*” (local health centre). These charge only a few Lempiras (about NZ\$0.50) for a doctor’s consultation, and medication is given free. All three medical brigades participating in this research were located near a *centro de salud* (the commonly used term for a CESAR or local health centre)- something the patients were aware of even if the teams were not:

“(The nearest centro de salud is) not far away, in the next village, but have no medication to give away, you only see the nurse too.” (patient)

“Yes (there a centro de salud here). There is also another one at the next town, not far away. She sees 15 or 20 patients per day, and does other jobs. She is in charge of four communities in total, (but) used to be eight. She has been working here for 8 years.” (local nurse)

However there are some very remote areas where the *Secretaria* does not reach. A small group from one of the teams participating in the research spent a day working with an indigenous group. This group lives 4 hours drive up the mountain, but reported that many living even further up came down for the clinic. There was no health clinic or nurse up there, and for some the teams visit was the first time they had seen a doctor. As I noted

in my research journal-

In part it appears that they have isolated themselves to preserve their culture and identity, and many were reluctant to see the doctor- some refusing care, others refusing to give their name or discuss their problems- but the fact remains that these people most definitely do not have accessible, affordable, available or appropriate health services.

Most *centros de salud* provide only basic health services. Hospital services are available in the cities and many large towns, however these may be quite a distance for the patients to travel. For example, while most of the mothers in one brigade location told the team they had had their babies at the hospital, this had entailed several hours walk down rough roads while nine months pregnant, then walking back up the mountain carrying the baby soon after the birth. In addition, most rural communities do not have access to a broad range of services such as dental or optical services, and health education and promotion activities are limited. In one brigade location, the only “dentist” for a large area was a woman whose deceased husband had been a dentist. He had taught her some basic dentistry, and she was able to pull teeth for those who could not afford to travel to the city to see a dentist. Once the teeth were pulled, people then went to see the local mechanic who sidelined in making dentures.

While medical brigades are encouraged by the Ministry as a means of reaching more remote areas where they have poor coverage of national health services, this was the only group involved in this research that went this far off the road. As the discussion of the characteristics of STMMs in Chapter 4 notes, this may be indicative of what Chambers (1983) terms “tarmac bias”, the tendency of outsiders to follow networks of roads when visiting rural developing countries. The fact that local health services appear to follow the same bias, is a situation which partially explains why STMMs are welcomed by the Secretaria:

“The Secretaria focuses where there is there the biggest concentration of people with needs, (that is) Tegucigalpa and San Pedro Sula, and tries to stretch the money to help small communities but we are aware that many of those communities are very poor and have no medication, so there is when the medical brigades provide support that we cant provide.” (Official, Sec. de

Salud)

Another significant issue affecting publicly provided health services is resourcing. Patients and local health professionals noted shortages in medication and other resources for the *centros de salud* as a major cause for concern:

“(The centro de salud is) not far, but they have no medication... only Panadol and even that runs out sometimes.” (Patient)

There is considerable debate as to whether this lack of medication is because the *Secretaria de Salud* actually has insufficient resources, or that the resources are not reaching the areas where they are needed because of national and local level corruption. The *Secretaria* itself claims a lack of resourcing:

“...the Secretaria does what they can to provide services to the public, but because Honduras is a poor country and the budget of the Secretaria is so little for the huge needs...” (Official, Sec. de Salud)

Local health professionals and community members argue that the real problem with resources is corruption at the *Secretaria*, as scheduled deliveries do not always arrive, as a local doctor noted:

“...this does not necessarily mean that they actually send the medication every three months, for instance in (this) region last year we only got restocked twice during the year. This is probably because... somehow of all the medication that should come to (this area) only half actually arrives.” (Local doctor)

According to one NGO director corruption is also present at the local level, with stealing of medication being a big issue. In addition many *centros de salud* do not keep an inventory of medications, and the staff often lacks knowledge about medications and what to use them for.

Whether the issue is at national or local level, and it is quite possibly at both, the result is that the *centros de salud* frequently do not have medication to give the patients. As noted in the previous chapter, STMMs usually come with significant amounts of medication and

medical supplies. Therefore it is not difficult to see why patients, health providers and the *Secretaria de Salud* welcome them, as the following quotes suggest:

“(Medical Brigades) not only provide health services but also give medication to those that can't afford to buy it nor go to the doctor because of their economic situation... (Team Host)

“They bring medicine”. (Local doctor's response to a question about the benefits of Medical Missions in Honduras)

Almost all patients, when asked why they had come to the brigade clinic instead of their local provider, stated they came for the free medication, which was not always available at the *centros de salud*. This held true even for patients who were not unwell, as many lined up to get vitamins, mild analgesics and parasite medication.

There are alternatives to the government *centros de salud*. In particular there is a significant private sector offering medical services in Honduras, most towns have at least one private doctor. Medication is also usually available from private pharmacies, however the cost of seeing a private doctor and buying medication is usually well beyond the means of the poorest:

“There is one (private) doctor in town, he charges about 800-1500 Lempiras (US\$44-83) for a consultation and will not treat if the patient cannot pay, 1500 Lempiras is much more than poor families can afford.” (Team host)

Hassouna (1994) (quoted in Chapter 3) argues the profit motive of the private sector puts the price of health care beyond the reach of the poorest and this is evident here. The only alternative to the poorly resourced government clinics are well out of reach of the poorest, and this has contributed to the attractiveness of STMMs.

While availability and resource issues were the major concerns, they were not the only issues related to health services identified by Hondurans. There was considerable concern with the quality of care provided by the public health sector. Often *centros de salud* are staffed only by nurses, and many of these are not professional nurses and only have one years training. Where there is a doctor, this may be a newly graduated doctor completing their “social year”, a years posting to a rural clinic as part of the requirements

of a scholarship:

“There is one governmental health centre (here), staffed on an annual basis by graduate doctors working a compulsory year for the government. The clinic is not provided with medicines by the government.” (Team Host)

While it is beyond the scope of this thesis to investigate the extent to which this may be true, there is some evidence from the fieldwork to support the idea that the quality of care offered in Honduras, particularly in rural areas, is poor. When participating in the clinics I frequently came across patients who had seen a local doctor recently, but had been unable to get a diagnosis or satisfactory treatment- as indicated in this case from my field notes:

70 year old man with “dolor de cerebro”- pain in the back of the neck, and heat in lower back and legs at same time- probably arthritis in the neck radiating. The patient stated he had been to the hospital several times but they did not know what was wrong and they gave him a topical cream, which did not help. Patient was given anti-inflammatories, Tylenol for arthritis and vitamins.

In addition to the concerns about local care there is also a strong perception among Hondurans that North American doctors are better than local doctors. As a result people will come to a brigade clinic just to be seen by a “gringo” doctor.

“People would go to the government local clinic or hospital to the doctor, but I think it was of great blessing to have the brigade because they have a higher level of understanding and skill in medicine than the local doctors.”
(Community member)

“See we always look up to the Americans or to someone that comes from France or Germany, we think they know it all. We still do. That’s the kind of mentality we have here.” (Team Host)

Many expatriates working in Honduras also expressed concern about the quality of local care. One NGO director stated that she thought that patients may “unfortunately” be right with their belief that “Gringo” doctors and nurses are better than Hondurans. She believes

American doctors do get better training as many local doctors do not do residencies, and as a generalisation noted that doctors and health professionals in Honduras are not trained well in “bedside manners”, particularly compared with western doctors.

Finally, people will often come to a medical brigade clinic for non-medical reasons. In more rural areas the arrival of a group of foreigners may be a major community event. In one brigade location during fieldwork local women and children were observed spending much of the day, even after being seen by the team, sitting in the shade watching, prepared for the day with food and thermos' of coffee. When asked why they had come, in addition to the usual comments about medication and seeing a doctor, that they were curious about the group-

“We like to come and see the gringos.” (Patient)

“(We came to the clinic) to get some vitamins and worm medication and the kids wanted to see the gringos.” (Patient)

Politics and Religion

While communities and individual patients were enthusiastic about brigades because of the free medical treatment and medication, team hosts often had other reasons for inviting or working with STMMs, in particular political and religious motives. As discussed, religion plays a major role in motivating team members to work in Honduras. But the relationship is not one-sided. As with the team members themselves, STMMs are seen by many in the Honduran Christian community as both a means of serving their communities and as a tool for evangelism.

“One of the reasons why we help the team is because we have a desire to serve, specifically for kingdom of God. Yes we would help teams of any kind in the future because the church wants to get involved, to serve ... by helping of the medical teams we are encouraged to serve the Lord.” (Church Member)

“We like hosting teams that offer two services, firstly the medical help,

especially those with that are specialists and also those that are willing to do some evangelism. Also... they (the teams) can provide tracts, New Testaments and evangelism information to facilitate the sharing of the gospel.” (Local Pastor)

Of the three teams in the research, one was hosted by an evangelical Church and another by Catholic nuns- although interestingly the team hosted by the nuns was the one non-religious team participating in the research. The close relationship between STMMs and the Church is not surprising. As discussed above, compassion and caring have long been part of Christian service. In addition, Hondurans are a traditionally religious people. Most patients showed no surprise at, or objection to, the use of prayer, preaching and other religious tools during the course of a brigade, it appeared to be considered quite normal.

In addition to those who used medical brigades for religious purposes, there were others who saw them as a political tool. While medical brigades are frequently used for political purposes (as noted in Chapter 4) none of the teams in the research were politically motivated. Despite this, the politicisation of health was evident in two of the brigades.

In the first case, one brigade was assisted for one day by two local paediatricians whom they assumed to be volunteers. Towards the end of the day a team member observed that they had political propaganda with them and, after seeing the children, were giving the parents political information. On further investigation, it became clear that one of the paediatricians was running for office in upcoming elections. This upset the team hosts and the team, who did not want to be associated with any political group. One of the hosts was particularly angry and planned to make a statement on local radio distancing the brigade from the politicians.

In the second example, one of the teams was hosted by a government-owned corporation, who made many of the decisions about where the team was to go. They provided all accommodation and transportation free, and it was their employees who publicised the brigades in the communities. While the politicisation was not overt, questions remain over the motivation of the company, which had vested interests in the area. There are also significant questions about how the brigades were being used in this area, as the company had some responsibility for providing health care to communities affected by their activities. It appears they may have been using brigades to fulfil those

responsibilities at considerably less cost than setting up permanent facilities.

Conclusion

While motivations for involvement with STMMs are immensely varied, their role as service providers in health care in Honduras is a direct result of a timely intersection of circumstances. On the one hand, individuals and groups, motivated by a desire to help are offering their services and resources at little or no cost. On the other hand, Hondurans continue to suffer from a wide variety of medical needs, worsened by significant issues with the provision of health care service and resources. It is easy to see how the brigades appear to Hondurans to be an attractive solution to their health needs, and are therefore welcomed by all levels of society, from government to individuals.

While the patients and communities welcome STMMs primarily for the services and resources they provide, the basis of the relationship between the teams and patients is often unequal, the result of underlying assumptions and beliefs. In addition the teams, and often their hosts, may have personal, religious and political motivations that colour the nature of their interactions with the patients and community. These motivations, assumptions and beliefs have an impact on, and therefore consequences for the service provided by the teams. These consequences will be examined in the next chapter.

Chapter 7: Benefits, Limitations and Consequences

The rising numbers of Short Term Medical Missions (STMMs) is evidence of the fact that many Hondurans as well as the mission participants themselves see them as beneficial. However it is clear from the discussion in the preceding chapters that there are also limitations to their use as providers of health care, and that their long-term use has significant consequences, both for Hondurans and for Honduran health services. This chapter will examine in more detail the benefits and limitations of STMMs as health services providers in Honduras, and will then discuss what the consequences of their continued use may be.

The Benefits of Using STMMs as Health Service Providers

While the use of STMMs as health service providers remains controversial, it is clear that the brigades, and the organisations that sponsor them, clearly believe that the work they are doing is beneficial:

“There is only so much that can be done (with the) medical treatment that is available on a mission brigade to remote areas. We realize that it is only basic and “Band-Aid” surgery because of where we are located. Does our presence even for a week make a difference? Yes, we feel it does. With support from its host organizations, (our) brigades can be quite efficient in providing care to many and being able to deliver basic meds where appropriate.” (NGO Director/ Team Leader)

The main benefits of STMMs can be divided into three areas: the services they provide, which essentially fill gaps in the health care system; the economic boost they give the health system and the tourism sector: and the ability they have to raise the awareness of mission participants to needs in the developing world. The following is a discussion of these benefits.

Service Provision or “Gap Filling”

STMMs come to Honduras with the aim of providing health services, and for that the Hondurans welcome them. The provision of health services is therefore the most obvious benefit of using medical brigades, particularly where need is high and local health services are poor.

As discussed earlier most teams address mainly minor medical issues, but some make an effort to provide health promotional activities. As one team member described the benefits of their presence in Honduras:

“(We have done) health education, health maintenance, visual success in allowing people to see distances and to read. Well child monitoring. We clearly made a significant impact on a whole generation of mountain people...”

(Team member)

While there is no data available on the exact numbers of patients seen by Medical Brigades in Honduras, it is clear that STMMs typically see large numbers of patients during a mission. For example, the teams participating in this research saw 820, 1969 and 1866 patients respectively. As noted in Chapter 6 teams and hosts argue that many of these patients would not have been able to access health care if the brigades had not come:

“...there were two cases that illustrate to what extent this medical brigade has improved the health of this community and individuals. Firstly there was a 15 year old girl who was diagnosed with diabetes by this team... this young lady can (now) monitor and keep her diabetes under control ... this would not have been possible without the service of the medical brigade and its equipment. Secondly there was the case of a young man that was diagnosed with heart problems ... (If the team had not come)... the two young people... would have continued to live with the problems and would have sought help only when it was severe.” (Team Host)

“(We) assisted in various medical and dental (services) that they would not have the chance to obtain.” (Team Member)

As discussed in Chapter 3, “gap filling” is a term that has been used to describe the activities of NGOs as service deliverers in areas where there is only partial service delivery by governments (Desai, 2002; Whaites, 2002). It is clear that this process applies to STMMs, and indeed is one of the key roles of STMMs in Honduras. However the degree to which patients would not have been able to access health care without the brigades is difficult to ascertain. As outlined in Chapter 4 Honduras does have a well-established health care system, with health clinics across much of the countryside. However it is clear that there are still many in rural areas without easy access to clinics, and even where access is not an issue, there are significant problems with the resourcing of the clinics and with the quality of care given. Teams working in areas where local health care services are insufficient may well be filling a gap by providing care to patients who would otherwise not be seen, as a local doctor noted:

“I think short term teams are not the solution but due to the extreme need of the poor people, short term teams (can) patch or fill the gaps.”

Although no surgical or specialist teams were included in the fieldwork, which concentrated on general medical teams, the problems highlighted in Chapter 4 suggest that this is an area where real gaps may exist and which would benefit from further research.

While even general medical teams may be welcomed as gap-fillers, it is arguable whether they actually result in improved health status. It is possible that using STMMs to “fill gaps” actually results in a worsening of health status. As noted in Chapter 5, although brigade activities may address some of the consequences of poor health conditions, little, if any, attention is given to preventative care. As Montgomery (2000) states much of the curative efforts merely delay morbidity or mortality, rather than reduce them.

It is also debatable whether STMMs are in fact filling the biggest gaps, if they are actually reaching those that need it most. As the team location and poverty distribution maps in Chapter 4 (Fig.4.2 and 4.3) clearly show, few teams go to the poorest areas. This “spatial bias” (discussed in Chapter 4) was particularly evident in one of the fieldwork locations, where many of the patients appeared well-dressed and carried cell phones. As Montgomery (2000) notes it is unclear whether the teams are treating only individuals who really have no access to medical care because of an inability to pay for it, or if they are

diverting some otherwise paying or potentially paying patients from local practitioners and facilities. If these groups are in effect competing with local providers, there is a possibility that they could put local providers out of business, further restricting access to health care. This concern is legitimate. One organisation undertaking surgical work in Honduras stated that they were unable to return to a particular location because of issues with local specialists. A “heated” meeting had been held with the specialists and despite explaining that they were only treating patients from the immediate area the specialists were concerned that patients from the city were travelling to the mission location for the free surgeries, and they were very worried about the loss of business. For this reason, this organisation now believes that they should only be offering services not already provided

The process of “gap filling” has also been criticised on the basis that reliance on outside agencies causes further erosion of the capacity of governments. This issue will be discussed further later in this chapter.

Economic Considerations

There are two ways in which STMMs have a beneficial economic impact in Honduras. The first is related to the free services and resources (e.g. medication) provided by the team. Although the financial cost of bringing a team to Honduras is quite substantial, the money is being spent by the teams and their supporters, and the services and resources are almost always free to Hondurans. These donations of time and resources may in fact act as a subsidy for health care in Honduras. This is particularly relevant for specialist and surgical teams, as the cost of hiring trained specialists and surgeons is often beyond what countries like Honduras can afford to pay in the public sector (Smart et al., 2004).

Despite this, STMMs are arguably difficult to justify in economic terms. For example, as noted above, the availability of free services can create issues for private providers who may be unable to compete with volunteers who donate their services. The loss of business and potential closure of some has implications not only for the availability of services in the area, but also for economic growth.

There are also arguments about the large amounts of money spent by the teams and whether this is justifiable. Smart (2004) has calculated that the individual volunteer cost

for STMMs is consistent at about US\$1000 per volunteer per week. He estimates that the cost of a team of 25 individuals on a two week mission, plus the supplies and medications brought to Honduras can easily amount to well over US\$50 000. When the sheer number of teams arriving in Honduras each year is considered (see Chapter 4), the level of expenditure is obviously significant. Critics argue that this money would be better spent funding permanent clinics and local health professionals (Van Engan, 2000). This argument is countered with the reality that while individuals may be happy to spend US\$1000 or more to travel to Honduras and participate in a medical brigade it is much more difficult to collect the same amount of money in donations for the development of long-term facilities (Smart et al., 2004: 63).

The second means through which STMMs make an economic impact is as social tourists. As noted above, teams spend large amounts of money, and although much of that is spent on international travel and the purchase of medications and supplies, a significant amount is spent within Honduras on internal travel, accommodation, food and souvenirs. Caceres (2004; 2005b) estimates that the social tourism segment of the country's tourism market accounts for \$75-100 million in revenue annually- about one quarter of the country's total tourism revenue of around US\$400 million. For this reason the projecthonduras.com network has been actively seeking the involvement of the Honduran tourism sector and the National Tourism Institute in their program to encourage social tourists to come to Honduras. As Caceres (2002) notes in an essay on the projecthonduras.com website:

“When people talk about the Honduran economy, they should refer to the “social tourism sector” or “social tourism industry” as easily as they refer to the tourism, maquiladora, coffee, lumber, banana, shrimp, and cigar industries. When this is the case, then we’ll know that there is a true understanding of the contribution social tourists are making, and precisely what it is worth.”

Awareness

A frequent argument in favour of STMMs is the way in which they are able to heighten team members' awareness of the needs of developing countries, and to inspire them into

further action (Montgomery, 2000). This awareness was clearly reflected in comments regarding their mission experience:

“This mission was a very positive experience for me. I feel that medical missions, no matter limited the resources, are still beneficial to the providers and the recipients. In addition, I feel that it is very important experience and (you should) learn as much as you can about people and their cultures. It leads to a better understanding in general of people and the world.” (Team Member)

“Personally it has been very fulfilling... I have learned first hand the problems and barriers people face.” (Team Member)

The combination of increased awareness of needs, and the feeling of personal fulfillment (discussed in Chapter 6), leads to many team members returning to Honduras, as the following indicates:

“This was the most valuable time I have ever spent. I will return when the opportunity presents (itself). The people are so receptive and the children are so lovable. It was a wonderful experience to see how other cultures live, the many needs in these areas and I am so thankful for the blessings I received personally by being able to spend time in Honduras.” (Team Member)

The eye opening and awareness raising potential of first hand experience is impossible to deny. For many team members participation in a medical brigade is their first experience of a third world nation. Because of the nature of the work done by brigades, team members are exposed to the community in ways that most holidaymakers are not. They may be working in small or rural communities where tourists rarely if ever venture, and get first-hand experience of the facilities (schoolrooms, community halls, homes and bathrooms) used by these communities. As health providers they also see first hand the impact of poverty on peoples' health and lives. Many are shocked by their first encounters with malnutrition and 'tropical' diseases. As a result many are drawn into further action, either returning with a team, or supporting the work of agencies in Honduras in other ways.

While the awareness raising potential of STMMs almost universally considered a positive

outcome their ability to raise awareness of issues related to poverty, injustice and inequality has been questioned. As noted in Chapter 3, Montgomery (2000) argues that team members tend to explain behaviours and circumstances in terms of the personal qualities of individuals rather than in the context of larger structural and cultural issues. While teams may come face to face with poverty, generally they are not challenged to confront the question of why the people they treat do not have access to medical services and sanitary conditions in the first place (Montgomery, 2000). During the course of the fieldwork, only one host was observed making an effort to educate team members on the causes and effects of poverty in the area they were working, through talks and discussions in the evening and the distribution of books on the subject. However even these efforts are limited by the short time frame and general busy-ness of most teams. These issues are discussed further below.

The Limitations of Using STMMs as Health Service Providers

While STMMs usually arrive with the best of intentions, and most want to do the best they can, there are many issues that limit the ability of teams to provide good quality services. Some of these issues are quite clear, and acknowledged by the teams themselves, while others are less obvious and often only recognised by locals and those who have worked in the country for a long period of time. As discussed in Chapter 4, Honduras has turned down medical help in the past, due to their lack of knowledge of the Honduran context and of tropical ailments, and the amount of support needed. Limitations identified in the course of this research support that assertion. The particular limitations arising from fieldwork fit into five main groups- Language and Culture, Resources, Personnel, Knowledge and Time and Commitment. These are discussed further below.

Language and Cultural Limitations

Language and cultural limitations originate in the fact that the teams are from a different cultural and language background than their patients, and often the host organisation they are working with. It is a significant issue because the ability to communicate with patients is essential in providing quality health services. The health provider must be able to obtain a clear and accurate history from the patient, something that is especially important in a short-term context where patient records are not usually available. They must also be

able to communicate treatment options in order to gain consent, to explain therapies including medication doses and finally, to be able to educate the patient on relevant issues.

The ability of the STMMs observed during this fieldwork to do these things was significantly impaired by language limitations. As most teams originate in the United States the first language of most team members is English, while the local language is Spanish. This is the cause of many problems and misunderstandings during STMMs, as the following illustrates:

“Please help me, I just got my glasses, I asked the eye doctor if I can go and get this medication, but I did not understand what he said.” (Patient to research assistant)

“Did you understand the doctors instructions?” (Research assistant)

“Not really, he gave me these drops but I can’t read the directions.” (Patient)

Several times over the weeks observing the teams I noted team members attempting to communicate in poor and broken Spanish, with the result being confused and often unhappy patients. For example, I observed nurses from one team attempting to do assessments in limited Spanish, but frequently addressing the patient in English or using sign language in an attempt to communicate. This, and poor Spanish grammar, led to misunderstandings and significantly limited history taking. Language issues also affected the teams’ interactions with hosts and local health provider. One team doctor, asked by a local nurse to write a referral for a patient requiring surgery, wrote the referral entirely in English. The nurse, who spoke no English had to find a translator to re-write the referral in Spanish. Even team members with a reasonably good grasp of Spanish, sufficient for travel and social purposes, often had problems communicating in the specialised context of medical work, and I observed many overstretching their abilities. For example a team member with “good” Spanish was working without a translator and appeared to be doing well. During the course of the first day one of his patients approached a Honduran team member to complain that he did not understand what he had been told. When asked about the patient, the American team member stated that the patient had got what he needed and was “happy”, and did not explain any further. The patient however did not look happy as he left the clinic.

As a result of the poor levels of Spanish spoken by most team members there was a heavy reliance on translators. Translators may be members of the team specifically recruited as translators, or local volunteers. The ability of the translators varied considerably, as did their familiarity with medical terminology. The number of translators per team also varied, with some having sufficient for all non-Spanish speaking team members to have a translator, while others had just two or three for the entire team. One team, faced with an insufficient number of translators, was observed using a 12-year-old boy to translate in medical clinics. Even where good translators were available issues arose, including the translator's familiarity with medical terminology, and the ability of the doctor and patient to discuss personal and intimate details. The best translators are still second-best to direct doctor/patient communication. In a study of nurses as translators for Spanish-speaking patients, Elderkin-Thompson, Silver and Waitzkin (2001) found that errors occur frequently in interpretations provided by nurse-interpreters during cross-language encounters, with the result that the complaints of many non-English-speaking patients may be misunderstood by their physicians.

Effective communication also requires good listening skills. While listening, and being able to understand is an important skill for health professionals, in the context of STMMs it becomes considerably more difficult. Time limitations, preconceived ideas and cultural misunderstandings all impact on a team member's ability to hear and understand what a patient is saying. In one case, I observed a consultation involving an elderly lady who had fallen at home and hit her head. The nurse asked if she had felt dizzy prior to the fall, an indication on an underlying medical problem, and despite the patient answering no, the nurse continued to talk as though the problem was related to dizziness. The translator eventually asked the patient exactly what had caused the fall, and the patient replied she had been climbing on a bed to reach an item up high and had slipped. Even once that had been explained, the nurse finished the consultation by advising the patient to see her doctor if she experienced any further episodes of dizziness.

The ability to hear and understand a patient is closely related to a health professional's understanding of the culture in which that patient lives. A lack of cultural knowledge or cultural insensitivity can have a very negative influence on the quality of care given by teams. Cultural factors, such as culture shock may also limit the teams' ability to work effectively, as the following illustrates:

“And also another question that to me is very, very important. How would they feel to come into a third world country, and how would they feel to be in front of a person that is not clean, because some people cannot be clean and some people are against dirt. And some of our people did come like that. You noticed that the ones that had that old clothes... (Some) of them were not clean...” (Team Host, commenting on how teams should be prepared for working in a developing nation)

“One group came, and they were not prepared to come to a third world country and after the second day, you know how nature is, you get tired and then you get very hard with the patients, and especially if you do not understand what people are trying to tell you, they don't wait for somebody else to translate... it's like a culture shock. I had that experience with one group, the second and the third day was really, really sad.” (The same host, on her experiences with medical teams and cultural difficulties)

Cultural misunderstandings also affect the relationships between the team and local health professionals and other local volunteers. Members of one team were heard to complain how the local health professionals who had volunteered to help at the clinic took a lot of breaks and seemed to spend much of their time “socialising” - not realising that this was an important part of Latin American culture, and that the nurses needed to maintain their relationships with community members.

Cultural problems underlie many of the problems encountered by teams in their relationships with the Hondurans. Particular cultural issues observed during fieldwork include the “mañana” attitude (as in “when will this be done” - “mañana” “, tomorrow), and sexuality issues.

The work of STMMs can be hindered by cultural difference, which can cause frustration and conflict. For example the so-called “mañana” attitude is the cause of much frustration amongst team members, who are only in the country for a limited time and want to get as much done in that time as they can. One NGO director described this as conflict between the American desire to “fix” things immediately, and the more process oriented Hondurans who may try to fix, but have the belief that only God can change things. He suggested that team members need education on these issues, and on local needs and on limitations.

More significantly, as noted in Chapter 3, NGOs have been criticised for delivering assistance without reference to the local culture. This leads to the provision of services that may be inappropriate, or even damaging, to the society they are trying to help. This is particularly evident with teams who have an overtly religious base (discussed above under 'religion'), and when teams attempt to address sensitive issues such as sexuality.

The issues related to sexuality are illustrated by one nurse/ patient encounter I witnessed. The patient was in her mid 20's and was pregnant with her sixth child. She was experiencing significant pregnancy related health problems. The nurse tried to reinforce to her the stress that multiple pregnancies so close together were placing on her body, which the patient appeared to understand. The nurse continued on with questions about contraception, clearly trying to ascertain what knowledge the patient had. The patient became very withdrawn and was obviously uncomfortable with the questions, before admitting she knew little about contraceptive methods and indicating that her husband would not use them anyway. While the team members were frequently surprised at their patients numerous pregnancies and lack of knowledge, it was difficult for them to address these issues because of the short term nature of their work, and their unfamiliarity with the underlying cultural issues that lead to these situations. One long-term NGO director in Honduras listed several related issues that she believed brigades should not touch-including domestic violence, HIV/AIDs, abortion, young girls (12-14) being taken for marriage and men with multiple sexual partners. She argued that brigade members are familiar with a society where these issues are more readily addressed, and where people can be referred to social services, but that in Honduras there are few resources and few places to go. For example, there is only one woman's refuge in the country, and it is culturally a huge thing for a local woman to leave her husband and community and take her children to go and stay with a group of other women. Because these issues require long term intervention and cultural change, it is arguable that it is inappropriate for STMMs to attempt to address them.

Resource Limitations

While STMMs are seen by many to be providers of resources, the medical care they give is, in fact, limited by the resources they have available. As noted in previous chapters the teams are often reliant on donated supplies and medication. Additionally, the resources-

medication, medical supplies and equipment- available for use at a team clinic is often limited to what can be shipped and carried from the USA, and to the clinic location. There is not usually any means of restocking medications and supplies that are used over the course of the mission, although some teams- where possible- will buy small amounts locally. The reliance on donations, particularly for medications, limits what is available for any one mission, and can lead to the bringing of inappropriate medications, as some mission participants noted:

“It would be good to have more control over what they medication is bought. This time we had little control as the medication was donated... We sent letters to drug companies, many of who have programs for providing for missions. Unfortunately most donations came pre-packaged and we couldn't always choose what was needed. When we could choose often what we wanted was not available.” (Team Member)

One team leader was aware of the problems but had difficulty turning down inappropriate donations:

“These medications were all donated... if it were up to me I would have only selected medications- this antibiotic, one of these... but you can't look a gift horse in the mouth.” (Team Leader)

The more experienced teams had fewer problems as they had a better idea of what to expect and how to prepare, but still acknowledged difficulties:

“There is never a way to exactly "guess" everything we may see on a trip so appropriate and evaluations over a period of time has given us a good idea of what to pack, how much, etc. Again, there are times when we will run out of meds as we cannot predict exactly how many patients will be suffering with what illness. (We) check with the host organization ahead of time to get an idea of what illnesses to expect. Various medicines and supplies sometimes are limited as to what has been donated and what we can afford to purchase but most basic items are always available.” (Team Leader)

Teams are also limited by the equipment they have available- usually only the most basic and portable. Portable equipment for diagnosis carried by all teams involved in the

research included scales, sphygmomanometers and stethoscopes. Some of the teams carried additional equipment, which included a blood glucose meter, Haemoglobin analyser and peak flow meters. Treatment options in the clinics were limited to the medications the team carried, basic dressing supplies and some simple, portable equipment such as portable nebulisers and IV giving sets, and (where the team included dentists) portable dental units. Even when the equipment was available, limited supplies (for example medication for the nebuliser) and the failure of equipment created problems for some teams, limiting even further the services they could offer- as this team member noted:

“Due to the number of patients, we could only take care of- in many cases- the worst problems. Due to limitations- no x-rays, breakdown of amalgam mixer and light cure unit- we could not do many of the things we might in our office.” (Team Member- dentist)

Other resource constraints faced by teams include issues related to the locations in which they work. Temporary clinics in school or church halls do not afford the luxury of space or privacy, nor provide the standard of hygiene required for some procedures:

“I don’t think it would be wise to do many invasive procedures without proper conditions.” (Team Member)

Because of this, assessments, diagnosis and treatments carried out by the teams were inevitably very basic and limited, a fact most team members acknowledged:

“I guess there was only so much we could offer with what we had. At times it was frustrating to not be able to do more. But I feel that we left them better off than they were before, if even in some small way.” (Team Member)

Personnel Limitations

There is a perception in Honduras that Western health professionals are better than their Honduran counterparts. While there may be some truth in these perceptions, there are also many limitations to using expatriate health professionals in this environment. As noted in Chapter 3, Walsh (2004) argues that most Western health professionals are

accustomed to worked in technologically advanced environments and as a result are ill-equipped to work in third-world environments, and may offer inappropriate care. This was reflected in the teams participating in the research as. While levels of experience varied, the majority had spent most of their career working in a first world environment and were unfamiliar with the problems of developing nations. Many were unprepared for the conditions they faced in Honduras, an issue discussed above under "Language and Culture".

For one of the teams participating in the research, the experience was a first for everyone on the team:

"This is the first trip like this for all of us. Many of us... have hardly been out of (our home state)." (Team Member)

This led to struggles by many of the team members- it was reasonably clear, especially early in the week, that many of the team members were not particularly confident practising in such an unfamiliar environment. Assessments initially took quite some time- partly because of the translation issues and partly because they spent a lot of time reading and re-reading patient notes and consulting each other and the doctor. I had first hand experience of this lack of confidence myself with a different team later in the fieldwork, when I was asked if I would mind doing some patient assessments. I felt quite nervous at first and a little like I had been thrown in the deep end. Although the day went smoothly and I did not encounter any major problems, I wondered how many other health professionals find themselves out of their depth on these missions.

Adequate preparation can go some way towards addressing these issues:

Once a person makes the trip and is able to determine needs, materials for treatment, conditions and issues requiring treatment, it better prepares individuals as well as teams to plan, collect specific supplies, and proper individuals to treat specific conditions more appropriately and positively.
(Team Member)

STMMs are also often limited by the size of the teams and who volunteers. As noted previously the composition of the teams varies significantly. While some teams may consist almost entirely of health professionals, many are largely made up of lay people.

While these lay members of the team may be trained by the team to do various medical tasks- dispensing medication and taking blood pressures for example- they are not health professionals, and medical teams consisting of large numbers of lay people are therefore limited as to the services they can provide.

Services may also be limited by the health of the team members themselves, and the dynamics of the team. All three teams participating in the research were affected by illness, mostly travel related illness such as diarrhoea and vomiting, and respiratory conditions. Teams are usually well prepared in terms of vaccinations and malarial prophylaxis, however some travel-related illness is probably inevitable with large numbers of Westerners travelling into poverty-stricken areas. While this may not constitute a major limitation to most teams, when a team member is ill, it will have an affect on the number of patients seen, and depending on the position in the team held by the sick individual, may impact what services can be provided at that time.

Team dynamics also have an impact on the services provided. Teamwork is very important to these groups and most work hard to maintain good working relationships. While most teams observed functioned well together tensions did arise at times, sometimes slowing the pace of work or distracting individuals, as one team member noted:

“(We had to) learn how to get along with each other. The heat was a big factor. Individual personalities sometimes caused friction, but for the good of the patients were self-suppressed.”

Knowledge Limitations

Despite the limitations related to resources and personnel, the logistical preparations undertaken by each team are usually quite extensive- collecting medications and supplies, and making arrangements for the clinics and team- including accommodation, food and transport. However as noted above one area of preparation overlooked by many teams is preparing themselves for the conditions they will face in Honduras, that is the medical conditions, as well as the physical and social conditions the people live in, and the health care environment in the area the team will be working in. This is a common concern

amongst those who have observed short-term medical teams. As noted in Chapter 3, Bishop and Litch (2000: 1017) point out that Western doctors visiting for a short time may have little knowledge of local illness presentation, cultural elements or language, they may offer inappropriate treatment in an effort to “do something”, and that doctors who practice in this way may be on legally difficult ground.

Lack of knowledge was an issue that affected all three teams involved in this research. Only one team (of the three participating in the research) provided team members with information about the conditions they may see in Honduras prior to the trip. While many team members try to learn what they can before they leave, there appeared to be little if any formal training on healthcare issues in Honduras. Additionally, very few, if any doctors and nurses participating in the missions have any training in tropical medicine, and their understanding of development issues was limited.

The potential impact of this on the care given is dramatic. An American doctor, working in Honduras with an NGO, expressed his concern at the lack of training, particularly in tropical medicine, a concern arising from his own experience as an American trained doctor. He initially felt as a physician he could treat most patients he saw adequately, but later realised that he was actually missing a lot of what was really happening. In one incident he saw an emaciated elderly man, who presented with a cough. His initial diagnosis was that the man had an Upper Respiratory Tract Infection and would have treated it as such, however on this day he was working alongside a local doctor. The local doctor immediately recognised the symptoms of Tuberculosis, something the American doctor had seen very little of in his practise in the US and admitted he was very unfamiliar with. Had the local doctor not been present he would have missed the diagnosis and potentially mis-treated the patient.

Problems can also arise because short-term volunteers are unfamiliar with the patients and usually have no access to patient files (where they exist) and histories. Team members often have no way of knowing what treatment patients have had in the past, and rely on oral histories to find out what is happening now (see the Language and Culture section above for the difficulties inherent in taking oral histories in this context). For this reason most teams are cautious about prescribing certain medications. However this lack of knowledge becomes more of an issue where there are patients with sensitive problems such as psychiatric illnesses and HIV/Aids. In one case observed during this research a

young boy presented to the team clinic obviously unwell with stomach pain and severe dehydration. The team spent much time debating the cause of his illness- eventually concluding he had parasites. While the team did the assessment the local nurse was present, watching. Familiar with the child's family, she suspected the boy had AIDs but did not tell the team because of the social stigma associated with such a diagnosis, and because she did not believe-possibly correctly- that there was much they could do (see the discussion of cultural issues above), and she already was planning to have the child tested and followed up.

Unfamiliarity with the patients and their backgrounds also created some issues for another team. An older woman arrived at the clinic looking unwell. On examining her, the team could not find any cause for her symptoms, however she was given a place to lie down while the team observed her and treated for dehydration. About lunchtime the patient was found to be missing. On discussing this with the team host the team was informed that the patient was in fact well known in the community as having psychiatric problems, and that she was probably quite well physically.

Mission team members are often not only unfamiliar with the types of medical conditions and patients they may face, but they are also largely unfamiliar with the Honduran environment including social issues, culture and the local health system. Most team members have a limited grasp of the problems faced by Hondurans, and the reasons why such problems exist. One host did make an effort to address this, giving talks after dinner to the team about the situation in Honduras and in the town. She believed that for the most part team members were interested and did make an effort to learn about "the reality of the country", but this effort may not be sufficient. One American doctor (living in Honduras) expressed concern that while some teams did well, others did more harm than good because of their ignorance of the local situation. Ignorance of local conditions can limit the ability of teams to address health issues successfully- resulting in treatment and advice that is inappropriate and possibly useless, and possibly in dangerous..

Teams are also often unaware of what local health care providers are already working in the area they are holding their clinic. All three teams involved in this research were affected by this- as noted in Chapter 6 team members in one particular location were quite unaware that the building across the road from the schoolroom where they were working was actually the local *centro de salud*. It appeared that many team members believe

there were no services in the areas where they work, despite the fact the hosts almost always have contact with the local health providers. During the research, team members often only became aware of the presence of other health providers when the local doctor or nurse showed up at the team clinic. For example, when a local nurse turned up at one of the team clinics, a team member was heard to say, “so there are nurses here...”. Although two of the teams involved in the research were working with local organisations who have long term health care programs, and who did have links with other public and private providers, the fact that individual team members may be unaware of these links can have an impact on the provision of health care by the team in the area in two ways. Firstly, team members are deprived of the opportunity to liaise with those health professionals who will have a better understanding of the local situation and may already know the patient, and secondly they are not able to provide patients with the referrals they may need. Local health care providers also miss a potentially valuable opportunity to participate.

Time and Commitment Limitations

By definition, STMMs are only in the country for a very short, defined period of time- usually 1-2 weeks. This is often exacerbated by the distance teams may have to travel to clinic locations- one team in this research travelled 2½- 3 hours to and from clinics every day. This lack of time is seen by many as one of the main shortcomings of medical teams in health care provision. Such a short time frame limits the number of patients that can be seen, and the type of treatments that can be given. For example, as discussed in Chapter 6, one of the dilemmas the teams all face daily is the management of patients with chronic conditions- with diabetes, high blood pressure and heart disease being some of the more common complaints. Most team members acknowledge that it can be dangerous to treat these conditions without the ability to follow up, however they struggle with the knowledge that these conditions are treatable and something could be done to help. Some teams choose to give medication and refer the patient- where possible and without knowing if the patient will follow through- while others do not treat these sorts of conditions as a rule. Whether or not the patient is treated at the clinic, it remains clear that the short-term nature of medical missions has a significant limiting effect on what health services they can provide. In addition, short-term teams are not usually in a position to address the

social issues that may be contributing to ill health, nor are they able to assist with issues such as sanitation, water and nutrition- all important aspects of health care requiring long-term development.

Most team members are aware of the limitations of short-term work:

“I think we made a short term medical impact. I don’t think long term impact can be fully achieved until an adequate water supply is available for everyone.” (Team Member)

“(Did we make an) impact on health status? Yes- but very limited, no long term measures for example water, nutrition.” (Team Member)

These limitations are acknowledged and addressed by organisations with experience in bringing STMMs to Honduras, as one team leader explains:

“Time is always a factor when working a four day week as there are always many more that could be seen. But it is stressed to the medical personnel prior to the trip that it is important to give appropriate time to those who need it and not worry the lines of patients that still may be waiting. One of the top priorities is for quality and compassionate care and not quantity - of how many we can see in a week. This issue is supported by the host organization in working a good schedule out with the various villages knowing that each professional (team member) can see a certain number of patients each day (give or take). We hope we provide the same care and compassion to the patient as we would expect back home.”

In recent years some organisations involved in STMMs have become more concerned about the longer team needs, and in order to address these issues have established long term programs alongside the short-term missions:

“This brigade in particular (has had a impact on health in the area) because they do referrals and follow up the illnesses they find. None of the other brigades do that, just hand out medicines and leave.” (Local nurse commenting on the long-term program implemented by one organisation)

While teams can have a longer-term impact by working alongside more permanent projects, they can also have a detrimental affect of those same projects. A director of one organisation raised concerns that existing projects may be put on hold or “taken over” by a team that is unaware of what is already happening. Although I did not observe this directly during the fieldwork, I did note one instance of the effect of a team on a long-term project, in this case a feeding centre for undernourished children. Most of the children had gone home for a vacation immediately before the team arrived, and after the vacation many parents did not return their children to the feeding centre, located right across the road from the team clinic- the result of persistent rumours in Honduras that Americans kidnap Honduran children for adoption or sale overseas.

The Consequences of Using STMMs as Health Service Providers

It is clear that STMMs have begun taking a significant role as health service providers in Honduras despite significant limitations. They offer an undeniably attractive option to Hondurans- health services that are free, and that are perceived as being superior to local services. These services arguably provide a subsidy to the national health system and an economic boost both locally and nationally. Team members, despite some awareness of the shortcomings of STMMs, clearly believe their work is ultimately positive:

“I feel that medical missions, no matter how limited... are still beneficial to the providers and the recipients.” (Team Member)

However the benefits of using STMMs to provide health services are obviously limited and short term. While immediate health needs may be met, the long-term impact of STMMs on Hondurans and the health care system in Honduras may in fact be a negative one. Over the course of the research it became quite clear that the sheer numbers of teams and expanding range of services they provide could have far-reaching consequences for Hondurans and for the Honduran health care system.

Reinforcement and Expectancy

As more STMMs continue to “fill gaps” in the Honduran health system, they appear to be feeding into a cycle which could ultimately lead to a situation of dependency. Motivational

factors- both team and Honduran- lead to the use of STMMs as health care providers, which flows into the consequences of STMMs. These consequences feed back to the motivation. In particular two factors have emerged which lead to this cycle- reinforcement and expectancy.

Reinforcement is the process by which the attitudes and beliefs of locals and team members are strengthened by contact with STMMs. This is particularly evident where teams return on a regular basis. Team perceptions of the needs in Honduras, and their consequent feelings of personal fulfilment at being able to 'help' are reinforced by return trips. As they continue to return, offering free services and medication, Honduran ideas about the availability and superiority of “gringo” health services and medication are reinforced.

As discussed in Chapter 6, team members gain much personal fulfilment from participation in a STMM, and this, combined with heightened awareness of the needs in Honduras (discussed above) leads many to return. This is evident in the teams participating in the research. While one team was entirely first-timers, the other two teams were predominantly made up of individuals who had participated in teams in the past:

“The first time (I went to Honduras) it was (because that was) where the team was going, after that I was hooked on the friendliness, openness and terrible need of the people of Honduras.” (Team Member)

“Perhaps the most significant experience on the later trips is the awareness that we gain more from those we serve than we give. The next year's trip is a light to guide through the year, a goal which gives my life a real purpose... as opposed to just earning a living.” (Team Member)

Past team members, motivated by their increased awareness of the needs and the personal fulfilment felt during a brigade, add to the demand for further brigades. Many return each year, some even becoming involved in setting up and running organisations to bring teams to Honduras.

While there is an increasing demand for STMMs from western health professionals, there is also obviously a strong demand for teams from Hondurans themselves. As noted above, one of the benefits of STMMs was the meeting of short-term health needs. As the

teams were able to meet obvious short-term health needs, and provided medication and resources for free, the ideas of Hondurans about the teams were reinforced. This was particularly true in areas which had seen teams in the past, where the visits of multiple teams lead not only to the reinforcement of ideas but to further expectations that help will come from outside. As Korten (1990: 140) has noted, external aid, or gifts from foreigners have a way of creating expectations within the community that development will come from outside and not as a result of the people's own efforts.

This was evident in patient interviews. Most patients stated that if the team had not come they would have gone to a Centro de Salud, however despite this many of the patients appeared to have an expectation that a team would come, bringing free services and medication. In some cases these expectations are so strong that patients actually wait for a brigade to come, particularly for services that cannot be easily met locally. For example, one patient stated that his doctor was not able to provide him with the medication he needed and had actually suggested he wait for the next brigade. In another case, a patient asked if the team was giving away glasses. When informed this particular team was not, she stated she would wait for the next team to come. Several patients actually arrived at brigade clinics carrying prescriptions from their local doctor, hoping the team will be able to give them what they need as they could not obtain them through the Centro de Salud or afford to pay privately:

"I came (to see the brigade) because I heard they were giving glasses and I need glasses. I also need medication that a local doctor prescribed for me but I don't have the money to buy... With sacrifice I went to the local doctor and paid L 50.00 (US\$3) hoping that he would give me the medication, but he did not and just gave me the prescription that will cost me L500.00 (US\$28) to buy." (Patient)

With the increasing numbers of teams working in Honduras it is probably not surprising that patients have an expectation that another team will eventually come, and therefore may choose to wait to be seen by teams perceived to be both better trained and better equipped than local services. However while the poor health status of Hondurans is clearly linked to poverty and to problems with local health services, if patients are indeed waiting for a brigade to meet their needs then clearly the brigades may be a factor in worsening individual health status. Montgomery (2000: 3) highlights this as a major

concern for STMMs, stating that:

“In individual cases, there may even be an erosion of health status if the person waits for the foreign physicians and free care and medication before seeking medical attention, resulting in a deteriorated condition that could have been avoided with more timely attention”

The expectation that teams will arrive and will provide free services is a consequence of the sheer numbers of teams working in Honduras. This expectation is also reflected in the confidence shown by many of the patients. Patients came to clinics openly asking for what they needed or wanted:

“Most of the people that came to the medical clinics, they came for the free medication mainly, most of them when we were writing down their names they said ‘what we want is some vitamins and worm medication’, they knew what they wanted, and they knew they would get it.” (Team Host)

This expectation showed most clearly in areas which had hosted teams frequently, and where teams had items other than medication to give away. As noted in Chapter 5, patients often asked for items they wanted, or had seen being given away. Some team members recognised the implications of this-

“(Teams should not) have members play Father Christmas and shower the locals with gifts, candy and useless trinkets. This practice is demeaning to the locals.” (Team Member)

While expectancy and confidence were most notable at an individual level, similar issues were evident at a community level. As discussed in Chapter 5, teams often arrive at the invitation of a community group, who are often frustrated with the lack of health services and their inability to help, and who perhaps view the teams as an easy way to meet these needs. The lure of free medication also plays a part:

We... aim to convince the team to leave the medications that they did not use so that we can hand it over the local clinics or churches to the people of the community where the teams have been working.” (Team Host)

Even at a national level there is evidence of an expectation that teams can provide services to those the *Secretaria de Salud* cannot reach. Certainly the *Secretaria* encourages teams to come, and tries to keep procedures and requirements simple for them. This attitude may help explain why the *Secretaria* does not appear to be taking an active role in the regulation and coordination of medical brigades:

“...we (only) know about those (teams) that apply for the permission but not for those that (do not and that) go only to small communities... (We know that) medication is often given there but we do not have any record of it. We are aware that many teams comes to Honduras and we as the Secretaria de Salud welcome them here, and try to make the process of entering (the country) as simple as possible.” (Official, *Secretaria de Salud*)

Dependency

The issues related to the increasing use of STMMs, and the cycle of reinforcement and expectancy that this has created, has serious implications for the health of Hondurans and for the Honduran health care system. In particular the cycle of reinforcement and dependency that has appeared alongside the growing number of teams, is creating an attitude of 'dependency' among Hondurans. Dependency is defined by the Oxford dictionary (Pearsall & Trumble, 1996: 390) as something “the state of being dependent, esp. on financial or other support” and “reliance, trust, confidence (in another).” While it cannot be said that the Honduran health system is fully contingent, or dependent on STMMs, this research has shown that there is an increasing level of reliance on short term teams for the provision of care to the poorest and to rural areas. This is evident at all levels, from individuals seeking health care, to the *Secretaria de Salud* itself. As shown above, individuals and communities in Honduras are becoming conditioned to STMMs as a form of health care provision, and in some cases they are becoming the main suppliers of medication. This conditioning is evident among existing health providers, some of whom actively seek restocking by medical brigades, and at government level with *the Secretaria de Salud* viewing STMMs as a means of getting health care services to those they are unable to reach.

This dependency is reflective of the use of a relief paradigm in the face of long-term

needs. As discussed in Chapter 3, STMMs are what Korten (1990) describes as a first generation relief strategy. As a relief strategy STMMs can be seen as having a role to play in development, at a first level, as a relief mechanism in emergency situations or where other forms of assistance are unavailable. In Honduras this is consistent with the increase in the number of STMMs following Hurricane Mitch. However, six years after the hurricane there is no evidence of the withdrawal of STMMs, and only limited evidence of the implementation of longer term programs by the NGOs that bring STMMs. It appears that STMMs are no longer simply providing medical relief, but are becoming entrenched as a form of health care provision.

Some NGOs in Honduras have begun to come to the conclusion that medical brigades are a relief mechanism. One NGO director no longer calls STMMs “medical brigades”, believing this term is now inappropriate as brigades are associated with emergency situations and the hurricane is long over. Instead they call them “Medical Mobile Units”. Despite this, they continue to use what are basically STMMs, albeit with a longer-term focus, sending teams back every 6 weeks to the same areas to follow up on the medical care. Although this may address some of the issues related to the short term nature of STMMs, as Montgomery (2000) points out the question still remains regarding the desirability of dependence on outside resources and personnel for their health care. As she suggests, STMMs may well remove some pressure from the national and local governments to provide and respond to health needs with long-term solutions, and in this way, they may cosmetically mask deeper ills of social, political, and economic inequities.

The issues of dependency and the consequent masking of deeper problems are consistent with arguments about the problems associated with the role of NGOs as gap-fillers. As governments become dependent on NGOs for service delivery, their capacity to provide these services is diminished (Lancaster, 1999; Whaites, 2002). There are concerns about the long-term impact of NGO service provision on the sustainability of national health systems and access to quality services (Desai, 2002). While there is little direct evidence from this research that Honduran health care services are eroding as a direct result of the use of STMMs as health providers, theoretically the issue of the erosion of local health services is concerning. The welcoming stance of the *Secretaria de Salud*, the requests for medication from the *Centros de Salud* and the expectation of many Hondurans that the teams can and will provide indicate that the teams may well be having

a negative impact on Honduran health services.

The concept of dependency also involves power relationships, implying a situation where power is out of the hands of the receivers. The Oxford online dictionary (2005) definition states dependency includes being “attached in a relation of subordination”, that it is the “opposite to independent”. This is evident in the relationships experienced by local health professionals and communities in the planning of brigades- discussed in Chapter 5. In need of health care and not wanting to lose the opportunity to have a brigade visit their area, they accept the timing, location and service preferences of the team and hosts.

The unequal power relationship is also evident in the paternalism of the teams. Paternalism is the process by which providers intentionally confer a treatment or service upon a person or persons without their consent, justified by their limited autonomy or diminished capacity and with the explicit purpose of doing good for, or avoiding harm to, that person (Cody, 2003: 288). It is a contentious issue in both health and development. In the case of STMMs it can be argued that there is evidence of paternalism in both the individual doctor- patient relationship and the relationship between the teams and the communities they work in. The paternalism of teams is illustrated by their use of the term help. As discussed in Chapter 6 the “help” offered by the teams is often a response to their own perception of the neediness of Hondurans. The teams clearly want to do “good”, but in most cases appear to offer services based on their own understanding of what is needed, resulting in a relationship of superiority and inferiority.

Finally, the dependent nature of the interaction between STMMs and those they come to “help” may in fact be a reflection of larger issues of dependency in Honduran society. As one team host put it:

“...see we always look up to the Americans or to someone that comes from France or Germany, we think they know it all. We still do. That’s the kind of mentality we have here... we put ourselves down because there is a lack of (self esteem) in our Hondurans, we think we are not worth anything. There’s a lot of people here with that kind of attitude.”

Conclusion

Short Term Medical Missions (STMMs) continue to be widely perceived as beneficial, both by those providing the services and by those receiving the services. However there are clearly many limitations to the use of STMMs as health service providers, some of which have been identified within Honduras as the discussion on the disaster response to Mitch indicates (see Chapter 4). This research has shown that the Honduran disaster coordinators were correct in their assertion that the burden of foreign doctors may outweigh their positive contribution, as their use as health providers is significantly limited by differences in language and culture, the limited resources they are able to bring, personnel issues, lack of knowledge and the short amount of time they have. While many of the organisations bringing teams and some individual team members acknowledge these limitations, it is likely they are largely unaware of the potentially significant, long term consequences of using expatriate medical teams as health care providers. In particular it is clear that, as Korten (1990) has argued, the long-term use of a relief paradigm may create dependence on the relief provider, and the findings of this research indicate a that there is indeed growing level of dependence on STMMs as health care providers.

While it is clear that STMMs do provide much needed service in many areas, and can be an effective means of meeting short-term medical needs, for the most part they function as a first generation relief strategy rather than providing longer-term solutions. The result of this is a cycle of expectancy and reinforcement, and a culture of dependency within the health care sector. The use of STMMs clearly does not result in empowerment or self-reliance, and they do nothing to address the reasons why such a situation exists in the first place. The result may be a never-ending cycle of poor health as STMMs fill gaps by meeting short-term needs but do not address the underlying causes of ill health. Even more concerning is the possibility that the use of such teams may in fact remove pressure from the government and national health providers to invest in long term solutions to the problems, thereby perhaps causing an overall worsening of health status among Hondurans.

Chapter 8: Conclusion

This goal of this research was to identify the particular role of short-term medical missions and to address some of the issues that surround them within the context of health care in Honduras. However the actual identification of the role of STMMs, that of health service providers, became evident early in the research process, and the data collection and analysis therefore became a broader exploration of that role. In particular this thesis has analysed some of the reasons why STMMs have taken the role of service providers in Honduran health care, and the actual and potential consequences of using STMMs as health service providers.

The Role of Short Term Medical Missions

It is clear from looking at Honduran health statistics and from the data collected during this study that Honduras faces major issues related to health and health care. Overall the health status of Hondurans remains poor, with children suffering disproportionately from ill health related to poverty. The incidence of infectious diseases and malnutrition reflect the poor housing, sanitation and water supply, uncontrolled vector occurrence, unemployment, low educational achievement and poor access to health services faced by many Hondurans.

While Honduras has a well-structured health system in place, there are significant gaps in the system and access to health services remains a major issue. The Honduran health system has been criticised by international agencies as being functionally unsound, unable to deliver comprehensive protection to individuals or communities and fragmented, with poor co-ordination and referral systems. The results of this became clear during the research, as patients and local health professionals highlighted problems with access to services and the resourcing of public clinics. One of the most concerning issues for Hondurans was their inability to obtain even basic medications. Although the public health system is supposed to provide medication for free following consultation at a *centro de salud*, the *centros* are frequently under stocked and often completely run out of medication.

There is clearly a need for improved health services in Honduras, particularly for the poor and for those living in rural areas. However a history of political crises, structural adjustment programs and natural disasters has left the State unable to meet the health needs of all. This has led to significant growth in the NGO sector, with NGOs now taking responsibility for providing health care to much of Honduras' poor and rural population.

STMMs have emerged as one method by which NGOs and religious groups in Honduras are providing health services. This study has shown that STMMs are clearly what Korten (1990) terms a first generation, or relief and welfare strategy, offering temporary alleviation of the problems faced by Honduras. They have increased in popularity over the past few years partly because they provide "free" services to largely impoverished communities, and they utilise a clearly willing and available resource, Western health professionals looking for a way to "help out". There appears to be an increasing number of these individuals, both health professionals and lay people, motivated by the desire to do good, by religious convictions or simply for personal reasons, who are willing and able to give a week or two each year to travel to Honduras. The demand for opportunities to work in Honduras has become so strong it has in fact led to the emergence of a new industry, termed "Social Tourism", which caters to the logistical and tourist needs of these groups.

As a result of the obvious need, and the willing resources available in the form of western volunteers, STMMs are now being used to provide health services across Honduras, attempting to fill gaps in the national health system. The services they provide include assessment and curative services to individuals, resources such as medication and medical supplies to individuals and communities, and a limited amount of health education. Because of their roots in the biomedical model of health, and the limitations of short-term work, the activities of STMMs tend to have a curative emphasis. The key tool of the teams observed in this research, and arguably most teams involved in family or general medicine, was the "clinic" where patients are seen one-to-one or in family groups by a doctor or nurse. Consultations are usually brief, and treatment simple. Most patients are prescribed some medication, often just simple analgesics, vitamins and parasite medication. It appears that very few patients are sent home without being given something. The majority of patients present with only minor complaints, although a few patients may be referred on, where possible, to local health care providers for conditions

requiring further treatment.

This research has shown that while the arrival of a team draws large crowds of people, the majority do not come because they are unwell, most come in the hope of obtaining medication not available at their local *centro de salud* including vitamins and basic analgesics. While the teams see the provision of medication solely as a part of the service they provide, it is often one of the main reasons why Hondurans welcome, even invite, the teams. This applies not only to individuals, but at community and national levels also, where teams are seen as being an answer, at least a temporary one, to the problems of resourcing small and rural clinics.

The use of STMMs to provide health services is significantly limited by language and culture, resources, personnel, knowledge and of course by the short-term nature of the brigades. Language and cultural differences frequently result in mis-communication and limit the effectiveness of consultations and of any teaching. Limited resources and personnel, and local knowledge deficits have significant implications for the quality of care given, however the very nature of short-term medical missions is perhaps the most limiting factor. Not only are teams unable to follow up on individual patients, they are often unable to see and respond to the social, economic and political causes of ill health in the areas in which they work. Preventative actions undertaken by teams are usually minimal, often limited to short teaching sessions and the giving away of toothbrushes, shoes and vitamins. Because of these issues it has to be considered that STMMs may not be the most appropriate means of meeting health needs. As a relief mechanism they are well suited to meeting short term needs where the health system is unable to cope, although the evidence suggests that at best teams are able to offer only immediate attention to minor and temporary ailments. The limitations outlined in this thesis have led some to conclude that the teams do not make a significant improvement to health in the communities in which they work, and in fact may actually have a negative impact. Some have gone as far as to accuse teams of malpractice.

While this research did not directly address the issues related to the impact of STMMs on the health status of Hondurans, it did raise some important potential and actual consequences of the use of STMMs as health care providers. In particular the issue of dependency was identified. Data collected during the course of this research indicates an increasing level of reliance on short-term teams for the provision of care to the poorest

and to rural areas, at local and national levels. While there is no evidence that the functioning of the Honduran health system is actually dependent on STMMs, there is clearly an expectation that team can and will provide services. This dependency is shown quite clearly in the issue of medication provision, where the *Secretaria de Salud* is often unable to maintain medication supplies to all *centros de salud*, and therefore welcome teams who arrive with their numerous boxes of donated medication. There is also an expectation from the *Secretaria* that STMMs are able to provide services to remote and isolated areas that their services do not reach.

The findings of this study also highlight the problem of paternalism, operating from what Parfitt (1998) terms a “vertical approach”, where decisions are made by outsiders, and medicine is given away in a paternalistic manner. This type of approach has been implicated in the development of dependency, and indeed this tendency is reflected in the research. It also is in accord with Korten’s (1990: 141, 143) ideas regarding relief. Relief strategies, in this case STMMs providing health services, do not result in empowerment or self-reliance, but tend to create a long-term dependence on the NGO and the services it provides. STMMs are unable to do anything to remove to causes of poor health, and it is possible that in time their capacity to give assistance may be overwhelmed by growing demand.

Unfortunately it seems that Honduras may be forming a dependency based on an expectation of what they may receive, rather than the reality of what the teams can actually provide. This tendency towards dependency is probably related to the long-term use of a short-term tool, and the emphasis on help coming from outside. Honduras has a long history of dependence on the USA in particular, and the use of STMMs in health care may indeed be a reflection of larger issues of dependency in Honduran society.

Further Questions

It is clear that there are huge needs in health care in Honduras, and as service providers, STMMs are attempting to fill a significant gap. However this study has perhaps raised more questions than it answers. In particular it has raised questions about whether they are indeed actually filling real gaps, and if they are, whether they are the most appropriate means of doing so.

The study results indicate that STMMs are not in fact able to effectively fill the gaps in healthcare that they are welcomed to Honduras to fill. There is some irony in the fact that there is a significant tarmac bias to the locations in which the teams work, despite the expectation that they will offer services to the more remote and impoverished regions which national health services are unable to reach.

STMMs are also largely bio-medically focussed with limited ability to provide the health promotion and education services that are clearly needed. They tend to treat mainly minor ailments, expending a lot of time and effort dispensing Paracetamol and vitamins, while being very limited in their capacity to treat more serious health problems or to provide the long-term treatment and follow up required for chronic conditions. While this study has concentrated on general medical teams, there is unfortunately a clear shortage of surgical and specialist services within Honduras. Further research would be useful to determine the need for and role of specialist teams.

Even where teams are filling gaps, their effectiveness is severely limited by their short term and expatriate nature, and their prolonged use does nothing to empower Hondurans, potentially contributing to issues of dependency and inequality. They are clearly not the most appropriate means of addressing health needs. This raises the question of just what is the most appropriate means to meet health needs in Honduras. On a global level the issues of who should be responsible for providing services, particularly to poor and rural populations, and how and what services should be provided has been widely debated in the international health and development literature. However these questions need to be examined further within the Honduran context, and with reference to what is already happening and what resources are already available.

STMMs are one of those resources available to Hondurans, and as such they are an attractive means of meeting health needs, largely because of their low cost (to Hondurans), their access to resources especially medication and perceived expertise. If the use of STMMs as direct health service providers is discouraged, there is a risk that Honduras will lose this resource. There is clearly a need to re-examine the role of STMMs and to look for a way in which they are able to contribute in a manner that is beneficial to Hondurans and supportive of the Honduran health care system.

The resolution of these issues will not be easy, as it requires thinking beyond the provision

of short-term teams, and looking at longer-term issues of sustainability and the appropriate use of resources. While it is beyond the scope of this study to examine potential solutions to these issues it is my opinion that there are a couple of paths that could offer a way forward. At an organisational level these include the integration of teams into longer-term projects, as some organisations are beginning to do. Professionals wishing to work in Honduras on a short-term basis should be appropriately trained and directed to existing projects where their individual skills can be best utilised, and where their practise in such an unfamiliar environment can be monitored.

Resolution of these issues will also require discussion at a national level and the involvement of the *Secretaria de Salud*. Current policy at the *Secretaria* is focussed on encouraging the teams with little energy spent on monitoring or evaluating the impact they have. The ideal resolution is of course an improvement in national health services, removing the gaps teams are being asked to fill, however this is probably unlikely without large scale, structural change. In the meantime a more proactive approach to monitoring the teams and to encouraging long term over short-term solutions would go some way towards improving the situation. As Oken, Stoffel and Stern (2004) have noted STMMs may be best able to make a lasting impact if they become integrated into local public health and rural development systems.

Finally there is need for increased discussion of these issues between the organisations who bring teams, and within academic circles. Although some commentators and practitioners have begun to look more closely at this issue (Montgomery, 2000; Oken et al., 2004), this work tends to be focussed more practically, on how to improve missions rather than rethinking the entire paradigm in which they work, and most of it is non-academic in nature.

While STMMs continue to plug gaps in the health system in Honduras, it is vital that these questions raised in this research are addressed. Just what is the most appropriate means of providing health care in Honduras? What is the best way Hondurans can use the willing and available resource represented by STMMs? If these questions are not addressed and STMMs continue to be utilised as Service Providers, without integration into longer-term programs, the implications for the health of Hondurans and for the Honduran health care system may be significant.

Appendix 1: General Information Sheet

'La Brigada Medica': An exploration of the role of short-term medical teams in health care in Honduras

Proposed research project for
 Master of Philosophy (Development Studies)
 Massey University, New Zealand

INFORMATION SHEET

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Background to the research project-

Short Term Medical Missions (brigades) are increasingly common phenomena in developing countries around the world. Offered by medical, religious and other organisations, these brigades enable western health professionals an opportunity to "give back" or "help out" by taking part in short-term programmes, while seeking to provide medical services to the poor. However while some work is being done on the evaluation of medical missions they are a largely unresearched form of providing medical and health care. In particular there is little research on the particular role these teams have in health care provision in developing countries, and on the perceptions and attitudes of locals (both lay and professional) towards the teams and the work that they do. This research has been designed to address these issues and provide some insight into how the role of these teams is perceived by those they seek to help.

Honduras, long a recipient of overseas aid, has been chosen as the location for this research as it has seen an influx of these teams in recent years, related in part to the devastation caused by Hurricane Mitch in the late 1990's. It now has an established network of NGO's and agencies supporting relatively large numbers of medical teams.

Participant Recruitment

This research will involve three months of fieldwork in Honduras. Three of four medical

brigades will be involved in this project. At each brigade site approximately 5-6 community participants will be approached for interviews, along with local health professionals and other interested parties. It is not anticipated that there will be any risk or discomfort for participants, however interviewing will be discontinued at the participant's request.

Research Methods

The primary methods used in this fieldwork will be observation, in-depth interviews and focus group discussions. Questionnaires maybe distributed as appropriate or necessary.

Observation will be of medical teams on location in Honduras. This may involve some participation during clinics depending on logistics and preferences of the team, however the primary objective is to observe the interaction between the team members, local health professionals and the community.

Interviews will be undertaken with individuals including medical mission team members, NGO/ sponsoring agency staff, local health care providers and members of the community.

Focus Group Discussions will be organised as necessary to address and explore issues with particular participant groups (for example team members, interested community groups).

Use of the Data

The data collected in this course of this research will primarily be used in a thesis, which is part of the requirements of a Masters Degree in Development Studies at Massey University, New Zealand. However here is also a possibility that this may lead into a larger research project. Research findings may be published or presented at appropriate conferences. Participants have the right to a summary of project findings (see below).

Ethics

A low risk ethics application has been accepted by Massey University ethics committee, and the project has also been assessed by a departmental ethics committee. *Please note- this project will not involved the collection of information specific to any individual and their health care.*

Participant's Rights

Participants are under no obligation to accept this invitation. Those who decide to participate, have the right to:

- decline to answer any particular question;
- withdraw from the study;
- ask any questions about the study at any time during participation;
- be given access to a summary of the project findings when it is concluded.

Anonymity and Confidentiality

All effort will be taken to ensure complete confidentiality and anonymity, however in the context of a small team or particular location this may be difficult to guarantee. These issues will be discussed with research participants prior to the commencement of data collection.

Please note that any individual medical details disclosed to the researcher will be held in complete confidence and will not be included in the research data collection or used in the final report.

Benefits to the Participants

While the objective of this research is the completion of my Masters degree, feedback to agencies and teams involved is planned at the completion of the project. This research will be addressing issues of very practical relevance to organisations sending missions as well as to the health care sector in Honduras and it is anticipated that this research will provide some insight into the role of the teams in health care provision in Honduras.

Funding and Support

This research is fully funded through a Massey University scholarship and a grant from NZAID.

Background of the Researcher

I am a New Zealand Registered Nurse, currently working towards a Masters degree in Development Studies at Massey University, New Zealand. I have experience as an RN in general medicine, occupational health and as a Clinical Trial Coordinator in diabetes research. I also spent nearly two years working with Mercy Ships, in the Philippines, Guatemala and Honduras.

I am married to a Honduran, who is also a full-time student here in New Zealand. He will be accompanying me during this research.

If you have any further questions or concerns please feel free to contact myself, or one of the supervisors at the contact addresses above.

Appendix 2: Team Questionnaire

“La Brigada Medica”: An exploration of the role of Short Term Medical Teams in Health Care in Honduras.

TEAM MEMBER QUESTIONNAIRE

The Small Print:

The data collected in this questionnaire will primarily be used in a thesis, which is part of the requirements of a Masters Degree in Development Studies at Massey University, New Zealand. There is also a possibility that research findings may be published or presented at appropriate conferences.

You are under no obligation to complete this questionnaire. You can decline to answer any particular question. Please feel free to email me with any questions about the questionnaire before answering.

Please note that all effort will be taken to ensure complete confidentiality and anonymity, and your name will not be used in the thesis or any publication. However in the context of a small team or particular location full anonymity may be difficult to guarantee.

- How many medical brigades have you participated in?
- How many of those were in Honduras?
- What is your motivation for participating in medical brigades?
- Why did you choose to come to Honduras?

(Team Name)

- What was your role in this brigade? (circle one)

Doctor

Nurse

Dentist

Dental Assistant

Optometrist

Optical Assistant

Translator

Other- please specify _____

- Do you think this team made an impact on health status in this area? (circle one)

Yes / No / Unsure

If yes- in what way do you think this team impacted the health of this community?

If no- why do you think this team did not make an impact?

- Did you have any interaction with local health care providers during this brigade (i.e. doctors, nurses, dentists or others working permanently in the community where the brigade served)? (circle all that apply)

Yes- consulted with local health provider about patient care or follow up

Yes- provided education or training for local health provider

Yes- social interaction

Yes- Other (please specify) _____

No

- In your opinion, were patient treatment and outcomes affected by any of the following?

Cost	Yes / No
efficiency	Yes / No
personnel	Yes / No
preparedness	Yes / No
time	Yes / No
self imposed limits	Yes / No
other resource limitations	Yes / No

If you answered "yes" to any of the above please specify how and to what extent treatment and outcomes were affected.

- Please comment on your overall experience of this mission

General Questions

- What activities do you think medical brigades should be doing in Honduras?

- In your opinion are there there any activities medical brigades should not do, any why?
- Do you have any suggestions for future missions?
- Are you willing to be contacted if I have any further questions?

If yes please enter your email address here _____

Thank you for taking the time to answer this questionnaire- your effort is appreciated.

A report on study findings will be available after submission of the thesis. Please let me know if you would like a copy of this emailed to you.

Appendix 3: Patient Questionnaire

“La Brigada Medica”: An exploration of the roles of Short Term Medical Teams in Health Care in Honduras

PATIENT QUESTIONNAIRE

- Male / Female
- Age:
- Children present?
- Age of children
- Where from
- How did you hear about this mission

- Why did you come today
 - Unwell (self)
 - Unwell (child)
 - For a general check up
 - Curiosity
 - To get free medication
 - Other

- If you or your child are unwell- what would you have done if the team had not come?

- Where do you normally go for health care?

- How far away from your home is the nearest health provider?

- How much would this health care normally cost?

- Why did you come here instead of to your normal health provider?

- Did you understand what the doctor/nurse told you?
- Do you think coming here has helped your health?
- Did they give you any pills?
- Do you understand how to take them?
- If this team came back here, would you come to the clinic?

Appendix 4: Conference Information and Questionnaire

Development Studies Programme
Massey University; Private Bag 11 222
Palmerston North; New Zealand
email: s.mclennan@massey.ac.nz

18 October 2004

To Attendees of the Conference on Honduras 2004

'La Brigada Medica': An exploration of the role of short-term medical teams in health care in Honduras

The purpose of this letter is to briefly introduce myself and to request your help with a research project. I am a New Zealand Registered Nurse, currently working towards a Masters degree in Development Studies at Massey University, New Zealand. As part of this degree I am completing a thesis on the role of medical brigades in health care provision in Honduras.

In order to gain some background information about medical brigades- who are they, what are they doing and where- I have devised a questionnaire for organisations who are working in health care in Honduras (including those not specifically involved with medical brigades).

If your organisation is involved in health in any way I would greatly appreciate a few moments of your time to complete the questionnaire, which is attached to this letter. Only one questionnaire per organisation is needed. It is a completely confidential survey and no identifying features will be included in the thesis or in any published reports.

If you have any further questions or concerns please feel free to contact myself, or one of the supervisors (Dr. Barbara Nowak and Manuhua Barcham) at the contact address above.

Regards

Sharon

Sharon McLennan Cruz, R.N. B.N.

La Brigada Medica”: An exploration of the roles of Short Term Medical Teams in Health Care in Honduras

CONFERENCE ON HONDURAS QUESTIONNAIRE

Instructions

- Please complete one questionnaire per organisation
- Mark boxes clearly with a tick.

1. How would you classify your organisation?

- Governmental
- Private- not-for-profit (NGO)
- Private- other

2. What health-related activities is your organisation involved in?

2a) What category of activity best describes the *primary or main* activity of your organisation? (tick **one**)

- Service provision
- Research activities
- Support services
- Policy advocacy
- Fund-raising
- Co-ordination

2b) Please list **all** health related activities your organisation is involved in:

3. History of your organisations work in Honduras:

3a) When did your organisation begin working in Honduras? _____

3b) Why did your organisation begin to work in Honduras? (use the back of the page if you need more space)

4. Has your organisation been involved in bringing Short Term Medical Teams (Brigades or Missions) to Honduras in the past year?

- Yes (please answer the questions 4a-4f then go to question 6)
- No (go to question 5)

4a) How many teams did your organisation bring to Honduras in the past year? (circle total number)

- 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21
- 22 23 24

4b) Please indicate on the map all areas your organisation has sent teams in the past year (mark sites clearly with an X, and write in name of town/ village if necessary)



4c) What type of teams was your organisation involved with in the past year? (tick all that apply)

- Surgical Number of surgical teams in past year _____
- Medical (Ambulatory Clinics) Number of medical teams in past year _____
- Dental Number of dental teams in past year _____
- Optical- Number of optical teams in past year _____
- Other- (specify type and number of teams) _____

4d) *Did your teams partner or work with any of the following in the past year? (Tick all that apply)*

- With the Ministry of Public Health
- With other government departments
- With other non-profit/ NGO groups
- With other private organisations
- With a church or a church based organisation
- Other _____
- None, the teams worked alone

4e) *Where have your teams worked in the past year? (Tick all that apply)*

- Within National, Regional or Area hospitals
- Within Regional Health Centres or other government clinics
- Within non-governmental hospitals
- Within non-governmental clinics or health centres
- In school rooms, church halls or similar
- In the open air

5. If your organisation has not bought teams to Honduras in the past year, are there any particular reasons why not? (Use the back of the page if you need more space)

6. What do you think is the most important contribution expatriates can make to health care in Honduras? (rank from 1-5, 1 being the most important and 5 the least)

- Direct provision of health services (clinics, hospitals)
- Running pilot programmes or new initiatives
- Providing support services (training of local personnel, management consultancy, provision of supplies)
- Facilitation/ coordination of medical and health services and/or NGOs
- Fundraising activities
- Awareness raising and advocacy, including government lobbying and policy advice

7. Is your organisation religious, or affiliated to a specific religious organisation? (circle one)

Yes / No

If affiliated with a religious organisation, which one?

8. Please add any other comments you have about medical teams in Honduras:

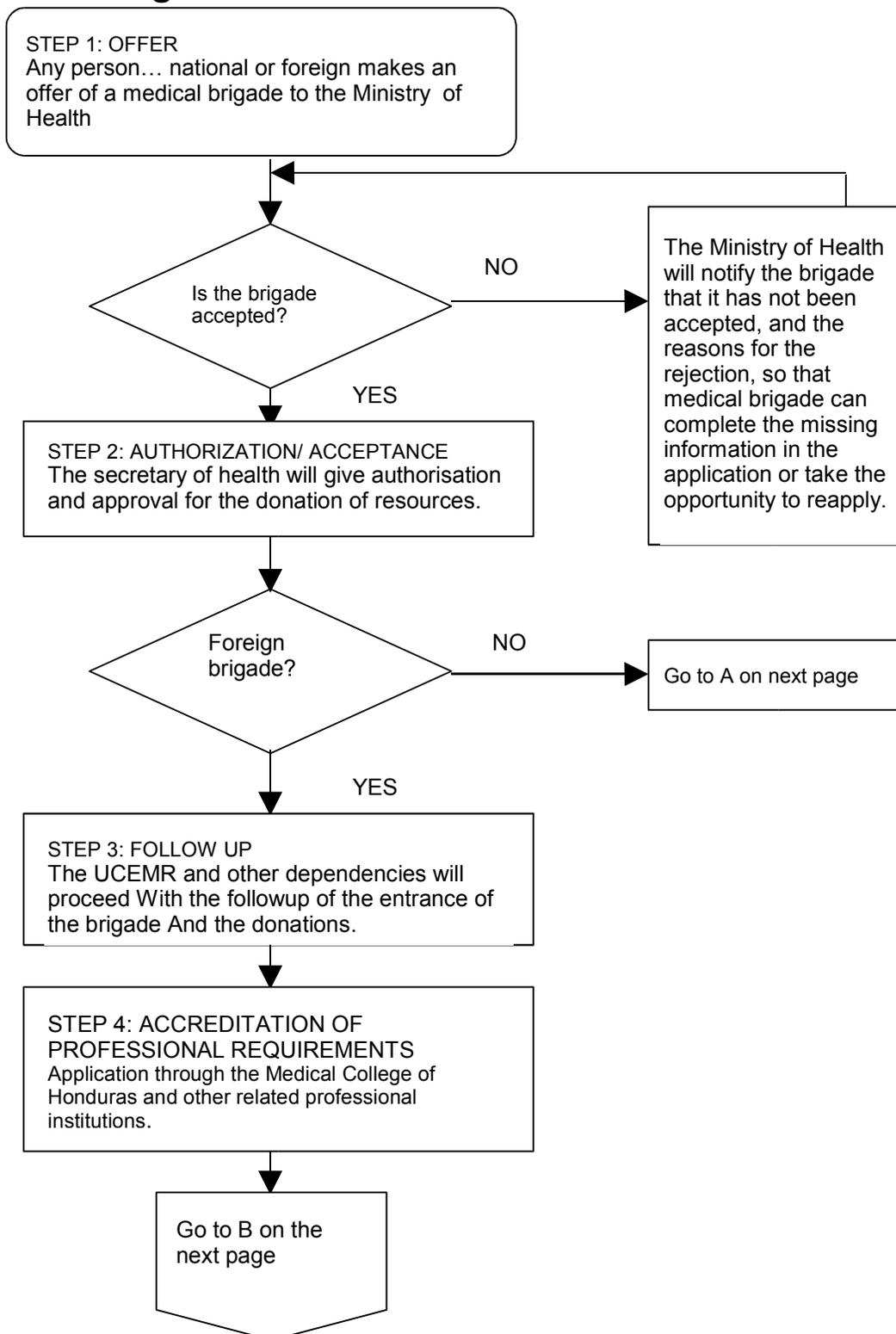
9. Other data (this information is voluntary, and will be kept in complete confidence. *If you would be happy to be followed up for further research please add your contact details*)

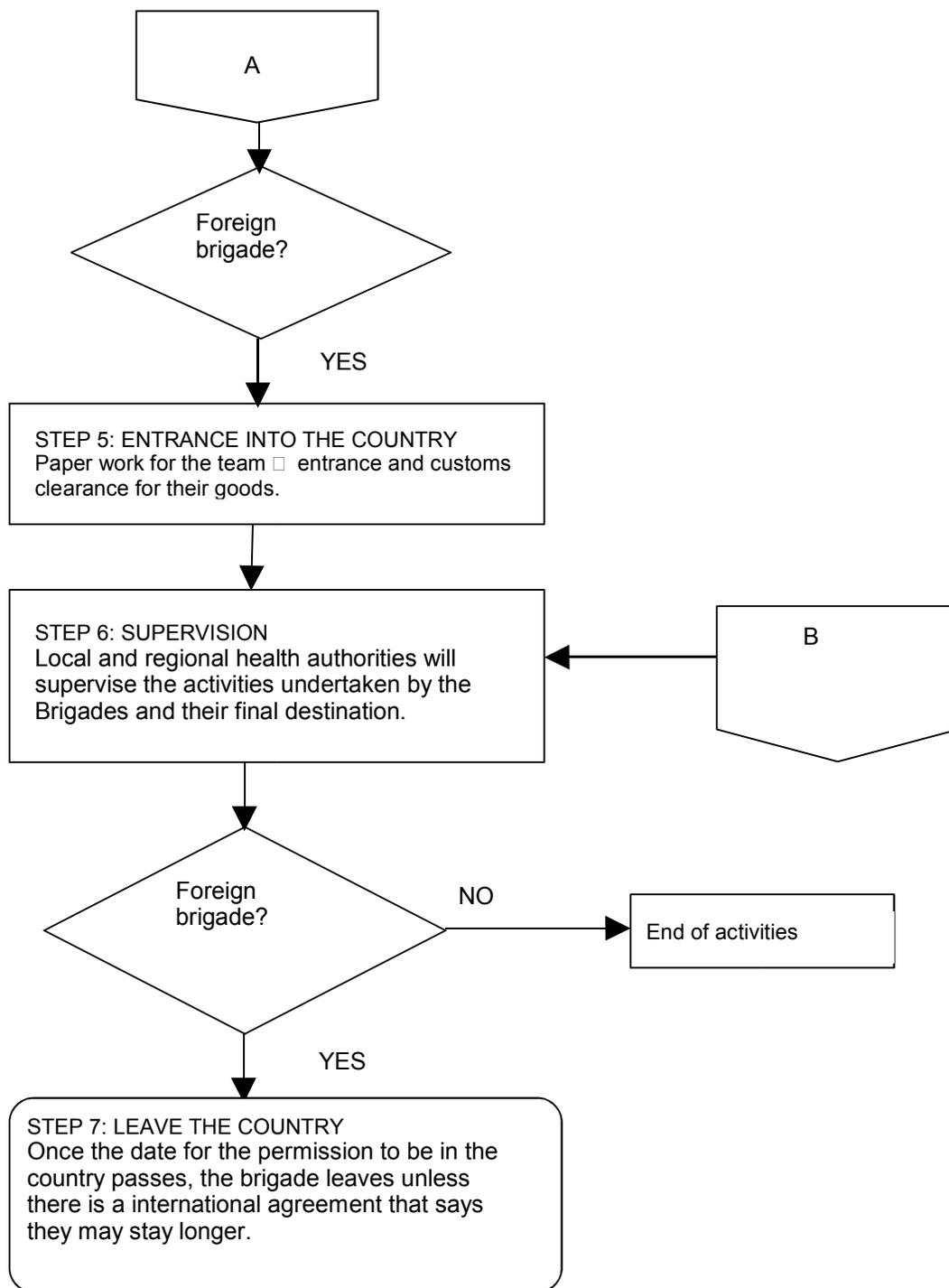
4a) Name of Organisation _____

4b) Details of individual/s who filled in this questionnaire:

Name	Position in Organisation	Contact details (for follow up)
------	--------------------------	---------------------------------

Appendix 5: Flowchart of the Authorisation Process for Medical Brigades





From the *Manual de Normas y Procedimientos en materia de Cooperacion en Salud*.
(Secretaria de Estado en el Despacho de Salud, 2001 : 92-93)

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