COMMUNITY ENGAGEMENT THROUGH MEDICAL MISSIONS

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"Maybe the greatest tragedy is that millions needlessly suffer and even die from illnesses that can be so easily avoided." Hand of Hope

MEDICAL MISSIONS INTERRUPTED: A GLOBAL HEALTH CRISIS

The idea for this article was planted in a conversation between the lead author and one of the co-authors in mid-2019, well before the outbreak of the coronavirus pandemic around the world. We began work on this article late in 2019; in hindsight, life then was much simpler given that COVID-19 has already changed the world in many ways. As a result, this article examines community engagement through medical missions in the world as it existed prior to the onslaught of COVID-19. The setting for this look into community engagement through medical missions is the country of Honduras.

Honduras is one of the poorest countries in Latin America, with more than 48% of the population living in poverty (WorldBank, 2020). The coronavirus pandemic and the resulting societal and economic disruption is a complicating factor wrapped around the many other problems that Hondurans have to deal with on a daily basis, including widespread violence, crime, poverty, rampant corruption, high un- and under-employment, age and gender discrimination, lack of clean water, food insecurity, land title issues, brain drain, poor health care, lack of education, drug trafficking, and climate change (Seeley et al., 2019; Thorpe, 2019).

The government of Honduras imposed significant restrictions to combat the spread of COVID-19. With the first two confirmed cases of COVID-19 announced on March 11, 2020, the government of Honduras implemented enhanced screening and quarantine measures to reduce the spread of COVID-19. All schools in the country have been closed since March 13. All borders (air, land, and sea) were closed as of March 15. Only evacuation flights have been allowed to leave the country, with empty planes allowed to land to evacuate U.S. citizens. Citizens have only been allowed to leave their homes to buy groceries, medicine, or gasoline, or to bank, one day every two weeks, depending on the last digit of their national ID number. Areas of the country with more cases of COVID-19 face even greater restrictions. The underlying reason for these severe measures is that the public health system has limited capacity for handling severe/critical cases of COVID-19. As of the publication time for this article, the national curfew has been extended until October 18, 2020; much of the country of Honduras is still in Phase 1 of a multi-phase reopening plan.

These restrictions have further complicated the ability of many Hondurans to receive medical care and needed medications. Medical teams have not been able to travel into Honduras since the middle of March when all borders were closed. Medical teams on the ground in Honduras at the time of the closures have been evacuated. The last medical team working with Clínica Carolina in Limón, a clinic operated by Carolina Honduras Health Foundation, departed Honduras on March 7, and the clinic is closed. All teams since then have been cancelled. The date for resuming medical mission team visits had not yet been determined at the time of writing this article. In April, the Honduran Health Department sent a doctor to the government clinic in Limón to provide medical care to the extent possible. As a result of these actions, the residents in Limón and the surrounding rural communities currently have limited access to health care. Those residents rely on public transportation to travel to

hospitals or clinics but that has been shut down since March 15.

On March 28, a container of medicines and other needed items for Clínica Carolina was shipped from the United States to Honduras. That container is now in La Ceiba, on the Caribbean coast of Honduras, waiting for the travel ban to be lifted so that the Honduran director of Clínica Carolina and a Honduran doctor can travel to the remote area of Limón and dispense these medicines to the people. The primary goal of the shipment was to send maintenance medications for hypertension and diabetes. Patients at Clínica Carolina rely on teams to supply these medicines, and at this point many have been without medications for months. Carolina Honduras Health Foundation has a plan in place for providing these medications, but they must now rely on the government and the locality to open travel restrictions so that the medications can be delivered.

A major health crisis such as the coronavirus pandemic, highlights the extreme importance of medical missions as a component of the health care system in developing countries. Residents of developing countries, especially those living in rural areas, have very few options for medical care (Hawkins, 2013; Montgomery, 2007; Roberts, 2006). Hawkins (2013) clearly states the importance of medical missions to the residents of developing countries, noting, "Short-term medical volunteers provide scarce health resources and services to developing countries" (p. E1). Decamp (2011) views short-term medical volunteerism as a component in the process of bringing "greater global health equity and mutual caring" (p. 102) to areas lacking a health care infrastructure. From the literature and from our personal experience, the importance of community engagement through medical missions is recognized as incredibly important to residents of under-developed regions of the world.

This article examines community engagement through medical missions based on the experience and approach of two non-governmental organizations (NGOs) serving the people of Honduras, Carolina Honduras Health Foundation (CHHF) and Foundation Casa de Luz (CDL). These organizations serve in different parts of the country; CHHF serves in the north, and CDL serves the residents of two cities in central and southern Honduras. The purpose for the community engagement described in this portfolio is to fill the gap in the health care system for the people who live in these areas of Honduras.

PURPOSE

Bajkiewicz (2009) briefly described three types of short-term medical missions as follows: (1) teams that bring relief care to areas struck by complex humanitarian emergencies, (2) surgical-dental teams that deliver medical services to regions where such services would otherwise not be available, and (3) mobile clinics in which physicians and nurses, along with other volunteers, travel to an under-developed country to provide services, often in multiple locations within a region. In the case of mobile clinics, "Treatment is based on physical exam data, limited laboratory availability, and empirical treatment with pharmaceuticals brought by the team" (p. 111).

This community engagement profile is focused on the second and third types of short-term medical missions, surgical-dental teams, and mobile clinics. These types of medical missions seek to address the stark reality that in under-developed countries "young children and families living in abject poverty have no access to quality medical and dental care" (CDL).

The setting for this community engagement portfolio is the country of Honduras, located in Central America. In a review of the medical missions literature, researchers (Martiniuk, Manouchehrian, Negin, & Zwi, 2012) reported that Honduras was the top destination country for medical missions trips, while the Unites States and Canada were the top sending countries. Honduras is bordered by the Caribbean Sea, Nicaragua, El Salvador, and Guatemala. Figure 1 is a map of Honduras in its geographical setting in Central America. The community settings for the medical missions covered in this community engagement portfolio are located in the Department of Colon (on the Caribbean Sea), in Zambrano, which is about a 45-minute drive from the city of Comayagua (shown on the map), and in the capital city of Tegucigalpa (shown on the map).

The co-authors of this community engagement portfolio represent Carolina Honduras Health Foundation and Foundation Casa de Luz, both of which are non-governmental organizations. Medical teams working through CHHF serve

Figure 1. Map of Honduras in Central America.

Hondurans living in the Department of Colon, while medical teams working through CDL serve children, teens, and adults participating in CDL programs in Zambrano and Tegucigalpa.

The idea for this community engagement portfolio was spawned in a conversation between the lead author and one of the co-authors. The discussion centered on the co-author's passion for medical missions, which led her to pursue a certificate as a medical translator. She serves as a volunteer translator with medical teams that come to Honduras under the auspices of CHHF.

Author Background – Lead Author

I hold a PhD in Leadership, a professional certification in Change Management Leadership, and a master's level seminary degree. I have more than 20 years of experience leading change initiatives in major corporations. I am currently a volunteer instructor, teaching leadership related classes at The Leadership Center in rural Honduras. One of my former students is the co-author who gave me the idea for this community engagement portfolio. Another co-author is the Team Coordinator for all medical teams that volunteer with Carolina Honduras Health Foundation. The fourth co-author is the President of Foundation Casa de Luz.

I am not directly involved in medical missions. However, I am indirectly involved in that I have taught numerous young Honduran women at The Leadership Center who serve as translators with medical mission teams when those teams travel to Honduras. One of those young women sowed the seeds for this article in a conversation I had with her about her experience serving as a volunteer translator/interpreter for Carolina Honduras Health Foundation. I have asked her to share her story, which includes fairly typical experiences of the young women that attend The Leadership Center.

Author Background – Volunteer Translator with Carolina Honduras Health Foundation and Graduate of The Leadership Center

I grew up in Francia, Limón, Colón, Honduras. My father is a farmer, and my mother has a small grocery store at home. I have two brothers and two sisters. In my early childhood I learned how to make tortillas by hand, cook beans and eggs, kill chickens, and make bread and tamales. My mother taught me how to do my laundry. She used

to tell me that she was teaching me how to become independent, and I would tell her how tough the job of a mother was. She always encouraged me to study and use my brain. My childhood was like anyone else in the community. I enjoyed playing hide-and-seek, marbles with my brother´s friends, and jacks with my girlfriends. Despite all of this, I consider mine the best childhood because I was not distracted by technology; for me it was pure innocence of curiosity.

Parents living in rural areas are advised to not allow their daughters to go the cities and study. The fear is that they will just get pregnant. The common wisdom is that investing in education for girls is a waste of money. However, I wanted to continue my education after high school. I moved to the city of San Pedro Sula, found a job, and began my studies at the public university. Unfortunately, that job did not work out. My family did not have the resources to help me, and without a job, I could not continue living in the city. Fortunately, it was at this time that the opportunity to continue my studies at The Leadership Center came along. I did not have many other opportunities to continue studying.

Since I enjoy doing business and like working in groups, I decided to accept the opportunity to continue my education at The Leadership Center. When I found out about the opportunity to attend The Leadership Center my thought was, "What a great blessing from God!" Thanks to The Leadership Center, I have developed my skills as a leader and as a broker for goods in an online environment. I saw this as an opportunity for me, a young woman from a rural area, to achieve her dreams.

After I graduated from The Leadership Center, I was invited to join a medical mission team where I served as a dental assistant. After that experience, I moved to La Ceiba, Atlántida, where I found employment at Levanter, a company dedicated to training bilinguals. There I had to pass a test to obtain a role as an interpreter. Being an interpreter involves breaking language barriers to help people you do not know to communicate and to accomplish their tasks and daily activities. My certificate as a medical translator gives evidence of my expertise in the medical interpretation field.

Serving through medical missions is more than an interest for me; it is one of my long-term goals. As a child, my mother used to take me to Clínica Carolina. She used to say, "Let´s go to get you vitamins and medication for worms. I see you are listless and have a big belly." I saw the North Americans and interpreters when I went to the clinic, and I said, "One day I want to help here." However, I did not know English. I determined that one day I would learn English, and I would serve as a translator for Clínica Carolina. I believe God heard me. I now serve as a medical translator once or twice a year with teams visiting Clínica Carolina. My schedule for serving is driven by vacation from my work and university studies.

I do not make a big difference in medical missions because I am not a doctor. I am a medical interpreter and that fills my heart with passion. I believe I make the difference by serving, and I put my knowledge in practice. As a result, my parents have told me that I am a role model for other girls and young women in my community.

Serving on a mission team is a relaxing time for me. I serve in my community, and it reminds me to be humble and to appreciate that moment of serving as an opportunity. Working as a medical interpreter at the clinic is priceless. In the morning I look through the window and see the long line of patients waiting for the clinic to open. I have used my translation skills to serve in different roles at the clinic, including dental assistant, triaging patients, and helping in the OBGYN department. Limón, where the clinic is located, is 30 minutes away from my house; however, I usually stay at the clinic. In the mornings at the clinic I sit by the balcony looking at the ocean, drinking coffee, and eating my breakfast. My workday starts by saying

Figure 2. Yudy serving as a dental assistant at a CHHF medical mission clinic.

"good morning" either in Spanish or Garifuna (a local language) and then getting the first patient chart. The doctor introduces him/her self, and then the patient starts the conversation. Usually the mothers take all their children for a regular checkup. I do this job because I know what it feels like to live in a rural area and to be sick. I know what it feels like to beg for medications in the public health centers and hospitals. I went through the same thing many times when having dengue, diarrhea, and abdominal pain, and then walking away with empty hands, going back home trying to find whatever natural supplements the neighbor or my mother´s friend would recommend.

I have visited various communities with medical mission teams, including Icoteas, Limón, and Francia. Community members have told me that the medical teams are the only hope in the area when it comes to medical care, medicine and supplies, and health education. The government does not invest in the rural areas because rural people do not tend to put pressure on the government to provide such care.

Every day I learn not only in class but also in real life. In class, as a student studying business in the university, everything is a protocol. In a classroom I learn how to make financial reports, how to evaluate projects, and how I have to use my knowledge. However, university instructors rarely teach students to seek their goals or to really see what is going on in the community. Instructors rarely encourage us to challenge ourselves, to serve the poor, or to be a change agent. Serving on a mission team brings a different perspective into my life.

I have many aspirations for my life. I often think about starting a business incubator, a place where I can teach other people about business, analyze their businesses plans, and advise them about new methods for selling products. I also dream of operating a consulting business for completing and filing taxes. I have a deep desire to support and encourage women. I do not want to empower women by telling them what to do at their homes or how they should treat their husbands, but by showing them that beyond our noses there is hope and there are opportunities. I want to encourage them to be mindful and persevere in the face of difficulty and challenges. I want to introduce new ideas to the women in the community in which I reside. I want women to see that having children at a young age and becoming single mothers requires more energy than reading a book or doing homework or hand crafts. In my crazy thoughts I feel like I have a passion to become a doctor. There is not a doctor in my family or my community. I also want to operate a store that sells lingerie and shirts with printed quotes, such as "I can do it," "Nothing will stop me," "I love to be a woman," "I am not afraid of this world," or "Born to challenge." When I am older, I want to say that I found the purpose for which I was born. At this point in my life I have a lot of things in my mind, but I am still looking for my purpose. I want to be myself and not to conform to the expectations that others put on me.

Author Background – Team Coordinator with Carolina Honduras Health Foundation

As team coordinator for all medical teams volunteering with the Carolina Honduras Health Foundation, I schedule all teams and provide assistance to each team leader. Clínica Carolina serves the impoverished in the remote areas of the District of Colon, Honduras. Medical care and medications are provided at no cost.

In 2006, my husband and I were asked to serve with a team led by the founder, Dr. Henry Gibson. Neither my husband nor I are medically trained. My husband's role on the mission team was to provide an engineer's evaluation of the repair and construction needs at the main clinic in Limón. My role was to serve as assistant in the pharmacy and other general duties. The mission was life-altering. We have now volunteered at the clinic more than 20 times and have led many teams in service to the people of the region.

Author Background – President of Foundation Casa de Luz

My husband and I have worked in cross-cultural ministry within the Central American nation of Honduras for nineteen years. We have served with Casa de Luz for the past 12 years (since June 2008) and have hosted medical/dental brigades during 10 of those 12 years. I serve as the president of Foundation Casa de Luz, a not-for-profit organization dedicated to sharing the love of Christ through poverty alleviation efforts, feeding centers, community development, and educational opportunities. Through the ministry of CDL, my husband and I lead a multi-cultural staff serving at-risk children and vulnerable people groups.

Prior to serving with CDL, we served seven years in another ministry, which had two main focuses: children's ministry and medical ministry. In that seven-year period, our main service was in children's ministry, but our duties often spilled over or blended into the medical brigade portion. During that seven-year period of leadership, we interacted on some level with dozens of medical brigades. I was trained as an Emergency Medical Technician (EMT-B) prior to arriving in Central America and have participated in and directed dozens of community medical brigades. When working with medical brigades, as well as in all aspects of serving, I passionately advocate for the dignified treatment of individuals living in poverty situations.

What I do know and believe is that to love well and to build authentic relationship takes a great deal of time, emotional energy, and it requires a costly investment in the lives of others. I love people and build relationship with them, which can include meeting practical/physical needs, because I am biblically mandated to do so. I am compelled by God to love others, to meet the needs of the poor, widows, and orphans. Both the Old and New Testaments are full of examples of this commandment. It is my honor and my heavenly mandate to love authentically and ease the suffering of others. This is the heart of God. If I have the privilege to speak the Gospel as well, then God be glorified in that also! I will not shrink back from that. If I do not get the privilege to speak the Gospel, I have still honored God and His heart because I have been obedient. People are people, not my projects. I love because I was first loved, and now as a Daughter of the King of Love, I am compelled by Him to love the least of these and ease suffering.

Carolina Honduras Healthcare Foundation and Foundation Casa de Luz have very different organizational missions and follow a slightly different process for short-term medical missions. However, the core principle underlying each process is to uphold the human dignity of the people being served.

PROCESS

Health care in Honduras is a challenge for those with limited resources and those living in the rural areas. The stark reality in Honduras is that young children and families living in abject poverty have no access to quality medical and dental care. The goal of medical missions conducted under the auspices of both CHHF and CDL is to change that reality for the people living in the areas in which they serve.

Carolina Honduras Health Foundation

As the second poorest country in the Americas, Honduras has limited medical care throughout the country; vast areas have little access to general medical care and no access to specialized services. With a population in excess of 8 million, 64% live in poverty (income of $2 per day per person) and 36% in extreme poverty. In the areas served by CHHF, the percentage living in extreme poverty is even higher. CHHF provides an essential link between these patients and those who are providing health care in Honduras.

Figure 3. Doctor examining a patient at a CHHF sponsored clinic

The mission of Carolina Honduras Health Foundation is to provide free medical, dental, and ophthalmic services, as well as medications to the poor and needy in the Department of Colon, Honduras. Underlying this mission is the foundational principle to work with selected people in the community, side by side, teaching and training them to advance their standards of health care. In addition to health-related services, CHHF offers educational scholarships to help a limited number of children complete high school and vocational or university education.

The area served by CHHF clinics stretches along the Caribbean Mosquito Coast and inland to nearby mountains. This includes the village of Limón, 23 hamlets, and a rural area encompassing 633.4 square kilometers. The clinic in Limón was constructed in 1997 and provides living accommodations for

volunteer medical and dental teams. In 2000, a satellite clinic was opened in Icoteas so that people would not have to travel the long distance to the Limón clinic. In 2014, CHHF began operating a third clinic in Chapagua, serving an additional 16 villages near the city of Trujillo. This clinic serves an area with a population of about 6,000. Prior to opening this third clinic facility, the residents of these villages had no health care available.

Because three permanent clinic facilities are not enough, short-term medical mission teams travel to remote villages and set up clinics in churches or schools in order to reach more people.

As can be seen in the Figures 4-7, medical mission teams provide care in clinics owned by Carolina Honduras Health Foundation, in schools, under the trees — wherever the patients need us. A typical team will work two days in Limón in the clinic there (where they also live) and three days in remote areas.

Figure 4.

Figure 5.

Figure 6.

Figure 7.

Volunteers for medical mission teams are recruited through the CHHF website (www.CHHF.org). We also send publicity through churches and religious groups. The best recruitment is word of mouth from volunteers who have been on previous teams and are amazed at the need and the response of the people who come to the clinic for medical care. Volunteers to the clinics pay their own expenses and also donate to provide the medications and medical supplies required for the team to fulfill its mission. Each year there are 18 or 19 teams scheduled for service at CHHF clinics. The number varies depending on the calendar and the rainy season when roads are impassable. We serve the communities of Limón, Icoteas, Chapagua, Punta Piedra, Planes, Plan de Flores, Francia, Feo, and Piedra Blanca, all within the Department of Colon.

As many as half of CHHF's team members are repeat volunteers. They return because they have established relationships with the people in the communities. They know many patients by name and understand their health issues. Most volunteer teams have at least one medical provider who is familiar with tropical diseases, and usually there is one who is fluent in Spanish. After returning to the same villages for more than 20 years, volunteers have come to understand the people, the culture, and the health conditions prevalent in the area.

Communities are served based on need and whether the yellow bus that transports teams can maneuver the roads to the area. People in need of medical care will walk for hours to reach one of the villages when a medical team is present. CHHF has Honduran personnel and local partners throughout the region. To promote the coming/presence of medical mission teams in a community, a local supervisor and a community development coordinator "get the word out." They spread the word on the radio, in churches, in schools, and throughout the communities.

In addition to medical care, CHHF's Community Development Coordinator works with the leadership in the villages to provide health education, to lessen the environmental impact of burning trash and cooking on wood-fired stoves, and to provide a variety of classes. She conducts classes in the local schools regarding parasites, healthy diets, and dental hygiene. In cooperation with the local government clinic medical staff, she holds classes for diabetics and hypertensive

Figure 8. Members of a medical team serve the residents in a remote village

patients in addition to classes for pregnant women and new mothers. There has also been a cooperative recycling project in which high school students collect recyclable materials and send them to a processing plant. This prevents these materials, especially plastics, from being burned in local trash piles, which is the custom in these Honduran villages, and which exacerbates respiratory issues in the population.

Foundation Casa de Luz

The mission of Foundation Casa de Luz is to provide quality childcare and academic enrichment to at-risk children while meeting practical, emotional, and spiritual needs of each child, their families, and their communities. The mission of CDL is focused on three primary areas of ministry, delivered on two ministry campuses (Tegucigalpa and Zambrano): children, medical and dental, and school for parents.

Ministry to at-risk children is the primary focus of CDL. The inner-city site located in Tegucigalpa provides quality childcare for working families living well below the poverty line. The children receive an excellent education opportunity in our program. Our rural program, located in Zambrano, is designed to supplement the public-school education the community children receive. Many public-school classrooms in Honduras lack basic resources, such as books, paper, and art supplies. Most homes in the rural town of Zambrano do not have the financial means to purchase school supplies. CDL provides a tutoring program for over 110 underprivileged children and teens in Zambrano. Our students are able to have exposure to age-appropriate activities through the CDL educational programming. We teach our young students to write, color, paint, and use various art mediums to express their creativity. The students at the Zambrano campus also receive academic enrichment in the areas of mathematics, reading, science, and English.

Figure 9. Lead author visiting the Zambrano campus along with two of his students and another instructor from The Leadership Center

Through the medical and dental ministry, we make the health and wellness of our children and families a priority by partnering with Honduran and North American dentists, dental hygienists, orthodontists, optometrists, doctors, and nurses to bring high quality care to impoverished Honduran communities. Our partnership with these professionals improves the quality of life for hundreds of children, teens, and adults participating in Casa de Luz programs. Casa de Luz children, families, and communities benefit from the following:

- Well-child check-ups
- Medical treatment for the ill
- Access to quality medications
- Access to accurate dental and medical information to replace dangerous superstitions, which put children, pregnant moms, and the

elderly at risk
- Wellness coaching and education in the areas of nutrition, diabetes, hypertension, parasites, and lice
- Teeth cleanings
- Dental work such as fillings and crowns
- Eye exams and appropriate eye-wear

A major facet of fulfilling our mission of transforming the lives of children and illuminating the path for Honduran families is to provide counsel and training for the parents of our children. Many times families can end up in crisis due to a lack of adequate parenting skills, a lack of knowledge about normal childhood development, a weak understanding of how to implement positive discipline, or because the parent does not possess a healthy foundation to facilitate open communication. Foundation Casa de Luz employs a Christian Psychologist to bring quality training to parents and specialized counseling services to our children and their families. An average of six times per year, our Psychologist and staff coordinate and execute workshops covering topics such as positive discipline, family finances, domestic violence prevention, health and nutrition, childhood development, emotional and spiritual health in a family, sexual abuse awareness, and much more. These dynamic workshops are titled "School for Parents," because the parents learn important life skills and information, which allows them to bring healthy change to their homes.

Figure 10. Dentist at Casa de Luz

Hosting short-term mission teams, including medical mission teams, compliments and supports the primary ministry of CDL. We have titled our short-term mission experiences PERSPECTIVE trips because we pray team members will gain a fresh perspective about authentic relationships, Honduras, foreign missions, a life lived with an eternal focus, and about what it means to serve in an intimate setting with a family doing ministry abroad. The core principles around which we design short-term mission trip experiences include authentic relationship building, loving well, and obedience to the call of God. Our life-principles of dignity, protection of the vulnerable, esteem for the person, partnership, and authentic relationship are the foundation upon which we design our short-term mission team experiences. Since hosting is only one aspect of our ministry duties, we do not usually host more than six PERSPECTIVE brigades in a year; typically, one or two of these are medical in nature.

Figure 11. Honduran professionals being trained for a CDL medical mission

The goal of our PERSPECTIVE team trips is to design and execute a short-term mission trip, which is built upon the premise that eternal impact is best experienced within authentic relationship and through repeat interactions. Success will be dependent upon obedience to the call to love well and live in transparency. It is our great delight to demonstrate the love of Christ toward mission team participants and live out our faith in authenticity before a watching world, even in our weaknesses or failures. We strive within the power of Christ to build relationships with our Honduran neighbors and invite our team participants to enter into that relationship in ways which edify, encourage, esteem, and empower all involved.

The challenge for me upon reading about a World Bank study entitled Voices of the Poor: Can Anyone Hear Us? (Narayan, 2000), was to craft short-term mission team experiences that do not add to the burden of the poor in any way, psychologically, socially, or spiritually. Instead, we seek to design team experiences in which all participants, those serving and those served, are truly esteemed, respected, and recognized for the gifts God has instilled inside each one.

In his book Toxic Charity, author Robert Lupton (2011) encourages readers to ask this question,

"Is there a way to bring more human dignity to the process of exchange rather than simply using one-way giving?" Lupton goes on to say, "To effectively impact a life, a relationship must be forged, trust built, accountability established. And this does not happen in long, impersonal lines of strangers. A name and a story have to be joined to each individual face. Highly personal life struggles must be explored, and with each person a unique action plan created." I believe this to be true for both my Honduran neighbors and our PERSPECTIVE team participants.

Having my own eyes opened to the connection between poverty, authentic relationship, dignity, and loving well, God challenged my mindset in regard to our Medical Brigade Ministry. Rather than have precious human beings who are suffering with an illness or injury stand in the hot, tropical sun and wait for hours on end, we made a decision that we would only do medical brigades that would allow for us to make appointments ahead of time for each patient family group. In this manner, each family has an appointed time to arrive and is given the assurance that their dignity will remain treasured as the family is treated as individuals in need of personalized care, and whose time is just as important and valuable as a wealthy person's time.

If a client misses his or her appointment, we allow a 15-minute grace period. If the person does not present within 15 minutes of the scheduled time, he or she is welcome to wait until the end of that day to see if we can squeeze him or her in before our departure from the ministry site. If we cannot, he or she can ask to see if any open appointment slots exist for any other days we would be serving in that community. For example, if a medical ministry team serves the same community on three separate days, then the third day (or part of the third day) could be reserved for make-up appointments or for those who did not have an opportunity to make an appointment prior to the beginning of the brigade. In a worst-case scenario, the patient comes each day and waits to see if any other patient is a no-show and takes that person's appointment slot. But, in each of the alternative situations, the responsibility of the consequence of not showing up for his or her original appointment rests on his or her shoulders, not ours, as we tried to provide a dignified process of appointment-based care but the patient did not comply with the time constraint.

After 20 years of living among, interacting with, investing in, and building relationship with precious Honduran children, men, and women I could no longer reconcile in my heart the idea of creating a team experience in which the poor are made to stand and wait for long hours in rainstorms or beating sun, with jostling and many times anger within the desperate crowd.

Figure 12. Doctor and patient at Casa de Luz

A Honduran woman named L. E. shared some of her "Team" experiences with me one day. She commented that before experiencing one of our appointment-based medical mission teams, she never knew quality medical care to the poor could be so enjoyable and personally honoring. Other team experiences had left her feeling pushed, void of the ability to ask questions or make comments, and she used the word "dog." She explained, "I felt like a sick dog, shoved and pushed from one area to another." But she said she really needed the medicines, so she tolerated the humiliating treatment with the hope that she could be healthy.

If I suggest that a poor Honduran can receive free medical care and free medicines and connect it to the suggestion (or even requirement) that the patient hears the Gospel, I am not sure I am loving that person in the best manner possible. I am personally still in process of wrestling through this point. I don't have it all figured out. I am asking myself several questions, including, "Where is the dignity in this? Am I cheapening the Gospel by 'selling' it along with a product a poor person desperately needs?" Perhaps the better process is to build relationship in a community, offer care for the body, then, out of the context of that established relationship, share the Gospel through words, quality time, and genuine care for the person.

CDL doesn't have a ministry medical fund, so either we fundraise for a specific brigade, or if

we are serving with North American medical care providers, they take the responsibility to bring the medications and supplies needed for the brigade or send us the finances to purchase items locally. Usually, for our situations, it has been a combination of both purchasing locally and the team members bringing supplies. We have worked with both local medical care providers and North American providers. We have never done recruiting. The local and foreign providers have always contacted us. It is important to note that Honduran law requires at least one Honduran licensed physician be on-site to give covering to the foreign care providers.

Finally, repeat participation of team members is highly encouraged. Deep relationships and connections are often created over a period of time. CDL encourages team participants to return with consistency in order to continue sharing in one another's lives.

The literature covering short-term medical missions raises concerns and makes recommendations about the operation of medical missions. The processes followed by both CHHF and CDL are consistent with the best recommendations for how teams should be conducted.

Lessons from the Literature

The discussion of medical missions in this paper is offered as an example of community engagement. This engagement takes place in communities in various parts of Honduras. According to the Center for Economic and Community Development at The Pennsylvania State University, "In its simplest terms community engagement seeks to better engage the community to achieve long-term and sustainable outcomes, processes, relationships, discourse, decision-making, or implementation" (PennState, 2020). Paltzer (2019) points out that community engagement "offers an approach to foster trust between a community and an outside organization as well as with other community members" (p. 32). He further asserts that, "Community engagement is essential in global health mission organizations in order to effectively integrate physical and spiritual health" (p. 30). The preceding discussion about process highlights the many ways that CHHF and CDL are dedicated to community engagement in their interactions with the communities they serve.

The literature raises a number of concerns about the way that short-term medical missions in general are planned and conducted.

Concerns. Over the past several decades, short-term medical missions have become "a well-established means of providing health care to the developing world" (Maki, Qualls, White, Kleefield, & Crone, 2008, p. 1). Millions of dollars and thousands of volunteer hours are invested every year through short-term medical missions. In spite of this significant investment, the literature covering short-term medical missions is relatively limited (Maki et al., 2008; Martiniuk et al., 2012). Sykes (2014) raises a concern about "the lack of critically reviewed evidence of activities and outcomes" (p. e38). He goes on to state that, "Relatively little attention is given in the medical and public health literature to the impact of these interventions on the population being served" (p. e38). The community and individual health benefits are not clearly articulated in the available literature.

In spite of the important role that short-term medical missions play in providing much needed health care in many communities, the literature that is available raises numerous concerns about the role of short-term medical missions and how they are typically conducted. One concern raised in the literature is that short-term medical missions are not integrated into the broader plans and programs for community health care and development (Melby et al., 2016). This can inadvertently lead to a shift in dependence on the visit of a short-term medical team and away from local governmental or non-governmental entities. The importance of local health care professionals and health promoters is diminished in favor of the "free" care and medications provided by the visiting medical missions team (Roberts, 2006).

Another major area of concern when the visit of short-term medical teams is not integrated into the existing local health care system, or at least with the operations of a local non-governmental organization, is that the medical care provided by foreign doctors may not be adequate or appropriate because the visiting medical team may be "unfamiliar with local health needs, local culture and the strengths and limitations of the health care system in which they must leave their patients for follow-up care" (Martiniuk et al., 2012). Montgomery (2007) echoes this concern when she asserts that, "Volunteers who will spend little

time in a community have little incentive to learn about the local culture, the people, and the health conditions to a depth necessary to provide effective health care" (p. 97). Roberts (2006) adds her voice to this concern, asserting that, "Public health and preventive measures are not part of the overarching goals for the transient clinics" (p. 1491), which may put community members at risk of receiving inappropriate care from the medical mission team.

Picking up this issue raised by Roberts (2006) and other researchers, a final area of concern raised in the literature is that short-term medical mission teams typically respond to the immediate medical needs presented to them by patients they see rather that addressing the underlying health needs of the community as a whole and investing in capacity development within the local health care system (Martiniuk et al., 2012; Sykes, 2014). On-going, structural issues, such as the lack of basic necessities including clean water, immunizations, insecticide treated bed nets to reduce the spread of malaria, health education, improved sanitation, improved nutrition, and the prevention of mother-to-child HIV, are typically not addressed by short-term medical mission teams. Yet addressing these fundamental issues is "more likely to reduce the burden of disease in a community" (Martiniuk et al., 2012, p. 6). As a result, "Missions are left treating illnesses rather than preventing them" (Martiniuk et al., 2012, p. 6). In his research on the value of a wide array of social programs, Wydick (2019) found that relatively simple and inexpensive heath interventions, such as clean water projects, deworming treatments, and insecticide-treated bed nets, are extremely effective and have a "big impact on human flourishing relative to their cost" (p. 104).

Core Principles. These concerns can be mitigated by following core principles highlighted in the literature when planning and executing the clinics held by visiting medical mission teams. An absolute focus on honoring the human dignity (Paltzer, 2019; Wydick, 2019) of those being served and a concern for "improving long-term health and well-being" (Paltzer, 2019, p. 31), serve as the foundation upon which the core principles of medical missions rest. The concept of human dignity is based on the belief that human beings have inherent dignity and value as creatures made in the image of God. Recognition and acceptance of human dignity "reflects a deep, penetrating insight into the value of every human being" (Wydick, 2019, p. 94).

A framework of core principles emerges from the review of the literature on short-term medical missions. These principles are discussed by multiple authors in a variety of medical-related journals. This framework consists of the following principles to guide the planning and execution of short-term medical missions:

- Mission
- Collaborative partnership
- Local capacity building
- Service of community health needs
- Evaluation

Mission. Each short-term medical mission team should develop a mission statement in collaboration with their local partner from the community to be served. The mission statement should articulate a clear sense of purpose for the mission and a set of common goals to guide the mission (DeCamp, 2011; Hawkins, 2013). The mission statement should be focused on conducting the work of the short-term medical team with an underlying intent to address the public health needs of the community (DeCamp, 2011; Suchdev et al., 2007). The mission statement also serves as an accountability guide (DeCamp, 2011) for the team during the conduct of the mission and as input to the evaluation of the team at the end of the mission.

Collaborative Partnership. A successful short-term medical mission is more likely when the mission statement is developed collaboratively with the local partner, and when all aspects of the mission are executed in collaboration with the partner. The local partner could be a non-governmental organization, a local government entity, or some other local organization (Suchdev et al., 2007). It is important that this be a "partnership of equals" (DeCamp, 2011, p. 97), which "seeks to empower the local community and reduce, if not eliminate, the sense that they are mere recipients of aid" (p. 97). These collaborative partnerships should be "bidirectional participatory relationships" (Melby et al., 2016, p. 3), which minimize the "economic and power differentials" (Melby et al., 2016, p. 3) between the short-term medical team and the host communities, and which mitigate the risk of creating a long-term dependency on the medical mission teams.

Local Capacity Building. Short-term medical mission teams should incorporate activities and funds to develop and/or strengthen primary health care systems in the communities they serve and to empower locals in their pursuit of health care (Melby et al., 2016, p. 4; Montgomery, 2007). Hawkins (2013) asserts that, "An overarching principle to follow in (short-term medical missions) is to build local capacity by working with local providers to support what they are doing" (p. E5). Decamp (2011) points out that building local capacity in the health care system involves more than simply constructing a clinic building or training health care workers but also incorporates activities to empower the voice of the local community in the pursuit of greater global health equity. Local capacity building is most effectively accomplished in the context of a collaborative partnership and is built on an understanding of health care needs and strengths in the local community (Hawkins, 2013; Melby et al., 2016). A collaborative partnership functioning within a strengthened local health care system will likely result in more sustainable outcomes from the short-term medical mission (Suchdev et al., 2007) and build trust in the community (Hawkins, 2013).

Service of Community Health Care Needs. One of the underlying ethical rules of modern medicine is, "First, do no harm" (Bishop & Litch, 2000; Slimbach, 2000). Members of a medical mission team must understand the local health needs of the communities they will be serving if they are to faithfully comply with this ethical principle. During the planning phase for a short-term mission trip, team leaders should work with their local partner to identify the health needs to be met during the mission and how best to meet those needs (Caldron, Impens, Pavlova, & Groot, 2015; DeCamp, 2011; Melby et al., 2016). Team members should become familiar with local health needs, the local culture, and the strengths and limitations of the local health care system prior to traveling (Martiniuk et al., 2012; Montgomery, 2007), and the team composition should include the medical expertise needed to properly address the local needs (Martiniuk et al., 2012). For short-term medical mission teams, "Service involves providing a combination of public health interventions and sustainable clinical care that address the community's priorities" (Suchdev et al., 2007, p. 319).

Evaluation. A common thread across the literature is the call for evaluation, or assessment, of the efforts of medical mission teams (Bajkiewicz, 2009; Caldron et al., 2015; DeCamp, 2011; Maki et al., 2008; Melby et al., 2016; Suchdev et al., 2007). Evaluation of team performance and accomplishments should be focused on the outcomes of the medical mission and whether or not the guiding mission statement was accomplished and the goals achieved (DeCamp, 2011). Representatives from the local partner organization and/or the community should be included in the evaluation process to ensure that health outcomes include factors such as "change in disease occurrence or improved access to consistent medical services" (Melby et al., 2016, p. 4). A robust approach to evaluation consistently followed by medical mission teams will reduce the concern raised in the literature about the lack of visibility into community and individual health benefits that result from the service of short-term medical mission teams.

The After Action Review is an approach that is commonly used in industry and by the U.S. military to evaluate the work of project teams or military actions. The After Action Review is a relatively straightforward technique that focuses on the following three questions: 1) What went well?, 2) What did not go well?, and 3) What could be done better or differently next time? Members of the medical mission team and representatives from the local community and/or partner organization should participate in the After Action Review. The atmosphere and facilitation of the After Action Review should encourage an open and honest dialogue, active participation on the part of all those involved, and sharing both experiences and learning from the conduct of the mission. The World Health Organization has developed guides and toolkits to assist teams in conducting After Action Reviews for public health events (WHO, 2020).

As is true for much of the short-term medical mission activity discussed in the literature, both of the organizations represented in this community engagement profile will benefit from adopting a more comprehensive approach to evaluation, such as the After Action Review process.

OUTCOMES

Typically, the outcomes of short-term medical

missions are described in one of two ways. The first way uses process indicators to discuss quantitative measures, such as the number of patients seen, the number of successful surgeries, or the amount of prescriptions dispensed. The second way focuses on health outcomes to discuss more qualitative measures, such as changes in disease occurrence over time or improved access to consistent medical care (Melby et al., 2016). For purposes of this community engagement profile, we currently have process indicators to report. As noted in the literature, there is a lack of reporting on health outcomes by short-term medical mission teams. A focus on health outcomes is an area for improvement in the process followed for short-term medical missions conducted under the auspices of both CHHF and CDL.

Poor health care is a major problem facing Honduras (Thorpe, 2019). This is especially true for those living in rural areas and for those living in poverty, whether in rural areas or in one of the cities. The primary benefit brought to Honduran communities through the medical mission teams hosted by CHHF and CDL is that residents of those communities receive medical, dental, and ophthalmic care, and prescription medications that they otherwise would not receive.

Carolina Honduras Health Foundation

CHHF has been serving the residents living in the Department of Colon in northern Honduras since 1997. The foundation currently operates three clinics to provide medical, dental, and other services to many villages and thousands of Hondurans every year. There are 18 to 19 medical mission teams scheduled every year to work out of the clinics operated by Carolina Honduras Health Foundation.

In 2019, medical teams served 10,374 patients and filled more than 35,600 prescriptions. In addition, teams provided dental care to 198 patients and vision care to 435 patients. More than 168 patients received a medical referral to a specialist. This referral program provides continuity of care and is one of the most important aspects of the medical mission program of CHHF. Referrals are made for both short-term needs, such as for surgery, and for longer-term conditions, such as sickle cell anemia.

Foundation Casa de Luz

Hosting short-term mission teams, including medical mission teams, compliments and supports the primary ministry of Casa de Luz, which is to provide quality childcare and academic enrichment to at-risk children. Typically, CDL hosts one or two medical mission teams in a year.

CDL did not host any medical mission teams in 2019 due to a variety of issues. In 2018, CDL hosted one medical brigade for a two-day mission trip. One day was spent in clinics in Zambrano and one day in Tegucigalpa. The mission team served 111 children and 67 mothers, for a total of 178 patients served.

REFLECTIVE CRITIQUE

The public health system in Honduras has an extremely limited capacity. In many rural areas, there are no clinics, there are no hospitals, and there are no doctors. Therefore, regular periodic visits to Honduras by short-term medical mission teams are a critical component of the health care system, especially in rural areas. The restrictions put in place by the government to control the spread of the COVID-19 virus has further limited the availability of health care options by eliminating visits from short-term medical mission teams. Community engagement through medical missions is essential for the ongoing health and well-being of residents in rural communities and for the poor living in the cities. Sadly, there are precious few health care options open to a large segment of the Honduran population other than short-term medical mission teams.

This community engagement portfolio is built on a foundation consisting of two major components. First, we presented the approaches to short-term medical missions followed by two different non-governmental organizations serving communities in different geographic locations. CHHF and CDL have very different organizational missions and serve the populations living in different settings. Yet both serve communities with very limited resources and few options for health care beyond that provided by these NGOs. Second, we explored the literature covering short-term medical missions. The process followed to construct this community engagement portfolio on the foundation of the approaches taken by CHHF and CDL and the review of the literature produced several important findings and recommendations.

Human Dignity

The literature raises concerns about medical

mission teams that do more harm than good to the local community (Melby et al., 2016), including medical mission team members delivering medical care and medications they are not qualified to deliver (Bishop & Litch, 2000; Roberts, 2006), medical missions that operate as "vacations with a purpose" (Slimbach, 2000, p. 4) rather than having a primary focus of delivering appropriate and professional medical care (Roberts, 2006; Slimbach, 2000), or medical mission trips that are a form of "surgical tourism" (Martiniuk et al., 2012), or "medical tourism –exotic travel to a developing region with a brief opportunity to practice medicine on local residents" (Bishop & Litch, 2000, p. 1017). These approaches profiled and discussed in the literature take on an aura of "'medical voluntourism', which may exacerbate economic and power differentials between provider and host communities" (Melby et al., 2016, p. 3). These concerns and descriptions do not conjure up images associated with respecting human dignity. Yet, "Retaining human dignity should be a driving motivation for improving long-term health and well-being" (Paltzer, 2019, p. 31).

In contrast to many of the approaches discussed in the literature, the approaches followed by both CHHF and CDL to plan and conduct medical missions are built upon a foundation of respect for human dignity, and both incorporate many of the positive recommendations made in the literature.

Personnel from Clínica Carolina work with people from the local communities, teaching and training them to advance their standards of health care, which gives local communities a voice in their health care. CHHF operates three physical clinics to serve the residents of communities and villages spread across the Department of Colon. The move to open multiple clinics was taken to provide health care where none was previously available and to minimize the distance that Hondurans have to travel to receive medical care. Medical mission teams serving under the auspices of Clínica Carolina work out of the physical clinics but also travel to remote villages and set up mobile clinics in churches and schools in order to serve those who would not be able to travel to a permanent clinic facility. These steps "recognize and affirm human dignity" (Wydick, 2019, p. 94).

Honoring human dignity is at the very heart of the appointment-based system used by the Casa de Luz medical brigade ministry. Patient family groups are able to schedule appointments ahead of time and visit the clinic site at their scheduled appointment time rather than standing in long lines for hours in the hot tropical sun with the hope of seeing a medical specialist before the clinic closes for the day. Grace is extended to patients who miss their scheduled appointment time, giving them other opportunities to see medical personnel. Appointment-based scheduling gives tangible evidence to patients that Casa de Luz honors their dignity as human beings created in the image of God. Appointment-based scheduling is a powerful way to "recognize and affirm human dignity" (Wydick, 2019, p. 94).

Collaborative Partnership

A collaborative partnership is at the heart of the approaches taken by both Clínica Carolina and Casa de Luz, both of which are non-governmental organizations that serve Honduran communities. Both have a well-established presence in the communities. CHHF opened its first permanent clinic facility in 1997 and subsequently opened two more physical sites to serve the people living in the Department of Colon. CHHF has a collaborative partnership with the local government clinic, conferring with and assisting the government clinic whenever possible. At least twice a year, CHHF donates medications to the government clinic. CDL began serving children living in an inner-city neighborhood in Tegucigalpa in 2005 and opened a second ministry campus in Zambrano in 2010. Both CHHF and CDL work with medical teams consisting of both Honduran medical personnel and medical mission teams visiting from the United States to provide medical care to the populations they serve, and both have existing mutually beneficial relationships with local governmental entities.

Service of Community Health Care Needs

Both Clínica Carolina and Casa de Luz are absolutely committed to serving the long-term health care needs of the communities in which they operate. The mission of Carolina Honduras Health Foundation is to establish and maintain centers for providing medical, dental, and ophthalmic health care services in the Department of Colon, Honduras. Through these centers, the CHHF Community Development Coordinator works with community leaders in local villages to develop and promote programs designed to improve overall

community health and to respond to the needs as seen by the locals.

CHHF works with a group of community leaders who meet monthly with the Community Development Coordinator. They decide the topics for education classes, and in the past have chosen such classes as control of diabetes, birthing, and breast-feeding. One aspect of the CHHF medical program is to track chronic health conditions and ensure patients have required medications. In addition, CHHF has a medical referral program in which patients who need specialized medical care are referred to Honduran doctors and clinics. These patients are assisted with obtaining medical appointments, learning how to advocate for themselves, finding transportation, and obtaining required medications. The Community Development Coordinator also monitors medical referral patients' health situations in order to ensure that the patient understands and follows medical advice.

Providing medical care is a key support ministry for Casa de Luz. As such, the health and wellness of the Casa de Luz children and families is so important that the organization partners with Honduran and North American dentists, dental hygienists, orthodontists, optometrists, doctors, and nurses to bring high quality care to the impoverished Honduran communities served by CDL. The partnership with these professionals improves the quality of life for hundreds of children, teens, and adults participating in CDL programs

TRAINING YOUNG LEADERS AT THE LEADERSHIP CENTER

Hidden behind the scenes in this community engagement portfolio is The Leadership Center, which does not directly host medical mission teams, yet there is active engagement in medical missions by graduates and students of The Leadership Center as many serve as translators when medical mission teams visit Honduras.

Figure 13. Inspirational sign on the main walkway of The Leadership Center

Service and community engagement are at the very heart of the women's leadership development program at The Leadership Center in Honduras. The lead author is an instructor in this program, and one of the co-authors is a graduate of The Leadership Center. Many students and graduates serve as translators when medical mission teams visit Honduras. This community engagement portfolio seeks to honor those students and graduates of The Leadership Center as well as the personnel and volunteers that serve with CHHF and CDL, the other two non-governmental organizations that are profiled in this community engagement portfolio.

Applying the Lessons from the Community Engagement Portfolio

All of the co-authors and our organizations have learned from the process of preparing this community engagement portfolio. The lead author will apply the lessons learned through this writing project in the classroom at The Leadership Center when working with students, many of whom will participate in medical mission teams as translators. The co-author who volunteers with medical mission teams as a translator will apply these lessons as she works with medical mission teams in the future. And the co-authors from CHHF and CDL will apply these lessons when they are able to once again host medical mission teams to serve the residents in the communities they serve.

May our Awesome God extend His grace and mercy in the country of Honduras and in the United States, which is the home country for most of the medical mission teams that travel to Honduras. At the time of writing this community engagement portfolio, no medical mission teams could travel to Honduras due to the health crisis and restrictions brought on by the COVID-19 pandemic. As a result, many people in Honduras face this health crisis without available medical care or medications, yet it is in such a crisis that medical care is most needed. May God work everything together, in the United States and in Honduras, so that medical mission teams can once again bring much needed medical care and medications to the people of Honduras.

Soli Deo Gloria!

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