International Experiences Handbook

Office of the Director of Global Health and Education

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Welcome to the International Experiences Handbook. We are excited that you are interested in doing an international elective. Wayne State University School of Medicine has had a robust history of students participating in clinical electives abroad. In 2012, the School of Medicine established a new Director of Global Health and Education to oversee all international clinical experiences. The goals of this office are to establish a policies and procedures for international travel, establish partnerships with Universities around the world to build a safe and meaningful educational experience and to establish bilateral medical student exchanges with these Universities.

This handbook contains information on suggested readings, possible funding sources, safe travel tips and descriptions of prior student’s international experiences.
Suggested Readings:

1. “Duffle Bag Medicine” by Maya Roberts
3. “Globalization and Health” by Tyler Green et al.
4. “A Model for Sustainable Short-Term International Medical Trips” by Parminder Suchdev et al.
5. “The Medical Student Global Health Experience: Professionalism and Ethical Implications” by S Shah and T Wu
6. AMSA’s “Creative Funding for International Health Electives”
7. AMSA’s “A Student’s Guide to International Health”
Duffle Bag Medicine

While the self-styled medical missionaries are piling into the back of the truck, I spot a young man, at most 19, wearing a cowboy hat, smoking a cigarette, and leaning against the makeshift frame that converts the backs of pickups into the primary form of public transportation here in Guatemala. He is not a licensed medical professional; he is an American on vacation and he is about to distribute medication to patients.

I do not think he is aware of the power he radiates in this community. We are in a modest-sized village in the temperate green midlands of Guatemala, the coffee region. The most substantial source of income here is from day labor on the plantations, during the November-to-March harvesting season. Clean bottled water and fresh produce can be purchased at a lively outdoor market on Tuesdays and Fridays. However, for most families, these are luxuries that agricultural day labor cannot consistently support.

This impoverished community has been home to a religious mission for 30 years. The mission orchestrates various projects, including coffee production for export, a reforestation initiative, and a permanent medical clinic. The mission also sponsors transient field clinics: groups of visiting physicians and nonmedical volunteers travel to various remote satellites of this village and deliver medical care for the day.

While conducting nutritional research here, I have watched groups arrive, travel to deliver care at transient day clinics, and depart after a week. The main goal of these clinics is for the volunteers to listen to medical concerns and to dispense medication to all who arrive. Some missionary groups have only one physician for every dozen or so volunteers. The physicians traveling with the group are responsible for delivering the care and for supervising the others, in an unavoidably hectic makeshift clinic. Some of the missionaries speak Spanish, but most do not. I have not come across a missionary who speaks Kaqchikel, which is the only language spoken by many people in the remote areas. One volunteer I spoke with translates Spanish for a group. This interpreter tells me that they all bring heavy duffle bags full of drugs, and by the end of the trip they hand out whatever is left, whatever they can, whatever the illness.

The teenager I spotted wears ripped jeans while working in the midst of a prevailing culture where even the poorest tuck in their shirts. He has confidently stung a stethoscope around his neck, proclaiming an ability to provide medical care, an assertion that is at best questionable. He is from a small US town; all he needs to do is be part of this transient medical team to finance his flight to Guatemala. He freely donates his time and energy, but he delivers “care” without the appropriate training, without knowledge of the predominant language, and without any clear accountability.

For many volunteers, this is not just about a mission, religious or medical. The mission’s administration ensures that this project also provides a wholesome family vacation destination. These missionaries bring donated pills—vitamins, acetaminophen, antibiotics. They also bring their stylishly sloppy jeans, their teenagers, and their hunger for their homeland’s cuisine, served three times a day in the mission’s cafeteria. This young man and his group are genuinely proud that they spend their vacation here and are especially proud of their contribution. But I worry that this pride prevents them from acknowledging that their actions may actually be harmful and do not necessarily address the complex needs of this community. Their short-term work is not integrated into a local infrastructure. Health promoters—local men and women trained to recognize serious ailments and to treat minor ones—are not introduced to these groups. Public health and preventive measures are not part of the overarching goals for the transient clinics; this inhibits the project’s long-term potential and puts the community at risk of receiving inappropriate care.

An expatriate friend of mine living in this community suggested this mental exercise: A foreigner sets up a clinic in your city. He does not speak much English, he will leave after a week or so, and he is not very likely to ever return. This foreigner tells you that he is a physician in his home country, but that he has never been to your community before and is not going to be working with your family physician or with other health professionals in your local health care structure. Would you take your children to see him if you had any other choice?

The people in this area do not have many options for medical care. Their community is rife with hunger, poverty, malnutrition, and high infant mortality. This community has severe medical needs and meager options for how to address them. It has become a practicing ground for first-year medical students and a venue where well-meaning missionaries can feel good about a one-time contribution without ultimately being responsible for their actions. These day clinics focus on treating as many patients as possible. “First do no harm,” which could serve as a point of reflection and perhaps as one safeguard, has not been incorporated into the ideology.

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Let us explore a very simple example: vitamins. A shipment of donated vitamins arrives to help this malnourished community. Missionaries load it into the pickup trucks, set up clinic, and give a bottle of vitamins to every parent who arrives. The volunteers emphasize to the parent that the vitamins are important and that they help children grow healthy and strong.

There are a number of possible outcomes from this gift:
1. The child eats the vitamins, but, like many children, eats most of the bottle in one sitting and gets constipated. The vitamins do not eliminate the parasites, which continue to inhabit his gut, and the child now has the unenviable combination of persistent parasitic infection and vitamin-induced constipation.
2. The child takes the vitamins and also happens to feel better. The next time an illness occurs, the mother drags the child down to the permanent clinic, because there is no field clinic that day, and tells the physician she needs vitamins. The physician explains that what the child really needs is metronidazole. He explains that she will give her child both. The physician writes both prescriptions, assuming that the vitamins will not harm the patient. The mother heads to the pharmacy, where she is told that the metronidazole is 14Q (quartals), and the vitamins are 50Q. She has enough for the previously suggested vitamins but decides to skip the unfamiliar drug.
3. Many Guatemalan-produced vitamins are not in a chewable form; they are injectables. Local health promoters tell me that vitamin B₉ is thought to give a high upon injection. Following the volunteers’ encouragement of vitamin use, there is a subsequent increase in complications from the triple injection she carried.

There are serious risks associated with eager distribution and inappropriate use of antibiotics. This is indeed an issue for the transient clinics. However, when volunteers follow neither their home country’s guidelines nor those of the local system, even the distribution of seemingly innocuous pills, like vitamins, can be frankly dangerous.

The use of untrained volunteers to deliver care and medication is not acceptable in the United States and should not be considered acceptable elsewhere. The inability to follow up with patients and the lack of long-term responsibility for medical care is a serious and largely ignored problem. This community does offer a legitimate opportunity for physicians to evaluate people who are ill, but no one can ultimately benefit from medical care that has no accountability.

Instead of trying to fine-tune this type of missionary involvement, I would like to propose restructuring how the volunteers interact with the community. First, volunteers should reflect on how their specific strengths can address the prevailing medical needs of the community. Non-medically trained missionaries can still address health issues, perhaps through the collaborative creation of a culturally sensitive teaching program. Some programs can run almost entirely on the energy and human companionship that all volunteers can bring. They can gather up children to draw a Guatemalan version of the food pyramid with chalk on one of the few paved roads in town. They can spend the afternoon cooking and cleaning with various families, observing the Guatemalan practices and reflecting on their own culture’s similarities and differences. Volunteers who want to donate money or supplies can refill local health promoters’ medical kits.

Finally, missionaries with genuine medical experience can reinforce the local medical infrastructure. They can review and revise local medical kits with the health promoters, teaching about medicine in the process. Clinicians should strive to integrate with the local staff and existing medical system. They should not enable or support nonmedical volunteers delivering poorly controlled care. Honest acknowledgment of limitations permits volunteers to work more effectively and to provide prudent care with a lasting, positive impact.

The young man on the back of the pickup truck neither demonstrated adequate respect for the standards of this community, nor exhibited insight into the consequences of his actions. Instead, he was fearlessly confident in his ability to help the local population, limited only by the number of vitamins and antibiotics he carried.

There is profound need in this community, but right now the vast amount of donated time, energy, and money does more to stoke the egos of the Americans sojourning here than it does to improve the lives of these Guatemalans. We need to respect the cultural setting and the local health care infrastructure while we are volunteering our services. We need to take long-term responsibility for our actions and for those we oversee. We must begin by acknowledging our own social history because recognizing the attitude we bring to our patients enables us to deliver effective care.

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International Electives: Maximizing the Opportunity to Learn and Contribute

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We are living in an ever-changing world that is witnessing enormous changes in population demographics. Although mass (and even forced) migration is not new, the dimensions of population growth and movement are unprecedented. People are immigrating and emigrating fast and far. Whether by choice or by force, humans are now inhabiting geographic areas previously untouched.

As demographics change so, too, do disease dynamics. In many resource-wealthy countries, diseases rarely seen in the last 30 years are now on the rise. Certain pathogens, challenged ineffectively by antibiotics, have undergone important mutations and now represent significant threats. Re-emerging infectious epidemics include transnational outbreaks of multi-drug-resistant tuberculosis and transmission of polio to and within previously elimination-certified countries. Pertussis (i.e., whooping cough) baffles today's physicians who never heard the famous "whoop" during their training. Other diseases, such as severe acute respiratory syndrome (SARS), are newly identified pathogens that readily cross geographic and administrative barriers.

Accordingly, interest in international electives at all levels (from policy to clinical) is rising, particularly among preclinical and clinical students, residents, and internists (collectively referred to here as "trainees"). Such trainees enroll in an often 2- to 12-week exposure to the world of international health. Trainee services offered during these courses run the gamut, from assembly-line delivery of a specific procedure over time (such as surgery for cleft palate) to the basic health services that fall under the umbrella of primary care. The time dedicated to preparation varies in both quantity and quality across institutions, and can be as minimal as an updated vaccination record. However, these opportunities to learn medicine outside of one's home country are now more abundant than ever before. Some institutions and programs have established their own international collaborations, and the American Medical Association is currently gathering information for such purposes. These experiences permit trainees to learn more about diseases commonly given short shrift, or ignored, in the standard medical education. Such opportunities are not limited to individuals from resource-wealthy countries traveling to resource-limited settings. Rather, training programs sponsored by governments, universities, and donors allow for individuals to seek training in resource-wealthy settings and return to resource-limited settings to practice what they have learned; ideally, such programs stem the "brain drain"
(ie, the exodus of educated citizens) from such settings.[10] Of note, though, is that many of these electives are unregulated (in reality and in the most formal sense) and require a considerable amount of effort on the part of the trainee to ensure that adequate training is received.

Although it is true that international electives fill important gaps in medical education, it is not usually just the opportunity for an enhanced knowledge base that drives individuals to seek international opportunities. Many trainees are moved by a sense of duty or moral obligation. Often enough, such sentiments are cited as the inspiration to undergo medical training; sometimes, they are the response to injustices observed in settings of poverty. Such settings are by no means rare: Nearly one third of people in low- and middle-income countries live on less than US $1 per day.[11] The impact of poverty on both the distribution and treatment of disease is profound: It is estimated that only ~50% of the people living in the world’s poorest 46 countries have access to modern healthcare.[12] More than 95% of deaths among children under the age of 5 years occur in resource-limited countries — and most of these deaths are preventable.[13] Many, perhaps most, of those pursuing international electives are driven by the desire to address the inequalities of risk and access so readily documented throughout what is termed “the developing world.”

In 2005, too few of the available international electives adequately help US trainees respond effectively to poverty and excess morbidity and mortality. As cross-sectional, time-limited experiences, they often (purportedly) focus on the needs of the students rather than the needs of the population served. Indeed, many students report to such electives convinced that, because very little is being done, any action will be helpful. Although we believe that most international electives are indeed designed with the philosophy of benevolence, it is still possible, alas, to do unintended harm. Those living in deplorable situations are not constructively viewed as weak, helpless individuals who benefit from any action whatsoever, and for several reasons. First, much has occurred prior to our current interventions, and, in many resource-poor settings, the intended recipients of such action are more aware of history than are trainees. As trainees enter from a cross-sectional point in time, others before them (in various sectors not limited to health) have probably entered and exited in a cross-sectional manner as well. Historical events preceding the trainee’s arrival can serve to affect the trainee’s work. Disease is not only addressed by provision of services, but it also requires an in-depth examination of the underlying causes of disease, including the social, political, and economic forces involved. Second, the processes of global interconnection mentioned at the outset mean that the notion of 2 worlds — one rich, one poor — is rejected by most living in poverty. We live in 1 world, not 2. Intervening abroad should be approached with the same ethics, diligence, and respect as intervening at home. Third, the idea that we may develop a parallel medical system that is “appropriate” for people living in poverty is discredited among those living in poverty. As practitioners, we should not resign ourselves to providing different levels of care simply because we are
presented with the oft-cited argument that healthcare resources are limited in some settings. Indeed, we must strive to provide an equal level of healthcare no matter where we are geographically. The challenge now facing those who develop international electives is how best to respond to global health inequalities. If these are not addressed, many trainees leave such electives having been passive spectators to poverty.

For those who enroll in such trainee efforts, not surprisingly, often the objective of the elective is approached from a teaching perspective. “What can I learn from this experience?” “How can this experience help me improve my clinical skills?” We suggest, however, approaching these international opportunities via a service perspective: “How might I best serve the destitute sick?” “How might I improve their situation?” These are not the questions that most medical trainees are encouraged to ask, but they make sense from both a “macro” and a “micro” perspective. From a macro point of view, the very term “improvement” implies not only clinical progress but also ethical responsibility, sustainable impact, and advancement in the lives of people struggling against poverty and disease. From a micro point of view, such a stance implies placing the interest of the patients first, doing what is necessary to improve clinical response to whatever intervention. Additionally, these questions are not at odds with each other. We argue that if the elective is approached from the service perspective, the clinical skills will inherently be acquired while simultaneously addressing the sense of moral duty and obligation mentioned previously.

On the basis of our experience in global health, we would like to advance 3 main principles that may serve to help trainees maximize their contributions in the context of international rotations. Although these principles initially appear simple, a large proportion of students are forced to violate at least 1 principle in the course of their international electives. After experience in some of the world’s poorest places, and in developing policies designed to redress health inequalities, we underline the following 3 admonitions.

Know the setting: It is surprising how little students know about their destinations. Reading the *Lonely Planet* is simply not enough, because complex social processes underlie almost all of the excess morbidity and mortality seen in the world’s poorest placed. Obtaining clinical knowledge is only part of the educational process; equal emphasis should be placed on understanding the political, sociocultural, and economic history of the settings in which we work. As we have argued elsewhere, understanding both the biological and nonbiological factors that influence the epidemiology of disease is key to the design of effective treatment and preventive interventions.¹ In no settings does treatment end with a simple prescription or procedure; effective therapy needs, invariably, to reflect the social conditions of patients. In addition, it is fundamental to understand how health systems function and, accordingly, what resources will be available to patients and those who care for them. When such information is available prior to international electives, it can allow trainees themselves to understand how
diagnosis and therapy may proceed even in the absence of significant changes. At times, such knowledge of the setting is instructive in the sense that expensive and unnecessary tests are avoided.

Expand the notion of treatment: Often students arrive with quantitative clinical goals as their end point for measuring success. "I will treat x patients per day. I will cure y cases." In most resource-limited settings, however, many factors can arise that may affect, in ways that are not wholly known, whether or not these goals are attainable. Civil strife, war, health-sector reform, or even lack of consistent electricity may profoundly affect such goals. From a developmental standpoint, the situation may arise in which preventive efforts constitute the quasi-totality of what is needed. Most often, however, a combination of prevention and care is required. Provision of clean water during a flood, for example, will have a significant impact on populations, as will the treatment of diarrheal diseases resulting from a lack of clean water. The combination of prevention and treatment is more synergistically powerful than either alone (as we have seen in our HIV and multi-drug-resistant tuberculosis treatment programs). Thus, we suggest that if goals are to be set, they are set realizing that disease management in resource-limited settings may involve equal components of prevention and treatment.

Continue the action: Once students complete their electives and return home, what they leave behind is often all too forgotten. But the experience should not end upon returning home. Throughout the elective, we strongly suggest documenting -- in a journal, for example -- your daily experiences. Before leaving, students should identify areas of work and opportunities meriting the attention of future trainees. Each student may profitably focus on identifying and supporting (not necessarily financially but in whatever capacity possible) another student in securing an international elective in the setting in question. This pushes trainees to identify the weaknesses of the elective as currently executed. Also important is the information-dissemination process, whether through interviews, photos, or writing about the experience in peer-reviewed journals. Raising awareness remains vital to expanding interest in this arena and to providing a better educational base for training and advocacy.

Ultimately, the purpose of such programs is 2-fold: to benefit the patient and/or community and to provide an educational experience for the trainee. The parameters defining "benefit" and "educational" are broad. The temptation exists to inadvertently contribute less and take more or simply enjoy the scenery (also popularly known as the "elective safari"). We have based much of this discussion on the experiences that we and our fellow colleagues from around the globe have gathered from assisting local populations in establishing long-term healthcare interventions -- and trainees were and still are an integral part. The issues that we raise have stemmed from our discussions with trainees and their conflict (as disclosed to us) between satisfying the academic objectives of clinical training and the moral objectives of service to the community. As previously
noted, we also understand that the same initiative and inherent drive in trainees seeking such electives may also be required in upholding these principles, as current, international electives are not all based on such mantras. But, we believe that the fundamental principles enumerated here can contribute to success from the perspective of both patient and provider, and thereby provide a basis for changing basic health inequalities. And as medicine bestows a special power upon a select few, the select few should use this power wisely, responsibly, and ethically.

References


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Globalization and Health

Research

Perceptions of short-term medical volunteer work: a qualitative study in Guatemala

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Abstract

Background: Each year medical providers from wealthy countries participate in short-term medical volunteer work in resource-poor countries. Various authors have raised concern that such work has the potential to be harmful to recipient communities; however, the social science and medical literature contains little research into the perceptions of short-term medical volunteer work from the perspective of members of recipient communities. This exploratory study examines the perception of short-term medical volunteer work in Guatemala among groups of actors affected by or participating in these programs.

Methods: The researchers conducted in-depth, semi-structured interviews with 72 individuals, including Guatemalan healthcare providers and health authorities, foreign medical providers, non-medical personnel working on health projects, and Guatemalan parents of children treated by a short-term volunteer group. Detailed notes and summaries of these interviews were uploaded, coded and annotated using Atlas.ti (Scientific Software Development GmbH, Berlin) to identify recurrent themes from the interviews.

Results: Informants commonly identified a need for increased access to medical services in Guatemala, and many believed that short-term medical volunteers are in a position to offer improved access to medical care in the communities where they serve. Informants most frequently cited appropriate patient selection and attention to payment systems as the best means to avoid creating dependence on foreign aid. The most frequent suggestion to improve short-term medical volunteer work was coordination with and respect for local Guatemalan healthcare providers and their communities as insufficient understanding of the country’s existing healthcare resources and needs may result in perceived harm to the recipient community.

Conclusion: The perceived impact of short-term medical volunteer projects in Guatemala is highly variable and dependent upon the individual project. In this exploratory study, project characteristics were identified that are consistently perceived to be either positive or negative. These findings have direct implications for anyone involved in the planning and execution of short-term medical volunteer projects, including local and foreign medical team members, project planners and coordinators, and health authorities. Most importantly, this preliminary study suggests avenues for future study and evaluation of the impact of short-term medical volunteer programs on local health care services.
Background
There is growing interest among healthcare providers in the field of global health; over 25% of all 2008 United States (US) medical school graduates participated in global health experiences during medical school. Beyond medical school, there are countless opportunities for physicians to volunteer their services abroad in resource poor countries, frequently in the form of medical missions that last for a week or two at a time. Several editorials in the medical and social sciences literature have raised important questions about potential unintended consequences of such short-term medical volunteer work [1-9]. Editorials such as these raise concern about the ability of short-term volunteers to provide safe and effective medical services in the setting of language and cultural barriers that impair clear communication between patients and healthcare providers. They also raise concerns about a lack of follow-up care for patients who receive treatment from groups with a short-term presence. They raise ethical concerns about people without formal medical training participating in these groups, or medical professionals practicing beyond the scope of their expertise and practice at home, in a setting where they are not held accountable for the consequences of medical interventions made. In addition to basic questions pertaining to patient safety, these editorials raise important questions about the impact of short-term medical missions on the larger medical systems in the countries they visit. For example, it is suggested that short-term medical groups that are not integrated with local medical systems do not understand local medical needs, and consequently, their efforts will be misguided. Furthermore, there is suggestion that groups providing free medical care in other countries undermine the livelihood of medical providers who depend on payment from patients in those countries. The literature in medical anthropology is filled with examples of unintended consequences of medical programs that pay insufficient attention to local conditions and culture and, perhaps more importantly, fail to consider the potentially incompatible and harmful cultural assumptions and values embedded in those programs [10,11]. With countless groups from wealthy countries participating in short-term medical volunteer work abroad, it is critical that we evaluate the safety and effectiveness of these interventions for patients, as well as the larger implications and consequences of such work on the development of medical systems and the health of communities where this work takes place. The editorials summarized above were written by medical professionals from wealthy countries with an interest in global health, and these writings serve as an important starting point in this discussion. Even more important, however, are the opinions and perspectives of those who live and work in the countries where this work takes place, and thus far, their voices have not been heard.

The aim of this study is to expand the critical discussion of short-term medical volunteer work by giving voice to the perceptions of a variety of persons who are involved in work alongside, or are affected by short-term medical volunteer programs. Because of its geographic proximity to the US and its natural resource base, the US has longstanding political and economic interests in Guatemala. Short-term medical volunteer work may be seen as one extension of those interests in the post-colonial era. As such, short-term medical volunteers often bring with them, albeit unconsciously, attitudes that foster dependence and lack respect for local practitioners and local knowledge and practices related to health. Understanding how short-term medical volunteer work is perceived by those living and working in receiving communities is a critical first step in designing and implementing healthcare programs that provide needed healthcare services to supplement and complement local healthcare systems without undermining their efforts. Specifically, we sought to explore the perceived utility and perceived impact (positive and negative) of short-term medical volunteer work in Guatemala from the perspective of healthcare providers and health authorities in Guatemala. Because of the short time available for the research, this study focuses on the perceptions of these individuals and not on the impact of short-term volunteer programs. Its purpose is to identify and describe the range of perceived issues surrounding short-term medical volunteer work as a basis for future in-depth studies.

We begin with a brief description of the Guatemalan healthcare systems and key health outcomes to provide the reader with an understanding of the context in which short-term medical volunteer programs operate. This is followed by a description of our research methods and findings and a discussion of short-term medical volunteer programs in the context of international aid and development to contextualize the themes identified herein. It is hoped that this report will stimulate further investigation into the specific topics raised within this report.

Healthcare and Health Outcomes in Guatemala
To understand the perceptions of healthcare providers, healthcare authorities and others working with short-term volunteers in Guatemala, it is important to recognize the provision of healthcare services in Guatemala and health status of the Guatemalan population based on leading health indicators. In 2007, Guatemala's per capita gross domestic product (GDP) was $5,400 US dollars (USD) in purchasing power parity [12], which is 130th out of 228 countries ranked, making Guatemala a "middle income" country on a macroeconomic level. Nevertheless, the income gap between the Guatemalan rich and poor continues to be enormous: 51% of Guatemalans live on less than approximately $2 USD per day and 15% of Guate-
Malans live on less than approximately $1 USD per day [13]. There is a well established correlation between a nation’s income inequality and the health of its population (e.g., infant mortality rate and life expectancy) [14]. In fact, Guatemala is considered to have extreme income inequality among Latin American countries and has the third highest rate of infant mortality and third lowest life expectancy among Latin American countries, behind Haiti and Bolivia [15]. All ethnic groups are affected by poverty in Guatemala (half of Guatemala’s 13 million people live in poverty, defined as less than $2 USD per day); however, indigenous Guatemalans, who account for 38% of Guatemala’s population, bear a relatively larger burden of the country’s poverty. Of Guatemalans living in poverty, 75% (3.7 million people) are indigenous.

The Guatemalan healthcare system is composed of three large sectors: The private sector, an autonomous social security institute, and the public sector. The private sector is subdivided into for-profit and nonprofit healthcare organizations. The for-profit facilities include private hospitals, clinics, pharmacies, and laboratories, all of which essentially offer the full range of services available in most industrialized countries. This sector is typically accessible only to the wealthiest people of Guatemala. As of 2001, less than 5% of the Guatemalan population was covered by private insurance. In 2001, there were approximately 200 nonprofit nongovernmental organizations (NGOs) in Guatemala engaging in health-related activities, 5% of which were estimated to have nation-wide coverage [14]. According to the Swedish International Development Cooperation Agency, there are 90 physicians per 100,000 population (9/10,000) in Guatemala [17], well below the level of 25 physicians per 10,000 population considered adequate by the World Health Organization (WHO) [18].

The Guatemalan Social Security Institute (IGSS) is a formally autonomous institution financed by mandatory contributions from workers and employers based on wages, and it has its own network of services for delivering care. IGSS provides coverage with a limited set of services to formally employed workers, who tend to be urban wage earners. As of 2001, 17% of the population was estimated to be covered by IGSS [16].

The public sector is run by the Ministry of Public Health and Social Welfare (MSPAS). This consists of a network of government hospitals, health centers, and health posts, which are staffed and maintained using public funds. As of 2001, 54% of the population was estimated to be covered by the MSPAS network. According to the PAHO Profile of Guatemalan Healthcare System [16], "the MSPAS does not guarantee the delivery of a package of services, nor do users tend to demand this as a right." As of 2001, 18.8% of Guatemalans were estimated not to have access to any part of the healthcare system described here [16]. Although access to professional medical care is limited to all ethnic groups in Guatemala, it is especially limited to indigenous people [13]. See Table 1 for a summary of key Guatemalan health indices.

It is worth noting that international efforts have been made over the past 40 years to address the inequity in access to healthcare among Guatemalans in the form of numerous development strategies. As an example, in the 1970s, international organizations such as the WHO, the United Nations International Children’s Emergency Fund (UNICEF), and the United States Agency for International Development (USAID) financed a program whose goal was to provide rural people with comprehensive primary healthcare services. However, this program was abandoned less than a decade later in Guatemala. It has been suggested that development programs such as these, which filter a great deal of money through the government, are frequently unsuccessful because they often do not address the underlying causes of poverty which are intimately related to poor health outcomes and may even serve to paradoxically reinforce governmental corruption and state suppression of the impoverished communities for which the aid is intended [19].

Methods

The fieldwork for this paper was conducted in Guatemala between October of 2006 and March of 2007, by two of the authors (TG and HG). Both field investigators were US medical students at the time with advanced but non-fluent Spanish proficiency. Prior to the initiation of fieldwork, the field investigators reviewed qualitative research methods and Guatemalan history and culture. The study was designed in consultation with anthropologists and physicians with prior field experience in Guatemala, and with extensive experience in qualitative research methodology.

In addition to the theoretical reasons mentioned above for choosing Guatemala as the research country, the researchers had multiple local contacts in the study area around the town of Santiago Atitlán. Santiago sits on the southern shore of Lake Atitlán, a large lake in the department of Sololá. The closest facility with higher-level emergency and surgical services is the government hospital in the town of Sololá. Reaching Sololá requires a 30 minute boat ride across the lake, followed by a 30 minute truck or bus ride; the boats do not run after dark. Santiago was historically a regional marketplace where indigenous farmers and merchants from the southern shore of Lake Atitlán and the lowlands to the south of the lake met to buy, sell, and trade goods. Today, it continues to be an almost exclusively indigenous region supported primarily by agriculture and tourism.
To acquire further context and contacts, the field investigators spent their initial 2 months living and volunteering in a small hospital under the supervision of fully trained Guatemalan and US physicians. The hospital in Santiago was established and is funded in large part by a US-based NGO. It is run by a Guatemalan administrative team, and supported by an executive committee made up of both long-term expatriates and Guatemalans living in Santiago. The hospital is staffed by paid Guatemalan physicians and long-term foreign volunteer physicians, as well as a mix of local and foreign volunteer nurses and medical assistants. In addition to its long-term staff, the hospital relies on short-term medical volunteers, including family physicians, emergency physicians, pediatricians, obstetricians and gynecologists, and general surgeons. After the initial orientation phase in the hospital, the field investigators continued to engage in hospital activities, in the spirit of “participant observation.” Participant observation, the process of both observing local culture and practices and participating directly in those activities, is an essential component of ethnographic fieldwork where the researcher is her/himself an instrument of data collection [20].

The project was reviewed and approved by institutional review board committees at the University of Colorado Denver in the US and in Guatemala. Over the course of this study, a total of 72 individuals were interviewed. Informants were selected using “purposive sampling,” a sampling strategy in which the researchers focus “on selecting information-rich cases whose study will illuminate the questions under study” [21]. This necessarily included a mix of Guatemalans and foreigners. Because the principal aim of this study was to assess Guatemalan perceptions of short-term volunteer work, the Guatemalans we interviewed are considered to be our primary informants, and their statements are most heavily weighted in the Results section of this paper. To understand the perceptions of Guatemalans, we interviewed a total of 23 Guatemalan healthcare providers (seventeen physicians, two nurses, and four community health promoters), five government health officials, and a group of seven parents whose children were treated by short-term medical volunteers. To understand the perceptions of those providing short-term medical services we interviewed 21 foreign medical providers including both short-term volunteers (fourteen) and long-term expatriates (seven), the latter having observed multiple short-term volunteer groups. Finally, we interviewed sixteen non-medical personnel working with a variety of NGOs or health-related projects who, by virtue of their long-term presence in the country, had the opportunity to observe
short-term medical volunteers over an extended period and were knowledgeable about the political, economic, and cultural context of Guatemalan health and health care. As a group, the respondents varied in their level of interaction with short-term medical volunteers, from extensive to no direct contact. All, however, had knowledge of the presence of short-term medical volunteers in Guatemala and had opinions as to their role in the country.

Interviews were semi-structured, and typically lasted for an hour, although some were significantly longer, and some informants were interviewed on more than one occasion. Most interviews included the two field investigators and a single informant, although we also led two small group interviews. Although we started with an interview guide of questions that we hoped to address with different informants, this guide was used loosely to ensure that information we thought would be significant was included. Following the model of James Spradley [21], these initial, exploratory interviews on a topic that has not been previously addressed in the literature were tailored to the experiences and expertise of our individual informants. Since interviews were not tape recorded and many took place in Spanish followed by our translation into English, many of the quotes are not verbatim, but rather represent closely paraphrased and translated passages that are our best attempt at capturing the idea the interviewee was expressing. All informants were presented with an information sheet in either English or Spanish which explained the goals of the project and provided the informant with written assurance of confidentiality. We quote informants anonymously in this paper to protect their confidentiality and privacy.

One obvious group of people whose perceptions would be important to evaluate are the end-users (i.e. patients treated by short term volunteer groups). However, in designing this study, we elected not to focus on end-user perceptions because it was felt that end-users in the midst of receiving treatment from short-term medical teams would be less likely to offer candid criticism of these groups, especially to two US medical student interviewers. Nevertheless, we did conduct one group interview with seven parents of pediatric patients undergoing surgical treatment by a short-term medical team from the US. In this interview, we asked them why they had pursued care from a foreign medical team rather than through a local medical facility: their comments are briefly addressed in the findings section that follows.

Shortly following each interview, the interviewers created a document summarizing the relevant points made during the interview. Direct quotes captured during the interview by the note taker were also recorded in these interview summaries. At the end of the field research period, these summaries were uploaded into Atlas.ti 5.2 (Scientific Software Development GmbH, Berlin), a computer software program which assists in the analysis of qualitative data. The two field researchers simultaneously reviewed each summary, labeling segments of text with codes that corresponded to the themes (or topics) relevant to the research questions. Once the summaries had been coded and annotated, the interviewers then analyzed all text segments coded under a given theme. These compilations of text segments, coming from multiple interviews but falling under a common theme, served as the basis for each subsection presented in the results section of this paper.

Results
Healthcare Needs of Guatemalan Communities
When informants were questioned about what they believed to be the most pressing healthcare needs in Guatemala, a number of public health measures invariably topped the list. The most commonly cited healthcare needs included improved efforts at disease prevention through health education and disease screening programs, improved public health infrastructure; and improved access to primary medical care, particularly in Guatemala’s rural areas.

A number of informants focused on poverty as the key determinant of the health disparities between the people of wealthy and poor countries. One Guatemalan surgeon working at a large national hospital stated the problem in the following way:

[Foreign] surgical teams only work on the tip of the iceberg when it comes to addressing the medical problems of this country. The problems of Guatemala—corruption, lack of resources, lack of education—all come from poverty. So poverty is the root of the problem, and surgery does not address poverty.

When the question of healthcare needs in Guatemala was posed to a high-ranking official at the Ministry of Health (MSPAS), he emphasized that the "primary problem in Guatemala is a lack of public health infrastructure and lack of primary care coverage due to a lack of financial resources," further explaining that:

[Short-term medical work] does not, and cannot, address these primary health issues of Guatemala. We already have many surgeons and other physicians who are well trained to take care of all problems common in our country. The lack of healthcare in rural areas is not due to a lack of physicians; it is due to a lack of resources to provide clinics, hospitals, and supplies to these areas.
While none of our informants suggested that short-term volunteer medical work could solve the country’s most pressing healthcare needs, there was nevertheless unanimous acknowledgement of the need for increased access to curative medical care, especially for the poorest populations in Guatemala. Informants cited the public healthcare system (MSPAS system), as tending to be the most accessible option to low-income populations in Guatemala. However, a Guatemalan primary care physician working in a foreign-funded hospital explained the pitfalls in the Guatemalan healthcare system:

Even though the national hospitals do not charge anything for their services, preoperative studies are frequently needed for scheduled surgeries. If the national hospital does not have the equipment to do the studies, the patient must go to other places to get them and at times has to pay a lot of money. So even though the national hospital provides health services for free, the patient frequently encounters costs that can prevent a poor patient from receiving necessary treatment.

In addition, given the high levels of poverty discussed above, simply traveling to a healthcare facility can be financially burdensome for a significant portion of the Guatemalan population. Compounding this problem is the paucity of specialists outside of Guatemala City and other larger cities. A physician who is an official at the College of Physicians and Surgeons, stated that “Eighty percent of Guatemala’s specialists live and work in Guatemala City, so there is a vast shortage of specialists elsewhere.” In explaining the reasons for the lack of Guatemalan specialists working in poor, rural areas, one official at MSPAS stated that:

Physicians working within the public healthcare system are underpaid...the financial incentives to work in a poor area do not exist. All of the specialists end up living in big cities, sometimes splitting their work between public and private practice.

In addition to the economic and geographic barriers to accessing healthcare, language and discrimination were also noted as significant impediments to care. One informant is a Guatemalan employee of a US-funded NGO that works closely with local community leaders in rural villages to seek out patients who are in need of surgery. This organization then coordinates the surgery, linking patients with visiting surgical teams. If needed, they also facilitate help to pay for the transportation, accommodations, and food for the patient. This informant reflected that many of the indigenous people (who tend to be those who live in the most rural, poverty-stricken areas) are afraid to have surgery and often only speak an indigenous language rather than Spanish, which prevents these patients from entering into Guatemala’s public healthcare system. An indigenous Guatemalan whose son was being aided by this US NGO had traveled 8 hours by bus with her son who was awaiting hand surgery from a US short-term surgical team. She stated that she felt physicians at the national hospitals helped those with money first, and then, if there is time, they would see the poor last.

**Dependence on Foreign Providers**

Over the course of our interviews, the issue of dependence was frequently raised by both Guatemalans and foreigners. One repeatedly cited criticism was that foreign medical projects remove or lessen the incentive for the government to invest in healthcare for their own people. A Guatemalan physician who works in a foreign-funded hospital which is currently the only hospital in the area offering 24-hour emergency and surgical/obstetrical care is, along with a number of other physicians in the area, petitioning the government to build a full-service, government-run health center in his area. He explained that in deciding where to invest money in improving healthcare services, the government "only considers the number of existing healthcare services already in the area, regardless of the quality of services provided." Thus, the presence of multiple NGO health projects in the area may actually impede development of the area’s public healthcare infrastructure.

In addition to the potential for governmental dependence on foreign medical aid, many informants described the problem of patient reliance on free medical and/or surgical care provided by short-term volunteers. A Guatemalan administrator working in a local NGO which provides reproductive health services throughout Guatemala, expressed her concerns regarding free care provided by foreign medical groups:

Patients get used to the free care and end up waiting for the next group to arrive to give them free care rather than seeking out ways in which they can help themselves. What will happen when all the NGOs leave? The people won’t know how to go about finding a way to get care.

Similar sentiments were noted by an American surgeon and head of an NGO in Guatemala, who stated, "If a volunteer group provides free healthcare, the community can become spoiled and end up relying on that service rather than on the permanent [government-run] system which already exists."

**Patient Selection and Payment Systems**

When our informants were questioned about ways in which dependence on foreign aid could potentially be
avoided, appropriate patient selection and attention to the payment system were most frequently mentioned. When discussing the issue of patient selection, there was almost universal agreement between both Guatemalans and foreigners that short-term volunteer groups should focus their services on the populations who are most in need. The most frequently cited challenge to short-term medical volunteer work was the task of reaching the patients who truly cannot afford other options for medical attention. We spoke with a Guatemalan physician working in a clinic that was hosting a North American short-term surgical group. He expressed his concern that the aid provided by volunteers may not actually be reaching the poorest people in Guatemala and emphasized that if patients who can afford to pay for their own private care receive free care from foreign volunteer groups, those volunteer groups end up competing with the private Guatemalan physicians (who could perform the same surgeries, but for a fee) for patients. He went on to describe the challenge of trying to suggest to the North American group that they perform a financial evaluation of all patients in order to help target those who truly cannot afford to pay for surgery. He stated that he sensed that the North Americans "seem to perceive everyone in Guatemala to be poor, and therefore do not think it is important to do a socioeconomic evaluation."

Informants' opinions on which payment system should be used by short-term medical groups were varied. One head coordinator of a short-term medical volunteer group stated that their group provided "completely free surgical care to every patient without an evaluation of their ability to pay." A number of informants criticized this form of care, suggesting that it becomes "detrimental to society" by causing disinvestment in healthcare by the government to take care of their own population, dependence on outside aid, and competition with the existing healthcare system.

A few informants were of the opinion that short-term medical volunteer work should be free to those patients who cannot afford care in Guatemala. One foreign-born surgeon, who has been operating full-time in poor countries for nearly 20 years, stated that he provides completely free surgery to the "poorest of the poor" through a private foundation. He described why he chooses to do this in the following way:

Last year, I did over 5000 free surgeries for the poor around the world and if my patients would have had to pay for this care, I probably would have done half that number of surgeries. The poorest patients do not have the resources even to be able to afford the transportation, accommodation and food while they are in the hospital, let alone the surgical and medical care...What's the definition of charity if it's not free!

In addition, two out of the four health promoters working in rural, poverty-stricken areas described the free care provided by short-term medical volunteers as one of the greatest benefits to their patients. One health promoter stated, "If [patients] have to pay for their care, some are so poor that they will have to choose between paying for food and paying for their medical care."

Of the 20 informants who discussed the issue of payment directly, fourteen believed that all patients should pay something for their treatment. Most believed that when patients were asked to pay for their treatment, they were in a better position to feel as though they had ownership of their own care, rather than being passive informants in that care. A leader of a US NGO that seeks out patients in rural areas in need of surgical care always has the patient pay something for this service (often it is only a few quetzals - equivalent to less than $1 USD). He described his reasoning in the following way:

I remember talking to a couple of patients who came back from a free surgical [short-term medical volunteer group] who were dissatisfied with their care. When pressed for why they were dissatisfied, they said the facility made them clean up their own area, or they didn't have tortillas - small, irrelevant reasons for their dissatisfaction with their care. I have never had that experience with patients who have to pay something for their care.

Another administrator at a Guatemalan NGO echoed these sentiments by saying, "Even the poorest people in the country can find five quetzals. The point isn't to cover the cost of the care. Rather, the point is to get people to take more responsibility for their own care."

Nearly all of the informants who believed in asking for payment from patients (including Guatemalan healthcare providers, health authorities, community members, and foreigners) suggested using a sliding scale system of payment, in which the amount patients are asked to pay is based on a careful socioeconomic screen performed by social workers and/or leaders of the patient's community, who are in the best position to know what the patient can actually afford to pay. Again, the informants emphasized that the payments should never jeopardize the patients' ability to obtain health care.

**Burden on Host Organization/Community**

Another major theme frequently discussed by the informants was that short-term medical volunteers have the potential to be quite burdensome (both financially and in...
terms of personnel time) for host organizations and communities in Guatemala. It should be noted that nearly every Guatemalan interviewee expressed appreciation for the service that visiting teams provided to their communities and many acknowledged the personal sacrifices that individual volunteers made in order to provide these services. Nevertheless, there was also a great deal of discussion about how this type of work can become financially burdensome for the host organization. One Guatemalan project coordinator of short-term medical volunteers expressed that he felt he was “half project coordinator and half tour guide. I have to arrange transportation, accommodation, food, and translators for all of the volunteers.”

Many informants noted that a big disadvantage to short-term medical volunteer work is the strain on local personnel time when the volunteer did not know the language or were unfamiliar with the clinic setting. A project coordinator of a US NGO stated that, “When the volunteer doesn’t speak the language, misunderstandings can occur and cause big problems, not only for patients, but also for local staff who work with the volunteers.”

Some short-term medical volunteer organizations have tried to combat this problem by asking their volunteers to pay for their own expenses. The head of an NGO which regularly organizes surgical short-term medical volunteer work in a private hospital in Guatemala, expressed the following thoughts:

We get into trouble when physicians just bring their hands. We ask all of our volunteers to cover their own expenses, such as travel, lodging, and food. We also cover the cost of each surgery, including supplies and electricity in the operating rooms, and to offset the financial burden on the hospital of providing follow-up care, our visiting groups make a donation to the hospital for each patient they operate on. We understand that it is very expensive for any facility to host short-term volunteers.

Numerous informants suggested that it is best to limit the number of people on a visiting medical team to only those who are necessary, as large groups tend to get in the way of the regular operations at host facilities and end up being a rather large burden. As an extreme example, a physician who has worked on various medical aid projects around the world, told us of a visiting medical team from the US which brought 78 people, including surgeons, primary care physicians, nurses, cooks, and translators. He continued:

Guatemala already has doctors, nurses, cooks and translators. So, it would be better to bring the specialists that may be seeded and then utilize as many in-country personnel as possible to carry out the mission. In that way, you are wasting less money, strengthening the country’s healthcare resources, helping the country’s economy, and increasing the quality of care.

Coordination

Many Guatemalan informants talked about a level of arrogance or elitism that they often see in visiting medical professionals. Most of these informants noted that when foreign providers work in coordination with the local healthcare providers, it reflects an acknowledgement that the local providers are competent. Working in isolation from the surrounding medical community was perceived to reflect the opposite sentiment. Furthermore, the respect shown to local providers by working alongside them is also perceived to be visible by the local patient population, which has a positive impact on the local provider’s relationship with their community.

Some Guatemalan physicians described their frustration with visiting medical teams who work in isolation from the local medical community. A Guatemalan surgeon who works in a private clinic as well as a national hospital poignantly stated:

Guatemalan patients, especially those with less education, tend to put more faith in a blonde haired, blue-eyed, white skinned foreign physician than their own Guatemalan physicians. These foreigners show up with their shiny new equipment and do their free surgeries without ever working with any of the Guatemalan physicians. US doctors come to Guatemala and practice medicine when and where they want. Guatemalan doctors may have a hard time even entering the US, let alone being able to practice medicine there. US physicians are not superior to Guatemalans. I am perfectly capable of taking care of my own people.

In discussing the utility of short-term medical volunteer work with the co-founder of a successful NGO that organizes US surgical teams to perform surgeries in Guatemala, he said, “Short-term volunteer work can be completely effective if it’s attached to a long-term program.” The importance of short-term medical volunteers coordinating their activities with groups that have a long-term presence in Guatemala was by far the most frequent recommendation made by our informants. In fact, it was often more of a demand than a recommendation, with some informants commenting that short-term medical volunteer work that is not coordinated with a long-term presence is "the worst kind of care," or that those short-term medical volunteers "might as well stay home."

When describing the benefits of coordination, one long-term foreign volunteer noted that the local healthcare pro-
vidor could offer the short-term medical volunteer knowl-
edge of resources, customs, and opportunities available to
the local population. In addition, by coordinating with a
long-term presence well in advance, many informants
pointed out that the local contact is able to recruit patients
for the volunteer group to see.

Additionally, coordination with a local, long-term pres-
ence is a legal requirement in Guatemala. In order for vis-
itng healthcare providers to practice medicine in
Guatemala, they are required to register with the College
of Physicians and Surgeons (Colegio de Médicos y Ciru-
ganos), providing evidence of credentials and a Guatem-
alan physician contact. Nevertheless, a number of
Guatemalan health authorities and healthcare providers
expressed concern that many groups of foreigners practice
medicine in Guatemala without communication or coor-
dination with the local healthcare system.

Meeting the Needs of the Community

Groups that do not work in coordination with a long-term
presence frequently provide services that do not match the
needs of the community. Many informants talked about
"de-worming campaigns" in areas without clean drinking
water sources; groups that provided free eye glasses with-
out an eye exam; or groups that indiscriminately handed
out vitamins as examples of particularly misguided inter-
ventions which reflect the lack of coordination and con-
sultation with the local healthcare community.

Another detrimental effect of groups who practice in iso-
lination is that services already provided by the Guatemalan
community end up being duplicaled by the volunteers.
For example, we spoke with a Guatemalan physician
working at a government health post in a community that
was recently devastated by a natural disaster. His area reg-
ularly receives many foreign medical aid groups; however,
"very few have actually come [to his health post] to ask
about what is needed." He further described the problems
with this lack of communication, citing an example of a
short-term medical volunteer group who saw patients
over a weekend and provided medications without any
records or understandable explanations to the patients of
why they needed the medication. He said those same
patients came to his health post the following week, un-
able to explain what was done and why they were taking
medication, forcing him to repeat their exams without any
benefit to the patient or the system.

Many informants pointed out that at the very least, it is
important to be in contact with local providers to ensure
that what the volunteers are doing is actually needed and
desired in the community. As one long-term foreign vol-
unteer stated, "First understand if the people who you
plan to help actually want it."

Follow-Up Care

Follow-up care frequently came up in the context of why
coordination with a long-term presence is important. As
one interviewee pointed out, "Most problems take longer
than one week to fix - without continuity, the care is not
complete." In addition, many Guatemalan healthcare
providers expressed willingness to provide the follow-up
care to patients with whom they had personal contact, but
stated that providing follow-up care to patients with
whom they were unfamiliar could be problematic. Many
informants suggested that one way to minimize incom-
plete care in the surgical field is to provide a record of
what was done and why (in the appropriate language) to
each patient, to the facility in which the surgery took
place, and to the physician who will be responsible for the
follow-up care.

One nonprofit private hospital was often cited as being
particularly excellent at providing follow-up care. This
hospital, through a small number of international NGOs
with which they coordinate, hosted surgical teams from
North America and Europe year-round and provided very
low-cost surgeries to pre-screened patients who were in
need. They involved Guatemalan surgeons and support
staff in the surgery, and had patients return to that same
dhospital (where each patient's records were kept) for their
follow-up care. They also hired a Guatemalan surgeon
whose primary responsibility was to take care of post-
operative patients and complications which arose from
surgeries performed by foreign volunteers.

Resource and Information Sharing

Surprisingly, a number of the foreign volunteers were
quick to point out that the benefits of short-term medical
volunteer work may be greatest for the volunteers them-
selves. However, the majority of our Guatemalan inform-
ants (including healthcare providers, health authorities,
and Guatemalans working on other health projects) as
well as the long-term foreign volunteers also emphasized
the fact that if coordination exists between visiting and
local healthcare providers, these short-term medical inter-
ventions can be a positive experience for the local provid-
ers as well. Many Guatemalan informants described the
educational opportunities for both sides when visiting
teams work together with the Guatemalan providers. Oth-
ers suggested educational exchanges between US and Gua-
temalan medical schools and sending the Guatemalan
physicians to educational conferences as ways to provide
mutually beneficial interactions.

The Guatemalan informants often cited the donation of
equipment, medications, and supplies as one of the great-
est benefits of short-term medical volunteer work. A Gua-
temalan ophthalmologist in private practice pointed out
that:
There is a cost for the local ophthalmologist to provide follow-up care to patients who cannot pay for it, so there needs to be a reciprocal benefit to the relationship. Money is not the solution – that disappears and doesn’t get to the patients. But, if volunteers leave something behind for the local physician, such as equipment, medications, operative instruments, or supplies that the physician could continue using when the volunteer group leaves, that benefits us and our patients.

It was often stated that donations amplify the impact of short-term medical volunteer work, as they improve the quality of services offered even after the volunteers are no longer present. However, the recipients of these donations often talked about the vast amount of expired medications they receive, which amount to what one interviewee referred to as “trash” that must be sorted through and disposed of, thus wasting valuable staff time. The argument that expired medications were “better than nothing” was not supported by our informants, as one interviewee commented, “If the medications aren’t fit for human consumption in the US, why should they be fit for human consumption in a poor country?”

**Quality of Care**

Many of the foreign volunteers and volunteer coordinators focused on the issue of quality of care when practicing outside of one’s own country. They talked about striving to provide the same quality of care as one would at home and working first and foremost out of responsibility and respect for the patient. As one long-term volunteer put it, “Always keep in mind that you are there to provide the best possible care for the patient – do things because the patient needs them, not for your own experience.” They emphasized using good judgment in making medical decisions, including conservative patient selection for surgical cases. Many volunteers also discussed the importance of knowing your limits as a visiting physician and restricting your work to cases that are within one’s technical limits and that fit the resources of the setting.

Along the lines of professional judgment, many informants (both Guatemalan and foreign) expressed concerns that some short-term medical volunteer groups may be trying to see too many patients per day at the expense of quality of care to the patients. Informants often worried that when volunteers focused on the number of patients seen per day, rates of complications increased, misdiagnoses and inappropriate treatment abounded, and patient education plummeted. In addition, the majority of our informants believed that religious and political discussion should be kept separate from the provision of patient care.

**Discussion**

Our study, although small in scope, is one of the first to systematically and critically examine the effects of short-term medical volunteer work. All major thematic areas in our results underline the challenges of outside groups working as equal partners. Is it paternalism or cooperation? Is it charity or aid? Is it experimentation or quality care? Have all stakeholders been properly identified? Let us say that a recipient community has been appropriately consulted and involved to develop the most suitable intervention with strong community ownership. Omitting other healthcare providers, organizations, and the Ministry of Health may nevertheless jeopardize the long-term success and sustainability of any effort. The very real power and wealth differential between short-term medical groups and their host communities make trust, understanding, and true partnership difficult.

The complex nature of feelings toward short-term medical volunteer groups in our study parallel the often nuanced and contradictory feelings toward the US and industrialized countries. Guatemalans have particular reason to be suspicious of the US: The US-based United Fruit Company and the Central Intelligence Agency coordinated the overthrow of democratically elected Guatemalan president Jacobo Arbenz in the early 1950s and brought an end to important social progress in Guatemala [23,24]. This US-backed “regime change” ushered in a 40 year period of state-sponsored terror, which resulted in up to 200,000 deaths and disappearances, and the displacement of over 1 million Guatemalan people [24-26].

The challenges facing foreign providers do not negate the potential benefits of external assistance. Despite its ranking as a middle income country, Guatemala holds some of the poorest health records in the Americas and holds the third-lowest position in the Americas in percentage of GDP dedicated to both private and public health care – 4.44% [27]. Because of widespread poverty in rural areas and poor compensation for physicians in the public healthcare system, there is little incentive for Guatemalan physicians to work in poor communities. Cuba’s medical assistance program helps bridge the gap in a manner that is directly integrated into Guatemala’s healthcare system. In 2002, 514 Cuban doctors were working in rural areas of Guatemala to staff public health clinics run by the Sistema Integral de Atencion de Salud (SIAS), the national health care system established under President Alvaro Arzu (1996–2000) that increased coverage in rural areas by 90% [27]. Cuban healthcare providers often stay for two years or more, have language on their side, and lack some of the baggage of health professionals from the US.

Short-term volunteer groups may yet identify a framework to contribute meaningfully. Very few have attempted to
identify guidelines that would make short-term medical work more effective, despite its limitations. Suchdev et al. listed seven guiding principles from their experience operating short-term medical groups out of the University of Washington: A clearly defined mission, close collaboration with the recipient community and its institutions, a focus on sustainability, education for the short-term team and the community, service by addressing true health needs, teamwork among short-term volunteers and rigorous program evaluation [28]. Much of the remainder of the existing literature rightfully draws attention to the pitfalls of short-term volunteer work, but has little to offer in terms of a generalizable solution [1-7]. To date, it appears that more scholarly attention has been directed to the educational, ethical and practical issues facing medical students on international electives [29-33]. The situation of these medical students is similar in many ways to that of short-term medical volunteers; they are often poorly prepared, poorly connected, and tempted to practice outside of their scope of competencies. Those unprepared will repeat the same mistakes, as for example, in Paul Farmer's words, "confute poverty with culture" [34]: Attributing differences in healthcare practices and decisions to different cultural beliefs, rather than to lack of resources and basic services.

According to our results, recipient communities may perceive very tangible benefits from short-term volunteer groups: Free or discounted care, improved access to healthcare overall, access to highly-trained specialists, and access to procedures not always possible within the local infrastructure. Local providers enjoy exchanging experiences and knowledge with foreign visitors, and appreciate the influx of supplies that accompany volunteer groups. On the negative side, it appears some of the least sophisticated groups offer services or treatment that are seen to be at best duplicative and at worst, harmful. For example, though some drugs may remain effective 1–2 years past their expiration date, the perception of harm may arise from using drugs that are no longer considered safe, legal, or effective in the US. Similarly, a surgical group not planning for appropriate local follow-up could also be seen as acting recklessly and creating the potential for harm. Such issues may be easily solved with proper planning and supplies. On the other hand, many situations described by our respondents do not present the opportunity for an easy fix. Well-intentioned, well-prepared groups provide services that may help many but may harm others through unforeseen externalities. For example, free care from outsiders improves access in the short-run, but may undermine local healthcare providers, and in the long-run may reduce access: The government might close public clinics with patient volumes that are dropping, and private physicians might leave for areas without competitors providing free care. This could only further increase the dependence on external assistance. Significant externalities in medical assistance are not unique to short-term medical volunteer groups. Garrett describes 'Dutch Disease' in developing countries, where large, expertly-planned and externally-funded vertical health programs draw human and material resources away from primary care, and from other vital sectors of the economy [35].

The debate over free care, raised by some of our respondents, has a long history and continues vigorously in the development circles [36,37]. Some believe that patients and communities will only truly take ownership of and responsibility for their healthcare if they have to pay for it. Other groups, such as Partners in Health http://www.pih.org/what/PIHmodel.html argue that healthcare is a right and that any fee is a barrier to health care access for the poor [34].

Our study has several limitations: 1) It relies on targeted expert informants rather than on the direct recipients of medical care from short-term medical volunteers; 2) It examines only one small part of the world, thus making generalizations difficult; 3) It lacks external reference points, given the scarcity of research on short-term medical work mentioned; and 4) It used field investigators who were outsiders: American medical students who were non-native Spanish speakers. Though there is little formal research with which to compare our results, the issues raised by authors previously cited [1-7] are similar across continents and countries, thus mitigating limitations 2 and 3. Regarding limitation 4, it would appear from their responses that many informants had no difficulty being frank and open with the field investigators. Language barriers may indeed have impeded understanding of subtle nuances; however, the concordance of responses, as well as their complexity, would suggest, at a minimum, adequate comprehension.

The possibilities for future research in short-term medical work abound: With regard to the perceptions of Guatemalan healthcare providers and authorities to short-term volunteer work, a more in-depth analysis of how informants' place in the Guatemalan healthcare system and in the global political economy of healthcare (e.g., links to foreign medical schools, to local, regional, and international NGOs, national and international professional associations, and religious organizations) would further illuminate the complex gradients of dependence and the flow of resources. With regard to short-term medical volunteers, surveys and group and individual interviews could assess their attitudes toward and perceptions of the countries in which they have worked both before and after service to improve preparation for volunteer work and design programs that build more truly reciprocal relationships. With regard to recipients of healthcare from short-term medical
volunteer groups, future studies should seek to understand who pursues care from short-term medical volunteers, why, and under what circumstances. Are there perceived or actual differences in quality or type of care? Are patients and their families satisfied with their care? Does seeking and obtaining care from foreign providers carry different social meanings, e.g., greater status, than care from Guatemalan providers or state-run clinics? Finally, is it our hope that this paper will stimulate studies in the economic, political, and health outcomes of short-term volunteer programs to critically assess their quality and effectiveness. What is the effect of the concentration of such services on the government investment in healthcare infrastructure and services in those areas? Do free or very low cost services provided by short-term volunteers truly draw patients away from private practitioners or state services? Are outcomes for procedures (e.g., cataract removal) or conditions (e.g., diabetes) different when care is provided by the regular healthcare system versus by short-term medical volunteers?

Conclusion

The perceived impact of short-term medical volunteer projects in Guatemala is highly variable and dependent upon the individual project and the perspective of the observer. In this exploratory study, certain project effects were repeatedly identified as being either positive, such as improved access for the underserved, or negative, such as drain on local resources. Other responses highlighted the complex consequences of short-term medical volunteer work, through unforeseen externalities on the healthcare system. These findings have direct implications for any involved in the planning and execution of short-term medical volunteer projects, including local and foreign medical team members, project planners and coordinators, and health authorities. Most importantly, this study suggests avenues for future study and evaluation of the impact of short-term medical volunteer programs on local healthcare services.

Competing interests

The authors declare that they have no competing interests.

Authors’ contributions

HG and TC carried out all interviews and data analysis and interpretation. All authors contributed to the conception and design of the study. All authors were involved with drafting and critical revisions of the manuscript, and all authors read and approved the final manuscript.

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A Model for Sustainable Short-Term International Medical Trips

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The health status of many people in developing countries is often dismal compared with the norms in industrialized countries. Increasingly, medical practitioners in the United States and other industrialized countries have become interested in global health issues, an interest that often takes the form of short-term international medical trips. We discuss several ethical issues associated with participation in such trips and use our experiences in developing the Children’s Health International Medical Project of Seattle (CHIMPS) to outline and illustrate a set of guiding principles for making these trips. CHIMPS is a resident- and faculty-supported international medical program founded in 2002 by pediatric residents at the University of Washington in Seattle. Members of CHIMPS work with a rural community in El Salvador to support ongoing public health interventions there and provide sustainable medical care in collaboration with the community and a local nongovernmental organization. The 7 principles developed as a result of this work—mission, collaboration, education, service, team work, sustainability, and evaluation—can be used as a model for health practitioners as they develop or select international medical trips. The importance of partnering with the community and working within the existing medical and public health infrastructure is emphasized. Many of the challenges of doing international medical work can be overcome when efforts are guided by a few specific principles, such as those we have outlined.

KEY WORDS: medical education; pediatrics; professional ethics; world health


Worldwide, nearly 11 million children under the age of 5 years die annually, mostly from preventable or treatable causes. In 2003, the average life expectancy for inhabitants of one developing country, Botswana, was less than half that of persons in the United States. The increasing interest of American physicians in the health care of populations in the rest of the world is almost self-evident if one judges by the many recent articles on the subject of working overseas. One reason is that US physicians take care of many patients from developing countries; a second is that in the intimately intertwined sociopolitical and economic web of today’s world, we understand that our actions have significant effect on the forces that determine global health. Finally, as pediatricians, we are taught that social justice is part of our mission, as exemplified by the motto of the American Academy of Pediatrics declaring that we are “dedicated to the health of all children.”

In recent years, interest has grown among physicians from wealthy nations in understanding and remedying disparities in global health. As one indicator, in 2004, over 22% of graduating US and Canadian medical students had participated in an international health elective, compared with 6% of 1984 graduates. Trainees who participate in international electives are more likely than their peers to report commitment to underserved populations and interest in careers in international medicine. Ethical Challenges of International Health Work

Despite its good intentions, international health work is not without significant ethical challenges. Given the cost, time, and logistics involved in working overseas, most international medical work is short term, in the form of volunteer brigades or training electives. Labeled by critics as “medical tourism”—“short-term overseas work in poor countries by clinical people from rich countries”—these trips can be seen as:

- Self-serving: provide value for visitors without meeting the local community’s needs.
- Raising unmet expectations: send volunteer practitioners and trainees who do not have appropriate language or medical training or accountability.
- Ineffective: provide temporary, short-term therapies that fail to address the root causes.
- Imposing burdens on local health facilities: provide culturally irrelevant or disparaging care and leave behind medical waste.
- Inappropriate: fail to follow current standards of health care delivery (continuity, access) or public health programs (equity, sustainability).

We believe that with foresight and collaboration, it is
possible to carry out a short-term international health trip that has a positive impact. Given the lack of published principles to guide international trips, we use our experience in founding a resident-run international medical project to develop guiding principles for other practitioners. These principles can serve as a framework for others who seek to participate in international work.

**GUIDING PRINCIPLES**

The Children’s Health International Medical Project of Seattle (CHIMPS), founded in 2002 by 2 pediatrics residents at the University of Washington, consists of residents, faculty, nurses, medical students, and other health professionals. Although CHIMPS has had moral support from the residency program, no faculty or administrative time has been provided, and residents have raised all supporting funds; faculty members have consistently volunteered to give stability to the program. Growing interest in CHIMPS (nearly 30% of interns participated in 2006) was a major factor in the hospital’s deciding to develop a global health pathway for residents.

CHIMPS organizes annual 1-week outreach trips during intern vacation to Los Abelines, a community in rural El Salvador, and collaborates with a local nongovernmental organization (NGO) to support ongoing public health interventions throughout the year. In addition, residents take 1-month electives in El Salvador to work on specific projects with the NGO. In this way, although our presence in-country is short-term, our collaboration with the community of Los Abelines is not. To direct our work there, we have developed 7 guiding principles, which are discussed below.

**MISSION: A COMMON AND SPECIFIC SENSE OF PURPOSE**

The mission statement is a tool to communicate the group’s collective beliefs. Our mission statement is:

“To ethically address underlying health issues and to provide sustainable public health interventions and medical assistance for underserved communities in developing countries.”

We regularly refer to our mission to keep us on course, even as the project grows and changes. It is important that the mission statement emphasizes addressing the public health needs of the community.

**COLLABORATION: A RELATIONSHIP WITH A COMMUNITY AND ITS INFRASTRUCTURE**

Partnership with an NGO, government agency, or other local organization determines the type and extent of work that can be done. Organizations that understand and work within the infrastructure of a community can facilitate the integration of medical and public health projects and assure their continuity.

The name of our partner organization, ENLACE, means “to link” in Spanish. Its mission is to collaborate with communities to develop integrated and sustainable solutions to poverty in El Salvador. In Los Abelines it has developed a health committee consisting of local community members who provide health education and simple health interventions. ENLACE also employs a local physician who makes weekly visits to the community. Accordingly, there is a continued medical presence in Los Abelines that goes beyond visits by CHIMPS.

**EDUCATION: FOR OURSELVES, THE COMMUNITY AND OUR PEERS**

**Educating Ourselves**

The process of educating participants in the trip about the community, its medical problems, and effective interventions for these problems should start well before each trip begins.

The first step is to understand how the sociopolitical context of a partner community affects its predominant medical problems and to identify evidence-based solutions so that resources can be focused appropriately. El Salvador, a small country in Central America, has high rates of poverty and infant mortality. Of every 1000 children, 24 will die within the first year of life. Los Abelines is among the most isolated communities in the Morazan Department, the focal point for El Salvador’s 12-year civil war. Community members have little or no access to safe water, electricity, or sanitation systems. Surveys during CHIMPS trips in 2005 and 2006 found that 47% used untreated water from the polluted river, and 50% did not have a latrine.

After a literature review and consultation with ENLACE staff, we have developed a series of public health initiatives that address the need of the community’s most vulnerable populations—women and children. We have worked with the health committee to identify and address 3 major health priorities: dental health, intestinal parasites, and nutrition. A brief description of the 9 interventions developed (on the basis of existing evidence and international guidelines and in collaboration with the community) is presented in the Table.

We require that a majority of group members traveling to Los Abelines have Spanish skills, and we have developed a medical Spanish class at our hospital to promote proficiency.

**Educating the Community**

Teaching the teachers allows the community to be an integral part of the process of improving health. We have developed educational materials (charterias) that include lectures and demonstrations on important health messages. We teach these interventions to the local health committee for ongoing use in public health work (Table).

**Educating Our Peers**

We facilitate increased understanding of international health issues in our home community through presentations, publications, lectures, and language classes.


TEAMWORK: BUILDING ON EACH TEAM MEMBER'S SKILLS AND EXPERIENCES

An ethical international trip involves appropriate supervision of all junior team members in a manner consistent with policies of patient care in the United States. In addition, it is important to bring team members with diverse specialties (i.e., physicians, nurses, physical therapists, dentists, health educators) so that volunteers can use their specific strengths to address the community’s prevailing needs. Upon our arrival in Los Abelines, the local physician oriented the team to the common health conditions, the treatments provided in the clinic, and the health beliefs of the residents. Working with this physician and the health committee has allowed us to learn about tropical medicine and provide better care for patients abroad and back at home.

SUSTAINABILITY: BUILDING CAPACITY FOR ONGOING INTERVENTIONS

Building a sustainable project involves working in a single location so that efforts can be augmented during successive trips. This approach demonstrates a commitment to an ongoing relationship and allows for a greater effect on the community’s health. Working within existing systems of care, the teachers allows the group to work with the community rather than providing care to them. In our example, this shifts the responsibility for community health improvement towards the year-long work of the local NGO, physician, and health committee and away from our intensive 1-week trip and the 1-month resident electives.

EVALUATION: A MECHANISM TO DETERMINE WHETHER GOALS ARE BEING REACHED

Conducting periodic evaluation is important for measuring a project’s effects and improving its design and implementation. By use of the structure-process-outcome model, we evaluate our program regularly. After consultation with our institutional review board, we have developed a database of clinical and laboratory data collected during annual visits and use this information to determine the effectiveness of our interventions and the changes needed. For example, in a convenience sample of patients presenting to the Los Abelines clinic in 2005, 30% showed evidence of iron deficiency on the basis of an elevated zinc protoporphyrin/heme ratio (ZPH), and only 28% ate meat once or more a week. The prevalence of malnutrition in children under 5 years of age, defined as a z score less than −2 for height-for-age or weight-for-height according to the 2005 World Health Organization Child Growth Standards (http://www.who.int/childgrowth/en/), was 44% and 6%, respectively, compared with national estimates of 18.9% and 1.4% in 2003. We have used this data to initiate interventions such as iron supplementation and development of a community garden (Table).

In addition, we obtain regular feedback from members of ENLACE, the local physician and health committee, and program participants through qualitative interviews.
and written evaluations. According to one ENLACE staff member, "Not only has the health committee members' confidence increased, as they have become the local 'experts' on public health issues through their collaboration with the CHIMPS and ENLACE staff, but the experience has allowed them to take ownership of their own and their community's health issues." We present the yearly data from patient surveys to the health committee to focus the community's public health work and our annual intensive trips and resident electives.

CONCLUSIONS

International work requires intensive logistical planning, financial support, enough skilled personnel, and institutional support for practitioners. Even with the best intentions and thoughtful planning, there are patients for whom adequate care cannot be given, and well-meaning interventions can have unexpected effects. Even so, we assert that the health of people around the world and of their communities is a global responsibility, one we as physicians in the United States share. Despite the challenges posed by short-term medical trips, when they are directed by guiding principles they can be a means of effecting meaningful improvement in the health of communities around the globe.

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The medical student global health experience: professionalism and ethical implications

S Shah, T Wu

ABSTRACT
Medical student and resident participation in global health experiences (GHEs) has significantly increased over the last decade. In response to growing student interest and the proven impact of such experiences on the education and career decisions of resident physicians, many medical schools have begun to establish programmes dedicated to global health education. For the innumerable benefits of GHEs, it is important to note that medical students have the potential to do more harm than good in these settings when they exceed their actual capabilities as physicians-in-training. While medical training programmes are beginning to provide students with the knowledge to put their GHEs in context, they must remember that they also bear the responsibility of training their students in a framework to approach these experiences in a principled and professional way. It is necessary that these institutions provide adequate and formalised preparation for both clinical and ethical challenges of working in resource-poor settings. This paper outlines potential benefits and risks of GHEs and outlines recommendations to some of the current issues.

In recent years, Americans have been jolted into awareness of global issues. Every day the media highlights images of war in Iraq, dialogues on AIDS in Africa, and accounts of natural disasters worldwide. Over the last decade, infectious diseases such as SARS and the avian influenza have created concern for health and safety globally. These stories reinforce the fact that conditions existing in other places are not as far away as they once seemed.

The field of medicine has appropriately responded with increased funding and support to healthcare students and professionals pursuing global health experiences (GHEs) addressing health disparities. Although research, teaching, and related activities are also GHEs, in this paper, we define GHEs in a clinical context. As national leaders of the Global Health Action Committee of the American Medical Student Association, we often advocate for GHEs and applaud increased support for medical students participating in them. In facilitating GHEs, however, we believe that medical institutions should consider implementing curricular material to better prepare their students for the unique challenges of practicing medicine in resource-poor settings. Medical schools bear the responsibility of fostering principled and professional frameworks for students to approach medicine, and it seems natural that this preparation ought to extend to patients served in any context, including those populations in resource-poor settings.

CURRENT STATE OF THE GLOBAL HEALTH EXPERIENCE
Increased understanding of the realities of global health has translated to rising student interest in participation in GHEs. A 2004 survey by the Association of American Medical Colleges (AAMC) reported that 22.3% of graduating American and Canadian medical students had participated in a GHE, an 11.5% increase from 2001. AAMC survey data has shown that over the past 20 years, there has been an overall increase in this number, from less than 10% of medical students participating in GHEs as recently as 1995.

Studies examining the benefits of these experiences for physicians-in-training have shown an increase in cultural sensitivity, enhanced community, social, and public health awareness, improved clinical and communication skills, and a greater understanding of the challenges of working in resource-poor areas. These studies have also demonstrated that residents physicians with GHEs are more likely to care for public assistance patients and immigrants, and are more likely to switch from subspecialty medicine to general medicine. Thus, increased awareness of global health disparities and the educational benefits of GHEs has led to increasing demands for formal medical education specific to resource-poor settings.

A growing number of medical schools have begun to organise that disparities in access to care result from a broad range of political, social, economic, and cultural issues. As a result, many have begun dedicating elective courses, academic tracks, entire academic departments, and even residency programmes to the study of global health and the alleviation of existing disparities. Even so, there appears to be an inadequate amount of formalised global health preparation in medical education. This is of particular concern considering that a large number of medical students have GHEs as early as the summer between their first and second year of medical school. Without improved structure, there is a danger that some medical students may only recognise the range of factors affecting health after they have already arrived in country, or may never attain this realisation.

ETHICAL CONSIDERATIONS
Our work with the American Medical Student Association, and our personal GHEs have brought us in close contact with a substantial number of medical students committed to alleviating global health disparities. The opportunity to serve an underserved population is an important factor motivating GHE participation for many of our peers. This ability to serve, however, is often...
Global medical ethics

tempered by the limitations in our clinical knowledge, given our status as physicians-in-training. This desire to help, combined with relative inexperience, can pose ethical conflicts and leave both patients and students vulnerable to negative outcomes, as the following account from a first year medical student demonstrates:

After finishing my first year of medical school, I participated in a mission trip to Mexico. Before flying to Mexico, I was not given any cultural, medical, or other training, nor could I speak Spanish. Upon arriving, I was assigned to a clinic where there were hundreds of patients but only one physician.

I remember vividly seeing a frail 11-year-old boy with polyuria, polydipsia and nocturia. My lack of medical training limited my differential. With only a scattered history and no other tests, I told him to limit caffeine intake and see if that helps. Thinking back, he could have had a urinary tract infection, any number of renal abnormalities, or worse, I sent him out without ruling out diabetic ketoacidosis.

As I was seeing patients by myself, other first year medical students were performing surgeries in the other clinic and later bragging about it. (Anonymous student, personal communication, 2 January 2000)

By no means does this experience occur in every programme or even with every student. Students who approach these experiences with harmful intentions are fortunately an exception; however our experience with hundreds of well-intentioned medical students through our own travels, education, and leadership roles with medical student associations has shown us the omnipresent ethical dilemma of practicing beyond one’s abilities. This vignette highlights a common perception that people who live in poverty will benefit from any medical services, irrespective of the experience, or lack thereof, of the provider. As discussions regarding medical student-run clinics for indigent populations in the United States have demonstrated, this is not always true. These clinics have been shown to benefit patients and medical students alike, much as GHEs do. Buchanan and Witten discuss the potential of these clinical interactions to teach medical students the ethical principles of altruism (“met society’s expectation of them in the practice of medicine”) and duty (“demonstrating a commitment to care for the poor and to advocate for healthcare access for the underserved”), as established by the AAMC’s Medical School Objectives Project in 1998. Teaching of these principles, however, is dependent upon adequate protection of the vulnerabilities of both groups. Indigent patients are a vulnerable population in that they often do not have alternative sources of healthcare. Unlike those who can afford to pay for healthcare, underserved populations often resort to accepting the care provided, even if it may be inadequate.

Likewise, medical students should seek adequate supervision in providing clinical care, as they are legally bound to always practice under the supervision of a licensed physician. Medical students, like all health professionals, have a primary moral and professional obligation to those for whom they care, regardless of setting. This “duty of care”, as described by Myer, depends upon the trust that underlies the doctor-patient relationship. Trust, in this case, involves the patient’s ability to rely on the clinician as a skilled professional who will help the patient make informed choices in the patient’s best interest. Medical students thus have an obligation to disclose their level of training and to not act beyond their capabilities to maintain this trust. Furthermore, one should consider that care offered in these clinics, even if conducted without the supervision of a licensed physician, could discourage patients from seeking care in better established health centres.

The argument can be made that given the shortage of health professionals in places such as sub-Saharan Africa, which bears 24% of the global disease burden but only 5% of the healthcare workforce worldwide, providing direct service in any capacity may be a better alternative to providing no services. Through our own GHEs early in our training, we know that it is difficult for first and second year medical students to assess our own limitations and knowledge. The structure of American medical schools is such that generally medical students must attain a certain level of knowledge prior to having clinical responsibilities. Circumventing this path in resource-poor settings creates a double standard of ethical and professional conduct.

A parallel could be drawn to current practices in international clinical research involving partnerships between researchers from developing and developed countries. In 1997, this debate of ethical standards garnered significant attention following a controversial clinical trial conducted in many developing countries to study the use of a short course of zidovudine for prevention of mother-to-child transmission of HIV. The investigators utilised a placebo-controlled research design, despite the existence of a proven and accessible standard of care. Subsequent discussions centred on the appropriate measure of control in the developing world, where regimens that are standard of care in the developed world simply do not exist for reasons of cost and/or infrastructure. Among others, Ansell, Ruthe and Wolfe, and the Nuffield Council on Bioethics argued that patients involved in US-sponsored trials should have access to the standard of care as would be provided to participants in the US. This view was in line with the principles of the Declaration of Helsinki, which states that participants should “be assured of the best proven and diagnostic method”.

The Council for International Organisations of Medical Sciences Guidelines, which were created to apply the Declaration of Helsinki principles to the developing world setting, state, “The ethical standards applied should be no less exacting than they would be in a case of research carried out in that [the sponsor’s] country.” More fundamentally, Ansell stated, “Human subjects in any part of the world should be protected by an irrefutable set of ethical standards.”

While there are well-established ethical guidelines for international clinical research, similar ethical standards for GHEs do not exist. Health system infrastructure and technological advances differ from one healthcare setting to the next, but it is possible for the ethical standards of GHEs to be more consistent. As we move towards a single international standard of ethical research, we encourage the equivalent criteria in the ethics of GHEs.

Conduct on GHEs can be placed in the context of US standards for medical professionalism by referring to the guidelines put forth by the AAMC. The AAMC defines the four key attributes of professionalism as:

- Adhering to high ethical and moral standards
- Responding to societal needs and reflect a social contract with the communities served
- Subordinating one’s self-interest to the interest of others
- Evincing [sic] core humanistic values

GHEs such as the one mentioned in the vignette demonstrate that many students need professionalism reminders and/or guidelines as they embark on GHEs. We recognise that students may be able to participate in more surgeries and procedures in
the underserved communities for many reasons. Increased participation in operations is not problematic on its own; the concern is with students partaking in procedures without sufficient supervision. Often, they may justify the breach of professional standards to themselves by prioritizing the educational value, which occurs in the US, but to a lesser degree. Yet, it is worth considering the reasons why underserved populations serve as educational tools.  

We should bear in mind that patients are likely unaware of a student’s educational status and/or unable to demand better care because of socioeconomic or cultural vulnerability. Thus, any medical liberties taken by students may violate the principles of professionalism as noted above, namely, “subordinating one’s self-interest to the interest of others.”

RECOMMENDATIONS

The teaching of professional conduct and sound ethical frameworks in large part accepted as the responsibility of medical institutions, as evidenced by an AAMC study that showed that 89.7% of the 116 medical schools surveyed offered some formal instruction related to professionalism. There is currently no standardized approach for teaching of professionalism in medical schools. There is, however, individualized professionalism training within the medical schools and a renewed push for professionalism research. The American Medical Association is working in conjunction with 27 medical schools on the Innovative Strategies for Teaching and Evaluating Professionalism (ISTEP) programme in order to foster the design of innovative methods to teach, monitor, and evaluate professionalism competencies. Examples of proposals include keeping log books, small group discussions, video series of vignettes, self-reflection papers, and other creative ideas. As these curricula are developed, it is feasible to incorporate education on global health ethics.

The course would not only emphasise the ethics of working with vulnerable populations, but also incorporate preparation for the health and personal safety challenges of working in these environments. Similar to the STEP Programme, pilot global health ethics courses should be designed, fostered, and supported.

The potential merits of a formalised global health professionalism curriculum are very clear. As an increasing number of physicians will work abroad, the curriculum would help ensure that every future physician is trained to “understand the extent and causes of ill health among the billions living in poverty in developing counties and the ways to prevent it,” thereby allowing them to potentiate their ability to improve the lives of their patients.

Global health ethics courses will help significantly in the maximisation of benefits for patients and students involved in these experiences. Patients, regardless of their finances, ethnicity, gender, or status, have the right to know if their medical provider is a medical student. They should always have the choice whether or not to receive care from a student physician. As a recent British Medical Journal editorial notes, “When in countries where healthcare provision is extremely scarce, students must recognise that there may be pressures to exceed their role. They must not diagnose illness, prescribe, or administer treatment without strict clinical supervision—however “unprofessional” this may feel. Students may not appreciate the dangers of treatment, particularly in countries where familiar medical problems are complicated by unfamiliar levels of poverty. In such circumstances, even with the best of intentions, inadequately supervised students risk doing more harm than good.”

Students also bear the responsibility of saying “no” and recognising their own limitations. They must understand that misconduct and/or maltreatment of any patient, regardless of status, is of consequence. Recognising that medical students are often ill-prepared to understand the complications which may arise as a result of practicing medicine with limited medical knowledge, medical schools should find a way to incorporate the ethical and medical consequences of practicing medicine beyond one’s capabilities into the medical curriculum. They have an obligation to teach medical students how to recognise when “to say no”, as this editorial suggests.

CONCLUSIONS

The recommendation of a global health ethics course is not a comprehensive solution. Therefore we are calling for more research on ethics education. Students with limited clinical experience can be taught that there are many ways for them to contribute to the health of their patients beyond the direct practice of medicine, including research, cultural studies, distribution of educational materials, and advocacy.

Currently, there are many organisations working to develop a model global health curriculum that can be applied to medical schools, including the American Medical Student Association, the International Federation of Medical Students’ Associations, and the Global Health Education Consortium. We encourage these efforts, recognising the enormous difference that increased understanding of global health disparities will make in the treatment of millions of patients. However, as we consider the experiences of many medical students engaging in GHES, our recommendation is that any such curriculum consistently emphasises measurable, practical, ethical, and professional ways of serving the underserved. With all of the excitement surrounding the development of new opportunities for students to be able to partake in international experiences, our ideal is that medical schools assist students in providing ethical and professional guidelines for global health experiences.

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AMSAs “Creative Funding for International Health Electives”

**Creative Funding for International Health Electives**

Medical students increasingly view international electives as desirable if not necessary experiences as the establishment of global communications and linkages becomes a necessity to much of the world and the population of the United States becomes increasingly diverse.

While a number of such options are offered by various colleges of medicine and osteopathy, the cost of participating in them is prohibitive for many. AMSA estimates that medical students spend an average of $2500 for a six-week elective. More students would be able to partake in international opportunities would increase if students were more aware of the potential sources of financial assistance.

This guide identifies possible sources of assistance - from grants to original fundraising efforts - that may help defray all or part of a student’s expenses for an international health elective.

- Established Funding Sources
- Non-Traditional Funding Sources
- Low Cost Electives
- University Funding Sources

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*The Creative Funding Guide for International Electives was prepared in collaboration with the International Health Medical Education Consortium (IHMEC) and the American Medical Student Association (AMSA) by Sara E. Pirtle, University of Nebraska Medical Center, Office of International Studies and Programs and by the International Health Studies Center of the American Medical Student Association Foundation. 1997*
Established Funding Sources

Belgian American Educational Foundation
Graduate fellowships for study in Belgium
The Foundation will award fellowships for advanced study at one of the Belgian Universities or other academic institutions of higher learning.
http://www.baef.be

Christian Medical and Dental Society (CMDS)
James S. Westra Memorial Endowment Fund
CMDS offers a program of grants-in-aid, through the James S. Westra Memorial Endowment Fund, that provides selected medical/dental students with clinical experiences of two weeks or more in mission settings in developing countries.
http://www.cmda.org/

Foreign Mission Board of the Southern Baptist Convention
This competitive program provides round-trip travel and hospitality for fourth-year students participating at one of the program's many international sites. Eight to ten students per year are accepted for a minimum of eight weeks.
http://www.sbc.net/missionswork.asp

Global Health Ministries Travel Grants
Global Health Ministries (GHM) may award up to four travel grants annually to assist approved fourth-year medical students to travel to a GHM related hospital or health care center in Tanzania, Madagascar, or Cameroon for an international elective of at least eight weeks duration.
http://www.ghm.org/

Medical Assistance Program International (MAP) International Fellowship Program
The MAP-Reader's Digest International Fellowship Program provides for 75% of the most economical regularly scheduled round-trip air fare to one site for senior medical students and resident physicians. Students serve with well-qualified physicians associated with rural or out-lying mission hospitals, clinics or community health programs recognized by MAP. The purpose is to offer clinical experiences in settings that will enable them to become familiar with the cultural, social and medical problems characteristic of developing countries and thereby encourage the students to seriously consider career involvement in Christian medical missions. A minimum of eight weeks must be spent on location.
http://www.map.org/what-we-do/map-fellows/

Academy for Educational Development (AED)
National Security Education Program (NSEP) - Graduate Fellowships
Scholarships for language study in less commonly studied countries/regions. May be combined with medical electives.
http://www.aed.org/
Network of Community-Oriented Educational Institutions for Health Sciences
The Network is an international collaborative effort of more than 250 medical schools and other institutions dedicated to making education relevant to the health needs of the populations served by its graduates. Students from member institutions can receive assistance in arranging international health electives at other member institutions.

Philippe Foundation, Inc.
The Philippe Foundation is a small organization specializing in the exchange of doctors between the United States and France emphasizing medical research, particularly cancer. These grants are designed to facilitate the exchanges, not provide the principal source of support. At the end of the stay, 2 copies of a report describing your results to close your file are required.
The Philippe Foundation, Inc.
Two Penn Plaza, Suite 1920 A
New York NY 10121 USA
Tel : (212) 687 32 90; Fax : (212) 687 34 18

The Harry Frank Guggenheim Research Grant
The Foundation welcomes proposals from any of the natural and social sciences and the humanities that promise to increase understanding of the causes, manifestations, and control of violence, aggression, and dominance. Highest priority is given to research that can increase understanding and amelioration of these urgent problems in the modern world. Priority also will be given to areas and methodologies not receiving adequate attention and support from other funding sources. Grants are made to individuals, not to institutions. The Foundation ordinarily makes awards from $15,000-$35,000 a year for 1-2 year. All awards are for one-year terms initially. Further funding requires annual applications for continuation of support. Final reports are mandatory within six months after the end of the grant period. Grants are usually made to senior scholars with PhD or MD degrees and a considerable track record for research on violence and aggression. Only original pieces of research on significant social problems related to violence and aggression solicited.
http://www.hfg.org/

The Rotary Foundation
Graduate scholarships for international study are available in any field and require a one year commitment. The scholarships cover travel expenses and provide a stipend for room and board. The applicant must be able to communicate in the host language. All applications are made and processed through the local Rotary Club.
http://www.rotary.org/en/AboutUs/TheRotaryFoundation/Pages/ridefault.aspx

The Swedish Institute (Svenska Institutet)
Guest Scholarships
The scholarships are granted only for studies/research which cannot be equally well
pursued in countries other than Sweden. Scholarships are usually granted for one academic year (9 months), but can also be awarded for study periods of short duration. Student must establish contact with a Swedish university department willing to accept the applicant before he/she applies. A copy of a letter from the Swedish university proving that the applicant is welcome there must be sent together with the letter requesting application forms.

http://www.si.se/English/

University of Alabama at Birmingham, School of Public Health

*International Health Research Opportunities* (funded by the National Institutes of Health and the John J. Sparkman Center for International Public Health Education)
The Department of International Health at the University of Alabama at Birmingham School of Public Health offers research training opportunities to minority undergraduate and graduate students who have an interest in the areas of nutrition, tropical and infectious diseases, reproductive health and/or sexually transmitted diseases and AIDS.

http://www.soph.uab.edu/

Wilderness Medical Society

*The Charles S. Houston Award*
The Wilderness Medical Society is interested in nurturing an awareness and appreciation among students of medicine for the medical aspects of outdoor and wilderness activities. The Charles S. Houston Award is given annually to one or two students who have submitted research proposals must likely to result in a substantive contribution to the field of wilderness and environmental medicine. The research is usually conducted over the course of a summer, approximately three months.

http://www.wms.org/
Non-Traditional Funding Sources

Below are suggestions of general types of organizations that may be receptive to carefully prepared requests from an individual or institution to provide full or partial support for an international elective opportunity. A proposal should include an anticipated budget and identify what the gains are for the organization, the host country, and the student. It is critical to follow-up with the donor group via a presentation, slide show, etc. after the completion of the elective. This not only allows the donor organization to see the results of its financial support, but lays the groundwork for future solicitation.

Religious Organizations

Many religious organizations are becoming more active in their support of service-related projects with an international focus. Although the organization as a whole may be approached, it may be more appropriate to request aid from a particular committee or arm within the organization that may be set up to act more directly on such a request, e.g., a social ministry committee or "missionary" group. A student who belongs to such an organization may have an enhanced chance of receiving a favorable response.

Sister City Organizations

Dynamic Sister City relationships can be the source of reciprocal programs, homestays, etc. which, when tied to an international elective, can significantly reduce its cost. To locate a contact for a program in your city or to initiate a Sister City relationship, request information from Sister Cities International. http://www.sister-cities.org/

Partners of the Americas

Partners of the Americas is the largest private, voluntary organization in the Western hemisphere engaged in economic and social development and technical training. The organization works by pairing US states and the District of Columbia with regions and countries of Latin America and the Caribbean in "partnerships." For example, Kansas is linked with Paraguay and New Jersey with Haiti. The partnerships partake in exchanges and organize development projects determined by local needs. These projects have included maternal/child health and nutrition, immunizations, AIDS prevention and education, and drug abuse prevention. In some instances, medical students have been approved to participate in these projects. Airfare is usually furnished for approved participants and either homestays are provided or low-cost room and board is available. http://www.partners.net

Ethnic Organizations

Local ethnic organizations may be interested in offering support for an elective located in the country of affiliation. New York Medical College in Valhalla, New York, for example, has been able to full or partially fund student international electives in Italy, India, Haiti, Greece, and the Ukraine by tapping this resource. Following the elective, the Medical College arranges a luncheon for the supporting group at which the recipient student discusses his experiences. While larger metropolitan areas usually host a number of active ethnic organizations and associations, smaller cities, too, often have one or more strong ethnic organizations that can be approached for assistance.

Local and Regional Chapters of Professional Organizations

Most medical and allied health sciences professions have their own professional
organizations. A well-written proposal directed to the appropriate group may receive a positive response. For instance, the Nebraska Academy of Family Physicians' Foundation has designated funds for several partial scholarships for students anticipating participation in a medical missions trip. Eligible students must be enrolled in a Nebraska medical school and have an interest in family practice.

Local and Regional Corporations
National corporations often receive many requests for funding, while local corporations are more accessible and can become more personally involved. A local corporation may consider awarding a grant or a scholarship as part of its public relations efforts.

Local and Regional Foundations
A locally or regionally based foundation may offer assistance to a student whose international elective is related to the foundation's mission.

Local and Regional Chapters of Civic Organizations
Area chapters of the Lions Club, Jaycees, Rotary, Junior League (for women only), etc. give generously to fund education often including international medical electives, especially those chapters located near the medical school or the student's hometown. Look for contacts in the phone book where you study and in your home town.

Local Newspapers and Magazines
Though not in the same category as the other non-traditional sources identified in this section, local publications in the city where the medical school is located and in the student's home town may consider paying a student to write one or more articles regarding health care issues in the country of the elective. A student who wrote a series of articles for a Philadelphia daily on health care in China recovered all of his trip costs and expenses.
Low Cost Electives

While a fully funded opportunity may be most desirable, a number of low-cost electives exist that are substantially subsidized by other sources. Room and/or board, for example, may be provided for the student or offered at minimal cost. The amount that a student will have to pay on his or her own varies considerably with each program. A low-cost elective, combined with a small scholarship from a local organization, such as a church, can considerably defray a student's expenses. Many low-cost opportunities are available; the sampling below includes just a few of them.

For further listings, consult the directory of International Health Electives for Medical Students.
http://www.amsa.org/AMSA/Homepage/EducationCareerDevelopment/IntlHealthOpps.aspx

International Federation of Medical Students Associations (IFMSA)
The IFMSA is a student-run organization arranging over 6,000 international exchanges for medical students each year. Member countries are located throughout Europe, the Middle East, Asia, Africa, and Latin America. Exchange criteria are established for each institution by the Deans and generally include a facility for English or the local language, insurance, etc. National and local medical student organizations arrange for amenities including room, board, and cultural programs. Usually bilateral exchanges are arranged, although unilateral programs are possible.

Effective in 1993, a coalition of US medical student associations, the USA-International Health Project, has formed as an agency for US membership in IFMSA. USA-IHP membership gives all US students the opportunity to participate in this international network of medical education. Any local student organization can participate and all US medical students are eligible regardless of membership status.

http://www.amsa.org/ifmsa

Network of Community Oriented Educational Institutions for Health Sciences
The Network is an international collaborative effort of more than 190 medical schools and other institutions dedicated to making education relevant to the health needs of the populations served by its graduates. Students from member institutions can receive assistance in arranging international health electives at other member institutions. Information on membership is available from the following address:

Office for International Relations
Pauline Vluggen
Faculty of Medicine
University of Limburg
PO Box 616, 6200 MD Maastrict
The Netherlands
Telephone: 31-43-881522
University Funding Sources

Work-study
Medical schools that use federal or state work-study funds may be able to use excess funds to help finance international electives. The cooperation of the financial aid director is necessary to use the funds for this purpose. The student may be required to work part of the year with the sponsoring department, who must also contribute to the stipend, depending on the school's policies. It may be possible for this contribution to come from another source, such as the alumni association.

Alumni Associations
Alumni boards may allocate funds for a specific international project which includes student participation. For example, the College of Medicine at the University of Nebraska Medical Center petitioned and received from the University of Nebraska College of Medicine Alumni Association a grant of $16,000 to fund an international elective in Belize for three years. Students receive room and board and half of their air fare for the one-month elective.

At Cornell University Medical College, two reunion classes designated their gifts to establish an International Fellowship to honor a well-respected professor. The Dean matched the gift, which is now an endowment, to provide travel funds for students selected by the school's International Committee.

Individual Alumnus/Faculty/Staff Support
Identification of alumni, faculty, and staff with international interests can serve as a basis for promotion and contribution requests for a particular program or cause. These individuals may be rich sources of information regarding overseas contacts, program development, funding ideas, etc. They may also help finance students. For example, a faculty member of New York Medical College personally finances the airfare of two medical students every year so that they may experience an elective in his home country.

Commitment from the Dean
At some schools the Dean's office commits funds for use in supporting international electives.

Student Efforts
A student organization may contribute to fundraising through sales of T-shirts, baked goods, etc.
AMSA’s “A Student’s Guide to International Health” 1993

Can be accessed at:
http://www.amsa.org/AMSA/Libraries/Committee_Docs/studguide2ih.sflb.ashx
Travel Tips from The US Department of State
http://travel.state.gov/travel/tips/tips_1232.html

A Safe Trip Abroad

When you travel abroad, the odds are you will have a safe and incident-free trip. Travelers can, however, become victims of crime and violence, or experience unexpected difficulties. No one is better able to tell you this than the U.S. consular officers who work in more than 250 U.S. embassies and consulates around the globe. Every day of the year, U.S. embassies and consulates receive calls from American citizens in distress.

Happily, most problems can be solved over the phone or with a visit to the Consular Section of the nearest U.S. embassy or consulate. There are other occasions, however, when U.S. consular officers are called upon to help U.S. citizens who are in foreign hospitals or prisons, or to assist the families of U.S. citizens who have passed away overseas.

We have prepared the following travel tips to help you avoid serious difficulties during your time abroad. We wish you a safe and wonderful journey!

Before You Go

What to Take

Safety begins when you pack. To help avoid becoming a target, do not dress in a way that could mark you as an affluent tourist. Expensive-looking jewelry, for instance, can draw the wrong attention.

Always try to travel light. You can move more quickly and will be more likely to have a free hand. You will also be less tired and less likely to set your luggage down, leaving it unattended.

Carry the minimum number of valuables, and plan places to conceal them. Your passport, cash and credit cards are most secure when locked in a hotel safe. When you have to carry them on your person, you may wish to put them each in a different place rather than all in one wallet or pouch. Avoid handbags, fanny packs and outside pockets that are easy targets for thieves. Inside pockets and a sturdy shoulder bag with the strap worn across your chest are somewhat safer. One of the safest places to carry valuables is in a pouch or money belt worn under your clothing.

If you wear glasses, pack an extra pair. Pack them and any medicines you need in your carry-on luggage.

To avoid problems when passing through customs, keep medicines in their original, labeled containers. Bring copies of your prescriptions and the generic names for the drugs. If a medication is unusual or contains narcotics, carry a letter from your doctor attesting to your need to take the drug. If you have
any doubt about the legality of carrying a certain drug into a country, consult the embassy or consulate of that country before you travel.

Bring travelers’ checks and one or two major credit cards and you ATM card instead of cash.

Pack an extra set of passport photos along with a photocopy of your passport’s information page to make replacement of your passport easier in the event it is lost or stolen.

Put your name, address and telephone numbers inside and outside of each piece of luggage. Use covered luggage tags to avoid casual observation of your identity or nationality. If possible, lock your luggage.

What to Leave Behind

Don’t bring anything you would hate to lose. Leave at home:

- Valuable or expensive-looking jewelry
- Irreplaceable family objects
- All unnecessary credit cards
- Your Social Security card, library card, and similar items you may routinely carry in your wallet.

Leave a copy of your itinerary with family or friends at home in case they need to contact you in an emergency.

Make two photocopies of your passport identification page, airline tickets, driver’s license and the credit cards that you plan to bring with you. Leave one photocopy of this data with family or friends at home; pack the other in a place separate from where you carry the originals.

Leave a copy of the serial numbers of your travelers’ checks with a friend or relative at home. Carry your copy with you in a separate place and, as you cash the checks, cross them off the list.

What to Learn About Before You Go

Local Laws and Customs

When you leave the United States, you are subject to the laws of the country you are visiting. Therefore, before you go, learn as much as you can about the local laws and customs of the places you plan to visit. Good resources are your library, your travel agent, and the embassies, consulates or tourist bureaus of the countries you will visit. In addition, keep track of what is being reported in the media about recent developments in those countries.
Things to Arrange Before You Go

Your Itinerary

As much as possible, plan to stay in larger hotels that have more elaborate security. Safety experts recommend booking a room from the second to seventh floors above ground level – high enough to deter easy entry from outside, but low enough for fire equipment to reach.

When there is a choice of airport or airline, ask your travel agent about comparative safety records.

Legal Documents

Have your affairs in order at home. If you leave a current will, insurance documents, and power of attorney with your family or a friend, you can feel secure about traveling and will be prepared for any emergency that may arise while you are away. If you have minor children, consider making guardianship arrangements for them.

Register your travel

It is a good idea to sign up for the Smart Traveler Enrollment Program --think of it as checking in-- so that you may be contacted if need be, whether because of a family emergency in the U.S., or because of a crisis in the area in which you are traveling. It is a free service provided by the State Department, and is easily accomplished online at https://travelregistration.state.gov. (In accordance with the Privacy Act, the Department of State may not release information on your welfare or whereabouts to inquirers without your express written authorization.)

Credit

Make a note of the credit limit on each credit card that you bring, and avoid charging over that limit while traveling. Americans have been arrested for innocently exceeding their credit limit. Ask your credit card company how to report the loss of your card from abroad. 1-800 numbers do not work from abroad, but your company should have a number that you can call while you are overseas.

Insurance

Find out if your personal property insurance covers you for loss or theft abroad. Also, check on whether your health insurance covers you abroad. Medicare and Medicaid do not provide payment for medical care outside the United States. Even if your health insurance will reimburse you for medical care that you pay for abroad, health insurance usually does not pay for medical evacuation from a remote area or from a country where medical facilities are inadequate. Consider purchasing a policy designed for travelers, and covering short-term health and emergency assistance, as well as medical evacuation in the event of an accident or serious illness.
Precautions to Take While Traveling

Safety on the Street

Use the same common sense traveling overseas that you would at home. Be especially cautious in (or avoid) areas where you may be more easily victimized. These include crowded subways, train stations, elevators, tourist sites, market places, festivals and crime-ridden neighborhoods.

- Don't use short cuts, narrow alleys or poorly lit streets.
- Try not to travel alone at night.
- Avoid public demonstrations and other civil disturbances.
- Keep a low profile and avoid loud conversations or arguments.
- Do not discuss travel plans or other personal matters with strangers.
- Avoid scam artists by being wary of strangers who approach you and offer to be your guide or sell you something at bargain prices.
- Beware of pickpockets. They often have an accomplice who will:
  - jostle you,
  - ask you for directions or the time,
  - point to something spilled on your clothing,
  - or distract you by creating a disturbance.
- Beware of groups of vagrant children who could create a distraction to pick your pocket.
- Wear the shoulder strap of your bag across your chest and walk with the bag away from the curb to avoid drive-by purse-snatchers.
- Try to seem purposeful when you move about. Even if you are lost, act as if you know where you are going. Try to ask for directions only from individuals in authority.
- Know how to use a pay telephone and have the proper change or token on hand.
- Learn a few phrases in the local language or have them handy in written form so that you can signal your need for police or medical help.
- Make a note of emergency telephone numbers you may need: police, fire, your hotel, and the nearest U.S. embassy or consulate.
- If you are confronted, don't fight back -- give up your valuables.

Safety in Your Hotel

- Keep your hotel door locked at all times. Meet visitors in the lobby.
- Do not leave money and other valuables in your hotel room while you are out. Use the hotel safe.
- If you are out late at night, let someone know when you expect to return.
- If you are alone, do not get on an elevator if there is a suspicious-looking person inside.
- Read the fire safety instructions in your hotel room. Know how to report a fire, and be sure you know where the nearest fire exits and alternate exits are located. (Count the doors between
your room and the nearest exit; this could be a lifesaver if you have to crawl through a smoke-filled corridor.}

**Safety on Public Transportation**

If a country has a pattern of tourists being targeted by criminals on public transport, that information is mentioned in each country’s [Country Specific Information](#) in the section about crime.

*Taxis*

Only take taxis clearly identified with official markings. Beware of unmarked cabs.

*Trains*

Well-organized, systematic robbery of passengers on trains along popular tourist routes is a problem. It is more common at night and especially on overnight trains.

If you see your way being blocked by a stranger and another person is very close to you from behind, move away. This can happen in the corridor of the train or on the platform or station.

Do not accept food or drink from strangers. Criminals have been known to drug food or drink offered to passengers. Criminals may also spray sleeping gas in train compartments. Where possible, lock your compartment. If it cannot be locked securely, take turns sleeping in shifts with your traveling companions. If that is not possible, stay awake. If you must sleep unprotected, tie down your luggage and secure your valuables to the extent possible.

Do not be afraid to alert authorities if you feel threatened in any way. Extra police are often assigned to ride trains on routes where crime is a serious problem.

*Buses*

The same type of criminal activity found on trains can be found on public buses on popular tourist routes. For example, tourists have been drugged and robbed while sleeping on buses or in bus stations. In some countries, whole busloads of passengers have been held up and robbed by gangs of bandits.

**Safety When You Drive**

When you rent a car, choose a type that is commonly available locally. Where possible, ask that markings that identify it as a rental car be removed. Make certain it is in good repair. If available, choose a car with universal door locks and power windows, features that give the driver better control of access. An air conditioner, when available, is also a safety feature, allowing you to drive with windows closed. Thieves can and do snatch purses through open windows of moving cars.
• Keep car doors locked at all times. Wear seat belts.
• As much as possible, avoid driving at night.
• Don't leave valuables in the car. If you must carry things with you, keep them out of sight locked in the trunk, and then take them with you when you leave the car.
• Don't park your car on the street overnight. If the hotel or municipality does not have a parking garage or other secure area, select a well-lit area.
• Never pick up hitchhikers.
• Don't get out of the car if there are suspicious looking individuals nearby. Drive away.

Patterns of Crime Against Motorists

In many places frequented by tourists, including areas of southern Europe, victimization of motorists has been refined to an art. Where it is a problem, U.S. embassies are aware of it and consular officers try to work with local authorities to warn the public about the dangers. In some locations, these efforts at public awareness have paid off, reducing the frequency of incidents. You may also wish to ask your rental car agency for advice on avoiding robbery while visiting tourist destinations.

Carjackers and thieves operate at gas stations, parking lots, in city traffic and along the highway. Be suspicious of anyone who hails you or tries to get your attention when you are in or near your car.

Criminals use ingenious ploys. They may pose as good Samaritans, offering help for tires that they claim are flat or that they have made flat. Or they may flag down a motorist, ask for assistance, and then steal the rescuer's luggage or car. Usually they work in groups, one person carrying on the pretense while the others rob you.

Other criminals get your attention with abuse, either trying to drive you off the road, or causing an "accident" by rear-ending you.

In some urban areas, thieves don't waste time on ploys, they simply smash car windows at traffic lights, grab your valuables or your car and get away. In cities around the world, "defensive driving" has come to mean more than avoiding auto accidents; it means keeping an eye out for potentially criminal pedestrians, cyclists and scooter riders.

How to Handle Money Safely

• To avoid carrying large amounts of cash, change your travelers’ checks only as you need currency. Countersign travelers’ checks only in front of the person who will cash them.
• Do not flash large amounts of money when paying a bill. Make sure your credit card is returned to you after each transaction.
• Deal only with authorized agents when you exchange money, buy airline tickets or purchase souvenirs. Do not change money on the black market.
If your possessions are lost or stolen, report the loss immediately to the local police. Keep a copy of the police report for insurance claims and as an explanation of what happened.

After reporting missing items to the police, report the loss or theft of:

- Travelers' checks to the nearest agent of the issuing company
- Credit cards to the issuing company
- Airline tickets to the airline or travel agent
- Passport to the nearest U.S. embassy or consulate

**How to Avoid Legal Difficulties**

When you are in a foreign country, you are subject to its laws and are under its jurisdiction. You can be arrested overseas for actions that may be either legal or considered minor infractions in the United States. Familiarize yourself with legal expectations in the countries you will visit. The Country Specific Information pages include information on unusual patterns of arrests in particular countries, as appropriate.

**Drug Violations**

More than one-third of U.S. citizens incarcerated abroad are held on drug charges. Some countries do not distinguish between possession and trafficking, and many have mandatory sentences – even for possession of a small amount of marijuana or cocaine. A number of Americans have been arrested for possessing prescription drugs, particularly tranquilizers and amphetamines, that they purchased legally elsewhere. Other U.S. citizens have been arrested for purchasing prescription drugs abroad in quantities that local authorities suspected were for commercial use. If in doubt about foreign drug laws, ask local authorities or the nearest U.S. embassy or consulate.

**Possession of Firearms**

The places where U.S. citizens most often experience difficulties for illegal possession of firearms are nearby – Mexico, Canada and the Caribbean. Sentences for possession of firearms in Mexico can be up to 30 years. In general, firearms, even those legally registered in the U.S., cannot be brought into a country unless a permit is obtained in advance from the embassy or a consulate of that country and the firearm is registered with foreign authorities on arrival. (NOTE: There are also strict rules about bringing firearms or ammunition into the U.S; check with U.S. Customs before your trip.

**Photography**

In many countries you can be detained for photographing security-related institutions, such as police and military installations, government buildings, border areas and transportation facilities. If you are in doubt, ask permission before taking photographs.
Purchasing Antiques

Americans have been arrested for purchasing souvenirs that were, or looked like, antiques and that local customs authorities believed were national treasures. This is especially true in Turkey, Egypt and Mexico. Familiarize yourself with any local regulations of antiques. In countries with strict control of antiques, document your purchases as reproductions if that is the case, or if they are authentic, secure the necessary export permit (often from the national museum). It is a good idea to inquire about exporting these items before you purchase them.

Health Issues

All travelers should familiarize themselves with conditions at their destination that could affect their health (high altitude or pollution, types of medical facilities, required immunizations, availability of required pharmaceuticals, etc.). While some of this information may be found in the documents listed above, the key resource for health information is the Travelers’ Health page of the Centers for Disease Control (CDC) website at http://www.cdc.gov/travel. The CDC website also provides general guidance on health precautions, such as safe food and water precautions and insect-bite protection. The CDC also maintains an international travelers' hotline at 1-877-FYI-TRIP (1-877-394-8747) or, by fax, at 1-888-CDC-FAXX (1-888-232-3299). See also the resources listed below.

Vaccination, Infectious Diseases, Pandemic Influenza, Foot & Mouth Disease, Chemical/Biological/Nuclear Incidents

General guidance on vaccinations and other health precautions may be found on the Travelers’ Health page of the Centers for Disease Control (CDC) website at http://www.cdc.gov/travel.

Fact Sheets on foot and mouth disease, responding to chemical, biological, radiological or nuclear incidents and other health issues, including pandemic influenza, may be found at http://travel.state.gov/travel/tips/brochures/brochures_1215.html.

For information about pandemic influenza, see http://www.pandemicflu.gov or the website above. Information about infectious diseases abroad may also be found on the website of the World Health Organization at http://www.who.int/en, and further health information for travelers is available at http://www.who.int/ith.

Insurance, Medicare & Medicaid, Medical Evacuation

Obtaining medical treatment and hospital care abroad can be expensive, and medical evacuation to the U.S. can cost more than $50,000. Note that U.S. medical insurance is generally not accepted outside the United States, nor do the Social Security Medicare and Medicaid programs provide coverage for hospital or medical costs outside the United States.
If your insurance policy does not cover you abroad, it is a good idea to consider purchasing a short-term policy that does. There are health insurance policies designed specifically to cover travel. Many travel agents and private companies offer insurance plans that will cover health care expenses incurred overseas including emergency services such as medical evacuations. The names of some of the companies offering short-term health and emergency assistance policies are listed on the Bureau of Consular Affairs website at http://travel.state.gov/travel/tips/brochures/brochures_1215.html.

**Bringing Medications or Filling Prescriptions Abroad**

A traveler going abroad with a preexisting medical problem should carry a letter from the attending physician, describing the medical condition and any prescription medications, including the generic names of prescribed drugs. Any medications being carried overseas should be left in their original containers and be clearly labeled. Travelers should check with the foreign embassy of the country they are visiting to make sure any required medications are not considered to be illegal narcotics. A listing of foreign embassies and consulates in the U.S. is available on the Department of State’s website at http://www.state.gov/s/cpr/rls/dpl/32122.htm. Foreign embassy and consulate contact information can also be found on the Country Specific Information for each country.

If you wear eyeglasses, take an extra pair with you. Pack medicines and extra eyeglasses in your hand luggage so they will be available in case your checked luggage is lost. To be extra secure, pack a backup supply of medicines and an additional pair of eyeglasses in your checked luggage.

If you have allergies, reactions to certain medications, foods, or insect bites, or other unique medical problems, consider wearing a "medical alert" bracelet. You may also wish to carry a letter from your physician explaining required treatment should you become ill.

Information on filling a prescription abroad and other health issues may be found at http://travel.state.gov/travel/tips/brochures/brochures_1215.html.

**Doctors and Hospitals**

If an American citizen becomes seriously ill or injured abroad, a U. S. consular officer can assist in locating medical services and informing family or friends. If necessary, a consular officer can also assist in the transfer of funds from the United States. Note, however, that payment of hospital and all expenses is the responsibility of the traveler. For more information, go to http://travel.state.gov/travel/tips/brochures/brochures_1215.html.

**Special Planning Considerations**

**Student Travelers**

Many college students travel during school breaks. While most students will have a safe and enjoyable adventure, for some the trip will become a nightmare with a serious impact on the rest of their lives.
Students planning travel may want to review
travel to Mexico may want to review the following as well:

Older Americans

Older American travelers should consider the following tips, review this information sheet, read the
section Tips for Traveling Abroad, and discuss the trip with a physician:

- **Local conditions:** Be aware of any effects the local topography or climate may have on you:
  If you are sensitive to altitude or to humidity, or to other attributes of your destination, consult with your physician.

- **Don’t over-program:** The additional physical activity undertaken during travel can be quite strenuous, and sudden changes in diet and climate can have serious health consequences for the unprepared traveler.

- **Pack wisely:** Don’t pack so much that you will end up lugging around heavy suitcases. Dress conservatively—a wardrobe that is flashy may attract the attention of thieves or con artists, while clothing that is very casual may result in being barred from some tourist sites overseas. Include a change of clothing in your carry-on luggage.

Traveling With Disabilities

Individual countries have their own standards of accessibility for disabled travelers. Some countries
have nondiscrimination laws that help to protect travelers with disabilities, while other countries do not. Preparation before you go can help ensure that your planned destination will be accessible, safe and enjoyable. Travelers with disabilities should review the Department of Transportation pamphlets New Horizons for the Air Traveler with a Disability and Plane Talk: Facts for Passengers With Disabilities. Both of these publications are available at the Department of Transportation’s website http://www.dot.gov. In addition, travelers with disabilities should review the information contained Tips for Traveling Abroad, and discuss the trip with a physician:

- **Research in advance:** Learn about planned stops and ask questions about services available. Consider the level of health care available, as well as local transportation needs to and from the airport, luggage assistance, and whether other help will be needed to leave the airport terminal. When making reservations, inform the travel agent or carrier of your disability and the equipment you use, and, if necessary, request a wheelchair be brought to the gate upon arrival and any other assistance needed while flying and at the airport. In all cases, ask that your needs and requests be documented as part of the reservation, and take down the name of the agent. That way, if there is a problem, you may be able to quickly show that you are entitled to the service you requested.
• **Seek medical advice:** Talk to your physician about the activities you have planned and your general physical condition, any immunizations that might be needed, and medications, whether prescription or over the counter, that you might need for your trip. Carry a letter from your attending physician, describing your medical condition and any prescription medications, including the generic names of prescribed drugs.

• **Your medications:** If you take prescription medication, make sure you have enough to last the duration of the trip, including extra medicine in case you are delayed. Pack your medication in your carry-on bag, since checked baggage is occasionally lost. Always carry your prescriptions in their labeled containers, not in a pill pack.

• **Documentation of immunizations:** Take with you proper documentation of immunizations.

• **Health and Evacuation Insurance:** Make sure you have adequate health insurance coverage while abroad, including coverage of medical evacuation (not covered by most domestic policies). Note that U.S. Medicare and Medicaid programs do not provide payment for medical services outside the United States.

• **Service dogs:** Some countries have restrictions on service dogs. If you intend to travel with a service dog, be sure to check on possible restrictions with the embassy or consulate of each country you will visit. This and other country information may be found on each country’s Country Specific Information. If service dogs are permitted, learn about quarantine or vaccination requirements. Find out what documents are needed, including international health certificates and rabies inoculation certificates, and if the documents need to be translated. Talk with your vet about tips for traveling with a dog, and how travel will affect the animal. You may also want to ensure that hotels will accommodate your service dog, and that there will be an adequate area for the dog to relieve itself.

• **Maintenance on equipment:** Have a maintenance check done on any equipment you will take with you, to ensure that everything is in working order before you leave. You may want to research the availability of wheelchair and medical equipment providers in the areas you plan to visit.

• **Carry written plans:** Carry with you your written itinerary and directions of where you wish to go. These can be shown to people who might be able to help you if you are lost. Another useful tool is a point-and-conversation guide.

For Additional Traveler’s Health Tips please see the CDC website

**Passports and Visas**

Please make sure your passport is up to date. Some countries will not allow you entry if your passport is set to expire in the six months from the date of entry.

It is the responsibility of the student to determine if they need a Visa to enter the country in which they wish to do an International experience.

[www.perryvisa.com](http://www.perryvisa.com) is a great resource for country specific Visa regulations.

For China Visas, we recommend [http://uschinavisa.com](http://uschinavisa.com)

The United States participates in the Visa Waiver Program which enables nationals of 36 participating countries to travel for tourism or business for stays of 90 days or less without obtaining a Visa.

As of August 21, 2012, 36 countries participate in the Visa Waiver Program, as shown below:

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